FAMILY VIOLENCE DEATH REVIEW COMMITTEE

Family Violence Death Review Committee submission on the Green Paper for Vulnerable Children

1. Introduction

1.1 Background

The Family Violence Death Review Committee (FVDRC) is a statutory committee of the Health Quality & Safety Commission mandated to (1) review and report to the HQSC on family violence deaths, with a view to reducing their number, and to continuous quality improvement through the promotion of on-going quality assurance programmes, and (2) develop strategic plans and methodologies that are designed to reduce family violence morbidity and mortality.

FVDRC members are drawn from a wide range of sectors – primarily justice, health, academic research, and family violence service NGOs – and all share an expertise in family violence. This submission is based on the collective personal views and professional experience of FVDRC's members.

1.2 Focus of FVDRC

Due to FVDRC's focus, which is set by its Terms of Reference, the Committee is most interested in children that are affected by family violence.

1.3 Family violence deaths: child abuse and intimate partner violence

In the period 2002-2008, 186 family violence deaths were identified by the FVDRC. Of these, 100 were intimate partner violence, 49 victims were children and 37 were another family member of the suspected perpetrator.[1] Indications are that these deaths represent a tiny fraction of the occurrence of incidents of family abuse and neglect in New Zealand over this period of time.

The 100 intimate partner violence deaths in New Zealand between 2002 and 2008 were overwhelmingly committed by males against their female partners and, sometimes, males against their former partner's perceived new male partner. From 2002-2008, there were 85 male perpetrators, 8 female perpetrators, and 9 perpetrators working in combination against one victim. There were 76 female victims and 24 male victims, the majority of whom were killed by male perpetrators (75 female and 13 male).

With respect to child family violence deaths, 35 of the perpetrators of child homicide were male, while 23 were female. Some of the child deaths were in the context of intimate

[1] Family Violence Death Review Committee. 2011. *Second Report: October 2009 to November 2011*. *Inaugural Report to the Health Quality & Safety Commissio*n. Wellington: Family Violence Death Review Committee. P 10.

partner violence.[2] Martin and Pritchard[3] found that children in their first year of life were most likely to be killed by a natural parent, with mothers frequently suspected of killing a baby in the first four months of life and fathers frequently suspected of killing an older baby in the 1-12 month age group. Fathers and stepfathers were more often the perpetrator as the child grew older.

Overall, the findings on child victim family violence deaths from 2002-2008 suggest the first year of life is the highest risk period for child death,[4] followed by one year up to five years. More than three quarters of the child victims in the period studied had died within their first five years of life. The majority of children died from injuries inflicted through assault. Associated factors included drug and alcohol use by the suspected perpetrators, physical punishment of the child, and an extreme response to intimate partner separation.

Dr Kelly (an inaugural member of FVDRC) has also commented that:[5]

> Most serious abuse and neglect occurs in children under [the age of] 3. Recognising it requires skill and vigilance, depending as it does on the interpretation of patterns of growth, physical injury and infant and child behaviour. It cannot depend on verbal or written statements, as the victims are too young to interview, and those responsible for the neglect or abuse are highly unlikely to volunteer the truth.

He goes on to note that:

> The long-term consequences in this age-group are particularly severe. Abusive head injury is not rare, the mortality and morbidity is high, and the numbers diagnosed are almost certainly only the tip of an iceberg. Even apart from direct physical injury, the emotional environment in the early years is crucial to the development of stable and secure children and adults. Much adolescent and adult failure and criminality can be traced back to infant and childhood experience.

The reason for including data on intimate partner violence in these submissions is that intimate partner abuse and child abuse are not always distinct phenomenon. There is evidence of a co-occurance between intimate partner violence and child physical abuse. In 30-66 percent[6] of cases, the same perpetrator is abusing both the mother[7] and any children.

Research also suggests there is little difference between the impact on children of witnessing intimate partner violence and experiencing actual abuse.[8] Furthermore, we know that children frequently do witness intimate partner violence when it occurs. For example, Martin and Pritchard's research *Learning from Tragedy: Homicide within Families*

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[2] Martin J, Pritchard R. April 2010. *Learning from Tragedy: Homicide within Families in New Zealand 2002-2006*. Wellington: Ministry of Social Development. P 36.

[3] Ibid. P 49.

[4] This is also highlighted in Duncanson M, Smith D, and Davies E. 2009. *Death and serious injury from assault of children aged under 5 years in Aotearoa New Zealand: a review of international literature and recent findings.* Wellington: Office of the Children's Commissioner.

[5] Kelly P. 2008. 'The Role of Health Services in Child Protection'. Emailed to the Childabuse@paediatricsmail.org.nz 31/12/2008 4:39 p.m. P 2-6.

[6] Hester M, Pearson C, Harwin N. 2000; new ed. 2007. *Making and Impact: children and domestic violence: A reader.* London: Jessica Kingsley; Edleson JL. 1999. The overlap between child maltreatment and woman battering. *Violence against Women*, 5(2), pp. 134 to 154; Humphreys C, Thiara R. 2002. *Routes to Safety: Protection issues facing abused women and children and the role of outreach service*s. Bristol: Women's Aid Federation of England; Radford L, Hester M. 2007. *Mothering through domestic violence*. London: Jessica Kingsley Publishers.

[7] Gendered terminology is used in the submission to reflect the dominant patterns of intimate partner violence, namely that women are the primary victims and men the primary perpetrators of IPV. This is not to deny minority patterns of same sex violence and women perpetrating violence against men.

[8] Kitzmann K, Gaylord N, Holt A, Kenny E. 2003. Child witnesses to domestic violence: a meta-analytic review. *Journal of Consulting Clinical Psychology* vol.71, pp.339-352. This meta-analysis evaluated the psychosocial outcomes of children living with domestic violence and showed significantly poorer outcomes for children witnessing domestic violence on 21 developmental and behavioural dimensions than for those living without violence. The outcomes for children witnessing domestic violence, however, were found to be similar to those where children were also directly physically abused.

in New Zealand 2002-2006 [9] states that children were present at the homicide location in one-third of intimate partner violence homicide events. Similarly, the report *Findings from the Multi-agency Domestic Violence Murder Reviews in London*[10] states that 30 percent of children are actually witnessing the murder. In these situations, as well as witnessing an extremely traumatic event, children lose both of their parents, one to homicide and one to prison.

In fact, abusers may deliberately use violence against one family member to affect another, which is referred to as the 'double level of intentionality'[11], and might include hitting or threatening a partner in front of their children or hitting or threatening a child in front of their parent. Violence during pregnancy may be an instance of double intentionality but also starkly illustrates the blurred distinction between intimate partner violence and child abuse.

Furthermore, the parenting of a female victim of intimate partner violence will be affected by the abuse that she experiences, which will have serious long-term repercussions for children in her primary care. Undermining the health and wellbeing of the child's primary carer will have a significant and detrimental impact on her children.[12]

1.4 Key themes in this submission

The FVDRC would like to highlight a number of key themes that are present throughout this submission to the Green Paper on Vulnerable Children:

- Children's emotional wellbeing and physical safety needs to be the paramount concern in all governmental and non-governmental agency decisions, both those decisions that directly affect children and those which are ostensibly about the adults who care for the children.
- A whole-of-family approach needs to be taken to family violence. For example, if the child has a protective parent or has a primary carer who is experiencing intimate partner violence, the child's emotional and physical well-being should not be treated as separate from the safety and wellbeing of that parent. Similarly, stopping violence programmes should not be run without an integrated support system that addresses the safety of the victims involved.
- Children's needs are best met through a whole-of-government approach, underpinned by legislation, and supported by a cross-party agreement for action on vulnerable children.
- Workforce development is a priority. There is a pressing need for comprehensive training (covering child development and attachment, recognition and management of child abuse and neglect, and the dynamics of family violence) for all professionals working with vulnerable children, their families and their whānau.

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[9] Martin J, Pritchard R. April 2010. *Learning from Tragedy: Homicide within Families in New Zealand 2002-2006*. Wellington: Ministry of Social Development. P 35.

[10] Richards L. 2003. *Findings from the Multi-agency Domestic Violence Murder Reviews in London. London Metropolitan Police*. Available at: *http://www.ndvf.org.uk/files/document/914/original.pdf*

[11] Children and Domestic Violence: Its Impacts and Links with Woman Abuse. Presented by Linda Regan at the Impact of Domestic Violence on Children Conference, London, October 2001 available at: http://www.cwasu.org/publication_display.asp?type=7&pageid=PAPERS&pagekey=50

[12] Experiencing intimate partner violence can affect parenting in multiple ways, including:

- feeling emotionally and physically drained, with little to give the children
- inability to support the children, inability to deal with children's behaviour
- lack of financial support / poverty
- harsh and inconsistent parenting, potential to take out frustrations on the children
- inability to provide appropriate boundaries, structure and security for the children -with some children taking on 'parenting' or 'carer' roles
- home environment not conductive to supporting educational needs.

- Universal services, including health and education, need to have a minimum training and understanding around care and protection issues and take responsibility for early detection and intervention of child abuse and neglect. These issues cannot solely be the responsibility of Child Youth and Family (CYF) and the Police.
- Decisions about the risks posed to vulnerable children are best made through robust multi-agency working and decision making processes.
- Information sharing is one of the critical components of multi-agency working. Provisions to support information sharing between government agencies and non-governmental organisations (NGOs) need to be a priority.
- When working with vulnerable children and their whānau from Māori, Pacific Island, Asian and other ethnic groups, it is important that processes and practices are culturally appropriate throughout the system at all levels. All policy and programmes must be consistent with the principles of the Treaty of Waitangi and responsive to Māori.
- Creating an effective system to address the needs of vulnerable children will require a significant level of both financial and human capital investment over the medium to long term. Public spending needs to prioritise preventative and proactive responses, which focus on ensuring that all New Zealand children are given the best start in life, and early recognition and intervention in respect of those children who are particularly at risk. The long term gains from such spending are anticipated to outweigh the initial costs.

2. Sharing responsibility with parents and caregivers

2.1 Children's needs must be the paramount concern

Children's emotional wellbeing and physical safety needs to be the paramount concern in all professional and agency interventions – including those that directly affect the child and those ostensibly about the adults who care for children.

In the *Report to Hon Paula Bennett, Minister for Social Development and Employment: Following An Inquiry Into the Serious Abuse of a Nine Year Old Girl and Other Matters Relating to the Welfare, Safety and Protection of Children in New Zealand* (2011), Mel Smith stated that, when considering the principles of the Child, Young Persons, and Their Families Act (CYPF) 1989, all too often it appeared that the wishes of the parent or parents, and/or family or whānau prevailed over the immediate and long term interests of the child. The FVDRC supports Smith's recommendation that there is an 'incontrovertible need for all those involved in child safety, welfare and protection, to ensure a child centred perspective that focusses on the child, and that all other considerations be subordinated to the principle in section 6 of the Child, Young Persons, and Their Families Act 1989.'[13] The FVDRC recommends that the Government monitors how these principles are being understood and applied in practice.

Within adult focused services, such as Adult Mental Health and Drug and Alcohol services, it is important that the professional relationship is not misunderstood as being a relationship solely for the benefit of the adult. Rather it needs to be viewed as also an opportunity to promote the welfare of any child in the care of that parent and to intervene to protect the child if required.

[13] Smith M. 2011. *Report to Hon Paula Bennett, Minister for Social Development and Employment: Following An Inquiry Into the Serious Abuse of a Nine Year Old Girl and Other Matters Relating to the Welfare, Safety and Protection of Children in New Zealand*. P 93.

2.2 Resourcing parents and caregivers to address intimate partner violence

It is essential to provide effective services and programmes for parents and caregivers who are targeted by, or perpetrating, intimate partner violence. There is a need for:

- longer term recovery services for parents experiencing intimate partner violence
- recovery services for the relationship between a protective parent and their children
- stopping violence programmes for parents who abuse their partners and children that align with international best practise.

(a) Longer term recovery services for parents experiencing intimate partner violence

If a child who is exposed to family violence has a "protective parent"[14] or a primary caregiver who is being abused, then supporting that parent is likely to be the most effective way of promoting and protecting the child's welfare.

While crisis intervention initiatives[15] are effective in reducing risks in the short term[16], sustaining safety and re-building lives requires on-going longer term support, which is often not funded or available locally. It should not be assumed, for example, that the removal of the abusive parent will remedy the problems experienced as a result of the trauma of surviving abuse. The withdrawal of professionals because it is assumed that the child is safe at this point sets the protective parent up to fail just at the time when they may be in position to more easily obtain appropriate help for themselves and their children.

The NGO family violence sector requires sufficient flexible funding to enable them to focus on providing a quality service, rather than simply attempting to provide an adequate crisis response to the quantity of cases they are required to deal with. The FVDRC would like to see NGOs have the opportunity to provide effective longer-term services to victims and their whānau, rather than acting as a revolving door for the same families.

(b) Recovery services for the relationship between the abused parent and their children

Recovery processes require assistance not just for individual parents or children, but also for the relationship between them, including the parenting capacity of the adult carer.[17]

Research demonstrates that parenting can improve significantly in the first six months following separation if the abuser's violence is curtailed. Many children will recover their competence and behavioural functioning once they are in a safer, more secure environment. In particular, children who are not continually subjected to post-separation violence and protracted court cases over child contact show stronger patterns of recovery.[18] Children who experience high levels of extended family and community support also show the positive impact of this support, a factor particularly, though not exclusively, evident for indigenous children and minority ethnic children.[19]

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[14] It is important to note that not every abused parent is necessarily a protective parent.

[15] Such as advocacy support programmes offering services such as advice, counselling, safety planning and referral to other agencies.

[16] This is because intimate partner violence is not only an attack on the adult victim (usually the mother) but also an assault on their relationship with their children. World Health Organisation. 2009. *Violence prevention: the evidence: overview*. Malta: World Health Organization. P 2.

[17] Humphreys C. 2006. Relevant Evidence for Practice. In: C Humphreys, N Stanley (eds).2006. *Domestic Violence and Child Protection: Directions for Good Practice*. London: Jessica Kingsley.

[18] Humphreys C, Houghton C, Ellis, J. 2008. *Literature Review: Better Outcomes for Children and Young People Experiencing Domestic Abuse, Scottish Executive Domestic Abuse Delivery Group*. Edinburgh: Scottish Government. Available at http://www.scotland.gov.uk/Publications/2008/08/04112614/0

[19] Humphreys C. 2007. *Domestic violence and child protection: Challenging directions for practice Issue Paper 13.* Australian Domestic and Family Violence Clearinghouse. Available at www.austdvclearinghouse.unsw.edu.au pp 1-24. Humphreys notes that undermining the relationships the child has with their mother and or extended family is a common tactic of abuse (Zannettino 2006; Irwin *et al.* 2002; Radford and Hester 2006; Mullender *et al.* 2002) and one that workers will need to address (Humphreys *et al.* 2006).

It is essential that there are family violence programmes for parents to attend to support them, their understanding of the impact of family violence on their children and to heal the relationship and communication with their children. An example of such a programme is Kidshine,[20] which aims to help the primary caregiver or non-offending parent understand how the violence is impacting on their children, and to teach them parenting strategies to help their children cope.

(c) Stopping violence programmes for parents who abuse their partners and children

It is essential that parents who abuse their partners and their children first attend stopping violence programmes, *not* parenting programmes. The provision of culturally specific stopping violence programmes and kaupapa Māori approaches is vital. An example of such a programme is Tü Tika o Aro Tika designed by Tü Tama Wahine o Taranaki to provide a service for Māori men.[21]

FVDRC considers it imperative that stopping violence programmes are brought into line with international best practise. For example, it is of concern that such programmes in New Zealand may potentially only work with the perpetrator – relying essentially on perpetrator self-reporting as a measure of the success of the programme. By way of contrast, in the UK stopping violence programmes cannot be accredited by Respect[22] unless there is an Integrated Support Service (ISS) that makes proactive contact with their current, former and new partners and carries out risk assessment and case management to protect partners and children. Organisations running stopping violence programmes without an ISS cannot be considered for accreditation as they are unsafe. To be accredited, such programmes must also be situated within a "coordinated community response to domestic violence" and provide interagency working.

3. Show leadership: vulnerable children's action plan

3.1 Supporting all children to have the best start

It is important to adopt an approach that focusses on supporting the best start for all New Zealand children because it is impossible to accurately identify all of the children who are vulnerable for the purposes of targeting resources at those children. Caution should be taken when focusing on approximately 15 percent of our children, as it can lead to a false sense of security that it is only these children who are at risk of abuse and neglect, and this is not necessarily so. Vulnerability changes over time, particularly when children's developmental needs change.

UNICEF[23] has noted that children who fall behind begin to do so in the very earliest stages of their lives. It is of concern to FVDRC that New Zealand's investment in the early years of children's lives compares unfavourably with most developed countries.[24]

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[20] For further information please see http://www.2shine.org.nz/kidshine

[21] After working with women and children affected by domestic violence for more than ten years, Tü Tama Wahine o Taranaki came to the realisation that healing for the entire whänau could not be effected until men took responsibility for their behaviour and embarked on a healing journey as well. This resulted in the development of Tü Tika o Aro Tika. Te Puni Kōkiri. 2010. Rangahau Tükino Whänau *Mäori Research Agenda on Family Violence.* Te Puni Kōkiri

[22] Respect is the UK membership association for domestic violence perpetrator programmes and associated support services. Their vision is to end violence and abuse in intimate partner and close family relationships. Their key focus is on increasing the safety and well-being of victims by promoting, supporting, delivering and developing effective interventions with perpetrators. http://www.respect.uk.net/

[23] UNICEF. 2010. *The Children Left Behind: A league table of inequality in child well-being in the world's rich countries.* Innocenti Report Card 9. UNICEF.

[24] OECD. 2009. *Doing Better for Children.*

3.2 Addressing poverty

> In hard times, the poorest children should be the first to be protected, not the last to be considered. A child only has one chance to develop normally in mind and in body. And it is the primary responsibility of government to protect that chance – in good times and in bad.[25]

Low socioeconomic status (typically defined as family income below the poverty line, under-employment, and low education) is one of the major environmental conditions associated with child maltreatment. However, while the research shows an association between physical abuse, neglect and poverty, it is not a causal pathway. The majority of families living in poverty raise their children well.

Nevertheless, living in poverty often means that families and whānau are experiencing problems with overcrowding and poor quality housing, limited access to health care and childcare opportunities, and are frequently exposed to acute and chronic stressors. Poverty and deprivation thus contributes to the vulnerability of children and is associated with poor child health and social outcomes.[26] The effects of a disadvantaged environment can create ripples of disadvantage throughout a child's life.

3.3 Prevention and early intervention

Identifying problems early and intervening effectively is clearly preferable to responding only when the situation has become acute. The FVDRC notes that many children who are exposed to family violence and other harmful behaviour at a young age incur great costs to society later in their lives because they are more likely to cultivate at risk behaviour that leads to serious injury or death, develop criminal records, or become perpetrators of family violence themselves:

> Early interventions targeted toward disadvantaged children have much higher returns than later interventions such as reduced pupil teacher ratios, public job training, convict rehabilitation programs, tuition subsidies, or expenditure on police.[27]

An illustration of this point is provided in the World Health Organization's *Preventing violence* report.[28] The Prenatal/Early Infancy Project (PEIP) – a home visitation programme for high-risk families in Elmira, New York – was found to have produced overall public sector savings of US$27,854 per child through reduced health and social service use, and savings in the criminal justice and tax systems. A separate evaluation estimated that the PEIP cost the public sector US$6,550 per participant, while public sector savings were calculated at US$26,200, which was a net saving of US$19,650 per participant.

The FVDRC recommends that any action plan developed to help improve outcomes for vulnerable children have a strong focus on prevention and early intervention.

3.4 A co-ordinated "whole-of-government" and long term strategy

Many children at risk of abuse and/or neglect live in families and whānau facing a multitude of problems. In-order to effectively address the complexity of their lives any long term strategy must be equally multi-faceted.[29]

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[25] Unicef.2010.*The children left behind: A league table of inequality in child well-being in the world's richest countries*. P 21.
[26] Children's Social Health Monitor: 2011 update. Available at: http://www.nzchildren.co.nz/userfiles/Childrens%20Social%20Health%20Monitor%202011%20Update%20Master%20Word%20Document.pdf
[27] James Heckman quoted in Ibid, P 27.
[28] World Health Organization. 2004. *Preventing violence: A guide to implementing the recommendations of the World report on violence and health*. Geneva: World Health Organization. P 40.
[29] Independent Experts' Forum on Child Abuse November 9-10, 2009. Pg 1.

As noted by Ruth Herbert:

> Family violence encompasses a wide continuum of issues and a large number and diverse range of organisations/agencies, from both government and non-government sectors. The patchwork quilt of agencies opens possibilities for unnecessary overlaps, inconsistencies, gaps and misunderstandings between agencies and makes multi-agency collaboration at all stages of the Managing for Outcomes cycle both challenging and vitally important… The big, complex social problems that governments want to address… [including family violence] run across traditional departmental boundaries and involve crown entities, and non-government organisations.[30]

Accordingly, the FVDRC supports the development of inter-sectorial collaboration between ministries such as Health, Justice, Education and Social Development, an integrated service response and the implementation of long term action plans to address children's health and well-being and, in particular, the needs of children who are affected by family violence.[31] To this end, the FVDRC supports the recommendations made in *The Best Start in Life: Achieving effective action on child health and wellbeing* report to the Minister of Health by the Public Health Advisory Committee (PHAC).[32] The key points from the PHAC report have been reproduced below:

A) Strengthen leadership to champion child health and wellbeing

There needs to be a legislative framework with statutory responsibilities to ensure policies for children are sustainable across time and changes in government. This needs to be supported by a cross-party agreement for children that provides strategic direction and sustained investment in the early years.

B) Develop an effective whole-of-government approach for children

Policies should be developed around agreed whole-of-government child development outcomes rather than agency mandates so that we have a coordinated approach to addressing children's complex needs.

C) Establish an integrated approach to service delivery for children

Integrated services are required so that the 'whole child' is treated in the context of their wider family and whānau, rather than multiple services focusing on separate problems in silos. An integrated approach to service delivery requires a shift away from delivery by separate providers towards processes that support integrated delivery.

Integrated delivery is particularly important for the transition between maternity and child health services. Initial pilot reviews to develop the FVDRC's mortality review process suggested that infants and children can be particularly vulnerable and become lost to the system when they are transferring between care providers. In its Second Report (2011), the FVDRC wrote: "It is important that information about infant and child risk is shared between service providers and agencies, particularly when infants and children are transitioning between care providers. The transition from maternity care to the Well Child provider is an essential one." The Child and Youth Mortality Review Committee made similar recommendations in its *Fourth Report to the Minister of Health* (2008) and *Fifth*

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[30] Ruth Herbert, *Learning our way forward: Implementation of New Zealand's family violence strategies*, March 2008, dissertation for Master of Public Policy, P 58.

[31] For a copy of FVDRC's submission to the Family Court Review please email the FVDRC Secretariat at fvdrcenquiries@hqsc.govt.nz or go to the FVDRC website at http://www.hqsc.govt.nz/section/15290/mortality-review-committees/. Many of the FVDRC recommendations address inter-sectorial care and protection, and child-centred policy and practice issues.

[32] Public Health Advisory Committee. May 2010.*The Best Start in Life: Achieving effective action on child health and wellbeing*. Wellington: Ministry of Health.

Report to the Minister of Health (2009) on the need for a holistic approach to the continuity of care for children and young people transitioning between services. The FVDRC supports these recommendations.[33]

In the development of any initiative that affects front line practice, those working on the frontline should be part of the development process. Implementation plans should use a systems approach that includes (but is not limited to) practical guidelines and interagency workforce development to ensure all providers are competent for their scope of practice. Interagency training can lead to strengthened relationships, as trust can be enhanced through each agency knowing the level of training received and they understand each agency's role.

D) Monitor child health and wellbeing using an agreed set of indicators

A national set of indicators should be developed across government for children from birth to six years which can highlight trends and emerging issues, inform policy and facilitate international comparisons. National monitoring of child health and wellbeing should inform whole-of-government plans and policies.

In the absence of an agreed definition of 'neglect' and 'vulnerability' it can be difficult to achieve a shared understanding and develop an agreed set of indicators. (The same definitional issues occur within the family violence sector.) Firstly, shared definitions need to be developed, so that children who are being neglected and/or are vulnerable can be identified. A shared understanding can lead to the development of an agreed interagency response. In the absence of this shared understanding of what constitutes neglect, there is a risk that children may not be provided with the services they need based on the agency's consideration of neglect.

3.5 Monitoring, evaluation and evidence-based programmes

The New Zealand Independent Experts' Forum on Child Abuse[34] recommends that all programmes and policies to address at risk children must be based on evidence of what works and that all major policies must be subject to evaluation using rigorous scientific methods. The FVDRC support sthe forum's recommendations and further recommends that the implementation of overseas based progammes should be in the context of re-evaluation of their effectiveness in the New Zealand (and especially the Māori and Pacific) context.

Furthermore, any funded programmes must have a clear quality framework and quality measures. The key performance indicators need to be time-framed, reliable, measurable, and realistic. In addition, where inter-agency collaboration is required, reporting should include how this is being achieved and delivered. An independent body should monitor the quality of services delivered over time.

It is vital that when services are delivered, they are delivered well and consistently, no matter which ethnicity or social demographic is involved.

4. Show leadership: legislation changes

The FVDRC recommends that the Government:

[33] Family Violence Death Review Committee. 2011. *Second Report: October 2009 to November 2011*. *Inaugural Report to the Health Quality & Safety Commissio*n. Wellington: Family Violence Death Review Committee. P 16-17.
[34] Independent Experts' Forum on Child Abuse November 9-10, 2009. P 1.

1. Looks at strengthening health and education statutes, so that health and education professionals have some statutory responsibilities for child protection. Legislation should outline the action that such professionals must take if they are concerned about a child or young person.
2. Amend the Children Young Persons and their Families Act 1989, to require multi-disciplinary decision making in child protection investigations. (It is also imperative that agencies can and do share information and attend the child protection case conferences/family group conferences.)

4.1 Increased responsibilities and training for health professionals

In late 2008, Dr Patrick Kelly noted that he found it surprising that New Zealand had chosen not to enlist professionals other than Child Youth and Family and the Police as the "front-line" in child protection.[35] He noted that 'this is remarkable, given that large publicly-funded professional services, particularly in health and education, are already functioning in the zone that lies between the extended family (the true home of child protection) and the "statutory authorities."'[36] In his paper, *The Role of Health Services in Child Protection,* he points out that:

- Most infants and children diagnosed with serious abuse are not known to Child Youth and Family at the time their abuse is first recognised (although their extended families may well be).
- In contrast, all children born in New Zealand are known to a health practitioner – if one includes lead maternity carers and all primary healthcare providers. If there is any possibility for early intervention, health practitioners are a key to it.
- There are many more health professionals in New Zealand with expertise in the care of children and young people, than there are Child Youth and Family social workers. A conservative estimate suggests that there are at least 11,000 such health providers, in comparison to less than 1,000 statutory social workers.
- The health system will remain engaged with children and families, through one provider or another, long after the statutory authorities have closed the file.
- There is an extremely low rate of notification from many healthcare providers to statutory authorities. Many have limited experience of child protection processes and distrust the statutory authorities. For many healthcare providers, there is no infrastructure of advice and support within the health system to guide them in making decisions about what to do when they suspect abuse and neglect.

Dr Kelly states that, unlike the United Kingdom, there is no legislation in New Zealand (whether health or child protection) requiring health professionals to take some of the responsibility for keeping children safe. He comments that the consequences of the disengagement of the health system from child protection include:

> poor clinical practice and outcomes, failure to learn from those outcomes, inadequate health data, failure to share information between health providers, failure to develop good systems and processes, failure to engage with statutory child protection processes, and failure to research either the problem or the possible solutions.[37]

There is also a need for training so that health providers can recognise and manage child abuse and neglect. Dr Kelly pointed out that many children eventually diagnosed with abusive injuries are found to have been injured before, and have often been seen by health

[35] Kelly P. 2008. 'The Role of Health Services in Child Protection'. Emailed to the Childabuse@paediatricsmail.org.nz 31/12/2008 4:39 p.m. P 2-6.
[36] Kelly P. 2008. 'The Role of Health Services in Child Protection'. Emailed to the Childabuse@paediatricsmail.org.nz 31/12/2008 4:39 p.m. P 2.
[37] Ibid P 2-4.

providers who did not realise the significance of earlier symptoms. This suggests that appropriate health provider training and supervision could have a significant effect in the prevention of serious abuse. In addition, child health professionals have the necessary background to assess and interpret child health and behaviour, but have minimal training and support in the recognition and management of child abuse and neglect. With such training and support, they could become a very competent child protection workforce.

In the last few years, there have been significant improvements within the health sector's response to child abuse and neglect. The intention of the Ministry of Health's Violence Intervention Programme (VIP) is to achieve standardised family violence (child abuse and partner abuse) intervention in health services.[38] The national evaluation assessing hospital responsiveness to family violence suggests that almost all DHBs now have the required systems (management support, policy, resources, training and quality improvement activities) established to enable staff to identify, assess and respond to persons experiencing abuse.[39] The focus in the national VIP is on supporting DHBs so that violence intervention becomes embedded into practice and sustainable; the foundation is there to build on. This model of national programme support with local level implementation is effective[40] and can make a difference to sector responses, that in turn improves services for children and their families.

Further work to support child protection workforce development opportunities in health should be progressed.[41] The changes occurring within the DHBs since the implementation of the VIP programme also need to happen systematically within NGO and primary health care services.

4.2 Education professionals

Since schools come into contact with the majority of children and young people, the FVDRC recommends that all schools should be supported to establish an infrastructure to respond to child protection concerns . This would include having a child protection policy, designated child protection staff and providing child protection training to staff.

In order to progress the establishment of such an infrastructure, the FVDRC supports Mel Smith's recommendation that the Chief Executive of the Ministry of Social Development (MSD) take appropriate action to appoint an experienced social worker to a cluster of primary and secondary schools, as is currently the process for the appointment of experienced social workers to District Health Boards. Smith acknowledges that this may need to be progressive and suggests that MSD initially concentrate on areas with concentrations of low decile schools.

[38] Other projects, such as the Shaken Baby Prevention Project also provide opportunities for early intervention in the health sector. The project initially piloted is now being rolled out nationally. This model of piloting to determine the process for implementation prior to national implementation was also used for the VIP; it provides a process to design and refine the project so that the limited resources are maximised (time and resources are not used to develop the systems in multiple locations). It is recognised that standardisation is useful and this needs to be balanced with having some flexibility to enable programmes and projects to meet the local needs.

[39] Koziol-McLain, J., Gear, C., & Garrett, N. 2011. *Hospital responsiveness to family violence; 84 month follow-up evaluation*. Auckland University of Technology

[40] Many DHBs have established regular multidisciplinary/multi-agency forums for supporting best practice in relation to child protection.

[41] For example, the establishment of a Child Protection Clinical Network would create further opportunities in the future.

4.3 Mandated multi-disciplinary decision-making in child protection investigations

Frequently, recommendations[42] from death reviews concern the need to strengthen multi-agency working. The safest way to make decisions about whether a child or young person is in need of care or protection is to engage in multi-disciplinary decision-making. Often each agency will have a different piece of the jigsaw puzzle but not the complete picture.

However, in order to work together effectively, practitioners need to have an understanding of the similarities and differences between their professional ways of seeing and doing and need to learn about each other's theoretical and cultural frameworks, roles and responsibilities. Hence the challenge of multi-agency working is much wider than the practitioners involved. Leadership and support from senior management is critical for the clarification of roles and responsibilities, securing commitment, engendering trust and mutual respect, and fostering understanding between agencies.[43]

It is also important when working together that professionals go further than simply expressing their agency's understanding of the situation. They need to share the thinking that went into their assessments and communicate the strength of evidence that informs their judgements and decisions. While this may take more time it enables others to constructively challenge both the factual accuracy and interpretation of the situation and to collectively assess the strength of evidence informing any care and protection decision making.

The Paediatric Society, in their submission to the CYPF update team, state that though:

> Care and Protection Resource Panels may sometimes function as a forum for multi-disciplinary review, they do not provide an effective model of multi-disciplinary practise. In this respect, the New Zealand legislation is clearly deficient. Child Youth and Family, in general, operates on a model by which a single professional discipline makes the decision as to whether a child or young person is in need of care or protection.[44]

It would be valuable to provide a legislative mandate and guidance for multi-agency decision making in child care and protection investigations.

5. Show leadership: working with whānau, hapu, iwi and Māori leaders

In order to achieve the objectives of Whānau Ora, it is vital that culturally distinct approaches to violence intervention and prevention are supported and evaluated. Te Puni Kōkiri have undertaken research into Māori-designed, developed and delivered initiatives on family violence in order to document the culturally distinct approaches utilised. This research will contribute to the development of an evidence-based best practice framework to identify what works for Māori in addressing family violence.[45]

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[42]Office of the Commissioner for Children. 2002. *Final report on the investigation into the death of Riri-o-te-Rangi (James) Whakaruru, born 13 June 1994, died 04 April 1999*.Wellington: Ministry of Social Policy. Online at (executive summary only): http://www.occ.org.nz/__data/assets/pdf_file/0012/3306/OCC_James_Whakaruru_Report_Executive_Summary.pdf Office of the Commissioner for Children. 2003. *Report into the investigation into the deaths of Saliel Jalessa Aplin and Olympia Marisa Aplin***.** Wellington: Office of the Commissioner for Children. Online at http://www.occ.org.nz/__data/assets/pdf_file/0013/3307/OCC_Saliel_and_Olympia_Aplin_Invesitgation.pdf

[43]Atkinson M, Jones M, Lamont E. 2007. Multi-agency working and its implications for practice: A review of the literature. CfBT Education Trust

[44] Updating The Children, Young Persons And Their Families Act 1989: A submission to the CYPF Act Update Team Paediatric Society of New Zealand June 1 2007. Available at: http://www.paediatrics.org.nz/index.asp?pageID=2145864761

[45]Te Puni Kōkiri. 2010. *Rangahau Tūkino Whānau: Maori Research Agenda on Family Violence.* Wellington: Te Puni Kōkiri

It is important that policies designed to address family violence, including agency responses and practises, are also culturally appropriate and respond to the needs of Pacific Island, Asian and other ethnic groups.

6. Make Child Centred Policy Change: Review Government spending to get better results for vulnerable children

6.1 Targeted services

The World Health Organization guide to implementing the recommendations of the *World report on violence and health* states that though some *universal* violence prevention interventions may be relatively low-cost, many proven and promising universal prevention strategies require high levels of financial and human resource investments that are recouped only many years later, along with the additional monies that effective prevention saves to society.

Where it is economically not possible to implement universal violence prevention programmes, *selective* interventions among the population subgroups at the very highest risk of interpersonal violence are strongly encouraged. If properly designed, implemented and evaluated, these selective interventions will be affordable and capable of producing evidence of impact that can then be used to advocate for the scaling-up of interventions to cover increasingly larger proportions of the population. [46]

An example of the importance of targeted interventions in New Zealand is provided by Gateway Assessments, an interagency project between Child, Youth and Family, Health and Education. Vulnerable children's needs are not always identified through universal services. The gateway assessments aim to ensure every child or young person entering care receives an assessment that helps build a complete picture of the child or young person's needs, and sees that they get access to the right health and education services to address their needs.

A review of the gateway assessment pilots showed, on average, three more health needs per child were identified as a result of the assessments. Information from the pilots is consistent with international research, and showed that of the children who came into the care of CYF:

- approximately 65 percent have mental health or behavioural problems
- 40 percent of these are likely to need specialist services. Currently only around seven percent receive specialist mental health services
- 15 percent suffer from developmental delay
- 37 percent have impaired hearing
- around 40 percent need dental care or help with skin conditions.

Many have a combination of health and education needs and, in 88 percent of cases, had problems that had gone unidentified or untreated prior to them coming into care.[47] It is important that there are sufficient developmental pediatricians to support this project.

[46] *Universal* interventions cover entire populations irrespective of differences in risk between subgroups. Examples of universal interventions include laws governing alcohol licensing and sales, and violence prevention components integrated into the curricula of all primary schools. *Selective* interventions work with population subgroups known to be at elevated risk of perpetrating or being subjected to interpersonal violence. Examples of selective interventions include home visitation to prospective and new parents living in high-crime, low-income communities, or incentives for high-risk youth to complete secondary schooling and pursue higher education. World Health Organization. 2004. *Preventing violence: A guide to implementing the recommendations of the World report on violence and health*. Geneva: World Health Organization. P 40.

[47] http://www.cyf.govt.nz/keeping-kids-safe/ways-we-work-with-families/gateway-health-and-education-assessments.html

6.2 Funding for services

Tolmie and Brookbanks[48] describe a "punitive sentencing creep occurring over the last decade in New Zealand which has manifested itself in the form of greater proportions of offenders being imprisoned, and longer sentences of imprisonment being imposed, in spite of an apparent overall decline in rates of offending and no apparent rise in the seriousness of offending. Such an escalation of punitiveness seems to have intensified in the last couple of years as a consequence of a range of reforms, introduced in 2002, overhauling the laws on bail, sentencing and parole … Because of the documented sentencing creep there has been a sudden and unexpected rise in the prison population."

New Zealand's imprisonment rate is high compared to most other nations in the developed world. In 2008 it was 185 per 100 000, compared to 129 per 100 000 in Australia. The Salvation Army State of the Nation report[49] states that the overall imprisonment rate for the total New Zealand population during 2010-11 was 198 prisoners for every 100 000 people, up 2.7 percent on the previous year and 13 percent higher than five years previously. Māori imprisonment rates remain over three times that for the non-Māori population at 655 prisoners per 100 000 for 2010-11, up from 645 per 100 000 in 2009-10 and from 581 per 100 000 in 2005-06. The imprisonment rate for Māori males is over five times that for non-Māori males. This gap has closed slightly during 2010-11, but mainly because the rate of non-Māori male imprisonment rose faster than that for Māori males.

Imprisonment, as opposed to the range of other punishments which are available for criminal offending, is expensive. It costs approximately $90,000 a year to imprison someone, which is money diverted from other social spending. There is also no evidence that longer periods of imprisonment are effective in deterring people from committing crimes.[50] Furthermore, rates of recidivism are high. Within 6 months of release, 37 percent of offenders are reconvicted and, within 5 years, 86 percent are reconvicted. In fact, imprisonment has a "secondary criminogenic effect" in that it can operate as a "school of crime," disseminating knowledge of how to commit crime, forging relationships between inmates and severing links to mainstream communities.

The point the FVDRC want to stress is, not that some people should not be imprisoned, but that we are imprisoning more people than we need to and for longer periods of time at a huge economic and social cost. It would be a better use of public funds to spend some of the money we are currently spending on imprisonment on preventative and early interventions for at risk children and young people.

7. Make Child Centred Policy Change: Information sharing

7.1 Information sharing

The Smith Report[51] also stresses the importance of information sharing in the context of children at risk and makes the point that the requirement to share information must extend beyond government agencies and include all those working in the field. The FVDRC

[48] Criminal Justice in NZ, LexisNexis 2007 at p 71.
[49] The Salvation Army Social Policy and Parliamentary Unit. February 2012. *The Growing Divide: A State of the Nation Report From the Salvation Army 2012.* Salvation Army. P 29-31.
[50] M Bagaric, "Incapacitation, Deterrence and Rehabilitation: Flawed ideals or appropriate sentencing goals?" (2000) 24:1 Criminal Law Journal 21.
[51] Mel Smith, *Report to Hon Paula Bennett, Minister for Social Development and Employment: Following An Inquiry Into the Serious Abuse of a Nine Year Old Girl and Other Matters Relating to the Welfare, Safety and Protection of Children in New Zealand* (2011).

recommends that government consider how to progress information sharing between government agencies and NGOs.

Any guidance developed to support information sharing amongst practitioners needs to clearly stipulate what level of information needs to be shared in order to enable practitioners to work together successfully. For example, should practitioners inform others only of their conclusions or should they also share their thinking and communicate the rationale behind their decisions? As noted above when discussing multi-disciplinary decision making, while the latter takes more time, it provides a valuable safety mechanism by enabling others to amplify or challenge both the factual accuracy and the interpretation of the situation.

The Memorandum of Understanding between District Health Boards, CYF and Police requires each party to work together and share information. Examples of actions within the associated schedule 1 are the requirement for multi-disciplinary, multi-agency decision making and agreement regarding a multiagency safety plan. Agreements that formalise expected standards and include a monitoring framework contribute to effective inter-agency collaboration and information sharing.

7.2 Mandatory reporting

At the heart of the mandatory reporting debate is the concern about how best to use finite resources for children and their families and whānau affected by abuse and violence. The question which needs to be asked when considering introducing mandatory reporting, the requirements and scope of that reporting, and the manner in which it is implemented, is whether this would result in children being safer and receiving effective support?

One of the key issues which must be addressed is resourcing for those agencies that will need to respond to increased levels of reporting. As it is frequently the NGO family violence sector that is referred to support families experiencing family violence, the capacity of that sector needs to be addressed. It is important to ensure that the potential inundation of one system (CYF) is not simply replaced with the inundation of another (the NGO family violence sector).

An alternative possibility is to consider resourcing alternative pathways to provide services, which may be more efficient and effective. For example in Australia, Humphreys and Absler posit that only the most serious and chronic cases of children living with domestic violence should be referred to child protection, rather than the current practice in Australia of reporting huge numbers of children into a statutory service in which they and their mothers and fathers receive no effective intervention.[52] If such an alternative pathway is to be explored there needs to be sufficient capacity and expertise (in child development and attachment and recognising and understanding child abuse and neglect) within the NGO family sector to respond to and support those referred who are affected by family violence. Currently, there is no formal infrastructure to provide on-going child protection training to the NGO family violence sector.

Creating more rigorous criteria for notification and supporting increased professional discretion with more training, coordination and guidance, may allow the child protection system to be used in a more judicious and selective way.

Implementation of any legislative changes regarding mandatory reporting should only be considered if there is comprehensive planning and an implementation programme that ensures adequate and appropriate resources. Services required to report will need the

[52]Humphreys C, Absler D. 2011. History repeating: child protection responses to domestic violence. *Journal of Child & Family Social Work* 16: 464–473. P 1372.

knowledge and skills to enable them to identify, assess and refer children, young people and their families. This can be achieved through a systems approach that includes management support, coordinated activities, community collaboration, policy, resources, training, access to consultation and/or supervision, and monitoring and evaluation. It requires much more than a legislative change and training.

As stated by the participants at the *Experts' Forum on Child Abuse*, "Creating any effective system to prevent the occurrence and recurrence of child abuse will require a significant level of both financial and human capital investment over the medium to long term."[53]

8. Make child-centred practice changes: Improving the workforce for children

8.1 Workforce development

On-going training is critical to enhance professionals' ability to think critically, deal with complexity and practice in a culturally responsive way.[54] As well as on-going professional education, professionals also need good regular supervision.

The FVDRC supports the development of common principles and standards, including cultural safety competencies and quality standards, to guide those who work with children, as long as these processes are coupled with long term investment in on-going professional education.

For the first time in the UK, the social work sector has produced, and agreed to, an overarching Professional Capabilities Framework (PCF).[55] The PCF aims to set out clearly what is expected in terms of a social worker's knowledge, skills and capacity and how to build on these over time as they move through their careers. The minimum capabilities being developed for child and family social workers must include:

Knowledge:

- knowledge of child development and attachment and how to use this knowledge to assess a child's current developmental state;
- understanding the impact of parental problems (such as domestic violence, mental health, and substance misuse) on children's health and development at different stages during their childhood; and
- knowledge of the impact of child abuse and neglect on children in both the short and long term and into adulthood.

Critical reflection and analysis:

- the ability to analyse critically the evidence about a child and family's circumstances and to make well-evidenced decisions and recommendations, including when a child cannot remain living in their family either as a temporary or permanent arrangement; and
- skills in achieving some objectivity about what is happening in a child's life and within their family, and assessing change over time.

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[53] Independent Experts' Forum on Child Abuse November 9-10, 2009. P 3.

[54] Gillingham P, Humphrey C. 2010. Child Protection Practitioners and Decision-Making Tools: Observations and Reflections from the Front Line.

[55] The Social Work Reform Board (SWRB) was set up to take forward the recommendations of the Social Work Task Force for the reform of social work. Reform is led by the social work sector itself. Employers of social workers, educators, regulators, service users, government and the social work profession itself have worked collaboratively to develop tools that will drive up standards of social work practice and improve services for children, adults and families. http://www.education.gov.uk/swrb/about

Intervention and skills:

- recognising and acting on signs and symptoms of child abuse and neglect;
- purposeful relationship building with children, parents and carers and families;
- skills in adopting an authoritative but compassionate style of working;
- skills to assess family functioning, take a comprehensive family history and use this information when making decisions about a child's safety and welfare;
- knowledge of theoretical frameworks and their effective application for the provision of therapeutic help;
- knowledge about, and skills to use and keep up-to-date with, relevant research findings on effective approaches to working with children and families and, in particular, where there are concerns about abuse or neglect;
- understanding the respective roles and responsibilities of other professionals and how child and family social workers can contribute their unique role as part of a multi-disciplinary team; and
- skills in presenting and explaining one's reasoning to diverse audiences, including children and judges.

The development of a similar framework to the PCF in New Zealand, which incorporates the understanding of the health and developmental needs of children and cultural safety capabilities for social workers, would assist in avoiding the unintended dangers of the proliferation of procedures for social workers. Munro, in her review of the child protection system in the UK,[56] warns against the proliferation of procedures as a way to train and up-skill staff. Munro identifies that procedures have a number of weaknesses. Firstly, they can lead to people *just* following procedures and not seeking to understand them or trying to become more effective in their complex tasks. "Procedures can lull people into passive mind-set of just following the steps, and not really thinking about what they are doing."[57] Secondly, procedures are always incomplete and require skill and the use of the practitioner's judgement to implement them.

Key skills in family violence work are to engage and communicate with vulnerable children and adults, and make complex interpretations of information about children's, adults' and whānau needs. When an organisation does not pay sufficient attention to these key skills, then procedures may be followed in a way that is technically correct but is so inexpert that the desired result is not realised and may result in unsafe practice.

In intimate partner violence and child protection work, the needs and circumstances of children, adults and their whānau are so varied that procedures cannot fully encompass the variety. Attempts to develop procedures which cover more variety can quickly lead to the proliferation of procedures that become untenable to use in practice. Dealing with the variety of needs is better achieved by professionals' understanding the underlying principles of good practice and developing the expertise to apply them, taking account of the specifics of a child's, adult's, family's and whānau's circumstances.

8.3 Designated child protection professionals

The FVDRC believe that professionals working in early education centres, schools and health need to have access to advice from designated child protection professionals. They also need to have access to supervision and undertake regular child protection training and updating. A network of designated child protection professionals/teams needs to be established within health and education.

[56] Munro E. 2011.*The Munro Review of Child Protection: Final Report- A child-centred system.* London: Department of Education

[57] Kelin G. 2009. *Streetlights and Shadows: Searching for the Keys to Adaptive Decision Making*. Cambridge, Mass: MIT press. P 22

The FVDRC support the following specific proposals of Dr Kelly's: [58]

- That every District Health Board in New Zealand establish a dedicated "Child Protection Team". The resource required would vary according to population, and would require the development of a population-based formula. For some small DHBs, a regional team may be a more appropriate solution.
- Such a team will require the expertise of a paediatrician, a nurse specialist, a social worker, the participation of child and adolescent mental health services and administrative support. In most cases, clinicians involved will not be full-time in that role, and their integration into other aspects of DHB-based child and youth health services will be crucial to their ability to fulfil their roles.
- These teams will train and support primary and secondary healthcare providers in each DHB, develop safe child protection systems and processes within each DHB, work collaboratively with their colleagues regionally and nationally to ensure seamless and systematic national child protection processes, and collaborate in the research and audit necessary to develop evidence-based interventions.
- These teams will work in partnership with Child Youth and Family (CYF) and the Police.
- The FVDRC committee notes that similar proposals were first outlined by the Paediatric Society of New Zealand in the document *Through the eyes of a child*[59] in 1998. This plan for specialist child protection services has not been fulfilled within DHBs because of lack of funding and lack of vision, but must now been addressed.

Conclusion

A family violence death review is an opportunity to identify current strengths and weaknesses in the multi-agency family violence environment; it offers a "window on the system."[60] This kind of organisational reflection and learning is vital in order to improve the quality and range of services provided. A key part of the review process is to gain a deeper understanding not only of *what* has been going wrong but *why* the system has evolved this way. The emphasis is less on learning lessons from a particular death and more on using a single death to gain insights into how the multi-agency family violence systems are functioning more broadly.

The FVDRC are currently in the implementation phase of the death review process and would welcome the opportunity to inform MSD of key findings and recommendations from these reviews, which would identify changes or enhancements to systems, policy, and services that may contribute to the prevention of family violence deaths at the local and national level.

[58] Kelly P. 2008. *The Role of Health Services in Child Protection*. Pg 4.

[59] Health Funding Authority. 1998. *Through the eyes of a child: A review of paediatric speciality services*.

[60] Vincent CA. 2004. Analysis of clinical incidents: a window on the system not a search for root causes. *Quality and Safety in Health Care*, vol 13, pp 242-3.