



HEALTH QUALITY & SAFETY
COMMISSION NEW ZEALAND

Kupu Taurangi Hauora o Aotearoa


Family Violence Death Review Committee



He tao huata e taea te karo

Fifth Report January 2014 to December 2015





Ngā mate aituā o tātou
Ka tangihia e tātou i tēnei wā
Haere, haere, haere.

The dead, the afflicted, both yours and ours
We lament for them at this time
Farewell, farewell, farewell.

Citation: Family Violence Death Review Committee, 2014. *Fifth Report: January 2014 to December 2015*.

Wellington: Family Violence Death Review Committee.

Published in February 2016 by the Health Quality & Safety Commission,

PO Box 25496, Wellington 6146, New Zealand

ISBN 978-0-908345-20-5 (Print)

ISBN 978-0-908345-19-9 (Online)

This document is available on the Health Quality & Safety Commission's website: www.hqsc.govt.nz

For information on this report, please contact info@hqsc.govt.nz



ACKNOWLEDGEMENTS

The Family Violence Death Review Committee is grateful to:

- the Mortality Review Committee secretariat based at the Health Quality & Safety Commission, particularly:
- Rachel Smith, Lead Coordinator, Family Violence Death Review Committee
- Carlene McLean, Lead Coordinator, Family Violence Death Review Committee
- Shelley Hanifan, Manager, Mortality Review & Adverse Event Learning
- all of the Family Violence Death Review Committee regional panel members, and particularly the time, commitment and work of the participating agency members to gather and prepare agency records for the death reviews
- Irene de Haan, Chair of the Family Violence Death Review Committee regional panels
- the advisors to the Family Violence Death Review Committee.

The Family Violence Death Review Committee also thanks the people who have reviewed and provided feedback on drafts of this report.

If any of the issues raised in this report are personal for you and you would like to talk to someone, you can contact the following services for information or help. They are all free.

New Zealand Police

111

If you have immediate safety concerns for yourself or anyone else, dial 111 and ask for police.

Child, Youth & Family

0508 FAMILY

0508 326 459

Fax: 09 914 1211

Email: cyfcallcentre@cyf.govt.nz

If you think a child is in immediate danger, phone the police on 111. If you suspect child abuse or neglect, or are worried about a child or young person, you can call the freephone number 24 hours a day, any day of the year, and talk to a social worker. You can also send a fax or email.

Are You Ok? helpline

0800 456 450

This helpline can provide you with information and put you in touch with services in your own region for those experiencing or perpetrating family violence. The helpline operates every day of the year and is open from 9am to 11pm.

Women's Refuge

0800 REFUGE

0800 733 843

If you are a victim or are concerned about someone you know, you can call Women's Refuge helpline for information, advice and support about family violence. The helpline is available 24 hours a day, 7 days a week.



FOREWORD



The Health Quality & Safety Commission (the Commission) welcomes this ambitious fifth report from the Family Violence Death Review Committee (the Committee).

This report challenges us to think differently about family violence so system reforms can bring sustainable change.

Importantly, the report provides direction for significantly reducing family violence through the development of an integrated response. This involves agencies, organisations and practitioners working together to provide safe, high-quality and appropriate support and services to people who need them. The report puts those people at the centre of the system, and asks us to put their needs first.

This theme is central to the work of the Commission. We emphasise the importance of the consumer and their specific needs being central to good-quality, safe health services.

The same is true for all services. If we are to meet the needs of those we seek to help, we must start by understanding their needs – and understanding them well.

The Government has identified family violence as an area that requires concerted action to prevent patterns of intergenerational harm. The report's findings will contribute to the cross-government work programme of the Ministerial Group on Family Violence and Sexual Violence, and support its commitment for change.

Family violence is a challenging area. We commend the Committee for its perseverance and for progressing and sharing critical knowledge gained from understanding each death in order to prevent more unnecessary and avoidable deaths. In particular, we commend the Chair, Associate Professor Julia Tolmie, for the many hours she has dedicated to thinking, writing and consulting, and leading the Committee in the development of this report.

The Committee and its Chair have discussed the conceptual shifts outlined in this report with many individuals and organisations involved in addressing family violence. The ideas expressed resonate with a wide range of people working in this area. We hope and expect many others, like the Commission Board, will welcome the family violence thought leadership this report offers.

Professor Alan Merry ONZM FRSNZ
Chair, Health Quality & Safety Commission

Shelley Frost
Deputy Chair, Health Quality & Safety Commission

February 2016



CHAIR'S INTRODUCTION



This is the most ambitious report of the Family Violence Death Review Committee (the Committee) to date, because as a country it is time to change our collective understanding of family violence. New perspectives and new actions are essential if we are to prevent family violence in Aotearoa New Zealand.

Rather than taking a traditional approach and making a range of recommendations about specific aspects of the current family violence system, in this report we have focused on describing the shifts in thinking about family violence that are needed if we are to develop an integrated family violence system.

We then discuss how we can remap and build on existing work to move towards an integrated approach.

We cannot continue to have one-off interventions that fragment the complex issues experienced by those who perpetrate and experience family violence, and fragment the ongoing patterns of harm taking place within individual lives, families and whānau, and across generations.

Nor can we continue to question what the victim standing in front of us (already seeking our help) is doing about the violence she is experiencing.

What we have today is the legacy of not taking family violence sufficiently seriously. The words of the Victorian government could equally apply in Aotearoa New Zealand:

'For too long family violence has been perceived as a small, private problem with public assistance limited to the provision of crises emergency assistance, advocacy and counselling. The need to address family violence has been funded as if it is a marginal issue rather than a driver of much of the work for mainstream services.'¹

In spite of this, the Committee believes that there is currently a desire to change that may be unprecedented. There has never been such a strong cross-government focus on family violence as at this point in time. The Ministerial Group on Family Violence and Sexual Violence, led by Minister Adams and Minister Tolley, is committed to improving the systemic response to family violence. The group has launched an ambitious cross-government work programme.

In March 2015, New Zealand Police established an Internal Family Violence Change Programme. The focus is on improving and innovating New Zealand Police's response to, investigation of, and delivery of services to victims, offenders and their families and whānau.²


In 2015, all District Court and High Court judges attended conferences and workshops on family violence. The Institute of Judicial Studies commenced the development of ongoing judicial education on family violence.

Minister Adams has also initiated a 'fresh look' at the Domestic Violence Act 1995. This review is an opportunity for a 'comprehensive re-think of the way our system of law deals with family violence'.³ The work of the Law Commission complements this review. The Law Commission is reviewing the criminal defences to homicide for primary victims who kill their predominant aggressors and is considering the creation of a specific offence of non-fatal strangulation.

1 Victorian Government, *Royal Commission into Family Violence: Victorian Government Submission*, Victoria, Victorian Government, 2015, p. 42.

2 See Appendix 2 for further information on the New Zealand Police Internal Family Violence Change Programme.

3 Ministry of Justice, *Strengthening New Zealand's Legislative Response to Family Violence: A Public Discussion Document*, Wellington, Ministry of Justice, 2015, p. 3.



We are grateful for the opportunities we have had to share the information and findings from the regional reviews into the work programme of the Ministerial Group on Family Violence and Sexual Violence, the New Zealand Police Internal Family Violence Change Programme, the family violence legislation review and the work of the Law Commission.

We also want to acknowledge the health sector's commitment to addressing family violence. Since 2002, the Ministry of Health's Violence Intervention Programme has focused on training health practitioners to identify intimate partner violence and child abuse and neglect, and to provide a consistent response to victims. This is a strong foundation to build on.

Underpinning all this work is the dedication of the practitioners who respond every day to those affected by family violence. We feel very privileged to have met, and benefited from our conversations with, compassionate and skilled practitioners who do much more than they are funded or required to do in order to address the trauma and harm occurring within our communities.

We want to conclude by honouring the lives of those whose deaths we have reviewed. It is our responsibility to make sure we share the lessons we have learned, and use them wisely to inform our collective commitment to family violence prevention.



Associate Professor Julia Tolmie

Chair, Family Violence Death Review Committee

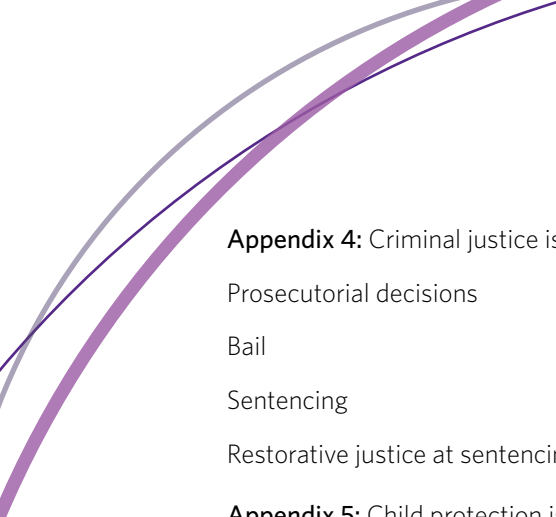
February 2016

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EXECUTIVE SUMMARY

Thinking differently – changing our collective story about family violence

The focus of this report is on changing the narrative about family violence in Aotearoa New Zealand. Transformational change requires a new story.⁴

This report encourages practitioners and policy makers to transform the way we collectively think about family violence. This ‘work before the work’⁵ is a prerequisite to system reform.

Attempting to reform the current system while we continue to think about family violence in exactly the same way will not produce the kinds of systemic changes we all want.

A pattern of harm

Thinking differently about family violence means understanding that family violence is not a series of isolated incidents affecting an individual victim. Rather, family violence is a pattern of abusive behaviour used by an *identifiable individual* that can encompass multiple victims (children and adults) – past, current and future.

A form of entrapment

Similarly, intimate partner violence (IPV) is best understood as a form of entrapment. When we frame IPV as a form of ‘entrapment’, it becomes apparent that:

- it is not appropriate to give victims the responsibility for keeping themselves and their children safe
- simply providing victims with a standard set of safety actions they can take is likely to be an ineffective response to their help-seeking
- victim safety requires systemic responses that focus on curtailing the abusive person’s use of violence
- structural inequities and ineffective responses to family violence compound the entrapment of victims, and their families and whānau
- victims’ responses⁶ to abuse are *acts of resistance* rather than *acts of empowerment*.

Entangled forms of abuse

Thinking differently about family violence also means understanding IPV and child abuse neglect (CAN) as entangled forms of abuse. Allowing a child to be exposed to IPV is child abuse and neglect. Parents who commit IPV may also be directly abusing their children.

Understanding the entangled nature of IPV and CAN in the child protection context shifts the focus from assessing the protectiveness of adult victims to assessing the level of risk and danger a partner’s/parent’s abusive behaviour poses to both child and adult victims.

Rendering visible the impact of the abusive partner’s/parent’s behaviour on family and whānau functioning makes it clear the decision to abuse an intimate partner who is a parent is, in fact, a parenting decision.

4 H. Bevan and S. Fairman, *The New Era of Thinking and Practice in Change and Transformation: A Call to Action for Leaders of Health and Care*, United Kingdom NHS Improving Quality, Leeds, UK Government White Paper, 2014.

5 <https://twitter.com/helenbevan/status/595154451666739201>

6 Responses include asking people and services for help, applying for a protection order, changing phone numbers, altering her and her children’s routines, moving locations and using violent resistance to protect herself and her children.

Reframing empowerment and safety as collective endeavours

The empowerment of victims has been placed at the wrong end of the intervention continuum. Victim empowerment should be the end goal of a collective safety response, not the initial premise of any safety work.

Safety and wellbeing for child and adult victims can only be realised through the connected actions of others – the protective actions of agencies, communities, families and whānau. Safety is not something individual victims can achieve alone.

In this report, the Family Violence Death Review Committee (the Committee) reframes victim empowerment and safety as *collective endeavours*.

Such a reframing requires fundamental change in the way the family violence system currently responds to victims and to people perpetrating family violence. This change includes the development of multi-agency strategies for containing, challenging and changing the behaviours of those using violence. Practice responses together must address the complexities of people's lives and cannot be confined to one-off single-issue interventions.

Acting differently – opportunities for system transformation

Shifting from fragmented islands of practice

Aotearoa New Zealand does not currently have a system that was designed to comprehensively address family violence. The current family violence system is therefore a 'system' only by default rather than by design.

The current family violence system is a fragmented assortment of services and initiatives – islands of practice – commonly underpinned by old ways of thinking about family violence (Figure 1). Furthermore, the current system was not developed to respond to the intersection of family violence with typically concurrent social issues and/or forms of vulnerability (such as trauma, mental health and addiction (MH&A) issues, and poverty).

Real help for victims of IPV within our current system is sporadic, unpredictable and frequently not available.⁷ There are also few strategies to address their partner's abusive behaviour.

⁷ C. Richardson and A. Wade, 'Islands of safety: Restoring dignity in violence-prevention work with indigenous families', *First Peoples Child and Family Review*, vol. 5, no. 1, 2010, pp. 137–45.

Figure 1: Overview of the current system⁸



Developing a road map for system integration

The second half of this report focuses on developing *part* of the 'road map' for moving towards an integrated family violence system.

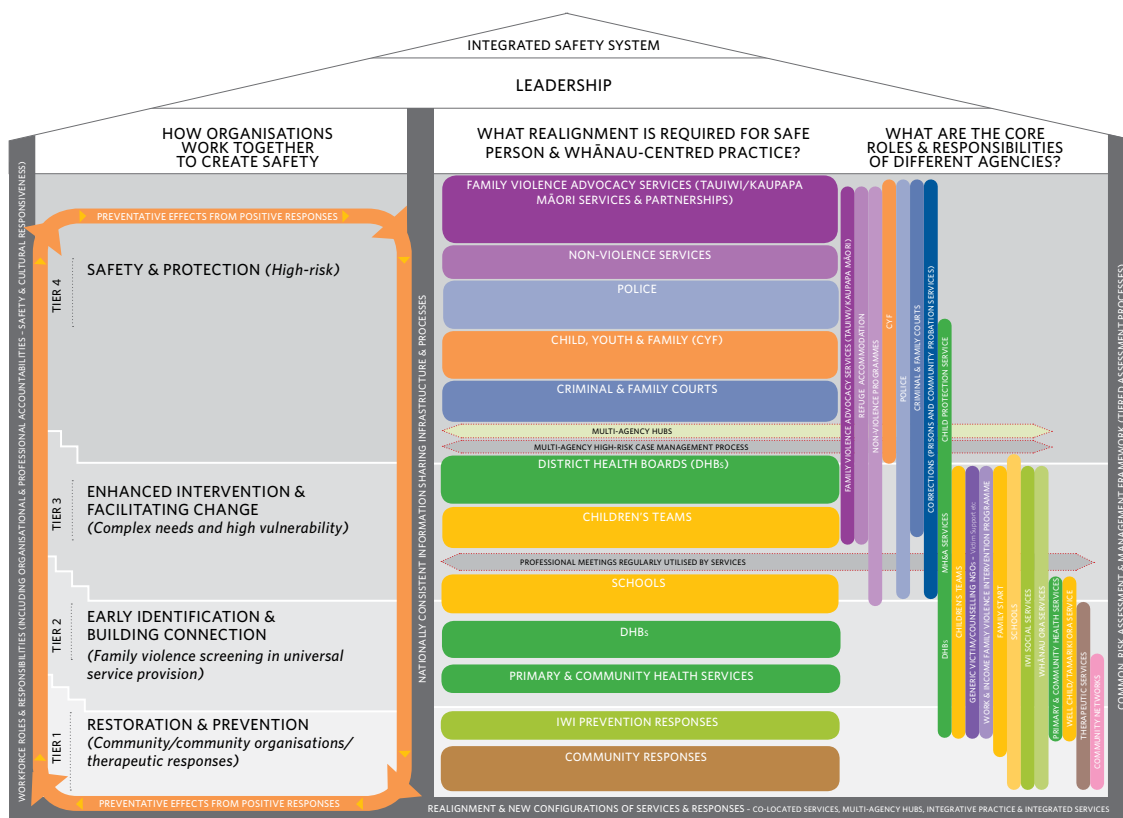
A road map is intended to help *shape the direction of system development*, rather than *detail the complete picture of the final destination* (impose preconceived solutions). The intention is to 'nudge' the whole system, because attempting to fix one part of a complex system in isolation from other parts can reveal or create unexpected further problems.⁹

The Committee has remapped the existing family violence workforce across four tiers of safety responses. Investment in the infrastructure necessary to underpin an integrated response across these tiers is also required. Figure 2 illustrates the Committee's proposed Integrated Safety System.

⁸ This is an overview of the current system. A full version of this map is available in section 2.1 or as a separate PDF at www.hqsc.govt.nz/our-programmes/mrc/fvdr/publications-and-resources/publication/2434/.

⁹ D. Snowden and W. Boone, 'A leader's framework for decision making', *Harvard Business Review*, vol. 85, no. 11, 2007, pp. 68-76.

Figure 2: Overview of the Integrated Safety System¹⁰



As noted in the Committee's *Fourth Annual Report*,¹¹ the Victorian government in Australia has modelled moving from 'a service system' that places responsibility on the victim to take action, to an 'integrated system response' that emphasises the responsibility of the multi-agency system for the safety of victims, and intervening with the abusive partner.¹² In Aotearoa New Zealand, Herbert and Mackenzie¹³ have laid the stepping stones for thinking about how to develop an integrated family violence system and what infrastructure is required to enable the system to function as a whole.

In this report, the Committee provides practical examples of how integrative practice and an integrated system can enable safer responses to people, their families and whānau. In addition, it commences thinking about how victim safety can be addressed in an integrated manner by the existing family violence workforce.

Current cross-government action on family violence

In July 2015, the Ministerial Group on Family Violence and Sexual Violence reported to Cabinet the intention to develop a 'family violence system framework' to address overarching system issues. This includes shared definitions; investment rationale and objectives; an outcomes framework and indicators; evaluation of system effectiveness; client-centred data; a workforce framework; and a research and evaluation agenda.¹⁴ The Committee is encouraged by this whole-of-system focus.

10 This is an overview of the Integrated Safety System. A full version of this map is available in section 2.1 or as a separate PDF at www.hqsc.govt.nz/our-programmes/mrc/fvdrc/publications-and-resources/publication/2434/.

11 Available at www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC-4th-report-June-2014.pdf.

12 Office of Women's Policy, Department of Planning and Community Development, *A Right to Safety and Justice: Strategic Framework to Guide Continuing Family Violence Reform in Victoria 2010-2020*, 2010. Family Violence Death Review Committee (FVDRC), *Fourth Annual Report*, p. 84.

13 R. Herbert and D. Mackenzie, *The Way Forward: An Integrated System for Intimate Partner Violence and Child Abuse and Neglect in New Zealand*, Wellington, The Impact Collective, 2014.

14 Cabinet Social Policy Committee, *Progress on the Work Programme of the Ministerial Group on Family Violence and Sexual Violence*, Cabinet paper, July 2015, para. 46, p. 8, https://beehive.govt.nz/webfm_send/68. See Appendix 2 for an overview of the whole-of-government work programme to reduce family violence.

There are currently other significant opportunities to improve key components of the family violence system. The work of the Modernising Child, Youth and Family Expert Panel and the family violence legislation review has the potential to enable greater system integration and safer responses to those affected by family violence.

The Committee’s recommended directions for system integration

The Committee intends its recommended directions for system integration to contribute to the important work of the Ministerial Group on Family Violence and Sexual Violence; the Modernising Child, Youth and Family Expert Panel; and the family violence legislation review. These recommended directions are also pertinent to the strategic work of the Children’s Action Plan.

The Committee recognises that system change takes time and has significant resource and workforce implications. Committed leadership is required to conceptualise, resource and develop an integrated family violence system.

Table 1: Recommended directions for system integration

<p>Legislation</p> <p>Frame integrative practice principles in legislation</p>	<p><i>The family violence legislation review</i></p> <ul style="list-style-type: none"> ▪ Include practice principles in the Domestic Violence Act 1995. These principles articulate the shifts in thinking that must underpin an integrative practice response.¹⁵ ▪ Amend the Sentencing Act 2002 to ensure victims’ safety is a mandatory and the primary consideration when determining the appropriate sentence in family violence cases. ▪ Amend the Privacy Act 1993 and the Domestic Violence Act 1995 to include a presumption of responsible and safe information-sharing between agencies where family violence concerns are present. ▪ Include in the Domestic Violence Act 1995 a requirement for agencies and service providers to put in place policies and systems that support the workforce to practise in a family violence responsive, safe and competent way (minimum safe standards of workforce competence).
<p>Investment</p> <p>Investment which sustains family violence expertise and strengthens opportunities for intervention with those perpetrating family violence</p>	<ul style="list-style-type: none"> ▪ Invest in specialist family violence advocacy services. ▪ Explore, pilot and evaluate a range of flexible responses for working with people perpetrating family violence.
<p>Infrastructure</p> <p>Develop the workforce infrastructure for an integrated response system</p>	<ul style="list-style-type: none"> ▪ Develop and implement a tiered safety response framework for the family violence workforce: <ul style="list-style-type: none"> – Tier 1: Restoration & Prevention – connected and protective communities – Tier 2: Early Identification & Building Connection – safety-responsive universal services – Tier 3: Enhanced Intervention & Facilitating Change – safety partnerships – Tier 4: Safety & Protection – safety teams ▪ Develop workforce strategies (for children and adults) to ensure each organisational cluster of services and their practitioners are able to provide safe and culturally responsive practice as appropriate to their tier.

15 FVDR submission on the Ministry of Justice’s *Strengthening New Zealand’s Legislative Response to Family Violence: A Public Discussion Document*, September 2015. See Appendix 3.

Organisational responsiveness

Strengthen organisational responsiveness to family violence across the family violence system

Justice sector

- Consideration should be given to developing an integrated justice strategy for those who perpetrate family violence that is directed at supporting victim safety (including hidden and future victims).¹⁶

Child, Youth and Family

- The Modernising Child, Youth and Family Expert Panel should consider integrating an IPV analysis within Child, Youth and Family practice frameworks and responses. This would support social workers to protect child and adult victims by assessing and engaging with the abusive partner/parent.

Ministry of Health

- District health board (DHB) MH&A services should consider strengthening their family violence practice responses. This means moving from referring victims to specialist family violence services (a Tier 2 response), to referring and working in partnership with specialist family violence services (a Tier 3 response) to address the ongoing safety and wellbeing needs of victims and people perpetrating family violence.

Preventing family violence (re)occurring

The report concludes with some reflections on prevention. For many whānau and families in Aotearoa New Zealand there is no pre-violence or primary prevention space.¹⁷ Children are born into families and whānau already experiencing intergenerational violence and are exposed to violence in multiple family contexts. Prevention for these families and whānau is about interrupting intergenerational patterns of violence and the associated transmission of trauma.

Opportunities to prevent family violence are therefore embedded in every response to family violence, not just those normally directed at primary prevention. Effective Safety & Protection and Restoration responses will have preventative effects. Prevention work will produce disclosures that necessitate Safety & Protection and Restoration responses. To prevent family violence, structural inequities must be considered and addressed in all of the systemic responses to family violence.

The foundations for the prevention of family violence can be built in this generation.

¹⁶ See Appendix 1 for a definition of hidden and future victims, as used in this report.

¹⁷ Ministry for Women, *Wāhine Māori, Wāhine Ora, Wāhine Kaha: Preventing Violence against Māori Women*, Wellington, Ministry for Women, 2015.

CHAPTER 1: INTRODUCTION

1.1 The structure of this report

In this chapter, an outline of the structure of the report is provided as well as some background information on the Family Violence Death Review Committee (the Committee) and the Committee's review process. A glossary of the terms used in this report is in Appendix 1.

In Chapter 2, the current family violence system is described and mapped. This system was not designed with family violence in mind. As a result, it sets up responses to family violence that are fragmented, a mismatch to the complexity of people's lives and sometimes harmful. This potentially undercuts the practice of the many committed practitioners who are working within the system to address family violence; an impact documented by numerous researchers. The Committee has briefly described these problems to provide a context for the rest of the report.

Many of the problems outlined in Chapter 2 are to be addressed by the whole-of-government work programme to reduce family violence, commenced in 2015 by Minister Adams and Minister Tolley. Appendix 2 gives an overview of this important work. This report is directed at supporting this cross-government work. Chapters 3 to 5 of the report describe shifts in thinking, system design and organisational practice that will support the development of an effective systemic response to family violence.

In Chapter 3 the Committee suggests there is a need to *think differently about* family violence¹⁸ if we are to have safer *responses to* family violence. If we do not collectively shift our thinking then any reforms to the family violence system are likely to be impeded by the old ways of thinking about family violence. Chapter 3 maps past and present ways of thinking about intimate partner violence (IPV), child abuse and neglect (CAN), and structural inequity, as well as reframing this thinking. Examples from the regional reviews are provided to demonstrate how misconceptions about family violence shape our current responses and can undermine their effectiveness.

Chapter 4 proposes an Integrated Safety System that is organised around four tiers of safety responses to family violence. These tiers must be supported by system infrastructure (for example, information-sharing processes and common risk assessment frameworks) to make the system function as a whole. The tiered response framework for the family violence workforce is as follows:

- Tier 1: Restoration & Prevention – connected and protective communities
- Tier 2: Early Identification & Building Connection – safety-responsive universal services
- Tier 3: Enhanced Intervention & Facilitating Change – safety partnerships
- Tier 4: Safety & Protection – safety teams.

The chapter also describes the shifts in thinking about the systemic response to family violence needed to underpin an Integrated Safety System.

Chapter 5 moves from an overview of the system to a consideration of what an integrated approach might mean for three key sectors of the family violence workforce. It considers how organisational responsiveness to family violence can be strengthened in the justice, child protection, and MH&A areas. In all three areas, multi-agency engagement with the person using violence could significantly increase victims' safety.

Finally, in Chapter 6, prevention in the family violence context, and the fact that prevention work is intertwined with safety and restoration work, is discussed.

¹⁸ Berger and Johnston suggest that to become more capable of dealing with complexity, leaders need to think differently (ask different questions), engage differently (take multiple perspectives) and act differently (see systems). The Committee has used these headings to frame this report. J. Garvey Berger and K. Johnston, *Simple Habits for Complex Times: Powerful Practices for Leaders*, Stanford, Stanford University Press, 2015, p. 13.

1.1.1 Why the focus of this report is not on making formal recommendations

While it will be clear throughout this report that the Committee sees certain directions and reforms as essential, it has chosen not to focus on making specific recommendations targeted at individual agencies. This is because the report is aimed at engaging in a different type of change process.

Reframing the narrative about family violence is a 'dialogic' approach that focuses on changing people's mindsets and how they think about family violence.¹⁹ The purpose of a dialogic approach is to change the conversations that shape organisations' and practitioners' everyday thinking and actions. This facilitates new ways of understanding and responding to family violence across the family violence system.²⁰

In contrast, 'diagnostic' approaches to change tend to be directed at identifying problems within the system and proposing specific solutions to those problems. The result is that different parts of the existing system are 'tinkered' with or realigned but transformational change of the overall system and of the practice responses of those working within the system may not occur. Traditionally, targeted recommendations for change frequently accompany diagnostic approaches.

The systemic changes the Committee is proposing in this report are dependent on shifting the collective narrative about family violence using a dialogic change process.

1.2 Terminology

Throughout this report, adult victims of IPV are referred to as women because women are the primary group affected as victims. The Committee uses language to discuss IPV that reflects the fact that, in most cases, the person using violence is male. The Committee recognises, however, that men can be victims from their female and male partners, and that IPV occurs in LGBTQI²¹ partnerships. While individual men can be victims of IPV, social patterns of harm reflect the fact that structural inequity and community values and beliefs (for example, about appropriate gender roles and gendered behaviour) support the perpetuation of male violence against women.

The World Health Organization has identified preventing violence as a global public health priority and has called for the use of a gender perspective, given its particular impact on women and children.²² Internationally, there is wide agreement across the research, policy and community sectors that addressing gender inequity and discrimination are essential components of family violence prevention.

In this report, the Committee has focused on IPV and CAN as the most prevalent forms of family violence. The use of the term 'family violence' throughout this report means IPV and CAN. The terms IPV and CAN are used when discussing the distinctive features of each particular type of violence.

While the focus is on IPV and CAN, the Committee acknowledges the occurrence of elder abuse and neglect, sibling violence and adult children's violence against their parents. Some of the analysis in this report is relevant to these forms of intrafamilial violence, as many forms of family violence co-occur.

1.3 Data

The Committee has not included updated quantitative data on all New Zealand family violence deaths in this report. This is because insufficient time has passed since our last report for a complete set of information on deaths that occurred in 2013 and 2014 to be finalised for reporting purposes. A data report, which sets out general trends across all family violence deaths, including family violence deaths occurring in 2013 and 2014, will be published by the Committee in mid-2016.

¹⁹ Helen Bevan differentiates between dialogic and diagnostic change. H. Bevan and S. Fairman, *The New Era of Thinking and Practice in Change and Transformation: A Call to Action for Leaders of Health and Care*, 2014, pp. 26-7.

²⁰ *Ibid*, p. 27.

²¹ Lesbian, gay, bisexual, transgender, queer and intersexed community.

²² World Health Organization, *Violence Prevention: The Evidence*, Geneva, World Health Organization, 2010, pp. 79-94.

1.4 Background information

1.4.1 The Family Violence Death Review Committee

The Committee was established in 2008 as an independent ministerial advisory committee hosted by the Ministry of Health. The Health Quality & Safety Commission (the Commission) assumed responsibility for mortality review following the New Zealand Public Health and Disability Amendment Act 2010, and the Committee is now hosted by the Commission. It is one of four permanent mortality review committees.

The overarching goal of the Committee is to contribute to the prevention of family violence and family violence deaths.²³ The Committee's functions are to 'review and report to the [Health Quality & Safety Commission] on family violence deaths, with a view to reducing the numbers of family violence deaths...' and to 'develop strategic plans and methodologies that are designed to reduce family violence morbidity and mortality...'

The members of the Committee are family violence experts from a range of disciplines across the social sector. They are selected in order to bring a wide array of skills, background experiences and perspectives to the table.²⁴

1.4.2 The family violence death review process

The Committee has developed a death review system designed to collect a minimum set of information about all family violence deaths in Aotearoa New Zealand, while selecting some death events to be subject to additional intensive, multi-sectoral regional review.

A standard set of information on all family violence homicides – collected from New Zealand Police and other agencies – is used to report general trends in family violence homicide. From these data, the Committee can determine how many deaths are taking place in each family violence category, the demographics of the deceased and offenders (of the death event), and the services with which they have been involved. This information is useful for monitoring general trends over time – for example, whether family violence deaths are increasing or decreasing, the co-occurrence of different types of abuse, and how many IPV offenders are predominant aggressors or primary victims in the abuse history prior to the killing. However, this information does not provide enough detail about what is happening in the systemic response to family violence and why, in order to 'develop strategic plans and methodologies' designed 'to reduce family violence morbidity and mortality'.²⁵

A subset of deaths is therefore chosen for the more intensive regional review process. The regional reviews are in-depth case studies.²⁶ They are conducted by regional review panels, which include representatives from the key agencies involved in the family violence response along with family violence and cultural experts.

The model informing the regional review process

The emphasis of the regional review process is less on learning lessons from a particular death and more on using a single death event to gain insights into how the multi-agency family violence system is functioning more broadly – to provide a 'window on the system'.²⁷

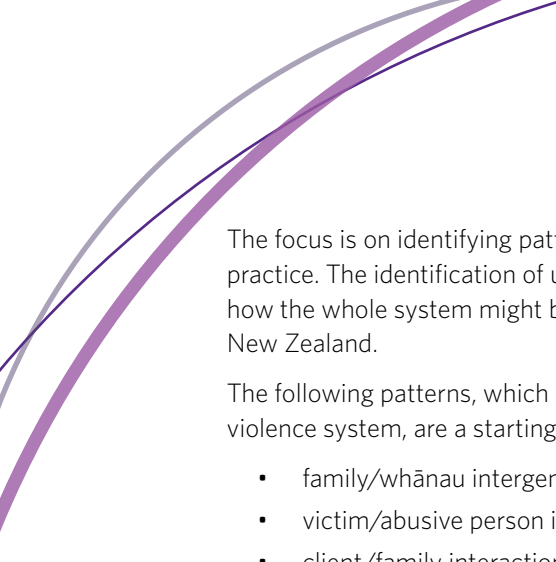
23 See www.hqsc.govt.nz/our-programmes/mrc/fvdr/our-programmes/mrc/fvdr/about-us/terms-of-reference/ for the Committee's terms of reference 2015.

24 See Appendix 6 for a list of current and past members.

25 See www.hqsc.govt.nz/our-programmes/mrc/fvdr/our-programmes/mrc/fvdr/about-us/terms-of-reference/ for the Committee's terms of reference 2015.

26 B. Flyvbjerg, 'Case study', in N.K. Denzin and Y.S. Lincoln (eds.), *The Sage Handbook of Qualitative Research*, 4th edn., Thousand Oaks, California, Sage, 2011, pp. 301-16.

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



The focus is on identifying patterns within the current system that either facilitate or compromise safe practice. The identification of underlying patterns of systemic factors provides a basis for considering how the whole system might be improved to prevent harm caused by family violence in Aotearoa New Zealand.

The following patterns, which highlight key interactions involving specific elements of the family violence system, are a starting point in the review process:

- family/whānau intergenerational experiences
- victim/abusive person interactions with informal support networks
- client/family interactions with practitioners
- practitioners' interactions with assessment tools
- practitioners' interactions with the organisational management system
- practitioners' thinking/reasoning
- communication and collaboration in multi-agency working and assessment
- the provision of services.

More information on the Committee and the review process can be found in the third and fourth annual reports.²⁸

28 The development of the review process was described in FVDR, *Third Annual Report: December 2011 to December 2012*, Wellington, Health Quality & Safety Commission, 2013, Appendix 3, www.hqsc.govt.nz/assets/FVDR/Publications/FVDR-3rd-Report-FINAL-locked-June-2013.pdf. See also FVDR, *Fourth Annual Report: January 2013 to December 2013*, Wellington, Health Quality & Safety Commission, 2014, pp. 26–8.

CHAPTER 2: MAPPING THE CURRENT SYSTEM

There is widespread appreciation that family violence is a ‘wicked’ problem.²⁹ However, the regional reviews suggest this appreciation has not yet translated into frontline practice with victims (both adults and children). Instead, the everyday practice responses in Aotearoa New Zealand are fragmented,³⁰ a mismatch to the complexity of people’s lives, and sometimes harmful.

This is the legacy of failing to appreciate family violence work is complex and requires investment in a specialised and skilled workforce, as well as a history of designing and funding family violence responses as isolated interventions.

2.1 A fragmented system

Aotearoa New Zealand does not currently have a system designed to comprehensively and effectively address family violence.³¹ Family violence initiatives,³² developed as a result of the commitment and hard work of many people, have been added on to other systems, such as health, child protection and criminal justice. Absent is an overarching strategic plan to provide cohesion and integration. This approach is the outcome of the historical perception of family violence as a marginal issue.

The result is a fragmented assortment of services and initiatives – a system by default rather than design.³³ Victims of family violence must try to navigate this complex system while experiencing trauma, often without the support of a skilled advocate who is compassionate and understands how the system works.

Necessary (but missing) infrastructure includes national and regional governance structures with a unified strategic vision; adequately resourced specialist family violence services; a common risk assessment,³⁴ risk management and response framework; nationally consistent information-sharing processes; and a skilled workforce with agreed practice standards.

Figure 3 maps the complexity and fragmentation of current family violence interventions.

29 The term ‘wicked’ is used not in the sense of evil or good but rather its resistance to resolution. Australian Public Services Commission, *Tackling Wicked Problems: A Public Policy Perspective*, Canberra, Commonwealth of Australia, 2007.

30 R. Herbert and D. Mackenzie, *The Way Forward*, 2014.

31 This includes preventing and responding to family violence.

32 Including the Ministry of Health Violence Intervention Programme, the Family Violence Interagency Response System (FVIARS), Family Safety Teams and Children’s Teams. There has been significant work progressed within each initiative. For example, the Violence Intervention Programme has developed a CAN memorandum of understanding between New Zealand Police, CYF and 20 DHBs.

33 A. Woodley and A. Palmer, *Working Together to Prevent Family and Sexual Violence in Auckland: An Approach*, Auckland, Point Research, 2014, p. 26. R. Herbert and D. Mackenzie, *The Way Forward*, 2014, p. 71.

34 This includes a range of risk assessment tools and processes.

Figure 3: Map of the current system



Note: A separate PDF of this map is available at www.hqsc.govt.nz/our-programmes/mrc/fvdr/publications-and-resources/publication/2434/.

2.2 Simple responses to complex lives

2.2.1 Single-agency/Single-issue responses

In the current system, agencies and practitioners are not well supported to make the linkages and partnerships between their specific area of practice and the broader supports needed by people experiencing family violence. Consequently, practitioners tend to focus on the issue to which they have been professionally trained and employed to respond. The outcome can be 'single-agency and/or single-issue' practice.

Where family violence has been added on to an existing system response, the 'identify, assess and refer' approach has often been adopted. This response is appropriate for some sectors of the workforce (for example, universal services providing a Tier 2 response)³⁵ because early identification in universal services, such as health and education, provides early intervention opportunities.

However, when the 'identify, assess and refer' approach is the main or only response throughout all tiers of the family violence system, it leaves those most vulnerable underserved. For example, in many Family Violence Interagency Response System (FVIARS) meetings³⁶ multi-agency members review police family violence reports and decide which of the participating agencies to refer the victim or other family members to. Because high-risk cases require an ongoing multi-agency safety response, a single-agency referral can leave victims without a complete range of the necessary supports and be ineffective in curtailing the behaviour of those perpetrating violence.³⁷

Family violence directly contributes to and accompanies a wide range of health (physical, sexual and mental) and social issues (such as employment and education), along with other sources of vulnerability (such as disability). Victims of family violence often have complex lives and are struggling with the multiple and cumulative effects of abuse and trauma on a daily basis. By way of example, for many women with histories of victimisation (as children and adults), alcohol or drug misuse is a way of coping. It helps them numb and block out these experiences.³⁸

Regional reviews provide evidence that 'single-agency/single-issue' practice, combined with the 'identify, assess and refer' approach, is unable to offer the wrap-around of services and support many victims of family violence need. In addition, it can hamper a practitioner's ability to address the issue that they are focusing on.

35 Tier 2: Early Identification & Building Connection - safety-responsive universal services:

- Family violence screening as part of generalist assessment.
- Practitioner in partnership with victim enacts basic safety strategy actions (safety strategy developed in light of what and who the victim has identified as being helpful, and addresses the children's safety and wellbeing needs).
- Practitioner follows up any referrals made (for children and adults) and/or stays engaged with the victim.

See Chapter 4 and the Integrated Safety System diagram (Figure 4 in section 4.4) for further explanation.

36 The FVIARS was established in 2006. In 2013, there were approximately 63 groups across New Zealand, which meet weekly. The number of FVIARS groups is dynamic. Membership varies; however, the majority involve New Zealand Police, CYF and the local Women's Refuges. Please see FVDR, *Third Annual Report*, 2013, pp. 48-56.

37 R.L. Snyder, 'A raised hand: Can a new approach curb domestic homicide?', *The New Yorker*, 22 July 2013, www.newyorker.com/magazine/2013/07/22/a-raised-hand

38 Four psychological outcomes have been associated with traumatic experiences in general and IPV victimisation in particular. These are depression, anxiety, substance abuse and post-traumatic stress disorder. S.C. Swan and D.L. Snow, 'The development of a theory for women's use of violence in intimate relationships', *Violence Against Women*, vol. 12, 2006, pp. 1026-45.

Example 1: A single-agency/single-issue response

In one regional review, the primary victim made multiple disclosures of IPV to her addiction counsellor. Although there was a referral to another health service, this did not result in her situation becoming any safer. The professional intervention was focused on getting her to stop drinking. However, responding effectively to her addiction issues required addressing the underlying reasons why she was drinking – that is, her experiences of child abuse and current experiences of IPV.

Providing safety *and* recovery from addiction therefore required an ongoing partnership between the substance abuse service and a specialist family violence advocacy service.

Having a multi-agency/multi-issue practice response would have also addressed the safety needs of other victims – the children – as well as initiating work with the abusive partner.

2.2.2 Mismatched safety responses

Current responses specifically designed to address family violence are often a mismatch with victims' needs. Effective family violence safety strategies build on the safety actions victims have tried and found helpful. A safety strategy should address the realities of people's lives (such as their financial resources, and their levels of social and whānau support), and include actions practitioners can take to maximise victim safety.

Regional reviews indicate that services across the family violence system are engaging in simple safety planning with extremely high-risk victims. For example:

- practitioners using safety plans from brochures in their professional practice, which were designed for use by members of the public
- using standardised or 'one size fits all' safety plans, which:
 - do not consider the victim's life experiences or other vulnerabilities – for example, their alcohol dependency or disconnection from positive whānau
 - do not explore what the victim may have already tried, what had worked/had not worked, what her worst fears were for herself and her children, and what her staying or leaving plans might be
 - are characterised by limited actions the victim can take – for example, a plan that she will go to a Women's Refuge or obtain a protection order. While temporary accommodation³⁹ and/or a protection order can be included in a plan, they are insufficient on their own to be the plan. These are not effective strategies in and of themselves for ensuring safety from abusive partners
- no concurrent safety strategising by practitioners, including:
 - what the practitioner will do if they do not hear from the victim
 - an assessment of the abusive partner's behaviour, motivation and willingness to engage
 - what actions practitioners will take with respect to the abusive partner in order to enhance victim safety.

Table 2 contains an example of a current safety planning resource,⁴⁰ which is comparable to what many agencies use as their safety plans. We have reframed the safety advice to illustrate how practitioners' responses might better meet the needs of victims.

39 If there are rooms available and the victim and her children are eligible. Refuge accommodation is often not a choice for women (including those with children) with the most complex needs (such as MH&A issues) and who are at greatest risk. Such women are often excluded from 'refuge' because of the additional risks they are perceived to present to refuge security and the safety and wellbeing of other women and children. In addition, many refuges do not accept adolescent boys.

40 This example of a safety planning resource is part of the broader Strengthening Safety Services, a Ministry of Justice initiative that gives victims of domestic violence access to safety services when there is no protection order in place. People who are waiting for a protection order to be made, and victims of domestic violence in the criminal courts, can be at their most vulnerable when proceedings first begin. Strengthening Safety Services is designed to help victims be safe immediately. A trained service provider will help victims with immediate safety issues and work out how they and their children can be protected from further harm. www.justice.govt.nz/family-justice/domestic-violence/support-programmes#victims

Table 2: Safety planning advice – current practice and potential practice

Current safety planning advice for a victim	Considerations	Reframing safety advice in order to become a better helper
<p>Instructions to contact the police if the victim thinks she or her children might be in danger</p>	<p>It is very likely the victim would have contacted the police before, or will have valid reasons why she would not.</p>	<ul style="list-style-type: none"> ▪ Have you called the police before? ▪ Were they helpful? ▪ Would you call them again? ▪ What retribution might your partner take if you call the police? ▪ What has happened before?
<p>Provision of relevant contact numbers for family violence services</p>	<p>Services need to facilitate connections to other services.</p>	<ul style="list-style-type: none"> ▪ Practitioner explains the different services available, such as family violence advocacy services, refuge accommodation and the Safe at Home service. ▪ They explain the responsibilities that services have to the victim and what she can expect. ▪ Practitioner asks about previous experiences with family violence services: <ul style="list-style-type: none"> - Have you been in a refuge before? - How was that? - Would you go again? - We can contact the refuge together at the end of this call if you like.
<p>Advise the victim as to what she can do to try to keep herself and her children safe</p>	<p>A victim will have already tried many things to stay safe, and she will have knowledge of how she thinks her partner will react and retaliate.</p> <p>She is asking for help, as she is unable to keep herself or her children safe.</p> <p>Research shows that the women who approach statutory services are those with the least social supports available.⁴¹</p>	<p>The practitioner asks what the victim has tried before, what worked, and what did not. This informs a tailored safety response based on what works for her. The practitioner explains what they can add to a victim's safety plan.</p> <p>List the actions you as a practitioner can undertake to make her safer or support her:</p> <ol style="list-style-type: none"> 1. 2. 3.

41 P.S. Nurius et al., 'Intimate partner survivors' help-seeking and protection efforts: A person-oriented analysis', *Journal of Interpersonal Violence*, vol. 26, no. 3, 2011, pp. 539-66.

Current safety planning advice for a victim	Considerations	Reframing safety advice in order to become a better helper
<p>Advise the victim as to what she will do and where she will go if she needs to leave empty handed:</p> <ul style="list-style-type: none"> an escape route from her home (eg, which doors, windows, lifts or stairwells to use) where to go when she escapes and how to get there (including form of transport if their car is unavailable) 	<p>Victims may have nowhere to go.</p> <p>Many victims have already thought about leaving. It is useful to understand what has stopped her from leaving.</p>	<ul style="list-style-type: none"> Are her family/whānau members, friends and/or neighbours people she can trust? Are they protective? Would they suggest she could stay at their house? Has she made any previous attempts to leave? What helped her, or what made it unsafe? If she wants to stay in her house, can her house be made more secure? What are agencies doing to curtail her partner's ability to be abusive? If a victim is telling a practitioner that she has to run from her home, the practitioner should be speaking with other services about the level of risk. In such circumstances, a multi-agency safety strategy needs to be developed.
<p>Advise the victim how to minimise the risk of serious injury in the event of immediate danger</p>	<p>Times of increased risk are the period leading up to leaving, leaving, and up to two years after leaving.</p>	<p>If a practitioner thinks someone is likely to be seriously injured, then the practitioner should be taking protective actions.</p>
<p>Advise the victim how to identify people in her community who can help her to be safe (eg, a neighbour)</p>	<p>Victims need to be able to determine who the safe people in their lives are, as not all people or family members understand the dynamics of family violence. Some people can inadvertently make her unsafe, particularly people who see it as important to be 'friends' to both the victim and their abusive partner.</p> <p>The general neighbourhood may also not be safe.</p>	<ul style="list-style-type: none"> Do family/ whānau members or friends collude in the abuse? Does she have safe people in her life? Who does she identify as safe people? What actions can she rely on them to take? If she does not have any safe people who are proximate to her, then there is more responsibility on the agency to take protective actions.
<p>Advise the victim how to access cash</p>	<p>There may be no money to access, or she may not have access to money.</p> <p>Many victims have limited access to money. This can be a deterrent to leaving as they worry about where they will live or how they can provide a safe home and food for their children.</p>	<ul style="list-style-type: none"> The practitioner needs to help her access her full entitlements from Work and Income, as appropriate. There may be a need for a support worker to advocate for her and attend appointments with her.

Victims' current safety strategies are shaped by:

- their cumulative abuse histories
- previous experiences of help-seeking from services
- retaliatory responses from partner(s)
- the emotional reserves they have available to cope with more trauma.

These previous experiences cast a shadow over any current safety interventions that agencies try to put in place. To become better helpers,⁴² all practitioners (even those working in universal services⁴³) can start by having a conversation with a victim about safety strategies she has previously tried.

For example:

*Identify past safety strategies:*⁴⁴

- What has she tried? How did it work?
- Would she try it again? If not, why not?
- What was her partner's reaction?

Identify current safety strategies:

- What personal, public and social/cultural resources has she identified?
- How does she think her partner will react to her strategies?

Practitioners can also advise victims about the supports available from local services for themselves and their children. A minimum safe response (Tier 2) requires practitioners to develop a safety strategy based on what and whom the victim has identified as being helpful. Then the practitioner:

- enacts safety actions in partnership with the victim
- follows up any referrals made and/or stays engaged with the victim
- regularly discusses and monitors the safety strategy within their agency's multi-disciplinary team and/or multi-agency processes or peer review process.⁴⁵

2.2.3 Referring victims and/or people using violence to parenting programmes

The regional reviews suggest generic parenting programmes aimed at teaching parenting skills are a mismatch with people who have experienced abuse and/or who are perpetrating violence.

Parenting programmes and support services need to specifically address people's own experiences of abuse and trauma over their life course. Those who have been parented abusively, who have been abused as adults, or who are abusive need help to address those issues and need to be supported to parent in an alternative way. Parents who have experienced difficult childhoods are usually aware of the need to provide a better experience for their own children but may find it difficult to do this without considerable support.

42 D. Wilson et al., 'Becoming better helpers: rethinking language to move beyond simplistic responses to women experiencing intimate partner violence', *Policy Quarterly*, vol. 11, no. 1, 2015, pp. 25–31, www.hqsc.govt.nz/our-programmes/mrc/fvdc/publications-and-resources/publication/2096/

43 Please see Tier 2 of the Integrated Safety System diagram (Figure 4 in section 4.4).

44 J. Davies, E. Lyon and D. Monti-Catania, *Safety Planning with Battered Women: Complex Lives/Difficult Choices*, California, SAGE Publications, 1998.

45 The Maternity Care, Wellbeing and Child Protection Multi-Agency Group is a DHB-facilitated multi-agency forum. The purpose of this forum is to enable the best possible outcomes for women and their families identified to have vulnerabilities during the maternity care period (antenatal to six weeks post-partum) by working in partnership with them. The aim of the multi-agency group is to strengthen families by facilitating a seamless transition between primary and secondary providers of support and care, and working collaboratively to engage support agencies to work with the mother and her whānau in a culturally safe manner.

Parenting programmes and services also need to address the entangled nature of CAN⁴⁶ and IPV, and consider how IPV can negatively affect victims' (most often mothers') interactions with their children. For Māori whānau, this will require Kaupapa Māori approaches.

Wrap-around support, knowledge and skills are crucial. It is widely understood that nurturing home environments are essential for children's wellbeing and development.⁴⁷ The gap is in the provision of support that effectively addresses what prevents parents from being able to provide such environments. Two-generation 2.0 approaches⁴⁸ to supporting families and children promote the human capital of children and parents together; investing in high quality, culturally responsive early childhood education for children; and education and support to get out of poverty for parents.⁴⁹ There may be a place in Aotearoa New Zealand for three- or four-generation approaches to addressing family violence within whānau and families.

2.3 Responses that may be harmful

The current family violence system can result in a range of unintentionally harmful responses to victims (from unhelpful to unsafe). There are multiple reasons for this. Harmful responses to family violence disclosures can occur because of the lack of a family violence system, as discussed above. For instance, there are currently different understandings of the dynamics of family violence, varying degrees of training and competence, few safe service accreditation processes throughout the family violence workforce and under-resourced specialist family violence advocacy services.

Most often, practitioners are not required to be actively involved with and accountable for child and adult victims' safety. Rather, there is a reliance on referring, along with insufficient responsibility in many agencies to work with victims and the people using violence.

2.3.1 Unhelpful responses close down future help-seeking

While the regional reviews demonstrate that IPV victims are proactive help-seekers, they often do not receive the help they need. This inadvertently compounds their entrapment.⁵⁰ For victims belonging to socially marginalised groups, what might appear to be simple help-seeking often involves extraordinary effort. Attending an appointment might mean managing their children's needs, pooling limited resources to access public transport, and navigating multiple sectors in the transport system, only to be confronted with complex referral pathways and people working in the services they are approaching for help who are often judgmental. Marginalised and disadvantaged people are more likely to receive negative social responses and may be particularly sensitive to the responses they receive.

Richardson and Wade⁵¹ state the nature and quality of social (including organisational) responses to victims' disclosures are a significant contributor to victim distress.⁵² It also determines the likelihood of successful outcomes.

46 Many parenting programmes lack strong evidence of effectiveness in reducing CAN. The programmes shown to be most effective in reducing CAN are Nurse-Family Partnership; Early Start; Parent-Child Interaction Therapy; and SafeCare. The Chicago Child-Parent Center, Head Start and other childcare programmes have also shown reductions in rates of CAN. Social Policy Evaluation and Research Unit, *What Works: Effective Parenting Programmes*, Wellington, SuPERU, 2015, p. 10.

47 World Health Organization, *Violence Prevention: The Evidence*, 2010.

48 Called 'two-generation 2.0' programmes (because they focus on two generations – the child and the parent), these programmes focus on improving education outcomes for parents at the same time as providing high quality early childhood education opportunities for children. Centre for Social Impact, *A Report to Bay Trust: A Focus on Opportunities to Make a Positive Impact in the First 1,000 Days of a Child's Life & Youth Engagement*, Centre for Social Impact, 2015.

49 The Leeds Initiative, *Leeds 2030: Our Vision to Be the Best City in the UK: Vision for Leeds 2011 to 2030*, Leeds, The Leeds Initiative, 2011, www.leeds.gov.uk/docs/Vision%20for%20Leeds%202011%20-%202030.pdf. Center for Working with Families, *An Integrated Approach to Fostering Family Economic Success: How Three Model Sites Are Implementing the Center for Working Families Approach*, Baltimore, Family Economic Success Unit, Annie E. Casey Foundation, 2010.

50 Entrapment is explored in more detail in section 3.1.2.

51 C. Richardson and A. Wade, 'Islands of safety: Restoring dignity in violence-prevention work with indigenous families', 2010.

52 A. Wade., *Telling it like it isn't: Violence, Resistance and the Power of Language*, presentation at the Federal Symposium: Choose Your Words Carefully: Talking About Victimization, Ottawa, 19 April, 2010.

Victims who receive *negative* responses to their help-seeking are:

- less likely to cooperate with authorities
- less likely to disclose violence again
- more likely to experience distress
- more likely to receive a diagnosis of a mental health disorder.

Examples of negative responses from the regional reviews include:

- a victim being told when reporting an assault from her abusive partner that she will most likely be arrested as well for using force
- a victim being told that if there is another police family violence report then Child, Youth and Family (CYF) will become involved again (her children had previously been removed by CYF from her care)
- a victim who rejects a house because it is not in a safe location being told she will not be offered another state-funded house if she rejects a second house.

Victims who have such experiences are less likely to trust that when seeking help on subsequent occasions they might meet a practitioner with a better understanding of IPV and receive a more helpful response.

Conversely, victims who receive *positive* responses:

- tend to recover more quickly and fully
- are more likely to work with authorities
- are more likely to report violence in future.

Examples of positive responses from the regional reviews include:

- a victim for whom English was her second language, asking a service to contact the police officer she had met a year earlier. The officer's actions had a lasting impact on the victim, as she:
 - remembered the time taken by the officer
 - trusted the officer could help protect her
- a victim on a community sentence at a home she shared with her abusive partner disclosed to a duty probation officer that she was fearful for her safety and had endured multiple forms of violence from different men. The officer recognised the seriousness of the situation and requested help. She was moved from the address that day.

2.3.2 An empowerment framework makes the victim responsible for the abuse

An empowerment framework, which many family violence and statutory services use to guide their practice, does not support safe responses. An empowerment framework is built on the philosophy that practitioners can empower victims experiencing IPV to address the abuse they are experiencing themselves. Working within an empowerment framework, practitioners commonly (mis)understand that their role is to develop a list of safety actions for the victim to take. As noted above, these actions are frequently generic and transactional in nature. A focus on what the victim needs to do is conflated with being *victim focused*. The regional reviews have found this unintentionally places the responsibility on the victim to achieve safety – a person who is seeking help precisely because they cannot achieve safety alone – rather than on the multi-agency system. Such an approach overlooks the fact that victims are living with high levels of risk and their partner's coercive and controlling behaviour entraps them.

Placing responsibility on the victim to achieve safety, when she is unable to keep herself or her children safe, can result in conversations about her poor choices and personal deficits. This constructs her as the problem – someone who is uncooperative, not wanting help and/or choosing to be abused. Her partner's responsibility for his abusive behaviour disappears from the picture.

The limitations of an empowerment framework in the context of family violence are discussed further in section 3.1.2.

2.3.3 Responses to people using violence are under-developed

Responses to people who use violence against members of their family are currently under-developed. If the physical violence *on a particular occasion* is assessed as 'low level', the criminal justice response is *at best* likely to result in a community-based sentence and attendance at a non-violence programme for the abusive person. It may also result in a sentence of discharge without conviction,⁵³ conviction and discharge,⁵⁴ or to come up for sentence if called upon.⁵⁵ The current focus of the criminal justice system is on reacting to past proven incidents of physical violence, rather than disrupting patterns of offending and keeping victims safe.

Currently, many non-violence programmes are built around the single-agency/single-issue response described above. They are not mandated to be part of a multi-agency response focused on victim safety. In one regional review, for example, there were multiple police call-outs while the abusive partner was attending a programme. The programme provider was unaware of these call-outs⁵⁶ and was under the impression the abusive partner was taking responsibility and modifying his behaviour. A mandated multi-agency response would mean these events informed the programme provider's assessment of and response to the abusive partner.

2.4 Conclusion

Although many committed and dedicated practitioners staff the family violence response system in Aotearoa New Zealand, it is fragmented and set up to produce simple and potentially harmful practice responses. When developing a system specifically designed to address family violence (an integrated system),⁵⁷ we require a number of shifts in practice.

It is necessary:

- for services to take time to comprehend victims' experiences and become better helpers
- to remove the responsibility for achieving safety from the victim and place it on the response system
- to place the responsibility for the abuse on the person using violence
- to increase the range of strategies available to contain, challenge and change abusive people's harmful patterns of behaviour.

53 Section 106, Sentencing Act 2002.

54 Section 108, Sentencing Act 2002.

55 Section 110, Sentencing Act 2002.

56 It is important to remember that reported offending is likely to be the tip of the iceberg.

57 See Chapter 4.

CHAPTER 3: THINKING DIFFERENTLY ABOUT FAMILY VIOLENCE

Family violence⁵⁸ has historically been thought of as a problem between individuals, which can be resolved by simple interventions. In this chapter, the Committee draws on the detailed histories in the regional reviews of violence, resistance and help-seeking, and the myriad of responses by communities and agencies, to expose common misunderstandings about the nature of family violence. These ways of thinking about family violence undermine our ability to respond safely.

How we describe a problem (for example, what we see as the concern and the cause⁵⁹) will determine our response to it, including what kinds of reforms we see as necessary. Yet rarely do we examine the assumptions that we have made and the underlying thinking that informs the construction of the problem.

In Chapter 3 of its *Fourth Annual Report*,⁶⁰ the Committee set out some of the misconceptions about family violence. Here it expands on that work. First, the Committee adds to and explains in more detail the misconceptions highlighted in the *Fourth Annual Report*. Second, the Committee provides further examples from the regional reviews of how this thinking underpins and undermines our current responses to family violence. Third, the Committee begins to map the manner in which such misconceptions operate to reinforce each other. Most importantly, the Committee begins to address the relationship between structural inequity and family violence.

Thinking differently about family violence is a prerequisite for system reform. Attempting to reform the family violence system while continuing to think about family violence in exactly the same way is unlikely to produce the kinds of systemic changes required. Old ways of thinking about what the problem is and how services should respond will undermine reforms. These shifts in thinking need to take place collectively – as shared understandings across the family violence workforce and society.

3.1 Thinking differently about intimate partner violence (IPV)

3.1.1 Descriptions of IPV: Marital conflict – incidents of physical violence – a pattern of harm

IPV used to be thought of as ‘marital conflict’. Over time, shifts in thinking have led to an understanding of IPV as a series of ‘incidents of physical violence’. The Committee suggests family violence is best understood as a ‘pattern of harm’.

‘Marital conflict’

Traditionally an abusive husband’s behaviour towards his wife was perceived as a relationship issue for which both parties were responsible. IPV was misunderstood as marital conflict – disputes between couples that belonged in the domestic or private sphere.

Incidents of physical violence

Concerted advocacy over time has meant that criminal offending occurring in the home has been brought into the public sphere and prosecuted as such⁶¹ – supplemented by the protection order process, which is directed at preventing further incidents. The result is a shift in the way we think about family violence. Now it is also possible to understand family violence as a series of incidents of physical violence (some of which are criminal offences) and disputes (which do not amount to a criminal offence).

58 The focus of this chapter is on IPV and CAN.

59 C. Bacchi, *Analysing Policy: What's the Problem Presented to Be?*, Australia, Pearson, 2009.

60 FVDR, *Fourth Annual Report*, 2014, pp. 71–88.

61 Particular forms of family violence, such as sexual violence and strangulation, are arguably still not adequately addressed in the criminal justice context.

Such ways of thinking are not mutually exclusive. The incidents of physical violence might be understood as occurring because of the abusive person's frustration about aspects of his relationship with the victim.

We can still see both modes of understanding IPV in operation today – in practitioners' descriptions of and responses to IPV, and in the processes, information and tools that frame and support those responses. Example 2, taken from the regional reviews, illustrates why it is problematic to understand family violence as relationship dysfunction manifested in discrete incidents of violence, as opposed to an abusive person's harmful pattern of behaviour.

Example 2: 'A dysfunctional relationship'

Peter committed a serious assault on his partner Zoe. He ambushed her and then attacked her while telling her that he was going to kill her. She managed to break free and seek help from a stranger. Peter was imprisoned for this offending and then released on conditions with the Community Probation Service.

During this time he had regular meetings with probation staff who were managing his sentence – often coming to meetings with his new partner (Samira). Despite the fact that Peter's offending history indicated he was capable of using extreme violence against an intimate partner if she tried to separate from him, no interventions were put in place for Samira. No attempts were made to speak to her alone to ask her about his behaviours (particularly as the relationship progressed beyond the early stages) and he was not seen as dangerous to her.

Samira was viewed as his support person and a positive influence in his life. The focus was on assisting him to stop drinking. When Zoe relocated a great distance from her home and community (because once Peter was released from prison she was too frightened to remain), it was noted that Peter was relieved as 'he no longer has to look over his shoulder'.

After his sentence finished, Samira attempted to separate from Peter due to his increasingly controlling behaviour.

He killed her.

A number of factors supported the response of probation staff in this case. For example, Peter was respectful and compliant, and the risk assessment tools practitioners were using did not incorporate an IPV lens. Underpinning their response was also a belief that Peter's 'bad relationship' with Zoe was the source of the violence. In a new, positive, trust-based and supportive relationship (and if he was not drinking) those problems could be left in his past.

The next example (Example 3) illustrates how the current response to family violence fragments and obscures the offender's harmful pattern of behaviour. Each incident of violence was viewed as a discrete event and responded to as 'low-level' offending. Each sentence was considered the appropriate punishment for that particular event. The result was that the offender's overall pattern of harmful behaviour was missed and the risk he presented was not addressed.

Example 3: 'Discrete incidents of violence'

Over a 15+ year period, Mark had 20+ convictions for IPV offending against multiple female partners. More than three of his partners had obtained a protection order when they were attempting to separate from him. He breached each order multiple times.

At the point of separation, Mark had attempted to kill previous partners. In each instance his partner had been warned by a third party and police were able to apprehend him upon arrival at their homes. These events resulted in convictions, including threats to kill/do grievous bodily harm, breaches of protection orders and possession of a weapon.

Mark was never imprisoned for his IPV offending. His sentence on his convictions for family violence offending near the end of his offending history was similar to the sentence he received at the beginning – supervision with Community Probation Service, and attendance at a non-violence programme. He received warnings after breaching the protection order against his last partner.

Mark killed his last partner when she was trying to separate from him. A third party called the police but she died before they arrived.

A pattern of harm

When it is appreciated that IPV is a *pattern of harmful behaviour* that *belongs to the abusive person* (not the relationship) and is *bigger than the incidents of physical violence* that occur on any particular occasion, a number of shifts automatically take place in our thinking.

- While any particular incident of physical violence might appear 'low-level', it is appreciated that it cannot be properly understood without being viewed in the context of the abusive person's *entire pattern of behaviour*. This includes other acts of physical violence, as well as controlling and coercive behaviour that do not involve physical abuse – the bigger dynamics in the pattern of abuse.
- Any episode of violence must be placed in the context of the person's patterns of abusive behaviour in *previous relationships*. This involves both appreciating that such information is relevant *and* being able to access it. Work is underway to rectify the fragmentation of information in some parts of the system – for example, greater information-sharing between the family and criminal justice systems, the police and the courts.
- For the victim, a violent episode is unlikely to be experienced as an 'incident'. As noted by Domestic Violence Victoria, 'For the majority of women experiencing family violence, it involves an *escalating spiral of violence*, rather than a one-off incident.'⁶²
- It becomes important when assessing the risk the abusive person poses to understand their history and social context. For example, it is highly relevant to understand any untreated trauma they may have and their level of connection to, and support from, their whānau and community.
- All intimate partners with whom an abusive person has a relationship will potentially be at risk from their behaviour. It is important to consider that IPV is not an event that only concerns those individuals who were involved in any particular episode. There is a public interest in protecting hidden and future victims.⁶³

62 Domestic Violence Victoria Submission to the Victorian Royal Commission into Family Violence, *Specialist Family Violence Services: The Heart of an Effective System*, 19 June 2015, p. 9, www.rcfv.com.au/getattachment/C7B3D161-D430-4305-BAD6-BF02095D02E5/Domestic-Violence-Victoria---02 [Emphasis added].

63 We would query, for example, how appropriate it is to embark on private dispute resolution processes in respect of a particular episode and particular victim. Interventions should also address the need to protect other victims, including flagging interventions on the public record for the purposes of future decisions about victim safety.

- The focus shifts from being reactive to preventative. If this is an ongoing pattern of harm, as opposed to a single incident, we need to consider what strategies we can put in place to disrupt that pattern of behaviour and/or protect those who are at risk from it. In Example 3, incarceration would have given Mark's last partner a period of guaranteed physical safety during the very dangerous post-separation period.
- Currently, beyond incarceration and community supervision, the main option for responding to people perpetrating violence is non-violence programmes. These are inadequate in their current format. They do not offer interventions that are sufficiently timely⁶⁴ or sustained to deal with men who have their own untreated trauma, who have had violent behaviour modelled as appropriate masculinity from a young age, who are isolated and disconnected from those around them, and who have entrenched and high-risk histories of offending. Nor do they adequately address co-occurring problems such as substance abuse or mental health issues. Furthermore, many non-violence programmes operate in isolation rather than as part of a multi-agency response to family violence that has victim safety as a core principle.⁶⁵ If we are to provide victims with safety, we need new and realistic ways of responding to people perpetrating violence and containing their behaviour. This is discussed further in section 5.2.
- If a person has a harmful pattern of behaviour, we need to see evidence of safe behaviours before we can accept their behaviour has changed. In many regional reviews, an abusive person's verbal expressions of remorse were taken at face value. In Example 3, Mark was sent to a non-violence programme after being convicted for family violence offending against his last partner, even though his behaviour was part of a long and entrenched pattern against multiple partners and there was no evidence, beyond his expressions of remorse, of any commitment to change. The judge said: 'You have indicated that you want to change and I am going to give you that chance.'

3.1.2 Victims' responses: Learned helplessness – empowered and autonomous victims – resistance and entrapment

Two assumptions underpin our current understanding of victims' help-seeking. These are:

- victims, with help, can effectively deal with the violence they are experiencing
- help is readily available to those prepared to seek it.

When it is appreciated that IPV is a form of entrapment with social and structural dimensions – which include sometimes unintentionally harmful responses by the family violence system – these assumptions are called into question.

Learned helplessness

When victims are charged with family violence criminal offending (in response to threats posed by their abusive partner), expert testimony has been introduced to explain their 'learned helplessness'.⁶⁶ The concept of learned helplessness suggests victims do not leave partners who abuse them because, as a result of being abused, they form the 'irrational' belief that:

64 A current issue is that men using violence only interact with the criminal justice system once their problems have become entrenched. The immediacy and intensity of interventions have particular value – not just the length of the programme. E. Gondolf, *Batterer Intervention Systems: Issues, Outcomes and Recommendations*, Thousand Oaks, SAGE, 2002. E. Gondolf, *The Future of Batterer Programs: Reassessing Evidence-Based Practice*, Boston, Northeastern University Press, 2012.

65 K. Diemer et al., 'Researching collaborative processes in domestic violence perpetrator programs: Benchmarking for situation improvement', *Journal of Social Work*, vol. 15, no. 1, 2015, pp. 65–86. L. Kelly and N. Westmarland, 'Domestic violence perpetrator programmes: Steps towards change', *Project Mirabal Final Report*, London and Durham, London Metropolitan University and Durham University, 2015. FVDRC, *Third Annual Report*, 2013, pp. 57–66.

66 Dr Lenora Walker was the first to apply the concept of 'learned helplessness', originally coined by Seligman and his colleagues to describe a condition developed by abused dogs, to women. L.E. Walker, 'Battered women and learned helplessness', *Victimology*, vol. 2, (3–4), 1977, pp. 525–34. W.R. Miller and M.E. Seligman, 'Depression and learned helplessness in man', *Journal of Abnormal Psychology*, vol. 84, no. 3, 1975, pp. 228–38. The concept has been widely criticised. See I. Leader-Elliot, 'Battered but not beaten: Women who kill in self-defence', *Sydney Law Review*, vol. 15, 1993, pp. 403–59.

- they do not have power in their lives
- the abusive partner is all-powerful
- they cannot escape the abuse.

Victims are therefore seen as developing a 'syndrome' that immobilises them, making them passive and helpless in the face of danger. Without such testimony the fact that victims did not leave an abusive partner or repeatedly seek help from the police is taken as evidence that the abuse was not as bad as claimed or that the victim chose to stay in the situation and was, therefore, partially responsible for it.

The regional reviews do not support the idea that victims experiencing IPV are passive and helpless. Victims are proactive help-seekers. Research also suggests that victims experiencing the highest levels of violence, and who have the lowest levels of informal support, are more active in seeking help from agencies.⁶⁷ In other words, victims seek help when they *actually need help*.⁶⁸

The form of a victim's help-seeking (when, from whom and how she goes about communicating her need) is, however, constrained by the actions of her abusive partner and the structural reality of her life. For example, a victim with a gang-affiliated partner may call the police but be unable to communicate with them openly when they arrive. It may be extremely dangerous for her to publicly cooperate with the police. That does not mean she does not need help.

The myriad of acts a victim may take in order to resist abuse must be overlooked if she is to be constructed as passive and helpless. If her help-seeking cannot be overlooked because it is too overt, then people assume this particular victim must have been lying about her abuse because she is failing to exhibit the symptoms of a stereotypical abuse victim.

Empowered and autonomous victims

Many family violence services use an empowerment framework to guide their practice.⁶⁹ An empowerment framework seeks to counter the *disempowerment* IPV victims have experienced by supporting them in their individual decisions about how to address the abuse they are experiencing. This framework appears to be used irrespective of:

- how potentially lethal the violence is
- the victim's cumulative abuse history
- the victim's health and social status
- the victim's level of trauma and vulnerability
- the strength of the victim's social relationships and/or cultural connections.

As the Committee noted in its *Fourth Annual Report*, an agency response based on an empowerment philosophy has the unintended and dangerous consequence of placing the responsibility to stem the abusive partner's violence and initiate safety plans on the *victim* rather than on the *family violence response system*.⁷⁰ It also avoids focusing on how we can contain the abusive person's behaviour so we can create safety for the victim. Instead, the focus becomes the victim and what actions she can take to help herself.

If victims are not able to achieve safety, an empowerment approach sets up a conversation about their poor choices or unwillingness to receive the help offered – for example, she failed to leave the relationship or sever all contact with her abusive partner, even though it was explained to her she was in serious danger. If she has dependent children, it sets up a conversation about the fact that she has the right to make these poor choices in respect of her own wellbeing but not on their behalf. If she did take appropriate actions (call the police, separate, seek a protection order and temporary accommodation in

67 P.S. Nurius et al., 'Intimate partner survivors' help-seeking and protection efforts: A person-oriented analysis', 2011.

68 Stark comments that 'abuse victims are aggressive help seekers'. E. Stark, *Coercive Control: How Men Entrap Women in Personal Life*, 2007, p. 12.

69 M. Morgan and L. Coombes, 'Empowerment and advocacy for domestic violence victims', *Social and Personality Psychology Compass*, vol. 7, no. 8, 2013, pp. 526–36.

70 FVDRC, *Fourth Annual Report*, pp. 83–4.

a refuge) and she and/or her children are nonetheless killed, then an empowerment approach sets up a conversation about the inevitability of the outcome (she did all the right things and therefore no one could have avoided this outcome).⁷¹

An empowerment framework does not adequately acknowledge or address the constraints of real people's lives, including:

- the impact of the abuse and the abusive partner's behaviour in curtailing the victim's choices
- the larger systemic and structural impediments victims face⁷²
- victims' varying levels of vulnerability.

Nor does an empowerment framework allow us to face up to the fact that what we are currently offering victims of IPV is not working for them.

A learned helplessness approach explains a victim's lack of autonomy and choice in terms of her own psychological processes, whereas an empowerment approach is premised on the assumption that all victims of IPV are operating from a space of autonomy and choice. Both approaches start from the same idea – that with appropriate action the victim is/would be⁷³ able to stop her partner's violence and achieve safety for herself and her children (unless he is unstoppable).

Entrapment and resistance

IPV is a form of 'social entrapment' with three dimensions:

- the social isolation, fear and coercion the abusive partner's violence creates in the victim's life
- the indifference of powerful institutions to the victim's suffering
- the ways in which coercive control (and the indifference of powerful institutions) can be aggravated by the structural inequities of gender, class and racism.⁷⁴

An entrapment approach requires an investigation *in each case* of the manner in which a particular victim's choices have been constrained by the violence they have experienced. This includes considering past responses to their help-seeking and the larger structural constraints of their lives, including the structural constraints of their families, whānau and communities. It involves interpreting their behaviour in that context.

It does not involve assuming all victims' experiences of, or responses to, abuse are the same (resulting in the need to treat everyone the same).⁷⁵ Nor does it assume victims automatically possess autonomy and choice or are deprived of autonomy and choice because of being abused.

Table 3 provides examples from regional reviews of the three dimensions of entrapment.

71 J.H. Aiken and K. Goldwasser, 'The perils of empowerment', Georgetown Law Faculty Publications and Others Works, paper 501, 2010, <http://scholarship.law.georgetown.edu/facpub/501>. Critique of the Empowerment Star for domestic violence victims: www.dvrcv.org.au/knowledge-centre/our-blog/empowerment-or-compliance

72 S. Strega, 'Anti-oppressive approaches to assessment, risk assessment and file recording', in S. Strega and S. Aski Esquao (eds.), *Walking This Path Together: Anti-Racist and Anti-Oppressive Child Welfare Practice*, Nova Scotia, Fernwood Publishing, 2009, p. 153.

73 If she had not chosen to act otherwise because of her individual choice (empowerment) or personal deficit (learned helplessness).

74 J. Ptacek, *Battered Women in the Courtroom: The Power of Judicial Responses*, Northeastern University Press, Boston, 1999.

75 An equality approach (as it is described in this report) overlooks the differences that exist between the victims' experiences, life circumstances, social supports and other contextual factors. The regional reviews have highlighted that while similarities exist for victims, each individual's circumstances and contexts differ in some way. Therefore, it is important to treat victims differently according to their individual needs and circumstances.

Table 3: Dimensions of entrapment and examples

Dimensions of entrapment	Examples	Quotes
<p>Social isolation, fear and coercion created in the victim's life by the abusive (ex) partner's violence</p>	<ul style="list-style-type: none"> ▪ Abusive partner always has one of the children with him so she cannot leave; and he has previously intentionally injured one of the children. ▪ Abusive partner threatens to kill the victim if she leaves him, and uses non-fatal strangulation as a means to communicate his lethal intentions. ▪ Abusive partner smashes victim's phones, prevents her from seeing her family and having connections to her community. ▪ Abusive partner increases stalking behaviour and threats after she has separated from him. ▪ Abusive partner insists everything they own is in his name, or runs up debts in her name. ▪ Abusive partner is unpleasant to her friends and does not like her going out. If she takes too long to complete an errand, he texts or goes looking for her. 	<p>'We were aware that her child was in [country], the child had been sent there without her consent.'</p> <p>'He will not let her tell anyone her address or phone number.'</p> <p>'I knew he meant business ... he was going to kill me ... I wouldn't wake up from this ... I would be leaving my kids behind.'</p> <p>'He told her she would never leave him alive and she would never be allowed to take his [child] away from him ... she was [so] terrified her teeth were chattering.'</p> <p>'We were ... advertising rooms to rent at our home, [she] pleaded over the phone for us to rent a room for her and her children, she said she did not want her partner to know where she was, he was very controlling ... she came that night.'</p> <p>'He liked to have control over [victim] and who she hangs out with.'</p> <p>'I never went to my sister's aid after that as I was worried for my life.'</p>

Dimensions of entrapment	Examples	Quotes
<p>The indifference of powerful institutions to the victim's suffering</p>	<ul style="list-style-type: none"> ▪ Victim has been abused in state care as a child. ▪ Victim is seen by practitioners as choosing 'abuse' and deserving what she gets. ▪ Practitioners' concern for the safety and wellbeing of the children is not extended to the adult victim. ▪ Victim is on Community Detention with a curfew at her abusive partner's flat. She will breach the curfew if she tries to escape from his abuse, as she cannot leave the property without prior agreed absences. ▪ Victim discloses the abuse multiple times to a range of organisations, only to receive similar advice about being responsible for keeping herself safe. ▪ Victim reports a breach of her protection order and the respondent receives a warning. She reports another breach and he receives another warning. ▪ A socially marginalised and vulnerable victim is admitted to hospital with injuries and then discharged without any referrals to family violence agencies or follow-up plan for her safety. 	<p>'[Victim] appears to have difficulty separating herself and ... is demonstrating victim behaviour.'</p> <p>'... she was putting herself at risk and making him breach his ... order by doing so, therefore she was more accountable for any risk potential.'</p> <p>'... she did not have any understanding of the level of risk she has placed herself in by returning home ...'</p> <p>'Claims to have been assaulted by her partner today ... [W]ants ... admission [to hospital].'</p> <p>Practitioner A: 'We have real concerns for his partner and definitely would not want him to be bailed with her. You know he is bailed there?'</p> <p>Practitioner B: 'Sigh ... I see that. Well I guess we will just deal with the next incident when it happens. I imagine she wants him there.'</p>
<p>Coercive control aggravated by structural inequities of gender, class and racism</p>	<ul style="list-style-type: none"> ▪ Abusive partner is a member of a gang that adheres to traditional views on gender roles and justifications for violence against women. ▪ Family members support abusive partner's actions and blame the victim for the abuse. ▪ Victim has no money, no car and little credit on her phone. ▪ Victim's whole family is living in extreme economic deprivation and has few resources. ▪ Victim is living with high levels of historical and intergenerational trauma affecting not just themselves, but their extended family and support networks as well. 	<p>'An officer asked [victim] where she was attacked. [Victim] replied, "I don't want to say because they are all [gang], my partner is [gang] and they all are too."'</p> <p>'I think the whole community knew what was going on, there is a bit of a culture ... of keeping out of other people's business.'</p> <p>'Community worker would like to have a meeting with [victim] ... and some whānau members to look at their social issues which have been going on for generations.'</p> <p>'She said that he did not have any alcohol free friends or family members.'</p>

Coercive control

Stark, with more than 20 years' experience in working with victims of IPV, comments:

'the women in my practice have repeatedly made clear that what is done to them is less important than what their partners have prevented them from doing for themselves by appropriating their resources; undermining their social support; subverting their rights to privacy, self-respect and autonomy; and depriving them of substantive equality.'⁷⁶

IPV, particularly as the victim's vulnerability increases, compromises her ability to be 'empowered' and to protect herself and her children. The very nature of coercive control makes it almost impossible for many victims to remove themselves and their children safely from an abusive partner, particularly when the coercive control intensifies. The violence is directed at isolating the victim from potential support and undermining her self-determination.

The indifference of powerful institutions

The Centre for Innovative Justice in Melbourne remarks that "family violence related deaths are "amongst the most preventable deaths in the community", with "red flags" often evident and potential victims known, many of whom express fears for their lives yet encounter a "wall of lethal indifference"."⁷⁷

As noted in the Committee's previous reports, the regional reviews provide evidence of victims fighting for their lives, yet many were unable to access proper support to achieve safety. This was despite the well-meaning efforts of many individuals (providing them with temporary accommodation, referring them to a lawyer to obtain a protection order, or advising them on actions they can take to keep themselves safe in the situation). The reality is that real help within our current family violence system is sporadic, unpredictable and frequently not available for victims.⁷⁸ There are also few constraints to address their partner's abusive behaviour.

Structural inequities

A number of primary victims in the regional reviews had unaddressed histories of childhood abuse and trauma, and compounding experiences of victimisation throughout their adult life.⁷⁹ These victims were extremely vulnerable. They were often grappling with a number of co-occurring issues such as addiction and mental health. Many were in positions of extreme economic disadvantage.

Gender inequity, racism, poverty, social exclusion, disability, heterosexism and the legacy of colonisation shape people's experiences of abuse. Victims who are in the most dangerous social positions may face higher levels of violence and have less support and resources to manage.⁸⁰ These victims may well have extended families and communities that are experiencing intergenerational trauma as the historical legacy of colonisation. They are also more likely to be confronted with discriminatory attitudes when seeking help from services charged with protecting and/or providing support to them and their children.

For example, Māori women are likely to have lower levels of education, be poorer, live in areas with poor quality housing and have their children younger. Māori women are more likely to experience racist attitudes and indifference when seeking help from agencies and services. They are also almost six times more likely to be hospitalised because of assault and attempted homicide, and 1.6 times more likely

76 E. Stark, *Coercive Control: How Men Entrap Women in Personal Life*, New York, Oxford University Press, 2007, p. 13. L. Kelly and N. Westmarland, 'Domestic violence perpetrator programmes: Steps towards change', 2015, p. 12. 'Abusive men attempt to enforce acceptance of their views, opinions, standards, emotions and needs.... The principle of this style of communication is that women and children should recognize and adhere to the man's perspectives. That women refused, at times for some and always for others, was one of the core dynamics in abuse. Many women spoke about the way that over time their voices and everyday actions were narrowed and they adapted to his views.' The micro-management of everyday life 'gradually shrinks ... women's "space for action"'. L. Kelly and N. Westmarland, 'Domestic violence perpetrator programmes', 2015, p. 35.

77 Centre for Innovative Justice, *Opportunities for Early Intervention: Bringing Perpetrators of Family Violence into View*, Melbourne, RMIT University, 2015, p. 31.

78 C. Richardson and A. Wade, 'Islands of safety: Restoring dignity in violence-prevention work with indigenous families', 2010.

79 L. Davies et al., 'Patterns of cumulative abuse among female survivors of intimate partner violence: Links to women's health and socioeconomic status', *Violence Against Women*, vol. 21, no. 1, 2015, pp. 30-48.

80 Richie states that poor women of colour are 'most likely to be in both dangerous intimate relationships and dangerous social positions'. B. Richie, 'A Black feminist reflection on the anti-violence movement', *Signs*, vol. 25, 2000, pp. 1133-7, p. 1136.

to die of assault and homicide.⁸¹ When their children are harmed, Māori women tend to be socially demonised, evident in the media's 'mother blaming', with little consideration of the horrific ongoing abuse and violence the women themselves live with.

Violence within Māori whānau (immediate and wider family) cannot be addressed without considering the impacts of colonisation on Māori whānau. The colonising agenda was assimilation of Māori and the dispossession of their land, language and cultural practices. The loss of land, along with the urbanisation of many Māori, disconnected them from their tūrangawaewae (place connected with whakapapa to stand) and their cultural connections. With this disconnection came the loss of the protective supports that are inherent in the traditional functioning of whānau, and also the important cultural beliefs that saw women and children as valued and protected members of Māori society.

These losses, combined with the imperative that Māori conform to dominant (ie, colonial) cultural traditions, meant the collective responsibility and obligation to protect and nurture women and children within whānau and hapū disappeared. In addition to structural changes to many whānau, gender roles that were traditionally complementary and involved men having an active role in caring for tamariki were changed. Instead, whānau became the private domain of men, and male dominance became a feature in Māori society.⁸² Māori women no longer held equal positions and could not rely on the protective korowai (cloak) of the wider whānau. In today's society, many Māori men are exposed to, and influenced by, dominant non-Māori forms of masculinity.⁸³

Structural inequities support the entrapment of family violence victims. For example, it is not unusual for victims to have no money because financial control is one of the strategies abusive partners use. Access to money, housing and food are essential for victims wishing to leave and set up a new life for their children. Victims who do not have employment, transport to attend agency appointments, or extended family who are able to provide them with temporary shelter and essentials, and who receive unhelpful responses from agencies, are particularly likely to be trapped in relationships with abusive partners. Such problems are acute for victims with gang-affiliated partners whose associates spread throughout their social networks.

The cumulative and compounding nature of entrapment

Just as a pattern of abuse has a cumulative and compounding effect on the victim, so does entrapment. Example 4 illustrates the layers and intensity of entrapment experienced by a primary victim.⁸⁴

81 Ministry of Health, *Tatau Kahukura Māori Health Chart Book 2015*, 3rd ed., Wellington, Ministry of Health, 2015.

82 Dobbs and Eruera in their literature review on the impact of colonisation on Māori whānau emphasise that there were very different impacts for Māori men and women. Western gender role-norms positioned women as subordinate to men and placed men in positions of power and authority – in the home and society. Colonisation 'disordered' the role and status of Māori women. The imposed colonial ideologies and structures fragmented Māori social structures – iwi, hapū, whānau and intimate partner relationships. T. Dobbs and M. Eruera, *Kaupapa Māori Wellbeing Framework: The Basis for Whānau Violence Prevention and Intervention*, Auckland, New Zealand Family Violence Clearinghouse, University of Auckland, 2014, <https://nzfvc.org.nz/issues-papers-6>

83 Ruwhiu et al highlight, as part of decolonising agenda, the importance of an indigenous approach to masculinity and male violence for Māori men. L. Ruwhiu et al., *A Mana Tāne Echo of Hope: Dispelling the Illusion of Whānau Violence – Taitokerau Tāne Māori Speak Out*, Whangarei, Amokura Family Violence Prevention Consortium, 2009, p. 35.

84 This is a composite case example based on primary victims' experiences from the regional reviews. We have changed details to ensure confidentiality.

Example 4: 'Cumulative and compounding entrapment'

Sarah's childhood was destroyed by her father's constant violence and abuse. He verbally humiliated and beat her mother, and hit her and her siblings. Her mother tried to cope by drinking. A family member sexually abused Sarah for many years. At high school she discovered alcohol and started drinking daily to cope. To buy alcohol she committed burglaries with gang-affiliated young people. Her teachers found her behaviour increasingly difficult and suspended her multiple times. Sarah started running away from home and living on the streets. Adult men who were grooming her for 'prostitution' raped her. Eventually, Sarah was taken into state care.

At 17, she was discharged from state care. Estranged from her parents and any positive social supports, and vulnerable, she met Jim at a hotel bar. He was 15 years her senior. Jim was a patched gang member. He made Sarah his partner. The only thing Jim had learnt from his stepfather was 'violence'. For Sarah the next 10 years involved:

- drinking, pills, P, parties
- being put down in front of friends, family and neighbours
- 'getting the bash' – if she fought back she got it even worse
- having chairs and other things thrown at her
- multiple episodes of rape
- multiple miscarriages
- feeling guilty and disgusted with herself for using alcohol and drugs, and not being there for her children.

Sarah was seen at the emergency department concussed with most of her teeth knocked out.

There were more than 15 police reports, and she had taken out a protection order, which Jim repeatedly breached. Her children were removed from her care and placed with relatives and this made her drink even more. Finally, Jim moved on from her and started living with another (younger) woman.

Sarah went to rehab and cleaned up. She eventually got her children back from CYF. Housing NZ gave her a home in a rough part of town where there were few community services. She had little money to do anything or go anywhere. She had debts she was paying back from her benefit, due to damage caused by Jim to previous Housing NZ properties.

All her siblings drank and some were now gang affiliated. If they came over they brought alcohol with them, which made it hard for her to stick to her sobriety. However, not seeing them made her feel isolated, lonely and depressed. Sarah felt judged by other people. She heard the hurtful remarks people and practitioners made about her family. She preferred the company of her siblings because at least they understood what she had been through.

She met her next partner, Harry, through one of her siblings. She was wary because he was a gang member, but he seemed okay and initially he treated her much better than Jim had. Her sister said that 'beside the hidings and all that' Harry came across like he really cared for her. After they started living together Harry's controlling behaviours intensified. He constantly accused her of infidelity. She was not allowed in the company of other men without him. When he was not around, he had his friends watch her. Her children were terrified of Harry and she was terrified of losing them again to CYF. Her previous experiences meant that she knew if she could not protect them from him she could lose them to state care. She was very worried about what might happen to them in state care because her sibling's child was sexually abused in state care.

Sarah was also scared to call the police. Harry had threatened to hurt her children if she called. He had strangled her and she knew he was capable of killing her and seriously harming her children. In the past, whenever Jim had been arrested he would afterwards return to her house and beat her up for having called the police. Would Harry be locked up or would he be bailed to her address? How could the police or the courts keep her and her children safe?

She wished the neighbours would call the police but they never did. Harry's abuse made her feel suicidal and brought back Jim's abuse all over again. She desperately wanted a different life for her children. One night she was so terrified of Harry, she called the police. They arrived but she was too intimidated by Harry to make a statement. She said it was 'just a verbal argument'.

The police issued Harry with a Police Safety Order. His reprisal was giving Sarah a serious beating.

Refuge was not an option as she was drinking again to try to block out the abuse. She had no car and nowhere to go. Harry knew where all her siblings lived.

Eventually she knew he would kill her.

The implications of understanding entrapment

If we understand family violence as a form of entrapment, with individual, structural and collective dimensions, then a number of shifts occur in our thinking:

- We do not assume it is appropriate to give victims, who are in danger from their abusive partners, and seeking help, the responsibility for keeping themselves and their children safe.
- We realise that providing victims with a standard set of safety actions they can take is likely to be an ineffective response to their help-seeking.
- To help victims, we have to understand the *actual circumstances* of the person we are seeking to help. This includes considering:
 - the operation and effect of the violence in the victim's and her children's lives – not just what has been done to her but what she has been prevented from doing for herself
 - the burden of cumulative harm she is carrying (not just from this abusive partner)
 - her larger social and structural context.
- We appreciate the importance of organisations having assessment frameworks that support the enquiry into, recording and analysing of cumulative histories of harm, the quality of victims' support networks and their health. Without specifically considering this information, services are in danger of providing responses that are not person-centred or safe.
- We begin to see the victim's actions in response to the abuse as *acts of resistance* rather than *acts of empowerment*. Victims resist their abusive partner's violence, but their resistance does not stop the violence.
- We understand the abuse as a violation of the victim's human rights, rather than a matter of her individual choice. A number of the primary victims in the regional reviews had been subjected to torture, often for extended periods, and were left with serious and permanent injuries – including brain damage, post-traumatic stress disorder (PTSD) and the loss of body parts.

- We read the victim's responses in the context in which they occur. For example, we may not necessarily take what she says in court at face value because there may be repercussions for her afterwards. Aggressive behaviour by a gang-affiliated victim does not mean she is powerful. It may mean she is attempting to protect herself. Using violence on a particular occasion may be an attempt to intimidate her abusive partner (the predominant aggressor), an act of self-defence, or an expression of frustration and desperation in the face of continuous abuse she is unable to escape. The use of violence on one occasion is consistent with being a primary victim in the overall relationship.⁸⁵
- We need to ensure our responses do not compound the victim's entrapment – for example, sentencing an offender to live in the home where his partner who is a victim of his violence and her children also live. Alternatively, making it a condition that she and her children move out: if she does not have a satisfactory place to live, wider social supports or adequate economic resources, this is unrealistic and unsafe. Expecting her to be the person to object publicly to such arrangements is an unfair burden. These arrangements are exceptionally risky for her children who are not her partner's biological children.
- If we are to provide victims with safety then we need new and realistic ways to respond to people who are using violence in order to curtail their abusive behaviour.
- We realise empowerment is not something that can be achieved by an individual victim. Victim empowerment needs to be a *collective endeavour*.

Reframing empowerment in the family violence context as a collective endeavour

Empowerment theory had its origins in the political activism of the civil rights movement and the educational work of Freire.⁸⁶ It was about the need for collective action – *the power of the collective* to effect change in oppressive educational and political environments *where an individual acting alone otherwise had no power*. The individual had no power because the 'structural problem of the elephant and the mouse – where the dominant institutions are not responsive to the demands of the mouse – means that disempowerment is *structural*...'⁸⁷

In the 1990s, the concept of empowerment was applied across a range of disciplines and started to be used in relation to individuals.⁸⁸ In 1994, speaking of the concept of empowerment as used in the health promotion context, Rissel cautioned that the 'lack of a clear theoretical underpinning, distortion of the concept by different users, measurement ambiguities, and structural barriers make "empowerment" difficult to attain'.⁸⁹

In the family violence sector, Rissel's fears have become a reality. The notion of empowerment has become disconnected from the idea of collective action. Instead, it has begun to operate as a barrier to victims receiving appropriate support, particularly those who are at high risk of serious or lethal harm.⁹⁰ The concept is used to:

- absolve agencies of their responsibility for victim safety
- make invisible the systemic barriers that impede victims' safe 'choices'
- shift accountability from the person perpetrating violence onto the victim.

85 See section 3.1.2. A primary victim/predominant aggressor analysis is essential. FVDRC, *Fourth Annual Report*, pp. 74–6.

86 P. Freire, *Pedagogy of the Oppressed*, New York, Continuum Publishing Company, 1970.

87 N. Pearson et al., *Empowered Communities: Empowered People Design Report*, Kununurra, Western Australia, Wunan Foundation Inc., 2015, p. 19, www.dpmmc.gov.au/sites/default/files/publications/EC%20Report.pdf

88 B. Fredericks, 'Which way that empowerment?: Aboriginal women's narratives of empowerment', *AlterNative: An International Journal of Indigenous Scholarship*, vol. 4, no. 2, 2009, pp. 6–19.

89 C. Rissel, 'Empowerment: The holy grail of health promotion?', *Health Promotion International*, vol. 9, no. 1, 1994, pp. 39–47.

90 D. Wilson et al., 'Becoming better helpers', 2015, pp. 25–31.

Empowerment has been placed at the wrong end of the intervention continuum. Victim empowerment should be the end goal of a collective safety response, not the initial premise of a safety process. Safety is not something individual victims can achieve alone. Safety can only really be realised through the connected actions of others. Empowerment and safety need to be reframed as *collective endeavours*. Please see section 4.4.1 for examples of collective safety responses.

Fundamental for victim empowerment is the presence of both autonomy and agency. The absence of these, particularly in the presence of coercive control and entrapment, precludes the ability to be self-empowering.⁹¹ It is only when a victim is in a long-term safe environment, where she is able to make self-determined choices, that she can be empowered.⁹²

This aligns with a Māori understanding of empowerment. Durie⁹³ states that a function of whānau is whakamana (to empower or validate), which aids whānau participation in society. The collective end goal is whānau participation, but this cannot be assumed to exist because there needs to be a safe enabling social environment for whānau empowerment to occur. Whānau need to be offered alternative ways of functioning. The trauma that has disempowered many whānau needs to be recognised, along with the need for support and development so whānau members can be truly empowered.

3.1.3 Understanding structural inequity: Individual or group deficit/equality – social justice/equity

Social and economic resources are not equally spread throughout the population. There are clear patterns in who has access to such resources. An association between deprivation and family violence exists in the Committee's homicide data.⁹⁴ And, as has been noted above, in many of the regional reviews, structural inequity⁹⁵ has compounded the entrapment experienced by the victim.

Here we describe the shifts in thinking that are required if structural inequity is to be adequately addressed in our response to family violence. Ways of responding to structural inequity that frame inequity in terms of individual choice or group deficit are documented. Such ways of thinking blame victims for the circumstances in which they find themselves and support responses to family violence that compound the entrapment of victims.⁹⁶

An approach to inequity that assumes treating everyone in exactly the same manner is fair and produces just outcomes has been described as a 'formal equality' approach. This approach overlooks the fact that not everyone has fair and reasonable access to opportunities to realise his or her potential and that this lack of access is socially patterned. Underpinning such an approach is the assumption that those lacking access to social and economic resources and experiencing trauma are in that position because they have failed as individuals to make sensible life decisions. Essentially, such an approach reframes social problems in terms of individual choice and deficit.

An alternative approach to thinking about equality, known as 'substantive equality', recognises that not everyone is on the same level playing field. Such an approach acknowledges that equal *outcomes* require different responses to people who are differently placed. However, taking such an approach to equality sets the more privileged group up as the standard others need to be supported to achieve. Implicit in such an approach can be the idea that some people need extra help because of their personal difficulty in achieving a norm readily achievable by others. In other words, taking such an approach can be compatible with an understanding of social patterns and issues in terms of individual or group deficit.

91 In the context of family violence and indigenous people reclaiming their rights to self-determination, it is probably more appropriate to talk about re-empowerment.

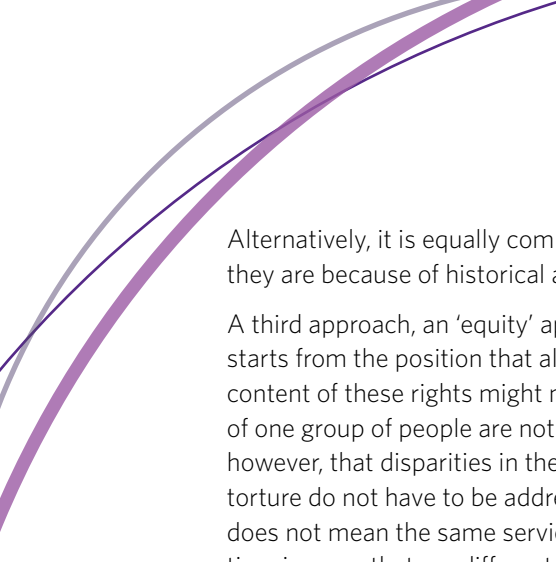
92 S. Perez, D. Johnson and C. Valie Wright, 'The attenuating effect of empowerment on IPV-related PTSD symptoms in battered women living in domestic violence shelters', *Violence Against Women*, vol. 18, 2012, pp. 102-17.

93 M. Durie, *Measuring Māori Wellbeing*, New Zealand Treasury Guest Lecture Series 2006, www.treasury.govt.nz/publications/media-speeches/guestlectures/pdfs/tgls-durie.pdf

94 FVDR, *Fourth Annual Report*, 2014, pp. 32-70.

95 See Appendix 1 for a definition of structural inequity as used in this report.

96 See section 3.1.2 for a discussion of the indifference of powerful institutions to victims' suffering.



Alternatively, it is equally compatible with a recognition that some groups of people are in the position they are because of historical and current inequity rather than choice or fault.

A third approach, an 'equity' approach, is founded in social justice and human rights. This approach starts from the position that all have the right to safety, dignity and self-determination. However, the content of these rights might mean different things for different people. In other words, the norms of one group of people are not set up as the standard for all others to achieve. This does not mean, however, that disparities in the prevalence of family violence and the right of all to be safe and free from torture do not have to be addressed. Equitable services and care for those affected by family violence does not mean the same services and care for everyone. It means doing the right things at the right time in ways that are different for different people and appropriate to their needs. All people must be provided with fair and reasonable access to opportunities to reach their full potential.

Achieving equitable outcomes is currently confounded by numerous factors – for example, unduly focusing on the stereotyped deficits of the social group people belong to, rather than understanding the systemic and structural issues that make accessing essential quality services for some groups challenging and problematic.

When the role of structural inequity in the entrapment that many victims of family violence experience is acknowledged, the need for empowerment to be a collective endeavour becomes even more obvious. Structural inequity is a social/collective problem that requires a social/collective response.

Intersectionality

People sit at the intersection of multiple hierarchies of disadvantage and privilege. These different hierarchies interact to produce experiences that are different in both their intensity and detail from those of others who do not share the same intersectional position. For example, in the family violence deaths, disparities are evident in prevalence rates for women, particularly Māori women, and Māori and Pacific children. All are more likely to be homicide victims than Pākehā women and children. Māori women are also more likely to be homicide victims than Māori men are and, even when they are the offender in the death event, are likely to be the primary victim in the relationship prior to that point in time, while Māori men are likely to be predominant aggressors. In other words, combinations of gender, race and class mediate people's experiences in different ways.

Intersectionality is underpinned by the following principles:

- diversity exists within and between cultural groups
- differences in power are evident in social structures
- individuals identify with multiple social groups.⁹⁷

Looking at a person's intersectional position requires moving away from simplistic understandings of identity and simple assumptions about how disadvantage operates in people's lives. For example, it cannot be assumed that all Māori women have safe, supportive whānau and that they are culturally connected. Using an intersectionality framework assists in uncovering the historical, social, structural and political contexts that explain the different experiences of family violence particular marginalised Māori women have and why their needs continue to be unmet.

97 Y. Nadan, J.C. Spilsbury, and J.E. Korbin, 'Culture and context in understanding child maltreatment: Contributions of intersectionality and neighborhood-based research', *Child Abuse & Neglect*, vol. 41, 2015, pp. 40–8.

Example 5 illustrates how structural inequity – as shaped by the unique combination of class, immigration status and gender in a victim’s life – operates to compound the victim’s entrapment by her abusive partner.

Example 5: ‘Intersectionality in action’

Paramajit’s family was very poor. They lived in a rural part of Fiji that was conservative, had high levels of poverty, and limited educational or employment opportunities.

Paramajit was married into a family with high standing in the community. Her husband was granted a temporary working visa for New Zealand. Her family all lived in Fiji and were dependent on her husband and his family for financial assistance.

Her husband started abusing her as soon as they were married. She suffered multiple miscarriages due to his abuse.

Paramajit had entered New Zealand under a partnership application. She was fearful of reporting the abuse to New Zealand Police because of the potential implications for her husband’s immigration status and the impact on her struggling family in Fiji.

3.1.4 Mapping misconceptions about IPV

Table 4 maps, summarises and reframes the misconceptions about IPV discussed in this chapter.

Table 4: How we have understood IPV as a social problem

	Reframing	Current understandings	Past understandings ⁹⁸
Understanding IPV	<p>Patterns of cumulative harm</p> <p>There is a pattern of coercive and controlling behaviours that can encompass multiple victims (adults and children) – past, current and future.</p> <p>Anticipation of hidden and future victims.</p>	<p>Incidents of violence⁹⁹</p> <p>Reported incidents of physical violence affecting current victim.</p>	<p>Marital conflict¹⁰⁰</p> <p>Violence occurred due to a dysfunctional relationship.</p> <p>Violent outbursts were triggered by victim's actions.</p>
Framing of victims' responses to partners' violence	<p>Resistance¹⁰¹</p> <p>Victims resist their partner's violence but their resistance cannot stop the violence. Their partners anticipate and sabotage their acts of resistance.</p> <p>Entrapment</p> <p>Individual and collective.</p> <p>IPV is a crime against a victim's autonomy and self-determination.¹⁰² Victims are entrapped by an abusive partner's coercive and controlling behaviours.</p> <p>Victims also experience social and collective entrapment. Structural inequities affect people's experiences of abuse and the resources available to them in responding to that abuse.</p>	<p>Learned helplessness¹⁰³</p> <p>The victim develops a syndrome that causes her to believe she is powerless to address the abuse.</p> <p>Empowerment¹⁰⁴ / Autonomous victims</p> <p>The victim can choose to take action to stop her partner's violence.</p>	<p>Forgiveness</p> <p>Forgiveness allows the relationship to continue.</p> <p>The alternative is to leave the relationship.</p>

98 The Platform Trust and Te Pou o Te Whakaaro Nui mapped the development of the MH&A sector over time from past, current and future (fourth wave). Platform Trust and Te Pou o Te Whakaaro Nui, *On Track: Knowing Where We Are Going*, Auckland, Te Pou o Te Whakaaro Nui, 2015.

99 An 'incident' refers to a distinct or definite event, implying a beginning and end. Most of our responses to family violence are incident-focused. See, for example, the FVIARS.

100 The Domestic Protection Act 1982 (the Act) had a conservative view of family and only addressed domestic violence between heterosexual couples living together. Domestic violence was understood as a relationship problem. The purpose of the Act was 'to encourage victims to seek protection from the Family Court which may be able to ameliorate the violence and strengthen the family unit by counselling'. Non-molestation orders were felt to be destructive to a relationship, and so could only be used if it was certain that the relationship was ending. G. Newbold and J. Cross, 'Domestic Violence and Pro-Arrest Policy', *Social Policy Journal of New Zealand*, no. 33, pp. 1-14.

101 C. Richardson and A. Wade, 'Islands of safety: Restoring dignity in violence-prevention work with indigenous families', 2010.

102 E. Stark, *Coercive Control: How Men Entrap Women in Personal Life*, 2007.

103 L.E. Walker, 'Battered women and learned helplessness', 1977. W.R. Miller and M.E. Seligman, 'Depression and learned helplessness in man', 1975. I. Leader-Elliot, 'Battered but not beaten: Women who kill in self-defence', 1993.

104 An individualised understanding of empowerment, situated within a 'stages of change' cognitive problem-solving intervention model. J. Prochaska and C. DiClemente, 'Common processes of change in smoking, weight control, and psychological distress', in S. Shiffman and T. Wills (eds.), *Coping and Substance Use: A Conceptual Framework*, New York, Academic Press, 1985, pp. 345-63.

	Reframing	Current understandings	Past understandings
Impact of IPV on victims	<p>Cumulative and compounding trauma affecting people individually and collectively</p> <p>‘A pile up of trauma and violence.’</p> <p>Victim’s own experiences of abuse over her life course impact her health and social outcomes, <i>as well as</i> the transmission of trauma across generations:</p> <ul style="list-style-type: none"> historical trauma (violence of colonisation) intergenerational family violence. 	<p>Impact of violence on individual victim’s multiple health and social outcomes</p> <p>A victim’s experiences of abuse are associated with poorer long-term health and social outcomes.</p>	<p>Harm to the relationship</p> <p>Counselling can assist in repairing the underlying relationship dysfunction.</p>
Victims’ use of violence	<p>Primary victim/Predominant aggressor</p> <p>Women’s use of violence is understood in the wider context of men’s violence against women. Women’s use of violence is different in intent, meaning and impact, and is often aimed at resisting their partner’s violence in order to keep themselves and their children safe.¹⁰⁵</p>	<p>Violent women</p> <p>Women’s use of violence against men is understood as the same as men’s use of violence against women.</p>	<p>Mutual violence</p> <p>‘She can give as good as she gets.’</p>
Abusive person’s use of violence	<p>Coercive control</p> <p>Coercion involves the use of force or threats to intimidate or hurt victims and instil fear. Control tactics are designed to isolate the victim and foster their dependence on the abusive partner.¹⁰⁶</p> <p>The worst harm is caused by the cumulative violations of a victim’s selfhood.</p> <p>The cumulative effect of the abuse entraps victims and impedes their ability to be self-determining.</p>	<p>Power and control</p> <p>Abusive partners seek power over victims and control them by using different forms of abuse. Physical and sexual violence are the most controlling forms of violence.¹⁰⁷</p> <p>The focus is on what has been done to the victim, not on what she has been prevented from doing for herself.</p>	<p>Loss of control</p> <p>Abusive partners are acting because of forces they cannot control.</p> <p>‘I just saw red and lost it.’</p>

105 A small proportion of women use coercive controlling violence against their male intimate partners.

106 E. Stark, *Coercive Control: How Men Entrap Women in Personal Life*, 2007.

107 www.theduluthmodel.org/training/wheels.html

	Reframing	Current understandings	Past understandings
Safety focus and approach	<p>Adult and child victims – safety is dependent on collective action</p> <p>Safety through connection – safety is dependent on the collective actions of agencies, communities and whānau.</p>	<p>Adult victim with a safety plan</p> <p>Transactional safety plans – the victim is provided with a safety plan (a list of actions she can take to achieve safety).</p>	<p>Relationship repair</p> <p>If the dysfunction in the relationship can be addressed, the violence will be resolved.</p>
Responsibility for stopping the violence	<p>Collective responsibility</p> <p>Agencies, practitioners, whānau and communities have the responsibility to hold abusive people in intervention contexts, as well as containing and challenging their behaviour.</p>	<p>Individual victim responsibility</p> <p>The victim is responsible for taking action to stop the violence.</p>	<p>Mutual responsibility: victim and person using violence</p> <p>Help from a neutral third party (eg, counsellor) can support both partners to address their part in the relationship dysfunction.</p>
Framing of social problems: <ul style="list-style-type: none"> ▪ structural inequity ▪ family violence 	<p>Promoting equity/Social injustice</p> <p>Everyone has the right to dignity, safety and self-determination but these rights may have different meanings and require differential responses.</p> <p>There is a need to address social injustice.</p>	<p>Substantive equality/Group deficit or social injustice</p> <p>People are differently placed. Some groups require different responses in order to arrive at an equal outcome.</p> <p>Compatible with a group deficit or social injustice understanding.</p> <p>Whose standards are the norm for everyone?</p>	<p>Formal equality/Individual or group deficit</p> <p>The same response to everyone.</p> <p>The outcome of equal treatment is not the same because of individual or group deficit.</p>
	<p>Intersectionality – approaches informed by an understanding of the gendered nature of violence and multiple oppressions¹⁰⁸</p> <p>Intersection of men's violence against women with multiple structural inequities.</p>	<p>Gender neutrality¹⁰⁹ and public health approaches</p> <p>Family violence is an epidemic that affects all people.¹¹⁰</p> <p>Alcohol and family violence are linked. Stopping drinking will stop the violence.¹¹¹</p>	<p>Apology and mediation</p> <p>Private disputes between individuals.</p>

108 The intersection of forms of oppression – for example, sexism and racism – and structural inequities, including the legacy left behind by colonisation and poverty. Atkinson and Woods state that the 'violence of colonisation' is layered with the 'violence of racism' and 'the violence of misogyny'. According to Atkinson this legacy has woven violence and its effects into the fabric of Aboriginal lives. J. Atkinson and G. Woods, 'Turning dreams into nightmares and nightmares into dreams', *Borderlands e-Journal*, vol. 7, no. 2, 2008, pp. 1–22. J. Atkinson, *Trauma Trails, Recreating Song Lines: The Transgenerational Effects of Trauma in Indigenous Australia*, Melbourne, Spinifex Press, 2002.

109 This includes gender-neutral child protection frameworks.

110 Despite its epidemic proportions and the value of public health analogies, IPV does not sweep invisibly through communities, leaving victims inexplicably in its wake. IPV consists of coercive and controlling behaviours used by identifiable individuals with whom the system might intervene. Centre for Innovative Justice, *Opportunities for Early Intervention: Bringing Perpetrators of Family Violence into View*, Melbourne, RMIT University, 2015, p. 5.

111 See section 5.4 for a discussion about the co-occurrence of IPV and substance use.

3.2 Thinking differently about child abuse and neglect (CAN)

3.2.1 Understanding CAN: Physical abuse - multiple forms of abuse - cumulative harm

The 'discovery' of CAN

The physical abuse of children was not 'discovered' and consistently considered by medical practitioners as a cause of physical injury until the early 1960s.¹¹² In hindsight, it is extraordinary that the accurate medical diagnosis of inflicted injury in childhood has such a relatively recent history. After the 'discovery' of physical abuse, other forms of abuse began to be recognised, such as neglect and sexual abuse. Emotional abuse in the form of exposure to IPV¹¹³ was really only acknowledged and a topic of study in the last couple of decades.

Children's exposure to IPV is a form of abuse

It is now well established that children exposed to IPV may suffer lasting psychological harm even when they are not physically injured. Often, their symptoms closely resemble those seen in the direct victims of violence. Despite this, there are still many practitioners working with children who fail to appreciate the significant and long-lasting effects (even into adulthood) that result from emotional abuse in early childhood and, in particular, exposure to family violence.

The terror of exposure to or anticipation of an episode of violence will have lasting effects on a young child. Terror produces a 'fight or flight' response in which a person becomes hyper-vigilant and hyper-aroused. Their heart rate is increased due to an outpouring of adrenaline from the adrenals. Blood pressure and respiration are increased and the release of glucose into muscle and muscle tone increases. Perry describes how this process happens in children exposed to trauma.¹¹⁴ When 'flight or fight' is not possible because the child is dependent on their caregivers, children may dissociate from the events they are exposed to and become detached and apparently non-reactive. Children may then 'freeze' and 'surrender'. As time goes on and the child is exposed to ongoing traumatic events, their individual adaptive response becomes apparent as being predominantly one of hyper-arousal or dissociation.

A common myth about children's exposure to family violence is that infants are too young to be affected. In fact, there is some evidence that infants as young as one year of age can develop trauma symptoms and their response is predicted by the severity of their exposure to IPV and the trauma response of their mother.¹¹⁵ Even infants in the first year of life can be aware when there is stress around them and the routines of their daily world are broken.

112 In 1946 radiologist Caffey published a series of cases of children with multiple fractures of the long bones in association with chronic subdural haemorrhage around the brain. J. Caffey, 'Multiple fractures in the long bones of children suffering from chronic subdural hematoma', *Amer J Roentgenol*, vol. 56, 1946, pp. 163-73. Initially these bone lesions were thought by some clinicians to be due to metabolic disease. Inflicted trauma was not routinely considered as a possible cause of physical injury in children at that time. It was not until 1962 that an American paediatrician Henry Kempe and his co-authors published the seminal paper 'The battered-child syndrome'. C.H. Kempe et al., 'The battered-child syndrome', *JAMA*, vol. 181, 1962, pp. 105-12. It was only after this paper was published that those working with children in the health setting began to more consistently recognise that children were vulnerable to physical injuries inflicted by their caregivers and initially only the more severe injuries were recognised.

113 Although the emotional neglect of children was acknowledged relatively early on, other forms of emotional abuse have only been studied in more detail in recent decades. In the late 1980s, a body of research began focusing on children who are 'bystanders' to violence. In the late 1970s and early 1980s, community-based programmes for battered women formed throughout the United States. Although the first priority of these programmes was to provide resources and safety for adult victims, a few programmes began to provide services to children. However, little public attention was brought to the issue at first. Innovative projects such as the AWAKE Project at Children's Hospital in Boston began to address the overlap of child abuse and domestic violence (www.childwitnessstoviolence.org/social-impact--history.html). In 1990, Peter Jaffe and colleagues published 'Children of battered women', describing both research and clinical experience on the range of difficulties faced by child witnesses to domestic violence. Around the same time, researchers and activists around the country began to document the experiences of children exposed to chronic community violence in urban neighbourhoods. In 1992, the Child Witness to Violence Project at Boston Medical Center began to provide specialised mental health services to young children who had witnessed either domestic or community violence.

114 B. Perry, *Effects of Traumatic Events on Children*, Houston, The ChildTrauma Academy, 2003, <http://childtrauma.org/>

115 G.A. Bogat et al., 'Trauma symptoms among infants exposed to intimate partner violence', *Child Abuse & Neglect*, vol. 30, 2006, pp. 109-25.

Children's exposure to IPV¹¹⁶ is an area that urgently needs attention in Aotearoa New Zealand. Fixing fractures for abused children is straightforward. Addressing their complex emotional trauma requires a multidisciplinary, evidence-based approach.¹¹⁷

IPV and CAN are entangled forms of abuse

As the Committee highlighted in its *Fourth Annual Report*, CAN and IPV are entangled forms of family violence.¹¹⁸ Exposure to IPV is a form of emotional abuse, so we do not need to ask if children have also been abused when considering the effects of IPV on children – it has already happened. What we need to consider is whether children have also been physically abused or exposed to sexual abuse or any form of neglect. The regional reviews indicate that children do not tend to experience isolated forms of abuse.

Understanding the entangled nature of IPV and CAN counters what Radford and Hester have coined the 'double disappearing act'.¹¹⁹ The double disappearing act refers to the needs of children affected by IPV disappearing from the focus of the Family Court and adult services involved with the family (the first disappearance), and then IPV being reframed and downgraded by these services as an issue of the abusive partner needing to attend a parenting course or to receive support for his alcohol abuse (the second disappearance). Unsupervised post-separation contact with abusive fathers is a common example of the double disappearing act in practice. In the context of family violence there are frequently multiple victims – child and adult – whose voices and needs must all be heard and addressed.

Exposure to abuse results in cumulative harm

The effects of exposure to violence on children are cumulative and, for some, start prior to their birth. Physical assault during pregnancy can result in injuries to the fetus and is associated with an increased risk of fetal death.¹²⁰ There is also a growing body of literature about the effect on the fetus of their mother's stress during pregnancy. Exposure to various prenatal stressors are associated with low infant cortisol postnatally,¹²¹ decreased human infant reactivity,¹²² affected intellectual and language function in toddlers¹²³ and increasing crying and fussing in infants in the first six months of life.¹²⁴

116 J. Edleson, 'Children's witnessing of adult domestic violence', *Journal of Interpersonal Violence*, 1999, vol. 14, pp. 839–970. Edleson describes the variety of ways in which children can be directly and indirectly exposed to IPV. A child may be:

- hit or threatened while in the mother's arms/the mother may be hit or threatened while holding or feeding the child
- taken hostage to force a mother to return home
- used as a physical weapon against the adult victim
- forced to watch or participate in assaults on their mother
- an indirect witness to assaults on another from a different part of the house
- used as a spy or go-between
- emotionally blackmailed: 'We would be together as a family if it weren't for your father/mother'
- likely to experience the aftermath of any violence: injuries to the adults involved, police involvement, etc.

The regional reviews also show evidence of children being used as instruments of revenge. Children have been killed by an abusive parent after the victim has separated from him. In these cases the perpetrator, usually a father, is essentially saying 'If I cannot have you I am going to take your child from you.'

117 In the *Fourth Annual Report* the FVDRC for the first time presented data on the number of children, including those in the adolescent and young adult age range, likely to be affected by the death of sibling, parent or partner of a parent as a result of family violence. It was recommended that a clear pathway of aftercare be prescribed for this vulnerable group. FVDRC, *Fourth Annual Report*, pp. 95–6.

118 See section 3.1.3. IPV and CAN are entangled forms of abuse. FVDRC, *Fourth Annual Report*, pp. 76–7.

119 L. Radford and M. Hester, 'More than a mirage? Safe contact for children and young people who have been exposed to domestic violence', in N. Stanley and C. Humphreys (eds.), *Domestic Violence and Protecting Children: New Thinking and Approaches*, London, Jessica Kingsley, 2015.

120 P. Gulliver and R. Dixon, 'The influence of ethnicity on the outcomes of violence in pregnancy', *Ethnicity & Health*, vol. 20, no. 5, 2015, pp. 511–22.

P. Gulliver and R. Dixon, 'Immediate and long-term outcomes of assault in pregnancy', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, vol. 54, no. 3, 2014, pp. 256–62.

121 R. Yehuda et al., 'Transgenerational effects of posttraumatic stress disorder in babies of mothers exposed to the World Trade Center attacks during pregnancy', *J Clin Endocrinol Metab*, vol. 90, 2005, pp. 4115–8.

122 E. Mohler et al., 'Emotional stress in pregnancy predicts human infant reactivity', *Early Hum Dev*, vol. 82, 2006, pp. 731–7.

123 D.P. Laplante et al., 'Stress during pregnancy affects general intellectual and language functioning in human toddlers', *Pediatr Res*, vol. 56, 2004, pp. 400–10.

124 H. Wurmser et al., 'Association between life stress during pregnancy and infant crying in the first six months postpartum: A prospective longitudinal study', *Early Hum Dev*, vol. 82, 2006, pp. 341–9.

In early childhood, exposure to family violence decreases IQ in a dose-responsive manner¹²⁵ and children with mothers subjected to IPV have been reported to be more likely to be suspended from school and to have frequent non-suspension-related absences.¹²⁶ PTSD can also affect learning through interference with concentration and attention at school. These cumulative effects can result in educational under-achievement that, in the long term, limits access to future employment opportunities and therefore independence and financial security in adulthood. Many of these children are experiencing not just the developmental effects of exposure to family violence but also the associated neglect, poverty and deprivation often present in their living environment.

As noted above, we currently respond to IPV as though it is a series of incidents of physical abuse that must be addressed, rather than a pattern of harm to be disrupted.

In a similar manner, we fail to respond effectively to CAN, including exposure to IPV, as a pattern of harm that requires disruption – one with multiple victims, multiple co-occurring factors and cumulative and complex effects. The Office of the Children’s Commissioner points this out in its *State of Care 2015* report. The report notes:

‘... front-end services and systems are currently geared towards investigating “event” based referrals. Many of the children now coming to the attention of CYF are doing so because of chronic long term issues that impact on their safety and wellbeing... The system as it currently operates does not always respond effectively to children with these chronic and cumulative threats to their wellbeing.’¹²⁷

The intergenerational nature of family violence

A consistent finding from the regional reviews is the intergenerational nature of family violence. This has implications when considering the out-of-home placement of children with other family or whānau. Can we presume a previous generation who were abusive and who parented a now-abusive adult can provide a violence-free environment for a vulnerable child who has experienced significant trauma? It is certainly possible, but it cannot be presumed. This is especially so as the child coming into their care may have a number of co-occurring health and wellbeing issues, as well as their exposure to abuse and neglect, and be difficult to parent.

Findings from the Adverse Childhood Experiences study demonstrated that exposure to family violence during childhood heightens the risk of intergenerational violence, with girls more likely to become victims and boys more likely to perpetrate IPV as adults.¹²⁸ If we are to interrupt the intergenerational transmission of violence, then preventing children’s exposure to family violence needs to remain our primary objective.¹²⁹

125 K.C. Koenen et al., ‘Domestic violence is associated with environmental suppression of IQ in young children’, *Development and Psychopathology*, vol. 15, 2003, pp. 297–311.

126 M.A. Kernic et al., ‘Academic and school health issues among children exposed to maternal intimate partner abuse’, *Arch Pediatr Adolesc Med*, vol. 156, 2002, pp. 549–55.

127 Office of the Children’s Commissioner, *State of Care 2015: What We Learnt from Monitoring Child, Youth and Family*, Wellington, Office of the Children’s Commissioner, 2015, p. 31.

128 C.L. Whitfield et al., ‘Violent childhood experiences and the risk of intimate partner violence in adults: Assessment in a large health maintenance organization’, *Journal of Interpersonal Violence*, vol. 18, no. 2, pp. 166–85. F. Lamers-Winkelmann, A.M. Willemen and M. Vissera, ‘Adverse childhood experiences of referred children exposed to intimate partner violence: Consequences for their wellbeing’, *Child Abuse & Neglect*, vol. 36, no. 2, 2012, pp. 166–79.

129 Emerging research examines the epigenetic effects (on psychological, behavioural and physical health) of exposure to violence on following generations. There is still much to be learned about these mechanisms and how they might influence any individual’s vulnerability to the intergenerational nature of exposure to family violence and whether the timing of the exposure is important.

A.S. Zannas, N. Provencal, E.B. Binder, ‘Epigenetics of posttraumatic stress disorder: Current evidence, challenges, and future directions’, *Biological Psychiatry*, vol. 78, 2015, pp. 327–35.

3.2.2 Responding to IPV in the child protection context: Bad husbands but good enough fathers – protective mothers – engaging with the person using violence and wrapping support around all the victims

Bad husbands but good enough fathers

As outlined above, IPV and CAN have traditionally been thought of and responded to as distinct forms of abuse. The result has been that men who are abusive to their partners have been accepted as bad husbands but presumed to be ‘good enough fathers’¹³⁰ for the purposes of unsupervised child contact or care after separation or the death of the mother. This fails to recognise that allowing a child to be exposed to IPV *is* CAN and that fathers who commit IPV may also be directly abusing their children.

Research documenting the harmful impacts to children of exposure to IPV (described above) has made some inroad into these attitudes, but they are slow to change. The regional reviews contain a number of examples of multi-agency practitioners transitioning children back into the care of their biological father after their mother’s new partner killed her, notwithstanding that the child was a protected person on a protection order in which their father was the respondent. Example 6 illustrates similar practice.

Example 6: ‘Bad husband – but good enough father’

Mary’s partner Vinne subjected her to years of abuse. He was very controlling and did not like her to leave the house. He did not let her have a mobile phone. Vinne had pulled a knife on her and threatened to kill her; he threatened to take their young child if she left him. A family member supported Mary to make a report to the police about Vinne’s abuse.

The police temporarily uplifted their child on the advice of multi-agency practitioners. They were concerned that Mary was not acting protectively or able to protect their child from Vinne’s violence.

Out of fear of his retribution for contacting the police, Mary withdrew her police statement. Vinne moved back in with her. Mary later separated from Vinne and proceeded with serious charges against him. These were before the courts at the time of her death.

Mary’s next partner killed her. After Mary’s death, Vinne wanted custody of their child. Members of the maternal family also wanted custody. Vinne attended a short course of ‘anger management’.

The plan was to transition the child back into Vinne’s care.

It cannot be presumed that because there is a biological connection there is also a robust and safe emotional connection (or capacity for such between the adult and child), especially in the absence of a comprehensive consideration of a person’s history of perpetrating violence.

130 M. Hester, ‘The Three Planet Model: Towards an understanding of contradictions in approaches to women and children’s safety in contexts of domestic violence’, *Br J Soc Work*, vol. 1, no. 5, 2011, pp. 837–53. The three planets are:

- **child protection** (public law); welfare approach; state intervention in abusive families; mother seen as failing to protect
- **child contact** (private law); negotiated or mediated outcome; good enough father
- **domestic violence**; considered a crime (civil and criminal law); violent male partner.

Protective parents

Parents have a duty, enforceable by the criminal law, to provide their children with the necessities of life and protect those children from harm. The duty to protect from harm, which existed until recently at common law,¹³¹ was enshrined in statute in 2011¹³² and extended.¹³³ Parental obligations to provide and protect are monitored by statutory services that have traditionally used Western ideals of attachment, child development and acceptable child-rearing practices to judge parents. Judgments of parents from ethnic minority groups with different cultural norms can be made without considering the social and structural inequities that result in these parents having inadequate resources and supports.¹³⁴

Although parental obligations to provide and protect are ostensibly gender neutral, their application in practice is gendered – both because parenting is still a gendered practice and because IPV is a gendered form of abuse. It is almost invariably mothers who are held responsible for ‘failing to protect’ their children from exposure to IPV in which they are the victim.¹³⁵ Many women criminally prosecuted for failing to protect their child from their abusive partner have been Māori women who are socially marginalised and have extreme childhood abuse histories of their own.¹³⁶ Many of these women were also unable to protect themselves.

Mothers are positioned as being capable of preventing their children’s exposure to their partner’s use of violence. Practitioners often envision this as being achievable through the mother’s separation from their partner or by attendance at couple counselling to learn how to communicate better (depending on the practitioners’ understanding of the dynamics of family violence). Mothers are perceived as neglectful and complicit in the abuse of their children if they ‘choose’ to remain with abusive partners or if they are unable to protect their children from further harm. The ‘failure to protect’ paradigm is another variant of the individualist use of empowerment theory discussed above.

The ‘failure to protect’ paradigm assumes that adult victims of IPV have the ability to choose to stop the abuse, while rendering invisible the systemic barriers (coercive control, structural violence and inequities) they face in doing so.

Focusing on the protectiveness of the adult victim as the means to achieve safety for the children leads practitioners to focus primarily on the actions the adult victim is taking to keep her children safe. This diverts attention away from the abusive partner/parent and the responsibility he must take for using violence. It also shifts the focus from what practitioners can do in order to support the safety of the adult victim and her children. This practice focus is exacerbated by the fact that it can be challenging, and at times frightening, for practitioners (especially for care and protection social workers, who are mainly women) to engage with abusive partners/parents. The limited range of specific services for people who perpetrate family violence makes it hard for practitioners to challenge their behaviour safely and respectfully.

131 *R v Lunt* [2004] 1 NZLR 498 (CA).

132 Section 152 was reformed on 19 March 2012 by section 6 of the Crimes Amendment Act (No 3) 2011 (2011 No 79) to include a duty on parents to protect a dependent child from ‘injury’.

133 Section 152 extends the duty to protect to harms which are not presented by another person. Section 195A extends the duty to protect beyond parents to other household members who are aware that the child is at risk of serious abuse from someone else.

134 Colonial and racist ideologies framed indigenous peoples and ‘other’ cultures as lacking Western standards of parenting and child rearing. This has resulted in policies and assessment processes built on dominant ideas about attachment, child development and acceptable child-rearing practices. Historically, child protection risk assessment frameworks have turned social problems into individual problems, making systemic issues such as sexism, poverty and racism disappear. S. Strega, ‘Anti-oppressive approaches to assessment, risk assessment and file recording’, in S. Strega and S. Aski Esquao (eds.), *Walking This Path Together: Anti-Racist and Anti-Oppressive Child Welfare Practice*, Nova Scotia, Fernwood Publishing, 2009.

135 J. Herring, ‘Familial homicide, failure to protect and domestic violence: Who’s the victim?’, *Crim LR*, 2007, pp. 923–33. J. Fugate, ‘“Who’s failing whom”? A critical look at failure to protect laws’, *NYU L Rev*, vol. 76, no. 1, 2001, pp. 272–308.

136 See, for example, *R v Witika* [1993] 2 NZLR 424; *The Queen v Harris* HC Wellington CRI-2004-078-1816, 26 August 2005; the case of Jill Tito, J. Rowan, 2006, 18 March, ‘Failure to stop son’s abuse brings jail term’, *NZ Herald*, www.nzherald.co.nz/nz/news/article.cfm?id=1&objectid=10372873

Consequently, it is often easier to focus on the adult victim and what is perceived as her problematic parenting.¹³⁷ This can result in positioning practitioners as victims' adversaries, rather than their safety allies.

Mothers, particularly Māori mothers who are socially marginalised and struggling with a raft of daily stressors, are keenly aware they risk losing the care of their children if they are not able to keep them safe. This inhibits many mothers from fully disclosing to practitioners the difficulties and danger they are in and their fears for their children.

In other words, the help-seeking efforts of mothers are profoundly influenced by the realistic fear of being judged as inadequate and of losing their children.

The regional reviews provide evidence that another danger of focusing on the adult victim's 'protectiveness' is that children of victims who *are* deemed to be acting protectively (for example, they have obtained a protection order and separated from their possessive partner) can be mistaken as no longer requiring a statutory care and protection response. Assessment of the ongoing danger (which is likely to increase on separation) posed by the abusive partner is missing. Also missing is the development of multi-agency plans to mitigate any ongoing risks to the children and their mother. While the victim may have separated successfully, this does not mean she and the children are safe. Furthermore, the children are likely to still be expected to have contact with their abusive father. Frequently, it is his close family who provides supervision.¹³⁸

Despite significant barriers, victims do take actions to safeguard their children

Despite significant barriers, the regional reviews provide multiple examples of victims resisting (overtly and covertly) violence and taking actions to safeguard their children. These include:

- a victim arming herself with a knife to prevent her partner continuing to assault her and threaten the children
- a victim taking multiple buses across town to take her child to hospital on the only day her partner was out of the home – although she did not overtly disclose that her partner had hurt her child, she nonetheless went to great lengths to bring her child to the hospital
- a victim who was pregnant presenting to the emergency department seeking help after being assaulted by her partner, while her abusive partner was at home with her child waiting for her to return
- a victim sending her child next door to escape and seek help from a relative who could call the police
- a victim attending a GP surgery with her child, concerned that her partner had hurt her child.

Often these victims did not receive helpful responses from services. Practitioners need to understand that any presentation by a victim may be the single opportunity she has to seek help. If she does not disclose an abuse history, family violence must be part of the assessment. Verbal non-disclosure on the part of a victim does not mean she does not want help. It may be because, for example, she cannot imagine a world where help is available and the nightmare she is experiencing can end.

137 A preoccupation with the parenting deficits of abused women is evident in the routine mandated use of parenting assessments and parenting programmes by Child Protection Services workers. By problematising the behaviour of mothers rather than the behaviour of perpetrators, Child Protection Services workers fail to protect children and divert attention away from perpetrators. K. Nixon and K. Cripps, 'Child protection policy and indigenous intimate partner violence: Whose failure to protect?', in S. Strega et al. (eds.), *Failure to Protect: Moving beyond Gendered Responses*, Nova Scotia, Fernwood, Publishing, 2013.

138 Many mothers experience contradictory directives from different systems. They are told to separate from an abusive partner (child protection) and then told to allow their child to have contact with their abusive father (Family Court). M. Hester, 'The Three Planet Model: Towards an understanding of contradictions in approaches to women and children's safety in contexts of domestic violence', 2011.

In the reviews of fatal inflicted injury child deaths, some health practitioners missed injuries in children that were in hindsight suspicious. Frequently, after the death of a child, multiple services hold adult victims responsible for failing to protect their child. However, safety and wellbeing for children and adults at risk of harm can only ever be achieved through a collective multi-agency and community response, not the actions of an individual who is being abused.

Engaging with the abusive person – wrapping support around all the victims

Understanding IPV victims’ experiences within an entrapment/resistance framework necessitates a different practitioner response, one that moves from assessing the protectiveness of adult victims to assessing the level of risk and danger that a partner’s/parent’s abusive behaviour poses to the child and adult.

If IPV and CAN are addressed as entangled forms of abuse then it is appreciated that if children are to be protected, services must act protectively towards adult victims. This includes curtailing the abusive partner’s/parent’s use of violence. We return to these issues in Chapter 5, section 5.3, when we discuss the need for a child protection response that is IPV competent.

3.2.3 Mapping misconceptions about CAN

Table 5 outlines, adds to, summarises and reframes the misconceptions about CAN in the context of family violence discussed in this chapter.

Table 5: How we have understood CAN in the context of the social problem of family violence

	Reframing	Current understandings	Past understandings
Understanding CAN	<p>Cumulative harm</p> <p>Recognising the effect of cumulative patterns of harm in the child’s family on a child’s wellbeing and development. Including:</p> <ul style="list-style-type: none"> historical trauma (violence of colonisation) intergenerational abuse multiple forms of CAN. 	<p>Multiple forms of abuse</p> <p>Understanding CAN as physical, sexual and emotional abuse (including exposure to IPV) and/or neglect.</p>	<p>Physical abuse</p> <p>Incidents of physical abuse.</p>
Responses to victims	<p>A holistic response to trauma, abuse and wellbeing</p> <p>An understanding of the intergenerational nature of family violence.</p> <p>Family violence is an adverse childhood experience.¹³⁹</p>	<p>Responses to multiple forms of abuse</p> <p>All forms of abuse recognised as harmful. Exposure to IPV recognised as emotional abuse.</p>	<p>Responses to incidents of physical abuse</p> <p>No screening for neglect, sexual abuse or emotional abuse (including exposure to IPV).</p>

139 The Adverse Childhood Experiences (ACE) Study is one of the largest investigations to assess associations between childhood maltreatment and later-life health and wellbeing. www.cdc.gov/violenceprevention/acestudy/

	Reframing	Current understandings	Past understandings
Impact of abuse on victims	<p>Intergenerational harm impacting multiple victims – child and adult</p> <p>Child abuse is a transgression of whakapapa.</p> <p>CAN and IPV are not separate forms of abuse. They are entangled.</p> <p>Recognition of the 'double intentionality' of the abusive person: Abuse directed towards one victim is intended to affect another in order to keep and/or increase control over both.</p>	<p>Impact of multiple forms of abuse on the wellbeing of the individual child victim</p> <p>Full understanding of the behavioural and emotional impact on the child of exposure to all forms of violence in their environment.</p>	<p>Impact of physical harm on the individual child victim</p> <p>'It is just a bruise. It will heal.'</p>
Responsibility for preventing the child's exposure to IPV	<p>Child and adult safety is dependent on the collective actions taken to curtail the abusive behaviour of the partner/parent</p> <p>Wrap-around support for all victims.</p> <p>Engagement with the abusive partner/parent and whānau.</p> <p>Understanding the decision to abuse a partner who is a parent as a parenting decision.</p> <p>Seeking to understand the impact of an abusive partner's behaviours on child and family functioning.</p>	<p>Adult victim of IPV is responsible for the protection of the child</p> <p>Mothers have 'responsibilities' to be protective.</p> <p>Fathers have 'rights' to see their children.</p>	<p>Exposure to IPV is not considered harmful</p> <p>'Bad husbands but good enough fathers.'</p> <p>Child's exposure to IPV is not considered harmful.</p>

3.3 Conclusion

This chapter sets out the shifts in thinking about family violence that have occurred in the past and those that are still required if we are to respond more effectively to family violence. In relation to all forms of family violence there is a need to move from reacting to particular incidents of physical abuse to an appreciation that family violence is a pattern of harm that:

- may have hidden and future victims
- is not confined to physical abuse
- is likely to have a cumulative and compounding effect on victims.

This reframing highlights the importance of developing strategies to disrupt and prevent future harm; including strategies that can adequately respond to the complexities of the lives of those who are using or experiencing violence.

CHAPTER 4: ACTING DIFFERENTLY – MOVING TOWARDS AN INTEGRATED FAMILY VIOLENCE SYSTEM

4.1 Introduction

In this chapter, the Committee discusses how we can reconfigure the existing family violence workforce across a tiered safety response continuum. We have focused on this as one of the key components of an integrated family violence system. The aim is to support moving towards an integrated family violence system focused on victim safety and responsive to the complexity of people's lives.

The Committee notes there is widespread acceptance of the need to develop an integrated family violence system if we are to respond effectively to family violence. In the *Fourth Annual Report*, it was observed that the Victorian government in Australia has modelled moving from 'a service system' that previously put responsibility on the victim to take action, to an 'integrated system response' that emphasises the safety of victims and the accountability of the abusive partner.¹⁴⁰ Herbert and Mackenzie have subsequently made a strong case for an integrated family violence system in Aotearoa New Zealand.¹⁴¹

Firstly, we discuss the challenges of reforming a complex system such as the family violence system. These challenges have informed the approach outlined in this chapter.

Secondly, a tiered workforce response to victim safety is proposed. The family violence workforce is mapped across four tiers that provide different safety responses. The aim is to ensure a safety response to people and whānau that is appropriate to their level of risk and need regardless of where in the family violence system a disclosure is made. The four tiers are:

- Tier 1: Restoration & Prevention
- Tier 2: Early Identification & Building Connection
- Tier 3: Enhanced Intervention & Facilitating Change
- Tier 4: Safety & Protection.

Clearly, for this approach to be effective, significant work is required to develop the necessary supporting infrastructure. There is also a need for increased investment in the development of the family violence workforce,¹⁴² including specialist family violence advocacy services and services for people using violence.

Thirdly, a case example from one of the regional reviews is provided. The practice observed in the review illustrates the adverse impact and outcome of a single-issue/single-agency response to family violence. We contrast this practice with what integrative practice could look like for a Māori whānau and a Pākehā family and how it could produce safer responses. The aim is to initiate a conversation about how organisations could practise differently if they were part of an integrated family violence system.

Finally, the Committee tracks the underpinning shifts in thinking about a systemic response to family violence that are required to support moving towards an integrated family violence system.

140 Office of Women's Policy, Department of Planning and Community Development, *A Right to Safety and Justice: Strategic Framework to Guide Continuing Family Violence Reform in Victoria 2010–2020*, 2010. FVDRC, Fourth Annual Report, p. 84.

141 R. Herbert and D. Mackenzie, *The Way Forward*, 2014.

142 See Part 3: Ten gaps in the current system, pp. 43–50 and Part 4: Opportunities for reform, pp. 51–55, Victorian Government, *Royal Commission into Family Violence: Victorian Government Submission*, 2015.

4.2 The challenges of reforming a complex system

The family violence system is best understood as a complex system.¹⁴³ Complex systems present particular challenges to policy makers for a number of reasons. They are resistant to change and frequently reorganise themselves after reform to continue to do what they have always done. Reforms can produce unexpected effects – often creating or revealing further problems. Furthermore, reforming one part of the system without addressing interlinking aspects is unlikely to result in any real change. It is also difficult to know where to begin in the process of reform because there are so many inter-linking aspects.

In addition, attempts to develop an integrated system in a fragmented manner – for example, by assigning pieces of the current system to different agencies – are likely to result in the same fragmented system with individual parts merely ‘tinkered’ with.

‘Complex problems cannot be solved by breaking them apart; they can only be addressed by looking at the whole system. They require a participative approach to create a shared view of the issue, thus opening up the possibility of concerted action.’¹⁴⁴

The process of reforming a complex system requires everyone to be on the same page and moving together. Reform is a long-term commitment, which requires reflective and iterative policy development and real-time evaluation of the emerging patterns in the system’s responses.

Continuous and responsive monitoring is necessary because interactions between the different parts of a complex system are not linear and predictable – rather, the system is dynamic and always changing.

In complexity theory, the patterns of interaction and influence between the interdependent parts of a complex system (that is, different sectors) are ‘feedback loops’.¹⁴⁵ Feedback loops can be positive (amplifying)¹⁴⁶ or negative (balancing).¹⁴⁷ The Victorian government experienced a positive feedback loop with their concerted focus on family violence. This focus attracted a significant increase in the reporting of family violence, which overwhelmed the response capability of the courts and family violence services. The experience of the Victorians would suggest more investment is required in support services prior to improving the response to family violence.¹⁴⁸

Change in a complex system occurs by changing the feedback loops and the ‘attractor’ patterns they make. The intention is to see what works and scale up (amplify) initiatives that are working well. This involves monitoring both positive and negative feedback loops and attractor patterns. ‘Achieving desirable change means allowing some small changes to continue because they are taking the system in a desired direction.’¹⁴⁹ Undesirable change needs to be counteracted. It is also important to be

143 A complex system has a number of defined characteristics:

- It involves large numbers of interacting elements.
- The interactions are non-linear and minor changes can produce disproportionately major consequences.
- The system is dynamic, the whole is greater than the sum of its parts, and solutions arise from the circumstances – they cannot be imposed.
- The system has a history and the past is integrated with the present. The elements evolve with one another and with the environment, and evolution is irreversible.
- Though a complex system may, in retrospect, appear to be ordered and predictable, hindsight does not lead to foresight because the external conditions and systems constantly change.
- In a complex system the agents and the system constrain one another, especially over time.

D. Snowden and W. Boone, ‘A leader’s framework for decision making’, 2007. FVDR, *Fourth Annual Report, 2014*, p. 31.

144 M. Frere, ‘A whole-of-government approach to family violence reform’, presentation at the Families Commission and the New Zealand Family Violence Clearing House Family Violence Symposium, 28 May 2012.

145 ‘Sometimes a desired change might not occur, because the feedback loops between the action of one component and the reaction of others in response cancel each other out (a negative feedback loop) ... At other times an action by one component can prompt a response which magnifies the effect of the initial action (a positive feedback loop) and a pattern of escalating or growing change is seen.’ E. Eppel, A. Matheson and M. Walton, ‘Applying complexity theory to New Zealand public policy principles for practice’, *Policy Quarterly*, vol. 7, no. 1, 2011, pp. 48-55, p. 49.

146 Positive feedback loops are amplifying and self-multiplying. They can have a snowball effect. Exponential growth can make the system crash, causing transformation in the system. G. Morcol, *A Complexity Theory for Public Policy*, New York, Routledge, 2012, p. 100.

147 Negative feedback loops keep systems balanced and stable. They operate like a thermostat. *Ibid*, p. 100.

148 See ‘4. Poorly resourced responses to family violence as demand for services grows’. Victorian Government, *Royal Commission into Family Violence*, 2015, p. 42.

149 E. Eppel et al., ‘Applying complexity theory to New Zealand public policy principles for practice’, 2011, p. 49.

innovative¹⁵⁰ – to design ‘safe to fail’ experiments.¹⁵¹ This means trying new interventions that will not do harm if they fail.

When working with ‘wicked’ problems¹⁵² and complex systems, the focus should therefore be on *shaping the direction of system development* (developing the parameters of a ‘road map’) and ‘nudging the system’ in that direction, rather than *detailing the complete picture of the final destination* (imposing preconceived solutions).

These understandings about complex systems have informed this chapter. Rather than proposing the development of a completely different system, we are suggesting building on, reconfiguring, investing in and providing infrastructure for the existing system of service provision so sectors and services are better able to provide safe responses to family violence.

In 2005, when the Victorian government started to develop an integrated response to family violence,¹⁵³ it accepted this required organisations to realign their core business to deal with family violence as a wicked problem.

The Committee recognises the process of reconfiguration will:

- require committed leadership
- require participation by multiple sectors, regions,¹⁵⁴ organisations¹⁵⁵ and people¹⁵⁶
- be complex and challenging
- require sustained (re)investment
- require the further development of system infrastructure
- be dependent on a shift in current thinking about the appropriate systemic response to family violence
- take time.

The alternative – remaining with the status quo – is not an option. Ineffective responses result in victims having to endure abuse for longer. This can be fatal. The regional reviews provide evidence of victims repeatedly making disclosures to multiple services, but frequently not receiving appropriate help.

SafeLives research from the UK shows that 85 percent of IPV victims sought help five times on average from practitioners in the year before they received effective help.¹⁵⁷ SafeLives has estimated that on average this means high-risk victims and their children suffered abuse for an additional 2.6 years, and medium-risk victims for 3 years, after seeking help.¹⁵⁸ For young children, this could be during their formative years. Exposure to abuse during this time will have a lifelong impact on their health and wellbeing.

An integrated system enables prompt and appropriate responses to victims, to people using violence, and to whānau, regardless of their entry point into the system.¹⁵⁹ Each help-seeking approach becomes an opportunity to interrupt the ‘spiral of violence’.

150 Innovation includes implementing old ways that catalyse change, as well as developing new ways.

151 D. Snowden and W. Boone, ‘A leader’s framework for decision making’, 2007.

152 The term ‘wicked’ is used not in the sense of evil or good but rather its resistance to resolution. Australian Public Services Commission, *Tackling Wicked Problems: A Public Policy Perspective*, Canberra, Commonwealth of Australia, 2007.

153 Department of Human Services, *Guiding Integrated Family Violence Service Reform 2006–2009*, Victoria, Victoria Government, 2006, www.dhs.vic.gov.au/__data/assets/pdf_file/0003/580971/guiding-integrated-family-violence-service-reform-2006.pdf. M. Frere, ‘A whole-of-government approach to family violence reform’, 28 May 2012.

154 Geographical regions such as local authorities.

155 Government, non-governmental and philanthropic organisations.

156 Survivors, people who have used violence, iwi and communities.

157 SafeLives, *Getting It Right the First Time: Policy Report*, Bristol, SafeLives, 2015, p. 3.

158 *Ibid*, p. 13.

159 The Victorian government highlighted the importance of consistent responses regardless of the entry point in the system. ‘Enhancement of the multiple entry to ensure that a person entering the system receives a consistent response regardless of the entry point’. Office of Women’s Policy, *Reforming the Family Violence System in Victoria: Report of the Statewide Steering Committee to Reduce Family Violence 2005*, Victoria, Department for Victorian Communities, 2005, p. 22.

4.3 Developing an Integrated Safety System

4.3.1 The importance of integrated system infrastructure

Within an integrated system, structures and processes that enhance communication and consensus-building across agencies and sectors are important, as is the infrastructure that enables the system to function as a whole. This includes:

- national and regional governance structures
- legislated principles to inform practice across the system¹⁶⁰
- the development of system principles that can usefully inform and animate an integrated response¹⁶¹
- shared risk assessment and response frameworks that enable safe and culturally responsive practice
- nationally consistent information-sharing processes
- organisational and professional accountabilities investment that builds capability and sustainability.¹⁶²

The cross-government family violence work programme and the Domestic Violence Act 1995 review provide opportunities to address many of these issues, such as workforce capability, information-sharing¹⁶³ and the development of common risk assessment and response frameworks.¹⁶⁴

In this chapter, the Committee has not embarked on a comprehensive description of the infrastructure required for an integrated system because this has been addressed elsewhere.¹⁶⁵ Instead, we have focused on adding to this work by remapping the existing workforce.

4.3.2 Integration is more than coordination

An integrated approach is more than improving the coordination of individual parts of the existing service system. In an integrated system agencies operate as one system, so that when a family violence episode is reported to any agency it is effectively responded to, as appropriate, by the whole system. This necessitates all agencies and practitioners making up the family violence response having a shared understanding of family violence and of the system they are a part of (including where they and other agencies sit within that system) so they are able to respond collectively to the complexity of family violence.

160 See Appendix 3.

161 For example, Herbert and Mackenzie set out the following seven principles:

- one problem, one system, many solutions
- local leadership, national support
- those affected are at the centre of the system
- perpetrator and system accountability
- primacy of rights to Māori as tāngata whenua
- equitable outcomes for all
- evidence-based learning and culture.

R. Herbert and D. Mackenzie, *The Way Forward*, 2014, p. 86.

162 For the evidence of the economic benefits of an integrated system, please see R. Herbert and D. Mackenzie, *The Way Forward*, 2014, pp. 102–13.

163 Information sharing between agencies

What changes could enhance information-sharing between agencies in family violence cases? For example:

- creating a presumption of disclosing information where family violence concerns arise
- stating that safety concerns 'trump' privacy concerns.

Ministry of Justice, *Strengthening New Zealand's Legislative Response to Family Violence: A Public Discussion Document*, 2015, p. 45.

164 The Ministry of Justice is developing a standardised risk assessment framework to assist professionals and practitioners to identify risk factors associated with family violence and to respond appropriately.

165 Priority areas: 5. Strengthen the Integrated Family Violence System including governance and workforce capacity, 6. Improve research and data systems to measure progress of reform and outcome. Office of Women's Policy, Department of Planning and Community Development, *A Right to Safety and Justice*, 2010, pp. 40–2. R. Herbert and D. Mackenzie, *The Way Forward*, 2014.

To contribute to safe responses, all services need to reconfigure their ways of working. Kaupapa Māori and tauwiwi (non-Māori) responses are essential. Integrative family violence practice¹⁶⁶ requires holistic person-centred and whānau-centred approaches. Although differing in its focus on victim safety, this holistic way of working aligns with a Whānau Ora approach. Services collectively need to address the multiple intersecting issues many people experiencing or perpetrating violence are struggling with if interventions are to be effective. These include experiencing:

- multiple abuses (across childhood and adulthood)
- substance dependencies and poor health
- poverty and racism.

Moving to holistic ways of working will require significant workforce development. This includes the development of practice responses that are person-centred and whānau-centred, and address the entangled nature of IPV and CAN. It also requires cross-sector capability-building that supports practitioners to be able to practise as part of a whole-of-system response.

Long-term investment in training and practice mentoring are necessary to support practitioners to think critically, deal with complexity and practise in a culturally responsive way.

4.3.3 What is safety?

Within an integrated system, different safety responses will be available so the safety response can be matched to the level of risk, complexity and need presented. The Committee defines safety in the broadest sense of the word. Safety is more than addressing the immediate physical safety of victims (a crisis response). Safety is a long-term collective process, which encompasses:

- the ongoing support of child and adult victims by agencies, safe whānau and community members
- addressing the multiple issues many victims, people using violence, families and whānau are struggling with
- sustaining safe behaviours by people who use violence
- upholding the dignity of people and their cultural identities
- providing opportunities for healing from trauma and violence to all family and whānau members.

4.4 Integrated Safety System

The Integrated Safety System diagram set out in Figure 4:

- maps the four different tiers of safety responses appropriate to different levels of family violence risk, complexity and need (first column)
- proposes reconfigurations of services and responses in order to respond better to the complexity of family violence and people's lives (second column)
- maps the current workforce across the four tiers of safety responses (third column)
- briefly describes key aspects of the infrastructure that is required to support an integrated response (pillars).

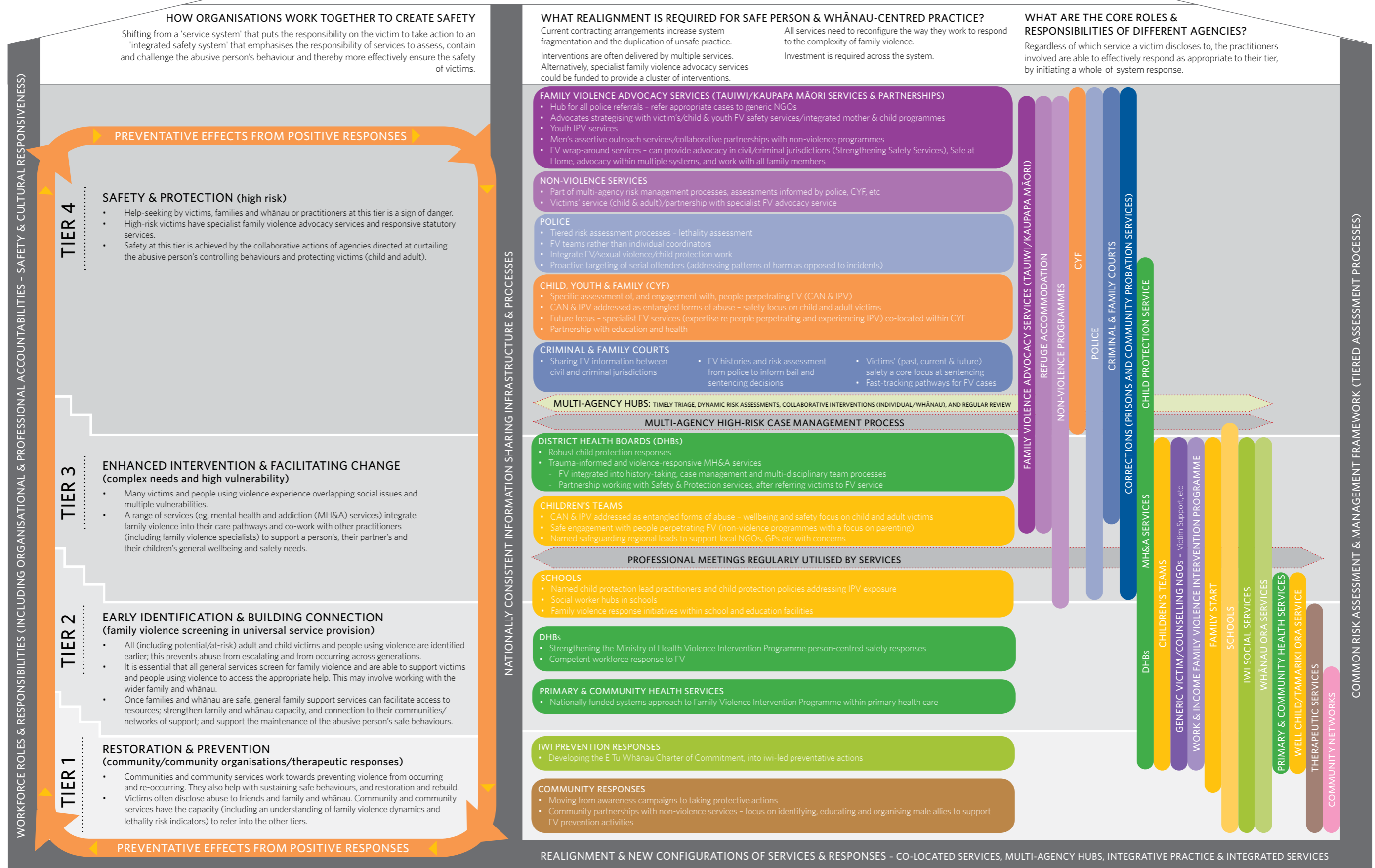
¹⁶⁶ Integrative responses:

- consist of an interdisciplinary non-hierarchical blending of different sectors in the family violence response system that provides a seamless continuum of decision-making and person-centred and/or whānau-centred safety and support
- are based on a specific set of core values that include the goals of addressing the complexity of needs (the whole person, the whole whānau), and assisting the safety and recovery of the person and/or whānau
- requires an integrated system infrastructure in order for integrative practice to be fully realised (common risk and response frameworks, and agreed workforce responsibilities and accountabilities).

This description of integrative practice is modelled on H. Boon et al., 'From parallel practice to integrative health care: A conceptual framework', *BMC Health Services Research*, vol. 4, no. 15, 2004, DOI: 10.1186/1472-6963-4-15.

INTEGRATED SAFETY SYSTEM

Figure 4: Integrated Safety System diagram



Note: A separate PDF of this diagram is available at www.hqsc.govt.nz/our-programmes/mrc/fvdc/publications-and-resources/publication/2434/.

4.4.1 Mapping safety responses over four tiers

A systemic response to family violence is reliant on a shared understanding of where individual agencies sit within the system and what they have to offer (their core roles and responsibilities).

We have addressed this by mapping agencies across four tiers of family violence safety responses (see the third column of Figure 4). Agencies can then be supported to build expertise and capacity appropriate to the tier they are located within.

While not all family violence cases warrant a high-risk case management response (Tier 4: Safety & Protection), it is necessary that universal services (Tier 2: Early Identification & Building Connection) are equipped to identify and refer those cases that do into such a process.

Agencies whose core function is a Tier 2 response – for example, primary health care and education – are optimal sites for the early identification of family violence, and early intervention for children and families needing support.

Once safety issues have been addressed, there is also a need for appropriate restorative responses (Tier 1: Restoration & Prevention).

We have positioned MH&A services at Tier 3 (Enhanced Intervention & Facilitating Change) because chronic and long-term trauma from family violence frequently accompanies MH&A issues.

Furthermore, it is impossible to treat MH&A issues effectively without addressing underlying trauma, and, even more significantly, ongoing safety. This will necessitate moving from the current Ministry of Health Violence Intervention Programme six-step approach¹⁶⁷ within MH&A services to a trauma-informed and violence-responsive approach that involves working in partnership with specialist family violence advocacy services (modelled in the case example in section 4.6).

An opportunity to prevent family violence is embedded in every response to family violence, not just those normally restricted to primary prevention.¹⁶⁸ As illustrated in the Integrated Safety System diagram, preventative effects occur throughout all tiers of response.

The tiers of responses are not intended to operate in a linear manner. For example, a family may move from a Tier 4 (Safety & Protection) response to a Tier 1 (Restoration & Prevention) response.

¹⁶⁷ Identify; provide emotional support; assess risk; safety planning and referral; document any current or past injuries thoroughly; refer the patient to a specialist family violence agency, police, lawyer or (for those under 17 years old) child protection service such as CYF, if required. Ministry of Health, *Family Violence Guidelines: Child and Partner Abuse*, Wellington, Ministry of Health, 2002, p. 40.

¹⁶⁸ See Appendix 1 for a definition of primary prevention.

Figure 5: Tiers of responses

Tier 4: Safety & Protection (high risk)¹⁶⁹

Specialist family violence service response

- Specialist family violence services receive family violence (IPV and CAN) high-risk referrals from Tier 1-3 risk assessments.
- An advocate builds a partnership with the victim and reviews risks – including making a lethality assessment and assessing risks to children.
- The victim and advocate implement the victim's safety strategy, utilising the advocate's specialist knowledge and system navigation skills.
- The advocate¹⁷⁰ is responsible for staying engaged with the adult and child victims, working in partnership with other specialist services (child and adult) and keeping other practitioners updated about any changes.
- The lead service/ specialist family violence service arranges forensic medical and mental health assessments as appropriate.
- A lead practitioner is responsible for working with the abusive person and keeping other practitioners updated about any changes.
- The advocate/lead practitioner regularly discuss the victim's/abusive person's/whānau's progress at their agency's/agencies' case review meetings.
- The agency refers to Tiers 1-3 as cases are closed.

Specialist multi-agency family violence response – safety teams

- The multi-agency high-risk case management process takes a 'safety team' approach.
- The safety team comprises of specialist IPV/CAN¹⁷¹ services and practitioners from co-working Tier 3 (Enhanced Intervention & Facilitating Change) services, such as MH&A services.
- Members of the safety team contribute their agency's specific skills/actions to the development of a comprehensive multi-agency safety strategy, which addresses the needs of all whānau members (child and adult victims, and the abusive person).
- Proactive outreach and risk management of abusive people is undertaken – how agencies plan to curtail and respectfully challenge the person's abusive behaviour and keep them connected and in sight.
- The safety team collectively maintains safety zones for victims (making safe spaces for victims – at home, in the community, and at school and work).
- Multi-agency practice is characterised by dynamic 'team' actions and regular feedback loops.
- There are circular referral loops – referral services are responsible for informing the referrer if they are unable to engage the victim/abusive person/whānau, are no longer engaged, and/or there are any escalating risk issues.
- There is regular multi-agency review of safety strategies and safety zones by the safety team.
- Safety is maximised through connection – services, safe whānau and community members weave a network of support around the victims (child and adult).

169 High-risk/chronic abuse and high complexity of needs and/or high vulnerability.

170 There is likely to be multiple advocates, one working with the child victim, and one with the adult victim.

171 This includes DHB child protection coordinators/teams.

Tier 3: Enhanced Intervention & Facilitating Change

Enhanced response – safety partnerships with lead practitioner(s)

- Family violence screening occurs throughout the service.
- Family violence is integrated throughout the agency's assessment (integrating the common family violence risk assessment framework)¹⁷² and case management processes. This requires addressing the safety and wellbeing of children and adults.
- The lead practitioner ensures any possible victim receives an appropriate medical/health assessment, including a detailed history and examination.
- The lead practitioner undertakes safety strategising with the victim – What has she tried? How did it work? Would she try it again? If not, why not? What personal, public and social/cultural resources does she have access to? How does she think her partner will react to her current strategies? What fears does she have for her children? What would it take for her to feel safe?
- The lead practitioner regularly discusses the victim's/abusive person's/whānau's progress at their agency's multi-disciplinary team meetings or peer review case meetings. The team regularly reviews the progress of clients and the safety and wellbeing needs of any children.
- The lead practitioner is responsible for staying engaged with the victim/whānau and/or abusive person/whānau respectively.
- High-risk cases are referred to Tier 4 (Safety & Protection) services.
- There is partnership case co-working with Tier 4 services, including multi-agency safety strategising.
- The agency receives referrals from Tier 1 (Restoration & Protection) and Tier 2 (Early Identification & Building Connection) for people with multiple issues who require more support.
- The agency refers to Tiers 1 and 2 as cases are closed.

Tier 2: Early Identification & Building Connection

Safety-responsive universal services

- Family violence screening occurs as part of all general assessment.
- A basic common risk assessment is utilised upon disclosure. This will direct a referral to the appropriate response tier, including Tier 4 (Safety & Protection) services where there are high-risk concerns.
- The practitioner in partnership with the victim enacts basic safety strategy actions (the safety strategy is developed in light of what and who the victim has identified as being helpful, and addresses the children's safety and wellbeing needs).
- The practitioner follows up any referrals made (for children and adults) and/or stays engaged with the victim.
- There are circular referral loops – referral services are responsible for informing the referrer if they are unable to engage the victim/abusive person/whānau, or if they are no longer engaged.
- The practitioner regularly discusses the safety strategy at their agency's case review/peer review meetings.
- The practitioner participates in meetings with Tier 3 (Enhanced Intervention & Facilitating Change) and Tier 4 (Safety & Protection) services.
- The agency receives referrals from Tier 3 (Enhanced Intervention & Facilitating Change) services as cases close (maintaining safety and wellbeing).

¹⁷² There is a common family violence risk assessment framework, which all practitioners use. There are different levels of assessment within the framework, including a basic level for all generic practitioners and a comprehensive assessment level for specialist family violence services.

Tier 1: Restoration & Prevention

Connected and protective communities

- Referrals are received from other tiers once safety is established.
- The focus is on the client's and/or whānau's wellbeing, including sustaining safety and safe behaviours, and supporting individual/collective transformation.
- Agencies work with the client and/or whānau to rebuild lives free from violence (individual/collective).
- Community initiatives are focused on preventing violence (re)occurring and changing attitudes and behaviours that condone violence against women and children.
- The community is supported to develop the capacity to proactively seek safety support for victims as appropriate to the severity of abuse.

4.5 Essential investment for a whole-of-system response

The experience in Victoria showed that responding more effectively to family violence will increase the visibility and needs of more victims.¹⁷³ Therefore, investment will be required to ensure increased demand for services across the system can be met so victims are not left enduring abuse for longer. Here we elaborate on two key areas where the regional reviews show an urgent need for significantly increased investment.

4.5.1 Investing in specialist family violence advocacy services

Family violence work is complex. The higher the level of risk and complexity in people's lives, the more they require specialist practitioners to support them.¹⁷⁴ New Zealand Police and other agencies such as those offering MH&A services are reliant on the existence of specialist family violence advocacy services (specialist advocacy services) to work in partnership with. Without adequately resourced specialist advocacy services, safety for victims is unattainable.

Moving towards greater system integration will require non-governmental organisations (NGOs) to become more agile and adaptive in their provision of services. Specialist advocacy practice is fluid, dynamic and responsive, and cannot be defined by the parameters of prescriptive victim programmes. Investment and contracting approaches need to enable flexible and emergent practice responses.

Current government contracting models, which fund multiple prescriptive victim interventions (such as Strengthening Safety Services, Safe at Home and Refuge provision) delivered by multiple services (some specialist and some generic), are not well suited for victims, their family and whānau. Victims, their family and whānau need a range of responses, preferably from one main service that is easily accessed. Kaupapa Māori¹⁷⁵ and tauīwi specialist advocacy services are both required.

173 Learnings from Victoria have demonstrated that as statutory services improve their identification of and responses to victims, there are flow-on effects to NGO specialist services. Aotearoa New Zealand can anticipate experiencing similar demand increases. Victorian Government, *Royal Commission into Family Violence: Victorian Government Submission*, Victoria, Victorian Government, 2015.

174 CAADA, *CAADA Insights 1: 'A place of greater safety'*, Bristol, CAADA, 2012.

175 Te Whakaruruhau is a Kaupapa Māori family violence advocacy service. Te Whakaruruhau has found that due to the complexities and dynamics of relationships, family violence and change, a transformational framework works best for Māori whānau. Te Whakaruruhau has developed the Ka Awatea framework, which is an intensive programme to support whānau wanting to break the cycle of violence. The underpinning philosophy for this programme is the belief that whānau can come up with their own solutions and with the right supports achieve sustainable change. Te Whakaruruhau's overall goal is to support whānau to take action for change where they become active participants in building positive life pathways. They achieve this by working with whānau to identify their dreams and goals:

- for themselves
- for their children
- for their relationship (if the partners are wanting to remain together).

They also identify the issues/barriers/risks preventing whānau from achieving their dreams, and explore and discuss sustainable solutions. The Ka Awatea programme has three phases:

1. rebuilding the whānau
2. strengthening the whānau
3. whānau and community reintegration.

Specialist advocacy services, which have the ability to work with all family and whānau members, need to be situated at points in the system where victims and people using violence seek help. Enabling face-to-face engagement with a specialist advocacy service as the initial contact, in contrast to, for example, the police offering a referral to the advocacy service, greatly enhances the likelihood that people will remain involved with the advocacy service.

Specialist advocacy services could work across multiple sites (or be co-located), such as hospitals,¹⁷⁶ multi-agency teams, primary care services and courts, and in partnerships with iwi social services.

4.5.2 Investing in services for people perpetrating family violence

A key theme throughout this report is the need to increase the range, intensity and effectiveness of the services available to work with abusive men. The most effective response to family violence is to work with those actually using violence.

This requires investment in the development, piloting and evaluation of a range of ways of working with abusive people in order to address their abusive behaviour and/or keep them connected and in sight.

Consideration should be given to developing assertive outreach services, early entry into and increased intensity of non-violence programmes, and holistic longer-term services (including residential options).

Greater investment into Kaupapa Māori tāne perpetrator rehabilitation and sustained behaviour change is also needed.

Example 7: Promising practice – agile and adaptive practice models

Te Whakaruruhau – Whānau Ora service

Te Whakaruruhau Whānau Ora Wellbeing Service offers a promising approach to interrupting the violence occurring in whānau.

Its approach is underpinned by the premise that keeping children safe involves helping women to be safe. Te Whakaruruhau recognises the protective nature of whānau has survived the damages of colonisation. Based on Māori values of whanaungatanga, manaakitanga and wairuatanga, Te Whakaruruhau aims to strengthen whānau affected by abuse and violence so that they can be connected, resilient and nurturing. Te Whakaruruhau's Whānau Ora Wellbeing Service extends beyond providing a refuge for women and children requiring a safe haven to offering tailored, holistic services that support women, children and men to become violence-free. A key strategy is an advocate who works with women in the community.

Co-locating Child and Family Services in Eastgate Shopping Centre in Christchurch

An alliance of NGOs formed in 2012 to develop an integrated co-located response system to enhance outcomes for children and families affected by or vulnerable to violence.

Operating across the continuum from prevention to earlier intervention, crisis management and wellbeing, the alliance comprises a range of specialist providers including Kaupapa Māori and mainstream; sexual and family violence; child, youth and adult; and regional and national organisations. Led by Aviva, alliance agencies will move into bespoke premises in Eastgate Shopping Centre, in Christchurch's communities of greatest need, in June 2016. Located on the first floor of the shopping centre, alliance services will operate alongside a new Integrated Family Health Centre and comprehensive community library and service centre.

¹⁷⁶ SafeLives recommends locating independent domestic violence advocates services in accident & emergency and maternity units. CAADA, CAADA Insights 1: 'A place of greater safety', 2012, pp. 10-12.

4.6 Case study – integrated practice

In this section, the Committee sets out the single-issue/single-agency practice that occurred in a regional review (with dates and other identifying details changed for the purposes of maintaining confidentiality) and contrasts that with hypothetical examples of safety-orientated integrative practice, which is responsive to Māori and Pākehā realities.

The purpose of this case study is to begin a conversation about what responsive family violence practice *might* look like if organisations were part of an integrated system, as well as illustrating some of the people- and whānau-centred advantages of practising in such a manner.

The Committee notes, for example, that practising in an integrated fashion would have resulted in an earlier response to the abusive partner's violence (long before the victim contacted the police). It would also have resulted in a response that:

- addressed multiple issues concurrently
- addressed the safety issues of the children (often hidden victims)
- actively engaged the abusive partner instead of placing responsibility for stopping the abuse on the adult victim.

Example 8: Regional review – Māori whānau/Pākehā family

Māori whānau case example

Background

Hera had been disclosing to services about Tamati’s violence for many years. However, Hera did not receive very helpful responses to her disclosures. Practitioners did not conceive that it was their responsibility to respond to Hera’s disclosures or try and stay engaged with her. Consequently, most agencies left it to Hera to initiate action to attempt to mitigate Tamati’s violence. Hera was killed by Tamati.

Practice that occurred	System issues identified	Possible safety-orientated practice in an integrated system ^a
District health board (DHB) addiction treatment provider		
<p>For years Hera had struggled with alcohol. Drinking numbed the multiple forms of abuse she had experienced as a child and as an adult (from multiple partners).</p> <p>In three years Hera made 5+ disclosures about Tamati’s (her current partner) violence to her addiction counsellor.</p> <p>The counsellor was supporting Hera to reduce her drinking. However, she did refer Hera to a health support service with respect to the IPV disclosures.</p> <p>After the end of the initial three-year engagement, Hera was re-referred. Although the referral identified concerns for her safety, she was offered an appointment with an addiction counsellor in a few weeks’ time.</p>	<p>Organisational focus was on stopping people drinking</p> <p>The DHB addiction service focus was on alcohol harm reduction. Many women with histories of victimisation (as children and/or adults) will be involved with addiction services. To support people to stop drinking, practitioners have to address why people are drinking (ie, their trauma and abuse) and assist them in a holistic manner as appropriate to their role.</p> <p>Hera’s drinking needed to be understood as a trauma response to her cumulative and compounding experiences of violence, some of which were ongoing. Hera disclosed Tamati’s violence to the addiction service long before she disclosed to the police. A family violence responsive addiction service could have taken protective actions for Hera and her children, and potentially enabled earlier intervention with Tamati.</p> <p>The ‘Screen, Assess and Refer’ is the recommended model in health.</p> <p>Addiction services can be one of the main services engaged with victims. Addiction services have the opportunity to proactively support victims and their children’s wellbeing and safety needs in <i>partnership</i> with specialist family violence services. The addiction service can contribute their specific skills/actions to the ongoing multi-agency case management process.</p>	<ul style="list-style-type: none"> • Hera is offered the support of a Kaupapa Māori addiction service (such as a Māori Alcohol and Drug Team (MADT)),^b which is part of a DHB addiction service). As part of Hera’s initial assessment the MADT ask about her whakapapa, the level of connection to and support from her whānau and their challenges, family violence in her wider whānau and her own experiences with her partner. They also ask about her level of social support from her community. Hera discloses being disconnected from her whānau and cultural identity, a history of CAN (including exposure to IPV as a child), IPV in her siblings’ partnerships, and IPV from Tamati. The MADT do not immediately assume that Hera’s whānau are a safe or productive source of support at this time.^c • Hera’s drinking is understood as a trauma response to historic and current experiences of violence. Her recovery from substance abuse requires addressing her history of CAN, her past and current experiences of violence as an adult, and uplifting the dignity of her Māori identity. The MADT work to affirm Hera’s identity as Māori by identifying her whānau, hapū and iwi. They connect Hera with kuia and kaumātua who can be a source of safety and support. In the longer term the MADT seek to reconnect Hera with her whānau. The MADT offer Hera marae-focused, whānau-centred and wairua-driven support and connection to Whānau Ora providers in her community. • The MADT, in partnership with the addiction service multi-disciplinary team (MDT), discuss Hera’s disclosure and consider what protective actions to take. Depending on the risks identified, there are multiple options. <ul style="list-style-type: none"> – The addiction practitioners are skilled in working with family violence (Tier 3) and consult with the DHB Child Protection Coordinator. This could result in a referral to CYF or a Children’s Team (who may then refer the children for a health and wellbeing or forensic assessment). Practitioners can support Hera to make a report to the police. – With Hera’s consent, an advocate from a Kaupapa Māori family violence advocacy service (a family violence Whānau Ora provider) meets her at a MADT appointment. This service has the capacity to work with Hera and her children (to address the violence and trauma they have been living with), and Tamati, together or separately depending on what Hera wants. The advocacy service is focused on addressing whānau violence and leads the family violence response. The use of Māori traditional knowledge and cultural practices are fundamental to addressing whānau violence and achieving whānau ora (wellbeing). – All practitioners and agencies work with the aim of keeping both Hera and her children safe; this includes engaging with Tamati. • As a beginning point, the Kaupapa Māori advocacy service explore the safety strategies Hera is already using. They build on these and provide a wrap-around support to ensure that all her and her children’s needs are being met (physical safety, wellbeing, material and cultural). In the longer term they advocate for Hera and her children within her community and her whānau, hapū and iwi. The local iwi have a long-term commitment to violence prevention that is about moving from a state of violence to a state of wellbeing. • The MADT and the addiction service MDT work in partnership with the Kaupapa Māori advocacy service and will be part of a multi-agency safety strategy if Tamati’s abuse escalates. The MADT and the addiction service MDT prioritise the ongoing safety and wellbeing of Hera and her children by discussing what multi-agency responses are being initiated with Hera, her children and Tamati as part of regular addiction service MDT meetings. • Responsive practice increases Hera’s trust and engagement with the MADT.

a. The practice described is occurring in an interconnected rather than linear manner.
 b. This approach exists in some DHBs.
 c. The challenge is to simultaneously enable the restoration of Māori whānau and the realisation of Māori whānau as a population-based protective factor, while managing the risks that some whānau are not safe supports for women and children.

Practice that occurred	System issues identified	Possible safety-orientated practice in an integrated system
New Zealand Police		
<p>Police records reveal that Hera was victimised by multiple partners over many years. However, she was not perceived as a high-risk repeat victim.</p> <p>In one year, 3+ reports were made to the police about Tamati's violence.</p> <p>Hera called the police as she feared for her safety, but she had to negotiate her safety on their arrival and was hesitant to provide statements on their attendance. The third attendance resulted in Tamati being arrested for an assault. The police made a report to CYF.</p>	<p>Limited response to family violence as a cumulative pattern of harm</p> <p>The Police Victim History Score captures all types of crime victimisations within 12 months.</p> <p>Experiences of multiple victimisations from multiple partners have a cumulative and compounding effect. Research by Davies et al^d shows how extreme and multiple victimisations, poverty and poor health intersect in compounding ways. Victims can be reticent about seeking help from the police because of the potential consequences and also because of fear. When victims seek help from the police, this is when the risk has escalated.</p> <p>Police risk assessment focuses on re-assault</p> <p>Police assess the risk of IPV re-assault. Lethality assessment was not part of the risk assessment process.</p>	<p>The National Intelligence Application, as part of a Victim History Scorecard (responsive to family violence victimisation), identifies that Hera has been victimised by multiple abusive partners over many years. The linked victim-focused 'graduated response model' directs officers to increase their efforts and ways of engaging with Hera.</p> <ul style="list-style-type: none"> Hera's second 111 phone call is played to attending officers en route to her address. This gives them an understanding of her level of fear and entrapment. They can hear the children screaming and Tamati threatening to harm them if Hera says anything to the police on their arrival. The police work in partnership with a specialist Kaupapa Māori family violence advocacy service, which is able to attend with the police. On arrival, officers focus on engaging with and containing Tamati, while advocates initially focus on engaging with Hera and her children. They also engage with Tamati. The face-to-face connection means the service is now known to Hera and Tamati. They are both more likely to trust and engage with follow-up support. Tamati is arrested for assault and removed from the property to a safe location. The police undertake a re-assault assessment and lethality screen with Hera. Hera discloses recent acts of non-fatal strangulation and that her children are terrified of Tamati. The police action a report of concern to CYF and a referral to the multi-agency high-risk case management process.
Child, Youth and Family (CYF)		
<p>CYF was involved with Hera and her children for many years because of the children's ongoing exposure to IPV and concerns about neglect due to Hera's drinking.</p> <p>The police report to CYF noted that both adults were intoxicated, Hera had injuries, the children were crying, and Hera was trying to keep Tamati away from them all.</p> <p>Social workers visited the home but Tamati sat beside Hera throughout the visit. This prevented her from disclosing. The case was closed on the agreement that a family support service would engage and make a report of concern if necessary. CYF informed Hera that any further police reports would result in their re-involvement.</p> <p>Hera refrained from making any further disclosures about Tamati's violence to services.</p>	<p>CYF practice must address the entangled nature of IPV and CAN</p> <p>Integrating IPV within child protection systems is a challenge internationally and in Aotearoa New Zealand. These systems were not designed with IPV in mind and are directed at responding in a child-centred manner.</p> <p>IPV and CAN are not separate co-existing forms of violence. Their entangled nature requires care and protection assessments to identify the risks to child and adult victims, and direct practice responses accordingly.</p> <p>Mandel's^e continuum of domestic violence practice is designed to assist child protection systems to shift towards a perpetrator-focused, child-centred, and survivor strength-based approach. Such an approach can help child protection systems become more IPV informed.</p> <p>Statutory child protection threshold or vulnerable children services</p> <p>Child protection and family support work trigger different responses. Tamati's abuse was responded to as an 'incident' (disconnected from the long CYRAS^f history) which could be addressed by a family support service.</p> <p>Understanding family violence as a cumulative pattern of harm requires practitioners not to focus on 'incidents', but rather the length of exposure/multiple experiences of abuse and the severity of the abuse.</p>	<ul style="list-style-type: none"> Social workers receive the police report and attend the high-risk case management meeting. In preparation for the meeting, they summarise the significant CYRAS history for Hera and her children, recognising that chronic exposure to/experience of IPV will have a cumulative effect on them all. At the high-risk case management meeting, CYF learns that Hera has a good relationship with the MADT. It is suggested that it would be safest and most supportive to speak to Hera at a MADT appointment, rather than her home. Social workers have culturally responsive practice tools, guidance and supervision to enable culturally responsive practice with Māori whānau. Social workers meet with Hera. She is supportive of them speaking with the children at school about their experiences and can be there to reassure her children that it is okay for them to talk with the social workers. They meet with the children to seek their views and understanding of the whānau's situation. They undertake safety planning work with the children. Social workers have had comprehensive training and practice mentoring on how to effectively and safely work with abusive fathers and stepfathers. They engage with Tamati after they have spoken to Hera and the children. They do not disclose what Hera and the children said, but talk with Tamati about the police report and their concerns about his behaviour. They ask Tamati about his whakapapa and his whānau's experiences to understand his life experiences and what safe whānau and social support he has available to him. Social workers hold Tamati accountable for his violence and changing his behaviour through intensive engagement with the Kaupapa Māori family violence advocacy service working with him, Hera and the children. The focus is on his long-term healing and rehabilitation. An intervention plan is developed which contributes to the multi-agency safety strategy. This addresses the needs of the whānau and engages Māori social service providers and communities to support and strengthen the whānau's cultural identity and safety.

d. Davies et al., 'Patterns of cumulative abuse among female survivors of intimate partner violence: Links to women's health and socioeconomic status', *Violence Against Women*, Vol. 21, no. 1, 2015, pp. 30-48.

e. The *Safe and Together Model Suite of Tools and Interventions* is a perpetrator pattern based, child-centred, survivor strengths approach to working with domestic violence. <http://endingviolence.com/our-programs/safe-together/safe-together-overview/>

f. Care and Protection; Youth Justice; Residences; Adoption; System.

Practice that occurred	System issues identified	Possible safety-orientated practice in an integrated system
Multi-agency communication and collaboration		
<p>Family Violence Interagency Response System (FVIARS)</p> <p>The police ‘incidents’ were discussed at FVIARS. Hera was referred to a Women’s Refuge. As Tamati pleaded guilty to the assault, he was referred to a non-violence programme (NVP). There were no progress updates at subsequent meetings. As there were no further police reports, there were no more FVIARS meetings.</p> <p>The Women’s Refuge phoned Hera once. There were no notes on what was discussed. No other actions were taken (eg, informing the police that they were not engaged with Hera, trying to connect with other services involved) apart from the police re-assault assessment. No service undertook an IPV risk assessment with Hera.</p> <p>Later that year, Hera engaged with a family support service and a community counsellor; neither was part of FVIARS. The counsellor did not ask about IPV.</p> <p>Tamati’s ongoing violence increased Hera’s drinking. The family support practitioners and counsellor were trying to get her help for her drinking.</p> <p>Hera needed support from a specialist family violence advocacy service that could initiate a ‘safety team’ approach.</p>	<p>Key services are missing from FVIARS meetings</p> <p>FVIARS is a police triaging process with limited membership. Nationally, DHB MH&A services and men’s NVPs are not regular members.</p> <p>No multi-agency safety plans as part of FVIARS meetings</p> <p>There are no multi-agency safety plans which consistently record what actions agencies are progressing, and when the plan is to be reviewed etc.</p> <p>Referrals to services do not equal safety outcomes</p> <p>Victims can be offered limited opportunities to engage before they are deemed to be not engaging. It should be agencies’ responsibility to find safe ways of engaging and staying involved with victims.</p> <p>Services work from an ‘empowerment’ approach</p> <p>The focus of FVIARS is frequently on what the victim is doing (getting a protection order, entering refuge, attending a programme). Victims cannot be empowered to stop their abusive partners’ violence. Victims resist abuse, but their resistance does not stop the violence. Empowerment needs to be reframed as a collective endeavour enabled by a systemic safety response.</p> <p>High-risk victims need specialist family violence advocacy services</p> <p>Mismatched services can enable unintentionally unsafe practice. High-risk victims require support from specialist services.</p>	<p>Agreed tiers of workforce responses (dependent on level of risk and complexity of need) ensure the right services respond to Hera, her children and Tamati. All services use a nationally consistent family violence risk assessment and response framework, which is facilitated by a mandated presumption of responsible information-sharing where there are concerns about family violence (CAN and IPV).</p> <ul style="list-style-type: none"> • Tier 1: Restoration & Prevention: <i>Proactive safety-seeking as appropriate to the severity of abuse</i> • Tier 2: Early Identification & Building Connection: <i>Family violence screening in universal service provision, safety-responsive universal services</i> • Tier 3: Enhanced Intervention & Facilitating Change: <i>Safety partnerships with lead worker</i> • Tier 4: Safety & Protection: <i>Safety teams and multi-agency family violence responses, specialist family violence services</i> <p><i>Multi-agency family violence responses</i></p> <ul style="list-style-type: none"> • The police identify safety and protection concerns (Tier 4). They make a referral to the high-risk case management process. • Members include DHB MH&A service, DHB child protection, Department of Corrections, New Zealand Police, CYF, Kaupapa Māori men’s non-violence service (NVS) (and tauīwi) and Kaupapa Māori specialist family violence NGOs (and tauīwi). • A ‘safety team’ approach is taken. Each agency contributes their specific skills/actions to the development of a multi-agency safety strategy for the whānau. • Department of Corrections, New Zealand Police, CYF and the Kaupapa Māori NVS focus on keeping Tamati connected and in sight. • CYF is the lead agency for the children, and liaises with the children’s school and services involved with the children. • There is regular multi-agency review of the multi-agency safety strategy by the ‘safety team’. <p><i>Specialist family violence advocacy services</i></p> <ul style="list-style-type: none"> • An advocate undertakes a comprehensive risk assessment with Hera – addressing lethality risk and risks to the children. • <i>Safety through connection</i> – the advocate asks Hera what she has tried before, what she would try again, who are safe whānau and community members, and which services she sees as helpful. This information is used to weave a network of support around Hera, her children and Tamati. • The advocate uses her specialist knowledge and system navigation skills to strengthen the multi-agency safety strategy. • The Kaupapa Māori advocacy service ensures that Hera’s, her children’s and Tamati’s experiences of services inform the direction and way that providers work with them.
Non-violence programme (NVP)		
<p>Tamati attended an NVP because of the assault conviction. As part of the assessment process the NVP did not request information from the police or CYF. The NVP made no contact with Hera. Tamati’s self-report was the main source of information.</p> <p>The NVP is not a member of the FVIARS process.</p>	<p>Siloed assessment, support and management of abusive partners</p> <p>NVPs have historically operated in a silo from other family violence multi-agency responses. This is problematic as NVPs are often one of the services that have the greatest engagement opportunities with abusive partners. There is generally an incentive for abusive partners to engage (eg, a discharge without conviction if they attend).</p> <p>Amending the Ministry of Justice Code of Practice could enable NVP providers to be required to proactively liaise with other agencies and take part in multi-agency risk management processes. Similarly, amending the Domestic Violence Act 1995 could support safer practice, by requiring NVP providers to have safe processes to seek information from victims, and to seek information from other services as part of their assessments and ongoing work. In accordance with international safe practice, NVPs should have parallel services for victims that focus on victims’ safety.</p>	<p>Tamati is offered a referral to a Kaupapa Māori men’s NVS which works in partnership with/or is part of the Kaupapa Māori family violence advocacy service. Healing for the entire whānau cannot be effected until Tamati takes responsibility for his behaviour and embarks on a healing journey as well. The Kaupapa Māori NVS:</p> <ul style="list-style-type: none"> • has a range of ways to work with Tamati. They can increase the intensity of the programme he is attending and have holistic longer-term services, depending on the level of risk he poses and his wider support needs (eg, programmes are run on the marae and are whānau-centred) • takes into account the heterogeneity of participants. Men who participate in the programme have diverse life experiences and come with varying degrees of knowledge, awareness and confidence about being Māori • sessions are structured around tikanga Māori (cultural values and practices) that assist in facilitating learning and self-examination and use a methodology that seeks to address violence from within a Māori cultural worldview • has a strong focus on the risks to Hera and the children. They participate in CYF meetings. The NVS ensures their reporting on Tamati’s progress (however small) does not overshadow the ongoing risks and harmful impact of his use of violence on the children • provides CYF with feedback, risk assessment review, and monitoring for change. This supports CYF’s accountability approach with Tamati and their ability to assess the risks he poses to the children and Hera. <p>The Kaupapa Māori NVS is a member of the high-risk case management process and contributes to the multi-agency safety strategy for Hera, the children and Tamati. The NVS’s main focus is on engaging Tamati and keeping him connected and in sight.</p>
<p>There were other services involved (for example, GPs, the Criminal Court and the Department of Corrections, and Work & Income). We have not included details of the practice response of these agencies here for reasons of confidentiality.</p>		

Pākehā family case example

Background

Mary had been disclosing to services about Tom's violence for many years. However, Mary did not receive very helpful responses to her disclosures. Practitioners did not conceive that it was their responsibility to respond to Mary's disclosures or try and stay engaged with her. Consequently, most agencies left it to Mary to initiate action to attempt to mitigate Tom's violence. Mary was killed by Tom.

Practice that occurred	System issues identified	Possible safety orientated practice in an integrated system ^a
District health board (DHB) addiction treatment provider		
<p>For years Mary had struggled with alcohol. Drinking numbed the multiple forms of abuse she had experienced as a child and as an adult (from multiple partners).</p> <p>In three years Mary made 5+ disclosures about Tom's (her current partner) violence to her addiction counsellor.</p> <p>The counsellor was supporting Mary to reduce her drinking. However, she did refer Mary to a health support service with respect to the IPV disclosures.</p> <p>After the end of the initial three-year engagement, Mary was re-referred. Although the referral identified concerns for her safety, she was offered an appointment with an addiction counsellor in a few weeks' time.</p>	<p>Organisational focus was on stopping people drinking</p> <p>The DHB addiction service focus was on alcohol harm reduction. Many women with histories of victimisation (as children and/or adults) will be involved with addiction services. To support people to stop drinking, practitioners have to address why people are drinking (ie, their trauma and abuse) and assist them in a holistic manner as appropriate to their role.</p> <p>Mary's drinking needed to be understood as a trauma response to her cumulative and compounding experiences of violence, some of which were ongoing. Mary disclosed Tom's violence to the addiction service long before she disclosed to the police. A family violence responsive addiction service could have taken protective actions for Mary and her children, and potentially enabled earlier intervention with Tom.</p> <p>The 'Screen, Assess and Refer' is the recommended model in health.</p> <p>Addiction services can be one of the main services engaged with victims. Addiction services have the opportunity to proactively support victims and their children's wellbeing and safety needs in <i>partnership</i> with specialist family violence services. The addiction service can contribute their specific skills/actions to the ongoing multi-agency case management process.</p>	<ul style="list-style-type: none"> Mary is asked about family violence during her initial assessment. She discloses a history of CAN and IPV from Tom. Mary's drinking is understood as a trauma response to historic and current experiences of violence. Her recovery from substance abuse requires addressing both issues together. The addiction multi-disciplinary team (MDT) discusses Mary's disclosure and considers what protective actions to take. Depending on the risks identified, there are multiple options. The practitioners are skilled in working with family violence (Tier 3) and consult with the DHB Child Protection Coordinator.^b This could result in a referral to CYF or a Children's Team (who may then refer the children for a health or forensic assessment). Practitioners can support Mary to make a report to the police. The practitioners refer Mary to a specialist family violence advocacy service, which has a children's advocacy service. They work in partnership with the advocacy service and will be part of a multi-agency safety strategy if Tom's abuse escalates. A greater range of effective services for abusive men enables the MDT, in partnership with the advocacy service, to connect Tom with an assertive outreach and/or behaviour change service. The addiction practitioners prioritise the ongoing safety and wellbeing of Mary and her children by discussing what multi-agency responses are being initiated with Mary and her children and who is engaged with Tom as part of their regular MDT meetings. Responsive practice increases Mary's trust and engagement with the addiction service.
New Zealand Police		
<p>Police records reveal that Mary was victimised by multiple partners over many years. However, she was not perceived as a high-risk repeat victim.</p> <p>In one year, 3+ reports were made to the police about Tom's violence.</p> <p>Mary called the police as she feared for her safety, but she had to negotiate her safety on their arrival and was hesitant to provide statements on their attendance. The third attendance resulted in Tom being arrested for an assault. The police made a report to CYF.</p>	<p>Limited response to family violence as a cumulative pattern of harm</p> <p>The Police Victim History Score captures all types of crime victimisations within 12 months.</p> <p>Experiences of multiple victimisations from multiple partners have a cumulative and compounding effect. Research by Davies et al^c shows how extreme and multiple victimisations, poverty and poor health intersect in compounding ways. Victims can be reticent about seeking help from the police because of the potential consequences and also because of fear. When victims seek help from the police, this is when the risk has escalated.</p> <p>Police risk assessment focuses on re-assault</p> <p>Police assess the risk of IPV re-assault. Lethality assessment was not part of the risk assessment process.</p>	<p>The National Intelligence Application, as part of a Victim History Scorecard (responsive to family violence victimisation), identifies that Mary has been victimised by multiple abusive partners over many years. The linked victim-focused 'graduated response model' directs officers to increase their efforts and ways of engaging with Mary.</p> <ul style="list-style-type: none"> Mary's second 111 phone call is played to attending officers on route to her address. This gives them an understanding of her level of fear and entrapment. They can hear the children screaming and Tom threatening to harm them if Mary says anything to the police on their arrival. The police work in partnership with a specialist family violence advocacy service, which is able to attend with the police. On arrival, officers focus on engaging with and containing Tom, while advocates focus on supporting the children and engaging with Mary. An initial face-to-face connection means the advocacy service is now known to Mary. Mary is more likely to trust and engage with follow-up support. Tom is arrested for assault and removed from the property to a safe location. The police undertake a re-assault assessment and lethality screen with Mary. Mary discloses recent acts of non-fatal strangulation and that her children are terrified of Tom. The police action a report of concern to CYF and a referral to the multi-agency high-risk case management process.

a. The practice described is occurring in an interconnected rather than linear manner.

b. In some DHBs the Violence Intervention Programme Coordinator may cover the child protection and partner abuse coordination roles.

c. Davies et al., 'Patterns of cumulative abuse among female survivors of intimate partner violence: Links to women's health and socioeconomic status', *Violence Against Women*, Vol. 21, no. 1, 2015, pp. 30-48.

Practice that occurred	System issues identified	Possible safety orientated practice in an integrated system
Child, Youth and Family (CYF)		
<p>CYF was involved with Mary and her children for many years because of the children's ongoing exposure to IPV and concerns about neglect due to Mary's drinking.</p> <p>The police report to CYF noted that both adults were intoxicated, Mary had injuries, the children were crying, and Mary was trying to keep Tom away from them all.</p> <p>Social workers visited the home but Tom sat beside Mary throughout the visit. This prevented her from disclosing. The case was closed on the agreement that a family support service would engage and make a report of concern if necessary. CYF informed Mary that any further police reports would result in their re-involvement.</p> <p>Mary refrained from making any further disclosures about Tom's violence to services.</p>	<p>CYF practice must address the entangled nature of IPV and CAN</p> <p>Integrating IPV within child protection systems is a challenge internationally and in Aotearoa New Zealand. These systems were not designed with IPV in mind and are directed at responding in a child-centred manner.</p> <p>IPV and CAN are not separate co-existing forms of violence. Their entangled nature requires care and protection assessments to identify the risks to child and adult victims, and direct practice responses accordingly. Mandel's^d continuum of domestic violence practice is designed to assist child protection systems to shift towards a perpetrator-focused, child-centred, and survivor strength-based approach. Such an approach can help child protection systems become more IPV informed.</p> <p>Statutory child protection threshold or vulnerable children services</p> <p>Child protection and family support work trigger different responses. Tom's abuse was responded to as an 'incident' (disconnected from the long CYRAS^e history) which could be addressed by a family support service.</p> <p>Understanding family violence as a cumulative pattern of harm requires practitioners not to focus on 'incidents', but rather the length of exposure/multiple experiences of abuse and the severity of the abuse.</p>	<ul style="list-style-type: none"> • Social workers receive the police report and attend the high-risk case management meeting. In preparation for the meeting, they summarise the significant CYRAS history for Mary and her children, recognising that chronic exposure to/experience of IPV will have a cumulative effect on them all. • At the high-risk case management meeting, CYF learns that Mary has a good relationship with the addiction service. It is suggested that it would be safest to speak to Mary at an addiction service appointment rather than her home. • Social workers meet with Mary. She is supportive of them speaking with the children at school about their experiences and can be there to reassure her children. • Social workers meet with the children to seek their views and understanding of the family's situation. They undertake safety planning work with the children. • Social workers have had comprehensive training and practice mentoring on how to effectively and safely work with abusive fathers and stepfathers. They engage with Tom after they have spoken to Mary and the children. They do not disclose what Mary and the children said, but talk with him about the police report and their concerns about his behaviour. • They undertake a social history and genogram with Tom to understand his life experiences and what family and social support he has available to him. • Social workers hold Tom accountable for the violence and changing his behaviour through intensive engagement with non-violence services (NVSs). • An intervention plan is developed. This addresses the needs of the whole family and engages the appropriate agencies.
Multi-agency communication and collaboration		
<p>Family Violence Interagency Response System (FVIARS)</p> <p>The police 'incidents' were discussed at FVIARS. Mary was referred to a Women's Refuge. As Tom pleaded guilty to the assault, he was referred to a non-violence programme (NVP). There were no progress updates at subsequent FVIARS meetings. As there were no further police reports, there were no more FVIARS meetings.</p> <p>The Women's Refuge phoned Mary once. There were no notes on what was discussed. No other actions were taken (ie, informing the police that they were not engaged with Mary, trying to connect with other services involved) apart from the police re-assault assessment. No service undertook an IPV risk assessment with Mary.</p> <p>Later that year, Mary engaged with a family support service and a community counsellor; neither was part of FVIARS. The counsellor did not ask about IPV.</p> <p>Tom's ongoing violence increased Mary's drinking. The family support practitioners and counsellor were trying to get her help for her drinking.</p> <p>Mary needed support from a specialist family violence advocacy service that could initiate a 'safety team' approach.</p>	<p>Key services are missing from FVIARS meetings</p> <p>FVIARS is a police triaging process with limited membership. Nationally, DHB MH&A services and men's NVPs are not regular members.</p> <p>No multi-agency safety plans as part of FVIARS meetings</p> <p>There are no multi-agency safety plans which consistently record what actions agencies are progressing, and when the plan is to be reviewed etc.</p> <p>Referrals to services do not equal safety outcomes</p> <p>Victims can be offered limited opportunities to engage before they are deemed to be not engaging. It should be agencies' responsibility to find safe ways of engaging and staying involved with victims.</p> <p>Services work from an 'empowerment' approach</p> <p>The focus of FVIARS is frequently on what the victim is doing (getting a protection order, entering refuge, attending a programme). Victims cannot be empowered to stop their abusive partners' violence. Victims resist abuse, but their resistance does not stop the violence. Empowerment needs to be reframed as a collective endeavour enabled by a systemic safety response.</p> <p>High-risk victims need specialist family violence advocacy services</p> <p>Mismatched services can enable unintentionally unsafe practice. High-risk victims require support from specialist services.</p>	<p>Agreed tiers of workforce responses (dependent on level of risk and complexity of need) ensure the right services respond to Mary, her children and Tom. All services use a nationally consistent family violence risk assessment and response framework, which is facilitated by a mandated presumption of responsible information sharing where there are concerns about family violence (CAN & IPV).</p> <ul style="list-style-type: none"> • Tier 1: Restoration & Prevention: <i>Proactive safety-seeking as appropriate to the severity of abuse</i> • Tier 2: Early Identification & Building Connection: <i>Family violence screening in universal service provision, safety-responsive universal services</i> • Tier 3: Enhanced Intervention & Facilitating Change: <i>Safety partnerships with lead worker</i> • Tier 4: Safety & Protection: <i>Safety teams and multi-agency family violence responses, specialist family violence services</i> <p><i>Multi-agency family violence responses</i></p> <ul style="list-style-type: none"> • The police identify safety and protection concerns (Tier 4). They make a referral to the high-risk case management process. • Members include DHB MH&A service, DHB child protection, Department of Corrections, New Zealand Police, CYF, Men's NVS (eg, Kaupapa Māori and tauiwi) specialist family violence NGOs (eg, Kaupapa Māori and tauiwi). • A 'safety team' approach is taken. Each agency contributes their specific skills/actions to the development of a multi-agency safety strategy for the family. • Department of Corrections, New Zealand Police, CYF and the NVS focus on keeping Tom connected and in sight. • CYF is the lead agency for the children, and liaises with the children's school and services involved with the children. • There is regular multi-agency review of the multi-agency safety strategy by the 'safety team'. <p><i>Specialist family violence advocacy services</i></p> <ul style="list-style-type: none"> • An advocate undertakes a comprehensive risk assessment with Mary – addressing lethality risk and risks to the children. • <i>Safety through connection</i> – the advocate asks Mary what she has tried before, what she would try again, who are safe family and community members, and which services she sees as helpful. This information is used to weave a network of support around Mary, her children and Tom. • The advocate uses her specialist knowledge and system navigation skills to strengthen the multi-agency safety strategy. • The advocacy service ensures that Mary's, her children's and Tom's experiences of services inform the direction and way that providers work with them.

d. The *Safe and Together Model Suite of Tools and Interventions* is a perpetrator pattern based, child-centred, survivor strengths approach to working with domestic violence. <http://endingviolence.com/our-programs/safe-together/safe-together-overview/>

e. Care and Protection; Youth Justice; Residences; Adoption; System.

Practice that occurred	System issues identified	Possible safety orientated practice in an integrated system
Non-violence programme (NVP)		
<p>Tom attended an NVP because of the assault conviction. As part of the assessment process the NVP did not request information from the police or CYF. The NVP made no contact with Mary. Tom's self-report was the main source of information.</p> <p>The NVP is not a member of the FVIARS process.</p>	<p>Siloed assessment, support and management of abusive partners</p> <p>NVPs have historically operated in a silo from other family violence multi-agency responses. This is problematic as NVPs are often one of the services that have the greatest engagement opportunities with abusive partners. There is generally an incentive for abusive partners to engage (eg, a discharge without conviction if they attend).</p> <p>Amending the Ministry of Justice Code of Practice could enable NVP providers to be required to proactively liaise with other agencies and take part in multi-agency risk management processes. Similarly, amending the Domestic Violence Act 1995 could support safer practice by requiring NVP providers to have safe processes to seek information from victims <i>and</i> to seek information from other services as part of their assessments and ongoing work. In accordance with international safe practice, NVPs should have parallel services for victims that focus on victims' safety.</p>	<p>Tom is referred to a men's NVS which works in partnership with/or is part of the family violence advocacy service. The NVS:</p> <ul style="list-style-type: none"> • has a range of ways to work with Tom. They can increase the intensity of the programme he is attending and have holistic longer-term services, depending on the level of risk he poses and his wider support needs (eg, working in partnership with addiction services) • has a strong focus on the risks to Mary and the children. They participate in CYF meetings. The NVS ensures their reporting on Tom's progress (however small) does not overshadow the ongoing risks and harmful impact of his use of violence on the children • provides CYF with feedback, risk assessment review, and monitoring for change. This supports CYF's accountability approach with Tom and their ability to assess the risks he poses to the children and Mary • works in partnership with the specialist family violence advocacy service to support partners of men engaging with the NVS. <p>The NVS is a member of the high-risk case management process and contributes to the multi-agency safety strategy for Mary, the children and Tom. The NVS's main focus is on keeping Tom connected and in sight.</p>
<p>There were other services involved (for example, GPs, the Criminal Court and the Department of Corrections, and Work & Income). We have not included details of the practice response of these agencies here for reasons of confidentiality.</p>		

4.7 Thinking differently about the systemic response to family violence

Table 6 maps the shifts in thinking about the appropriate systemic responses to family violence required if we are to begin to integrate the family violence system.

This includes the thinking that underpins system design and investment decisions.

Table 6: How we understand the family violence system

	Reframing	Current understandings	Past understandings
Framing of the social problem¹⁷⁷	<p>Complex</p> <p>The problem must be explored in new ways because the future cannot be predicted from the past.</p> <p>Capacities to explore the problem are spread across different places, organisations and sectors.</p>	<p>Complicated</p> <p>The problem can be explored in familiar ways by the right experts.</p> <p>Experts with the capacity to diagnose the problem can come up with the solution and implement it.</p>	<p>Simple</p> <p>The relationship between cause and effect is obvious to all.</p> <p>Capacity to resolve the problem is located in one organisation.</p>
Development of system responses	<p>Integrated</p> <p>A whole-of-system approach.</p> <p>Integrated system architecture (national and regional infrastructure)¹⁷⁸ is supported by a 'collective impact' approach.¹⁷⁹</p> <p>An independent authority¹⁸⁰ enables the right mix of devolution and top-down control.</p> <p>Integrative practice/ initiatives</p> <p>As the complexity of need and required diversity of outcomes increases, there is a greater need for integrative responses, such as:</p> <ul style="list-style-type: none"> social sector trials district health and social boards.¹⁸¹ 	<p>Coordinated</p> <p>Joined-up responses.</p> <p>Multi-agency initiatives.</p> <p>Cross-government working groups operating within existing organisational structures.¹⁸²</p> <p>There are numerous groups, networks and coordinators either directly or indirectly working on 'family violence',¹⁸³ eg, Family Safety Teams (co-located), Children's Teams,¹⁸⁴ and FVIARS groups.</p>	<p>Fragmented</p> <ul style="list-style-type: none"> single agency¹⁸⁵ (New Zealand Police, CYF, mental health services or physical health services) single issue (eg, mental health) single form of abuse (IPV or CAN). <p>Fragmented services disadvantage people with multifaceted needs.</p>

177 This summary is based on the work of David Snowden. J. Garvey Berger and K. Johnston, *Simple Habits for Complex Times: Powerful Practices for Leaders*, 2015.

178 In 2014, the Impact Collective noted that there were 218 groups, networks and coordinators either directly or indirectly working on 'family violence'. R. Herbert and D. Mackenzie, *The Way Forward*, 2014, p. 81.

179 Collective impact initiatives have centralised infrastructure - known as a backbone organisation - with dedicated staff whose role is to help participating organisations shift from acting alone to acting in concert. J. Kania and M. Kramer, 'Collective impact', *Stanford Social Innovation Review*, Winter, 2011.

	Reframing	Current understandings	Past understandings
Governance structures	<p>Integrated IPV and CAN governance structures</p> <p>‘The problem determines the system, not the system determining the problem.’¹⁸⁶</p> <p>For example, an integrated approach to the governance structures of the Ministerial Group on Family Violence and Sexual Violence and the Vulnerable Children’s Board.</p> <p>The work programmes are integrated.</p>	<p>Coordinated IPV and CAN governance structures</p> <p>Cross-government Family Violence and Vulnerable Children governance structures have common membership.</p> <p>Linkages are made between the work programmes.</p>	<p>Fragmented IPV and CAN governance structures</p> <p>Separate structures for cross-government Family Violence and Vulnerable Children governance.</p> <p>Separate work programmes.</p>
Role of evidence in the system	<p>Evidence informs whole-of-system approach/Evidence is understood as emergent</p> <p>‘What aspects of <i>success</i> are repeatable at what level of granularity?’¹⁸⁷</p> <p>Use of safe-to-fail experiments.</p> <p>System informed by evidence, as opposed to the system being determined by evidence.</p> <p>Understanding ‘evidence as an emergent property of interactions with and within the system over time; not some innate feature of the system that is constrained sufficiently to allow repetition’.¹⁸⁸</p>	<p>Evidence-based interventions/Evidence is understood as repeatable</p> <p>Understanding evidence as repeatability of cause and effect within similar contexts.</p> <p>Use of randomised control trials to test family violence interventions.¹⁸⁹</p> <p>There is increasing use of mixed methods, multi-level analysis and pragmatic trials.</p>	<p>Lack of systematic evaluation data</p> <p>Practice responses based on many community development initiatives that have not included an evaluation component.</p>

180 Multiple recent reports have suggested an independent authority responsible for the oversight of the family violence system. The Ministerial Expert Advisory Group on Family Violence recommended the establishment of the National Family Violence Coordinator position, with a supporting secretariat, to assist integration and collaboration across agencies, government and community provision. Expert Advisory Group on Family Violence, *Report of the Expert Advisory Group on Family Violence*, November 2013, www.beehive.govt.nz/sites/all/files/Report_of_the_Expert_Advisory_Group_on_Family_Violence.pdf. *The Way Forward* report recommended the development of a collective impact backbone agency. R. Herbert and D. Mackenzie, *The Way Forward*, 2014. Domestic Violence Victoria recommended an independent statutory authority. Domestic Violence Victoria Submission to the Victorian Royal Commission into Family Violence, *Considerations for Governance of Family Violence in Victoria*, 19 June 2015, www.rcfv.com.au/getattachment/CC13A6BB-AABF-47F8-874B-005920960B9E/Domestic-Violence-Victoria---01

181 The New Zealand Productivity Commission, *More Effective Social Services*, Wellington, The New Zealand Productivity Commission, 2015, p. 7.

182 Government agencies attempted to address silos by strengthening the horizontal ‘glue’ across agencies. *Ibid*, p. 8.

183 R. Herbert and D. Mackenzie, *The Way Forward*, 2014, p. 71.

184 The issues facing the Children’s Teams include system infrastructure issues. SuPERU, *Assessment of the Design and Implementation of the Children’s Teams to January 2014: Research Report 2/14*, Wellington, SuPERU, 2014.

185 Siloed agencies providing social services (or purchasing them) means there is no one with a view of the system as a whole and of its performance. The New Zealand Productivity Commission, *More Effective Social Services*, 2015, p. 7.

186 ‘Responding to the needs of children living with family violence’, Professor Cathy Humphreys, The University of Melbourne, presentation at the Northern Integrated Family Violence Services Forum, Melbourne, 24 March 2015.

187 ‘Evidence?’, David Snowden blog, 24 October 2015, <http://cognitive-edge.com/blog/evidence/>

188 *Ibid*.

189 J. Spangaro, A. Zwi and R. Poulos, ‘The elusive search for definitive evidence on routine screening for intimate partner violence’, *Trauma, Violence & Abuse*, vol. 10, no. 1, 2009, pp. 55–68.

	Reframing	Current understandings	Past understandings
System evaluation frameworks	<p>Evaluation is an integral system function</p> <p>An integrated system requires continuous review and evaluation of any integrative developments. This includes ensuring:</p> <ul style="list-style-type: none"> • evaluation is a planned and resourced part of the system design, implementation processes and system responses • there are culturally responsive evaluation methodologies¹⁹⁰ • there is a focus on process and outcomes (victims are kept safe, and reduction of family violence) underpinned by the notion of co-production¹⁹¹ • services and interventions are evidence-based • service developments and innovations are robustly evaluated and mechanisms are in place to disseminate and embed evidence into practice. 	<p>Evaluation of individual programmes</p> <p>Focus on specific programmes but not on how they function as part of a wider system response.</p>	<p>Haphazard</p> <p>Evaluation of services is poorly funded and ad hoc.</p>

190 Includes Kaupapa Māori and tauwiwi evaluation methodologies.

191 Co-production is characterised by people who are active agents and equal partners in the design and delivery of services and systems.

	Reframing	Current understandings	Past understandings
Development of NGO practice responses	<p>Integrative family violence services</p> <p>Specialist family violence advocacy services that work with multiple family members – integrating work with family members for safety and healing (eg, children’s and mothers’ programmes).¹⁹²</p> <p>A balance between specialist family violence¹⁹³ and generalist services so that a ‘no wrong door’ approach can be pursued while preserving high-quality specialist family violence expertise.</p>	<p>Connecting family violence services by co-location</p> <p>Co-located family violence services – children and mother’s family violence programmes may be co-located in one service but are not undertaken together.</p> <p>Generic services</p> <p>Generic family support services with specific family violence staff.</p>	<p>Separate family violence services</p> <p>A separate service for each family member:</p> <ul style="list-style-type: none"> • Women’s Refuge • men’s non-violence programmes • children’s programmes.
Approaches to NGO funding	<p>Integrated government contracts</p> <p>Flexible funding to enable bespoke/personalised responses.</p> <p>Integrated contracts from multiple government funders enable flexible wrap-around services enabling earlier intervention, holistic ‘whole-of-family’ rapid responses and longer-term support.</p> <p>Commissioning family outcomes across clusters of co-located services, rather than individual provider service outcomes.</p>	<p>Prescriptive programmes funded by individual government contracts</p> <p>NGOs with multiple contracts to deliver different programmes:</p> <ul style="list-style-type: none"> • Strengthening Safety Services • Ministry of Justice non-violence programmes • Women’s Refuge provision. <p>Practitioners with prescriptive client groups.</p>	<p>Public donations</p> <p>Services reliant on volunteers.</p>
Approaches to programmes and interventions	<p>Agile and adaptive practice models (emergent)</p> <p>Flexible and innovative ways of working with families affected by family violence.</p> <p>Person-centred and whānau-centred design. Whānau Ora providers and navigators.¹⁹⁴</p>	<p>Good practice models</p> <p>Multi-agency interventions – for example, initiatives for ‘hard to reach families’ or ‘vulnerable children’.</p> <p>Programmes and interventions with prescriptive content and delivery style.</p>	<p>Best practice models¹⁹⁵</p> <p>Single-agency interventions – for example, non-violence programmes.</p>

192 C. Humphreys and R. Thiara, ‘Supporting the relationship between mothers and children in the aftermath of domestic violence’, in N. Stanley and C. Humphreys (eds.), *Domestic Violence and Protecting Children: New Thinking and Approaches*, London, Jessica Kingsley, 2015.

193 Similar to Whānau Ora navigators who are ‘expert practitioners’, expert family violence practitioners are required. Te Puni Kōkiri, *Understanding Whānau-Centred Approaches: Analysis of Phase One Whānau Ora Research and Monitoring Results*. Wellington, Te Puni Kōkiri, 2015, p. 71.

194 Te Puni Kōkiri, *Understanding Whānau-Centred Approaches*, 2015

195 Best practice is always based on past practice. Using best practice is common, and often appropriate, in simple decision-making contexts. D. Snowden and W. Boone, ‘A leader’s framework for decision making’, 2007.

	Reframing	Current understandings	Past understandings
Purpose of public campaigns¹⁹⁶	<p>Community accountability</p> <p>Directed at developing the capacity of community members to support victims and constructively challenge abusive people's use of violence.</p> <p>Communities appropriately resourced to enact protective and preventative approaches.</p>	<p>Community mobilisation</p> <p>The aim is for greater community participation in family violence events, such as anti-violence marches.</p>	<p>Community awareness</p> <p>The aim is to raise community awareness about family violence and anti-violence resources.</p>
Proposed prevention frameworks	<p>Family violence prevention is intertwined with safety, restoration and transformative approaches</p> <p>The concept of whakapapa denotes the intrinsic interconnectedness of people and whānau in past, present and future generations. People are impacted by what has gone before, what is currently occurring and what can (re) occur.¹⁹⁷</p> <p>Whānau and gender transformative approaches.</p>	<p>Primary, secondary and tertiary prevention</p> <p>Primary prevention approaches understood as separate from secondary and tertiary approaches.</p>	<p>Crisis response</p> <p>Responding to victims after they have been harmed, in an individual incident type manner.</p>
Investment approach	<p>Proactive long-term investment</p> <p>A whole-of-system integrated approach to addressing and investing in family violence prevention.</p>	<p>Reactive spending</p> <p>Each government department responds to family violence within their services.</p>	<p>Minimal</p> <p>Family violence is understood as a marginal social policy issue.</p>

4.8 Conclusion

In this chapter, the Committee has set out part of the 'road map' for moving towards an integrated family violence system. We have begun to map the shifts in thinking and the reconfiguration of the workforce that would support a systemic and effective safety response to family violence. We are not proposing a 'model' – clearly, there is still significant work to be done and many conversations to be had as part of the ongoing process of iteration and development.

196 M. Kim, *The Community Engagement Continuum: Outreach, Mobilization, Organizing and Accountability to Address Violence against Women in Asian and Pacific Islander Communities*, San Francisco, Asian & Pacific Islander Institute on Domestic Violence, 2005.

197 Ministry for Women, *Wāhine Māori, Wāhine Ora, Wāhine Kaha*, 2015, p. 20.

CHAPTER 5: ENGAGING DIFFERENTLY - STRENGTHENING ORGANISATIONAL RESPONSIVENESS

5.1 Introduction

In this chapter, the Committee discusses some of the organisational practice changes needed to move towards an integrated response to family violence that has victim safety as a core focus. The focus is on three key parts of the workforce – the justice system, the child protection system and MH&A services.

5.2 The justice response

5.2.1 The significance of the justice response to victim safety

The justice system is unique in that it has the authority to constrain the abusive person's behaviour in the interests of victim safety. In other words, it 'is more powerful than the [abusive person's] power in the relationship'.¹⁹⁸

For example, a justice response can physically remove the abusive partner from the vicinity of the victim to provide her with immediate respite. For a victim who wishes to separate from a dangerous partner, a sentence of imprisonment, for instance, might provide her with a period of physical safety during a time of heightened danger. There were regional reviews in which, had this happened, the homicide could well have been prevented.

The regional reviews also contain multiple examples where opportunities to enhance victim safety were lost in the management of family violence offenders on community sentences. In such cases, there was a mismatch between the victims' safety needs and the particular justice response.

While cases where violent offenders have reoffended on bail have received attention in the media, family violence homicides committed while on sentence for previous violent offending were more common in the regional reviews. For example, of the 24 regional reviews involving IPV predominant aggressors,¹⁹⁹ 10 (40 percent) were on bail and/or community-based sentence at the time of the homicide. The majority (eight) were on sentence (one of these was also on bail). All eight had been sentenced for violence offences (six were family violence offences). The three who were on bail (one of whom was also on sentence) were all bailed for family violence offences. A number of other predominant aggressors were not on sentence at the time of the homicide. However, they would have been had they received more serious sentences for their recent family violence offending. Two others had received diversions and/or discharges without conviction for their prior family violence offending, which was within two months of the homicides. In two other instances, the police were not informed of the offending by another agency or they were informed but did not investigate sufficiently in order for charges to be laid.

Because family violence involves a known offender who has a pattern of harmful behaviour targeting identified or identifiable victims, there is the possibility of responding to current offending in a manner that minimises the possibility of future harm. We suggest there is a strong public interest in doing so.

198 C. Humphreys, C. Laming and K. Diemer, 'Are standalone MBCPs dangerous?', workshop presentation, NTV 2012 Australasian Conference on Responses to Men's Domestic and Family Violence: Experience, Innovation and Emerging Directions, 2012, quoted in Centre for Innovative Justice, *Opportunities for Early Intervention*, 2015, p. 7.

199 The predominant aggressors either killed a child, primary victim, or were killed by the IPV primary victim.

In this section, we briefly set out some of the issues to be addressed if we are to minimise the possibility of future harm. These issues include:

- the minimisation of family violence offending in the criminal justice system
- decisions based on incomplete information, due to the systemic fragmentation of processes, information and patterns of harm
- decision-making frameworks that do not have victim safety as a mandatory consideration
- the need to develop strategies, and a wider range of options, for responding to family violence offenders.

5.2.2 The minimisation of family violence offending

Family violence offending that presents in the regional reviews – even when it involves high-risk behaviour – can be charged and/or result in convictions for less serious violence offences. The Committee has frequently noted strangulation to unconsciousness and closed fist punches to the head prosecuted and/or convicted as common assault (section 196, Crimes Act 1961) or ‘male assaults female’ (section 194, Crimes Act 1961 – common assault with victim vulnerability). These offences have maximum sentences of imprisonment but tend in practice to result in community sentences. This is so, even when they occur within entrenched patterns of similar family violence offending over periods of time against one or multiple sequential partners. It is not clear what role plea bargaining – in the interests of the speedy and inexpensive resolution of cases – plays in this process.²⁰⁰ Defence counsel who view their client’s best interests as being narrowly confined to getting the least restrictive outcome in the case at hand may also have a role to play.

The tendency to respond to family violence as low-grade offending that merits community sentence has been noted elsewhere. For example, the Centre for Innovative Justice in Melbourne said:

‘few offenders convicted of offences specifically identified as related to domestic violence receive custodial sentences of any length. In fact, one Australian analysis of 20,000 cases found that less than one in five offenders received a prison sentence following conviction for “assault occasioning actual bodily harm” against an intimate partner. The study found that it was only when the conviction was for a more serious offence of “recklessly causing grievous bodily harm” that a prison sentence was likely.’²⁰¹

Part of the problem with charging and/or convicting the offender of a more serious interpersonal violence offence (even if the victim is injured) may be the difficulty of proving to the criminal burden and standard of proof that the offender intended to injure the victim or consciously considered there was a probable risk of doing so.²⁰²

Section 190 of the Crimes Act 1961 is designed to fill the gap between a common assault and a more serious offence that involves injury accompanied by a proven mental state on the part of the defendant. Section 190 provides that: ‘Every one is liable for imprisonment for a term not exceeding 3 years who injures any other person in such circumstances that if death had been caused he would have been guilty of manslaughter.’ A common assault where a reasonable person in the accused’s position would have realised there was the risk of harm to someone should result in a conviction under this section regardless of what the defendant personally intended or realised. However, section 190 is a complex provision and does not appear to be used in cases where it might be appropriate to do so.

200 Note that the Solicitor-General’s Prosecution Guidelines (July 2013) at 18.1 set out the value of plea discussions and arrangements as being to relieve victims of the ‘burden on the trial process’, deploy costs saved to other areas of need and provide ‘a structured environment in which the defendant may accept any appropriate responsibility for his or her offending’. Victims, where ‘practical and appropriate’, should be given the opportunity to make their position as to any proposed plea arrangement known to the prosecutor (18.5).

201 Centre for Innovative Justice, *Opportunities for Early Intervention*, 2015, p. 69.

202 See, for example, section 188 of the Crimes Act 1961.

New South Wales has the offence of assault occasioning actual bodily harm.²⁰³ The advantage of such an offence is that it allows a common assault that injures the victim to be prosecuted as a more serious offence even if the offender alleges he did not intend to injure the victim and had not thought this might be a probability. It is also more straightforward than section 190 and is easier to understand and apply. In its submission to the Ministry of Justice's review of the Domestic Violence Act 1995, the Committee has suggested considering enacting a similar offence in Aotearoa New Zealand.

5.2.3 Reducing system fragmentation

The criminal justice system was designed to respond to offences as particular 'incidents' of physical violence. As illustrated in Example 2 in Chapter 3, the result is that the justice system automatically fragments (often long) patterns of harmful behaviour into one-off events that are each separately responded to. The focus is on the physical violence, frequently without consideration of risk factors and other forms of harm, including the abusive person's ongoing use of coercive and controlling tactics. The primary focus at sentencing appears to be on reacting to what occurred on the occasion in issue, rather than the more difficult task of assessing risk and attempting to put strategies in place to prevent future harm.

Furthermore, there is a tendency when considering victim safety to focus on the victim of the immediate 'incident'/offence. The needs of hidden and future victims can remain unconsidered. For example, there are numerous examples in the regional reviews where the safety needs of hidden and future victims were overlooked – a child/children living in a house to which an offender was sentenced, or a new partner who entered the offender's life during a community-based sentence. Sometimes these were the victims killed. In order to prevent future harm, it is important to consider the risks the abusive person's behaviour poses to multiple victims – past, current and future victims.

A compounding issue is the number of agencies and stages involved in an offender's criminal justice process – another form of fragmentation. Decisions and disclosures of information made at each stage set up and limit those who must make decisions after them.

If victim safety is to be a paramount principle in the criminal justice response to family violence, then it needs to be supported and implemented at each point – at the point of information-gathering and sharing, charging, sentencing, and in the management of that sentence and any processes set in place once the sentence is over. This means a wide range of agencies must be involved in developing strategies to respond to family violence offenders in ways that support victim safety – New Zealand Police, prosecution services, judges, the Ministry of Justice, restorative justice practitioners and the Department of Corrections.

5.2.4 Fragmentation of information – raw data and analysis of risk

Decision-makers need sufficient information to assess the risks that family violence offenders present. Past patterns of behaviour (including abusive behaviour that does not involve physical violence and which does not result in a conviction) are highly relevant in assessing future risk. Yet frequently, information about the abusive person's family violence history, even if it is recorded in the justice system, is fragmented.²⁰⁴

203 Section 59, Crimes Act 1900 (NSW). This offence carries the maximum penalty of two years in the Local Court (section 268 of the Criminal Procedure Act 1986 (NSW)). However, the prosecutor may elect to deal with the offence at District Court level. If dealt with at District Court level there is a maximum penalty of five years or seven years (if the offence is committed in the company of another person).

204 For example, just because someone has no police or criminal record of family violence does not mean that they do not have a serious history of family violence offending. The term 'clean skins' has been coined to describe serial offenders who have no agency record of that offending. This can occur for a number of reasons. We know that family violence crimes are under-reported (the police estimate that only 18-20 percent of family violence is reported to them). Immigrant men may have a history in their country of origin that may not be accessible in Aotearoa New Zealand.

The result is that decision-makers at different stages of the criminal justice process are making decisions based on incomplete information. For example:

- information held by the police (or another agency) may not be provided to the court
- information held in the Family Court may not be provided to the criminal court. The affidavit evidence attached to the applications for protection orders in the Family Court will contain (current and prior) victims' accounts of the offender's violence (including risk factors for IPV lethality or threats to children). These affidavits are not routinely made available to the criminal court, although it is generally notified of the existence of a protection order
- a list of past convictions provided to a sentencing judge may not reveal which convictions involve family violence. Significantly, in the absence of a narrative of events, a criminal conviction per se can fail to reveal the serious nature of the offending. For example, breaches of protection orders may look very much like attempted homicides in their narrative detail. A conviction for 'male assaults female' or assault may in fact be a strangulation assault.

Work is currently underway to address the fragmentation of information within the justice system. For example, in August 2015 the Government announced a pilot in which judges making bail decisions in two District Court jurisdictions are to receive an overview of the defendant's police family violence history (a Police Family Violence Summary report), including police call-outs, protection orders, police safety orders and criminal charges. This will enable the judge to be more informed in making bail decisions about the risks posed by the abusive person.²⁰⁵ The Committee supports these initiatives.

In a submission to the Ministry of Justice's review of the Domestic Violence Act 1995, the Committee suggested mandating information-sharing between the Family Court and the criminal court in family violence cases and requiring New Zealand Police and other justice sector agencies to consistently provide judges with relevant information held by their services.²⁰⁶ It also suggested consideration could be given to developing integrated specialist family violence courts – integrating civil and criminal jurisdictions.

The Law Commission is currently considering the possibility of enacting a strangulation offence – which would flag a recurring risk factor for IPV homicide on an offender's record, as well as facilitating a more appropriate criminal justice response.²⁰⁷ Obviously, specialist family violence advocacy services that sit alongside and provide information into court processes would improve the quality of the information available to support safety decisions by the court.

In addition to the fragmentation of information within the justice system, the risk analysis that judges and prosecutors may currently access does not include an assessment of lethality and may therefore fail to pick up potentially homicidal offenders. The police currently use the Ontario Domestic Abuse Risk Assessment tool (ODARA) – an evidence-based IPV assessment adapted from Canada. One of the positive aspects of an ODARA assessment is that it provides a holistic score – meaning an abusive person's risk score does not fluctuate depending on how serious any particular episode of family violence offending was or what the victim felt able to disclose to the police on that particular occasion. However, ODARA is a re-assault predictor. It does not assess potential lethality and may therefore not flag some of the most dangerous cases of IPV. Obviously, it is important to assess the risk of re-assault, but, as the Committee pointed out in its *Fourth Annual Report*, there is currently a need for a supplementary lethality assessment.²⁰⁸

205 It is critical for judges to be trained in family violence so they can make informed decisions about the safety of adult and child victims when making a decision about bail or sentence: FVDR, *Fourth Annual Report*, pp. 108-9, 115. To this end, the Institute of Judicial Studies is investing considerable effort into curriculum development in family violence, and workshops and conferences on the topic of family violence have been conducted for all tiers of the judiciary.

206 The FVDR also suggested consideration of the evidence for an Integrated Specialist Family Violence Court. Such courts address some (although not all) of the current fragmentation of information and processes identified here.

207 FVDR, *Activities Report: July 2014 to 2015*, Wellington, Health Quality & Safety Commission, 2015, p. 7.

208 FVDR, *Fourth Annual Report, 2014*, p. 88.

5.2.5 Decision-making frameworks – prioritising victim safety

Victims' safety interests feature very little in the current frameworks that guide decision-makers. The legislation and guidelines for judges and prosecutors, who are making decisions on prosecution and sentence, tend to require consideration of victims' interests in terms of the harm done to them *as a result of past offending*.

While it is arguably possible under the Sentencing Act 2002 for a judge who is knowledgeable about family violence offending to use aspects of the legislation to give expression to victim safety, this is not an explicit requirement and will not automatically occur in all cases. The Bail Act 2000 alone clearly requires decision-makers to prioritise victim safety in certain types of family violence cases. Appendix 4 of this report describes the frameworks governing the charging, bail and sentencing of offenders in family violence cases and the extent to which they accommodate victim safety.

The sentencing courts tend to set a 'starting point' for the sentence based on the act of offending. Guideline judgments (such as *R v Taueki*,²⁰⁹ which sets out three 'bands' of offending for assaults causing grievous bodily harm) can be used in this process, as well as other cases involving similar offending. The starting point incorporates aggravating or mitigating factors particular to the *act of offending*. This starting point is then adjusted up or down to accommodate aggravating or mitigating factors *personal to the offender*. Considering victim safety would require a departure from this structure – it is neither directly relevant to the offending on this occasion nor personal to the offender. Legislative reform may be required to modify this case law.

The Committee believes reforms to the Sentencing Act 2002 should make victim safety a mandatory consideration in all cases where the offending involves family violence.²¹⁰ The police history of family violence call-outs and charges – not just convictions – should be considered, along with any protection order history, when appraising risk and safety needs.

Furthermore, the offender's remorse should mitigate the consequences of offending in family violence cases only when there is evidence of observed and sustained safe behaviours (as opposed to verbal expressions of regret and promises to change).²¹¹ Abusive people's apologies and promises to change are a recognised part of the pattern of abuse.²¹²

The Committee has also suggested reviewing the New Zealand Police and Solicitor-General's Prosecution Guidelines to ensure victim safety is a mandatory consideration in family violence cases.²¹³

5.2.6 An integrated strategy for responding to people perpetrating violence

The greatest reduction in family violence will occur when abusive men stop using violence against their female intimate partners and children.

While imprisonment might offer the victim a period of physical respite, prison is not a long-term solution to family violence. Men's prisons are not environments in which to learn about egalitarian and respectful ways of relating to women and children.

Non-violence programmes

Currently the main response to people who use violence is non-violence programmes. However, the operation of these programmes in Aotearoa New Zealand has a number of problematic aspects.²¹⁴

209 [2005] 3 NZLR 372.

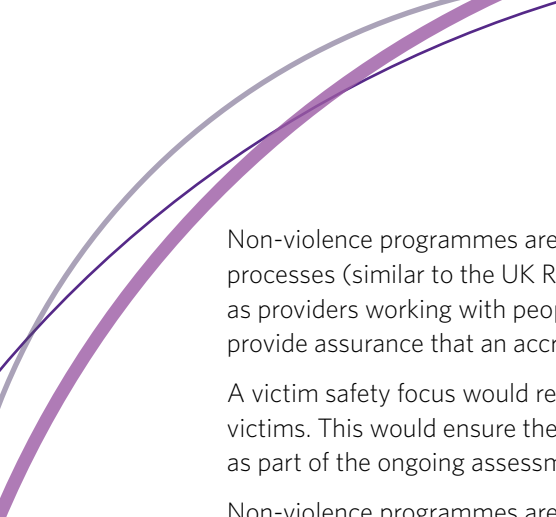
210 FVDR submission on the Ministry of Justice's *Strengthening New Zealand's Legislative Response to Family Violence: A Public Discussion Document*, September 2015.

211 FVDR submission on *Strengthening New Zealand's Legislative Response to Family Violence*, 2015.

212 Stubbs notes: 'Apologies are valued as an outcome of restorative justice, but may be particularly ill-advised in intimate partner violence contexts. Women face strong cultural expectations to accept apologies, but perpetrators of intimate partner violence commonly use apologies to placate victims only to re-offend.' J. Stubbs, 'Gendered violence and restorative justice', in A. Hayden et al. (eds.), *A Restorative Approach to Family Violence: Changing Tack*, Surrey, Ashgate Publishing Ltd, 2014, p. 206.

213 FVDR submission on *Strengthening New Zealand's Legislative Response to Family Violence*, 2015.

214 FVDR, *Third Annual Report*, 2013, pp. 57–66.



Non-violence programmes are not aligned with international standards of safe practice.²¹⁵ Accreditation processes (similar to the UK Respect standards) are needed for specialist family violence services, such as providers working with people who use violence and specialist advocacy services. These standards provide assurance that an accredited organisation is operating safely.

A victim safety focus would require non-violence programmes to work closely with parallel services for victims. This would ensure there were processes in place to routinely and safely seek the victim's views as part of the ongoing assessment process.

Non-violence programmes are currently siloed. Mandating programmes to be part of a multi-agency response would increase their effectiveness. This includes participation within case management processes and with agencies (such as New Zealand Police, Department of Corrections, CYF, etc) in the provision of feedback, assessments of risk and monitoring of abusive people's behaviour change. Non-violence programmes which are part of a multi-agency response can be used to keep people using violence 'connected and in sight' – so we know where they are and what they are thinking.

Non-violence programmes that require attendance one night a week over a short-term period are unlikely to be sufficient for abusive people who have entrenched patterns of using violence spanning decades, histories of childhood trauma and a raft of serious concurrent issues, such as drug and alcohol abuse. More sustained and holistic interventions are needed for these people, including interventions that address the co-occurring issues in their lives.

A recent review of Respect accredited non-violence programmes in the UK (these are part of a multi-agency response) found 'steps towards change for the vast majority of men attending' across a range of measures.²¹⁶ These results are promising, but cannot be extrapolated to programmes in Aotearoa New Zealand that do not have these features (ie, multi-agency risk management and parallel victim services).

Developing a systemic response to people who use violence

The No to Violence and Men's Referral Service in Victoria make the point we can restrain, punish, mandate and hold abusive men in intervention contexts but we cannot make them accountable. They say that:

'... family violence service systems, including criminal justice system components, cannot force accountability. They can punish perpetrators, but punishment is not the same as accountability. Genuine accountability requires the operationalisation of what accountability means for that specific perpetrator, based on what those affected by his violence need to see change about his specific patterns of coercive control. Men can be invited to act more accountably, and family violence service systems can have important roles to play in mandating men's attendance and providing "non-voluntary" interventions as a means to "hold" men in a journey towards accountability. However, service systems cannot make men accountable, only attempt to mandate, scaffold and hold them in intervention contexts that might lead some of these men towards behaving in ways that are more accountable to what their family needs from him.

Family violence service systems can place restraints around the man's violent and controlling behaviours. They can use incarceration, monitoring, supervision and predict consequences if the man does not change his behaviour, as a means to place restraints around his behaviour and tighten the web of accountability around him. These are important and legitimate actions with many perpetrators to reduce risk.

215 The existing code of practice for Ministry of Justice non-violence programme providers is based on principles of safety, responsiveness to victims, and holding perpetrators to account.

216 L. Kelly and N. Westmarland, *Domestic Violence Perpetrator Programmes*, 2015, p. 45.

However, this is not the same as holding the man accountable. Ultimately, accountability needs to be *internalised* by the perpetrator on a journey of change – he can be scaffolded and supported on this journey but he cannot be *made to be* accountable.²¹⁷

It is apparent to the Committee that non-violence programmes cannot be the only strategy for people using violence. Such programmes need to be part of a raft of interventions embedded throughout the justice response specifically designed for those who use family violence and directed at keeping victims safe.

We cannot expect one intervention to ‘fix’ the person’s use of violence. There is the need for strategies to manage and contain those people who are not willing or able to change. Such strategies could put restraints around people’s controlling and violent behaviours, escalate consequences for the continued use of violence, and provide continued support for accountability and change.

Developing an overall plan and particular strategies for those who use family violence will require conversations that involve New Zealand Police, prosecutors, the Ministry of Justice, judges, restorative justice practitioners, the Department of Corrections and non-violence programme providers. The Committee notes the following as some examples of innovative practice that could be considered.

Earlier interventions

Gondolf²¹⁸ suggests early entry into programmes has a significant impact. Abusive men who enter programmes pre-trial, rather than post-conviction, are more likely to remain engaged. Gondolf also recommends increasing the focus on programme intensity. As soon as possible after charges, abusive men should attend three or four times per week for the first four to six weeks.²¹⁹

Assertive early intervention outreach services for abusive men have been successfully developed in some regions. These are designed to make contact with men at early points in the criminal justice response – for example, ReachOut,²²⁰ which operates alongside existing services and supports for women and children.

Example 9: Promising practice – working with people using violence

ReachOut

ReachOut is a non-mandated earlier intervention service for men using family violence that aims to prevent re-victimisation by reducing the risk of re-offending. In 2012, ReachOut was developed in partnership between Aviva, New Zealand Police, CYF, the Department of Corrections and other local NGOs. It was piloted in North Canterbury and has since expanded into Christchurch.

Under a memorandum of understanding with Canterbury Police, ReachOut engages men named as subjects or offenders on police reports within 48 hours of a family violence episode in order to assess the risk of future violence and inform integrated safety planning for all family members.

217 No to Violence Male Family Violence Prevention Association submission to the Royal Commission into Family Violence Victoria, *Strengthening Perpetrator Accountability Within the Victorian Family Violence Service*, June 2015, p. 14.

218 E. Gondolf, *Batterer Intervention Systems: Issues, Outcomes and Recommendations*, Thousand Oaks, SAGE, 2002. E. Gondolf, *The Future of Batterer Programs: Reassessing Evidence-Based Practice*, Boston, Northeastern University Press, 2012.

219 The FVDRC submission on the Ministry of Justice’s *Strengthening New Zealand’s Legislative Response to Family Violence: A Public Discussion Document*, September 2015 suggested prioritising the exploration of a range of flexible responses for working with abusive men and their whānau.

220 L. Campbell, *ReachOut Men’s Community Outreach Service, Connections and Conversations with a Purpose: An Evaluation of the Pilot*, Aviva Family Violence Services, 2014.

The Victorian No to Violence and Men's Referral Service suggest there are four intervention points that offer early windows of opportunity to engage with abusive men in order to assess and reduce risk, each building on the momentum and information gathered at the earlier stage.²²¹ These are:

- during or in the immediate aftermath of a police call-out (including re-accommodation where appropriate) or contact by the child protection agency
- the 24-48-hour period immediately afterwards
- at the first District Court appearance for a protection order or criminal charges following on from the use of violence
- post-court follow-up.

They suggest the development of a 'Strengthening Risk Management Framework' to follow on from this early intervention point so there is a coordinated 'web of accountability' that builds on the initial engagement.²²²

A greater range of interventions

An increased range of interventions is required. Māori frontline workers highlighted to the Glenn Inquiry the importance of services for tāne and the need to recognise that, while tāne may perpetrate family violence today, they have their own stories as victims of CAN (including exposure to IPV). Healthy whānau are dependent upon all members of the whānau healing, including tāne.²²³ The Glenn Inquiry found that Kaupapa Māori-based services, using trauma-informed and holistic approaches, make a huge contribution towards creating safer whānau and communities. Part of the healing journey involves strengthening people's cultural identity and healing their wairua: 'Traditional healing practices play an important role to re-balance the dimensions of the whānau and its member's lives.'²²⁴

Services that are able to work with abusive men who are fathers and men with co-occurring problems, such as substance abuse or mental health issues, are required.

Residential programmes would offer the opportunity to remove the abusive partner from the physical vicinity of the victim while providing a range of interventions that address co-occurring issues. For example, Breathing Space at Communicare in Western Australia provides a three-month residential programme for men who use family violence.²²⁵ Participants are required to attend a two-hour behaviour change session twice a day in mid-morning and mid-afternoon from Monday to Friday. Case management services provide onsite help with life skills, helping participants access treatment for contributing factors such as drug and alcohol abuse. With a curfew of 9pm and appointments to attend, not much time is left for contacting partners or perpetrating violence.

Escalating consequences for continued harm

Some jurisdictions have developed policies that support the escalation of responses throughout the criminal justice system if abusive behaviour continues.²²⁶ These include the creation of offences that criminalise patterns of harm – for example, multiple breaches of a protection order.²²⁷

221 No to Violence, *Strengthening Perpetrator Accountability within the Victorian Family Violence Service*, 2015, p. 46.

222 *Ibid*, p. 48.

223 D. Wilson and M. Webber, *The People's Report: The People's Inquiry into Addressing Child Abuse and Domestic Violence*, Auckland, Glenn Inquiry, 2014, pp. 133-4.

224 *Ibid*, p. 134.

225 Communicare is hoping to expand this service to offer transitional accommodation for men moving back into the community. Centre for Innovative Justice, *Opportunities for Early Intervention*, 2015, p. 52.

226 *Ibid*, p. 53. For example, an automatic increase in consequences with each police attendance with the increased sanctions for the next attendance explained at each point. The FVDRC submission on the Ministry of Justice's *Strengthening New Zealand's Legislative Response to Family Violence: A Public Discussion Document*, September 2015 suggested the development of a strategy for perpetrators that escalates consequences for continued abusive behaviour.

227 Please see the Victorian 'persistent breach' offence. The insertion of section 125A into the *Victorian Family Violence Protection Act 2008* created an offence of persistent contravention of Family Violence Intervention Orders and Family Violence Safety Notices. The gravamen of this offence is the persistent nature of the breaches over a short 28-day period that demonstrates a disregard for the law.

Increased judicial monitoring of sentences

Judges have authority with those who use family violence – particularly those who have a ‘stake in conformity’. It has been suggested we could make better use of this by, for example, greater judicial monitoring of sentences:

‘Jurisdictions should ... explore opportunities for courts to increase ongoing monitoring of family violence offenders, including by being brought back repeatedly before the same judge, and by employing swift and certain sanctioning where offenders have failed to comply with orders. This being said, it is important that these opportunities do not place further burden or pressure upon victims to attend court or revisit their experiences. Rather, the role of the court is to step in and assume this burden – keeping the victim informed, but engaging directly with the perpetrator to hold him more effectively to account.’²²⁸

Summary

In summary, fragmentation throughout the justice system undermines an effective response to family violence offending. The Committee welcomes the efforts currently being made to address this issue. The Committee would also support an increased range of interventions for people who use violence, as well as the development of an integrated justice strategy for those who perpetrate family violence that is directed at supporting victim safety (including hidden and future victims). Such a strategy would address ways in which:

- restraints can be placed on controlling and violent behaviours
- consequences can be escalated for the continued use of violence
- support can be provided for genuine accountability and behaviour change.

5.3 Child protection responses

5.3.1 Importance of professional practice frameworks

Every day care and protection social workers have to make decisions in situations characterised by uncertainty and risk. Their work environment generally includes large and complex caseloads, along with stretched or limited resources.²²⁹ The current focus of the Modernising Child, Youth and Family Expert Panel provides an opportunity to address workload issues and to strengthen organisational responsiveness to children and their families and whānau affected by family violence.

The 2015 *Modernising Child, Youth and Family Expert Panel: Interim Report*²³⁰ identified four key areas for reform. One is the need to develop evidence-based and culturally competent professional practice frameworks to guide social work decision-making. The intention of this section is to inform the consideration of these professional practice frameworks. Such frameworks are important because they provide a lens through which practitioners interpret the children and adults they are working with, their lives and their life ‘choices’. This, in turn, sets up the responses that are considered appropriate.

Currently, CYF does not have a comprehensive family violence practice framework. This is a critical issue to address because children’s exposure to IPV is a core aspect of care and protection social work.²³¹ In 2013, CYF introduced a new assessment framework – Tuituia. Tuituia has multiple

228 Centre for Innovative Justice, *Opportunities for Early Intervention*, 2015, p. 64.

229 Office of the Chief Social Worker, *Workload and Casework Review: Qualitative Review of Social Worker Caseload, Casework and Workload Management*, Wellington, Office of the Chief Social Worker, May 2014.

230 ‘The system must shift from a rules, compliance and timeframe-driven practice to professional judgement based on:

- an evidence-based understanding of the impact of trauma on children and young people, the science of child development, and best practice approaches in building resilience in children and young people;
- a high degree of cultural competency and confidence to support the needs of all children, including Māori children; and
- a framework for decision-making that sets out the principles and tools to guide effective professional practice.’

Modernising Child, Youth and Family Expert Panel: Interim Report, Wellington, Ministry of Social Development, 2015, p. 16.

231 Robertson et al comment that domestic violence is the most common context in which child abuse occurs. N. Robertson et al., *Evaluation of the Whānau Ora Wellbeing Service of Te Whakaruruhau: Final Report*, Hamilton, University of Waikato, Māori and Psychology Research Unit, 2013, p. 3.

assessment domains. Of these, the parenting domains are problematic when assessing the parenting ability of a victim of IPV (most often the mother).²³² The legacy of the 'failure to protect' approach, discussed in Chapter 3, is visible.

In the context of IPV, the unintended consequences of social work practice influenced by a 'failure to protect' paradigm is that it actually *increases* the likelihood of harm to the child and adult victims, while *contravening* the child's 'best interests'. Strega and Janzen state that 'by asking women to do the impossible, that is, to control and manage men's violence, child protection systems ultimately fail to protect children'.²³³ The result may be that the children are harmed by the abusive partner/parent and further harmed by being removed from the care of their non-abusive parent who is not able to keep them safe.

IPV victimisation affects a victim's capacity to parent

Care and protection assessments of parenting ability need to address specifically the effects of IPV victimisation and perpetration. IPV in this context is not only an attack on a victim's self-determination but also an attack on the relationship between her and her children.²³⁴

Mothers experiencing IPV are parenting under siege. A mother's ability to care for her children can be significantly impacted at a practical level by the abusive behaviour of her partner when the violence affects her ability to provide for their basic needs. For example, in one of the regional reviews, a victim who refused to buy more alcohol for her partner, because she needed the money for food for her children, was assaulted and strangled by him to the point of unconsciousness.

IPV can also affect a mother's ability to parent because of the psychological effects on her and the children. For example, a mother may become depressed and partially disengaged from her children because of the trauma she is experiencing. The children, in turn, may become aggressive and develop behavioural problems that are difficult to manage. This may stretch her beyond the limits of her parenting skills at that point in her life and in that particular situation.

Adult victims of IPV who are involved with care and protection services are frequently marginalised women experiencing high levels of entrapment. These women will have limited resources available to protect themselves and their children from abusive partners, and are fearful of having their children removed. Trying to escape their partner's violence may mean living illegally in another relative's Housing NZ house with all their children in one room. This can only ever be a temporary respite as it places their relative's tenancy at risk. Alternatively, their partner may be a gang member whose associates are sent to find her if she does not return home at a designated time.

Adult victims frequently have their own histories of child abuse and exposure to IPV. The *Interim Report* states that children known to CYF by the age of five are five times more likely to have a parent who was also known to CYF as a child, compared with children not known to CYF by the age of five.²³⁵ Along with poor physical health, mothers may be struggling with substance abuse and mental health issues (which are likely to be exacerbated by the abuse they are experiencing) and have few safe family or whānau members to call on for support.²³⁶

232 See Appendix 5 for the Tuituia parenting domains.

233 S. Strega, and C. Janzen, 'Asking the impossible of mothers: Child protection systems and intimate partner violence', in S. Strega et al. (eds.), *Failure to Protect: Moving beyond Gendered Responses*, Nova Scotia, Fernwood Publishing, 2013.

234 C. Humphreys, 'Relevant evidence for practice', in C. Humphreys and N. Stanley (eds.), *Domestic Violence and Child Protection: Directions for Good Practice*, London, Jessica Kingsley, 2006.

235 *Modernising Child, Youth and Family Expert Panel: Interim Report*, pp. 32-3.

236 Victims are often prevented by their abusive partners from maintaining positive social and whānau connections.

5.3.2 Shifting the paradigm – engaging with the person using violence

If child protection policies and assessment frameworks directed social workers to start from the premise that victims of IPV generally resist the abuse of their children and themselves, but that their resistance does not stop their partner's violence, then victims could not be held responsible for the cessation of their abusive partners' violence.

Other jurisdictions (such as Western Australia,²³⁷ Victoria,²³⁸ the UK²³⁹ and the USA²⁴⁰) have developed child protection responses focused on addressing the behaviours of the abusive person. For example, the Safe and Together model:²⁴¹

- supports comprehensive, holistic, family- and whānau-centred practice
- works with the people using violence, who are the primary source of risk (addressing a gap in the current practice response)
- is specifically designed to promote the best interests of children, including safety, permanency and wellbeing.²⁴²

Furthermore, when social workers (in partnership with other services) intervene directly with the partner/parent using violence, and 'hold them in intervention contexts', the opportunities for cooperation and collaboration with adult victims greatly increase.

Figure 6 illustrates the multiple forms of harm caused to child and adult victims, and family and whānau functioning, by an abusive partner's/parent's behaviour.

237 Department for Child Protection, *Perpetrator Accountability in Child Protection Practice: A Resource for Child Protection Workers about Engaging and Responding to Men Who Perpetrate Family and Domestic Violence*, Western Australia, Department for Child Protection, Family and Domestic Violence Unit, 2013, www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Documents/Perpetrator%20Accountability%20in%20Child%20Protection%20Practice.pdf

238 J. Dwyer and R. Miller, *Working with Families Where an Adult is Violent: Best Interests Case Practice Model: Specialist Practice Resource*, Melbourne, Victorian Government Department of Human Services, 2014, www.dhs.vic.gov.au/__data/assets/pdf_file/0004/890428/Working-with-families-where-an-adult-is-violent-2014.pdf

239 J. Healy and M. Bell, 'Assessing the risks to children from domestic violence: Findings from two pilot studies using the Barnardo's Domestic Violence Risk Assessment Model', *No. 7 Policy and Practice Briefing*, Barnardo's Northern Ireland, 2007. The Scottish Government, *National Guidance for Child Protection Scotland*, Edinburgh, The Scottish Government, 2014, p. 114, www.gov.scot/Resource/0045/00450733.pdf

'Domestic abuse...

454. When undertaking assessment or planning for any child affected by domestic abuse, it is crucial that practitioners recognise that domestic abuse involves both an adult and a child victim. The impact of domestic abuse on a child should be understood as a consequence of the perpetrator choosing to abuse rather than of the non-abusing parent's/carer's failure to protect ... Agencies should always work to ensure that they are addressing the protection of both the child and the non-abusing parent/carer.

455. Protection should be ongoing, and should not cease if and when the abuser and the non-abusing parent/carer separate. Indeed, separation may trigger an escalation of violence, increasing the risk to both the child and their non-abusing parent/carer.'

240 F. Mederos, *Accountability and Connection with Abusive Men: A New Child Protection Response to Increasing Family Safety*, Family Violence Prevention Fund, 2004.

241 No to Violence, *Strengthening Perpetrator Accountability within the Victorian Family Violence System*, 2015.

242 Safe and Together principles:

- Keeping the child safe and together with the non-offending parent (safety, healing from trauma, stability and nurturance).
- Partnering with the non-offending parent as a default position (efficient, effective and child-centred).
- Intervening with the perpetrator to reduce risk and harm to child (engagement, accountability, courts).

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Figure 6: Multiple forms of harm²⁴³

Perpetrator's pattern

- Coercive control toward adult survivor
- Actions taken to harm children

Children's trauma

- Victim of physical abuse
- Seeing, hearing or learning about the violence

Effects on family ecology

- Loss of income
- Housing instability
- Loss of contact with extended family
- Educational and social disruptions

Effect on partner's parenting

- Depression/PTSD/anxiety/substance abuse
- Loss of authority
- Energy goes to addressing perpetrator instead of children
- Interference with day to day routine and basic care

Harm to child

- Behavioral, emotional, social, educational
- Developmental
- Physical injury

The Safe and Together model supports a shift from a 'failure to protect' approach to a perpetrator-pattern, child-centred and survivor strengths-based approach.

As shown in Table 7, a move towards IPV-competent child protection policy and practice requires a comprehensive assessment of risk, safety and protective factors and increased practitioner engagement with partners/parents who are using violence. Such an approach raises the parenting standards expected of abusive fathers by bringing into view the impact of their behaviour and choices on child, family and whānau functioning.²⁴⁴ This approach is also relevant for the Children's Teams.

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244 See Appendix 5: Safe and Together domestic violence-informed continuum of practice.

Table 7: Safe and Together practice and assessment approaches²⁴⁵

	Practice approach	Assessment approaches
1	A clear understanding that the perpetrator's behaviour, not the adult survivor's behaviour, is the source of the child risk and safety concerns.	<p>Assessment of the perpetrator's behaviour: not the relationship or the adult survivor's behaviour.</p> <p>Assesses the perpetrator's behaviour in terms of the risk to child safety and wellbeing – whether the couple are together or not and whether there is a protection order or not.</p>
2	An articulation of the impact of the perpetrator's behaviour on the child and family functioning.	<p>Assessment of the connection between the perpetrator's behaviour and child safety and family wellbeing: not just the impact on the adult victim.</p> <p>Comprehensive child safety assessments (for example, physical danger to the child and the traumatic impact on the child). In addition, there is a full assessment of the perpetrator's impact on the overall family functioning, including housing instability, maternal mental health and substance abuse, child mental health and substance abuse, disruption of extended family support, medical care, employment and educational stability.</p>
3	Child protection systems increase their assessment of, and engagement with, men as parents. Child protection systems improve their ability to assess the protective capacity of the adult victim.	<p>Assessment of the perpetrator's decision to be abusive and controlling as a parenting decision.</p> <p>Improved gender-based practice is essential in assessment and case planning. This includes having higher expectations of men as parents, and seeing family violence perpetration as a parenting choice.</p> <p>Instead of a focus on generic strengths, the model directs social workers to articulate the <i>specific actions</i> the adult victim has taken to promote the safety and wellbeing of the children (resistance).</p> <p>Workers are directed to build partnerships with adult victims. A better assessment of the strengths of the adult victim is critical to the development of more effective case plans and the safe reduction of the number of out-of-home placements for the children.</p>

For a child protection system to become IPV-competent, a similar practice approach needs to be applied to all areas of the organisation.²⁴⁶ In Aotearoa New Zealand, developing an IPV-competent child protection system would involve integrating IPV throughout the current care and protection continuum, from screening for IPV on intake through to guidance on safely addressing family violence (CAN and IPV) within family group conferences, and engaging with abusive partners/parents.

245 No to Violence, *Strengthening Perpetrator Accountability within the Victorian Family Violence System*, 2015.

246 This includes the paradigm, policy and practice (which includes data, definitions, forms and tools), training and supervision, legal, services, coordination and collaboration, institutionalisation and integration.

5.3.3 Promising results in practice

In the USA, the Safe and Together model has been associated with improved child protection practice, improved assessment and significant decreases in out-of-home placements for children.²⁴⁷ The Committee notes the close collaboration between domestic violence specialists (co-located advocates) and children's social services has been critical to these successful outcomes.²⁴⁸

In Florida, Mandel & Associates has collaborated with both the Florida Coalition for Domestic Violence and the Department of Children and Families for seven years. The Safe and Together project site in Northwest Florida has reported an increase in children not being removed from their families. From January 2012, when the programme began, to June 2013, domestic violence-related removals dropped from 20.6 percent of removals to 9.1 percent. Over almost a three-year period, similar efforts in the Florida Department of Children and Families produced a drop of approximately 70 percent in neglect filings in domestic violence cases and a reduction of approximately 50 percent in removals of children from their families in domestic violence cases.

5.3.4 The Aotearoa New Zealand context

Transporting models between countries is difficult. Attentive adaptations must take account of similarities and differences in the cultural and social landscapes.

Within child protection practice, risk-based assessments have been associated with deficit models of assessing family and whānau functioning (including mother-blaming, as discussed above). In Aotearoa New Zealand the response to this individual deficit and risk legacy has been the development of strengths-based approaches²⁴⁹ (especially within family support services), as well as the reclaiming of indigenous strengths-based approaches (Whānau Ora). Strengths-based approaches are promoted as the preferred way to work respectfully with families and whānau.²⁵⁰ Importantly, strengths-based approaches can draw upon support from extended family and the community, as well as enabling access to resources that can assist the family or whānau.

However, strengths-based approaches can also support overly optimistic assessments, which may not address the complex and pervasive impact of trauma and violence. The aspirations of strengths-based approaches must be balanced against the harsh realities of families and whānau affected by historical and contemporary state violence, structural inequities and family violence. With respect to Māori whānau, the challenge is to support simultaneously the restoration of Māori whānau as a protective factor, while managing the risk that some whānau are not safe supports for women and children.

Non-oppressive child protection practice is required. This develops an 'understanding of clients in the context of their social environment and life history'.²⁵¹ This requires looking specifically at safety and risk factors posed by those using violence, as well as looking at strengths and protective factors in the extended whānau, contextual factors and the family's desired outcomes.

247 K. Steinmann and S. Jones, *Ohio Intimate Partner Violence Collaborative: Final Evaluation Report of the Safe and Together Training Program*, Columbus, National Center for Adoption Law and Policy, 2014. David Mandel & Associates, 'Florida co-located advocates, Florida DCF and Safe and Together model combine to reduce removal of children from domestic violence survivors in half', Ending Violence blog posted 8 October 2013, <https://endingviolence.com/2013/10/florida-co-located-advocates-florida-dcf-and-safe-and-together-model-combine-to-reduce-removal-of-children-from-domestic-violence-survivors-in-half/>.

248 N. Blacklock and R. Phillips, 'Reshaping the child protection response to domestic violence through collaborative working', in N. Stanley and C. Humphreys (eds.), *Domestic Violence and Protecting Children: New Thinking and Approaches*, London, Jessica Kingsley, 2015.

249 Approaches which focus on strengths, a person's potential, and solutions as opposed to accentuating problems and deficits.

250 CYF, child/young person and family consult guidelines. The child/young person and family consults are based on the work of Andrew Turnell and Steve Edwards and referred to as Signs of Safety or, more recently, Safety Organised Practice. Turnell and Edwards argue that traditionally child protection casework is undertaken from the perspective of risk assessment, and that, given the goal is to achieve safety for the child or young person, risk is only half of the equation. The Safety Organised Practice approach seeks to balance the equation by eliciting the existing strengths, safety and goals of the family/whānau that can contribute to the safety and wellbeing for the child or young person. The approach is designed as a practical method of fostering a cooperative relationship between workers and family/whānau. www.practicecentre.cyf.govt.nz/policy/assessment-and-decision-making/resources/childyoung-person-and-family-consult-guidelines.html

251 C. De Boer, and N. Coady, 'Good helping relationships in child welfare: Learning from stories of success', *Child and Family Social Work*, vol. 12, 2007, p. 38.

5.3.5 Engaging respectfully with people using violence

A shift in child protection practice needs to be supported by a wider range of services for men who use violence. Many of the men coming to the attention of statutory services such as CYF and the Department of Corrections experience high levels of disadvantage and will require interventions that address their use of violence in addition to multiple other needs.

Richardson and Wade developed Islands of Safety,²⁵² a feminist and indigenous praxis model of family violence prevention work in a care and protection context. They found that asking victims and people using violence what responses they had received from family, whānau, friends and organisations to their experiences of violence (victimisation or perpetration) was an effective way to create safety and dignity, and to facilitate conversations.

Fathers who had been abusive to their children and female partners reported negative and humiliating social responses from practitioners – being treated as nasty, one-dimensional and non-redeemable. Richardson and Wade found that, in describing their experiences, men often revealed their own belief in the importance of fairness and a sense that everyone deserves to be treated with respect.

The majority of men who use violence have themselves been exposed to various forms of abuse and neglect in childhood, with a continuum of exposure to violence into adulthood. They also need and deserve opportunities to discuss these histories and to receive appropriate assessment and support with the aim of healing where possible. A focus on social responses creates spaces for family members to talk about their experiences, of state care for example, and how they have responded to other forms of adversity, including the legacy of colonisation. By acknowledging these experiences, practitioners can affirm the dignity of all family members while protecting the safety of children.

5.3.6 IPV-competent and culturally appropriate child protection practice

Although there has been a specific focus within children's social services on engaging men as fathers,²⁵³ the central challenge of how to work with abusive fathers/partners (as discussed above) in the day-to-day work of statutory care and protection remains. Internationally, there is a move to co-locate specialist family violence services within statutory child protection services to enable collaborative and IPV-competent child protection practice.²⁵⁴

In the UK, Safer Families in Edinburgh has co-located with one of the city's children's social services teams to provide a collaborative response to families of children exposed to IPV. London's Domestic Violence Intervention Project (DVIP) has co-located with Hackney children's social services. DVIP provides an onsite violence prevention programme and partner support service, as well as domestic violence expertise in risk and case management. To be transformative, co-location opportunities must reach beyond physical proximity to collaborative and integrative ways of working.²⁵⁵

Opportunities for collaborative practice in Aotearoa New Zealand could support the shifts in practice needed for effective care and protection responses in family violence cases. Such responses (as detailed in Table 8) engage with the abusive partner/parent and are IPV-competent and culturally relevant.

252 C. Richardson and A. Wade, 'Islands of safety: Restoring dignity in violence-prevention work with indigenous families', 2010.

253 This includes father-focused parenting programmes that specifically address IPV. Caring Dads programmes have had positive outcomes in improving fathering but less of an impact in addressing attitudes that support IPV. K. McCracken and T. Deave, *Evaluation of the Caring Dads Cymru Programme*, Wales, Welsh Assembly Government, 2012.

254 Fernando Mederos was appointed Director of Fatherhood Engagement at the Massachusetts Department of Children and Families in May 2006. His role is to maximise engagement with fathers whose families are involved with the child welfare system, and promote holistic, culturally based and domestic violence safety-orientated practice with fathers by child welfare workers. He is co-Chair of the Board of National Latino Alliance for the Elimination of Domestic Violence (Alianza).

255 N. Blacklock and R. Phillips, 'Reshaping the child protection response to domestic violence through collaborative working', 2015.

Table 8: Effective and ineffective child protection responses to family violence

Effective family violence responses	Ineffective family violence responses
Developing the protectiveness of the multi-agency response	A focus on the protectiveness of the adult victim (usually the mother)
IPV and CAN are addressed as entangled forms of abuse, which necessitates the development of integrated practice responses to child and adult victims and abusive partners/parents	IPV and CAN are addressed as separate forms of abuse, with separate practice responses for child and adult victims
Culturally responsive practice	Eurocentric practice (dominant cultural practice)
Child-centred responses that consider children in the context of their family and whānau	Child-centred responses that only focus on the child
Integrated child and whānau responses	

5.4 Mental health and addiction responses

5.4.1 The connection between family violence, mental health and addictions

Historically, addiction services were designed as single-issue interventions based on the needs of predominantly Western male clients. Practitioners focused on stopping the client drinking and assumed either that any other issues would resolve themselves through the recovery process or another service would address them.²⁵⁶ Similarly, mental health services focused on medical diagnoses and treatment of mental health conditions.

In the 1990s, a significant shift in health knowledge came with the recognition of the impact of traumatic experiences on people's physical and mental health. The Adverse Childhood Experiences study established a strong link between various childhood traumas and adult physical and mental health.²⁵⁷

Research over the past three decades has consistently demonstrated that experiencing IPV is associated with a range of trauma-related physical and mental health effects.²⁵⁸ IPV increases a woman's risk for developing depression,²⁵⁹ PTSD,²⁶⁰ substance abuse²⁶¹ and suicidality²⁶² as well as a range of other chronic health conditions. Many victims experience multiple forms of abuse during their lives – for example, CAN, sexual violence from family and non-family members, IPV and historical trauma, and ongoing structural inequity.²⁶³ These all increase their risk of developing trauma-related health and mental health conditions.²⁶⁴ Consequently, many victims access MH&A services because of trauma-related experiences.

256 S. Covington, 'Women and addiction: A trauma-informed approach', *Journal of Psychoactive Drugs*, SARC Supplement 5, November 2008, pp. 377-85.

257 V.J. Felitti et al., 'Relationship between childhood abuse and household dysfunction and many of the leading causes of death in adults: The adverse childhood experiences (ACE) study', *American Journal of Preventive Medicine*, vol. 14, no. 4, 1998, pp. 245-58. V.J. Felitti and R.F. Anda, 'The relationship of adverse childhood experiences to adult health, well-being, social function, and health care', in R. Lanius, E. Vermetten and C. Pain (eds.), *The Effects of Early Life Trauma on Health and Disease: The Hidden Epidemic*, New York, Cambridge University Press, 2010. S.R. Dube et al., 'Exposure to abuse, neglect, and household dysfunction among adults who witnessed intimate partner violence as children: Implications for health and social services', *Violence and Victims*, vol. 17, no. 1, 2002, pp. 3-17.

258 National Center on Domestic Violence, Trauma & Mental Health, *Current Evidence: Intimate Partner Violence, Trauma-Related Mental Health Conditions & Chronic Illness*, National Center on Domestic Violence, Trauma & Mental Health, 2014, www.nationalcenterdvtraumamh.org/wp-content/uploads/2014/10/FactSheet_IPVTraumaMHChronicIllness_2014_Final.pdf

259 K.M. Devries et al., 'Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies', *PLoS Med*, vol. 10, no. 5, 2013, e1001439, DOI: 10.1371/journal.pmed.1001439.

260 S. Perez, D. Johnson and C. Valie Wright., 'The attenuating effect of empowerment on IPV-related PTSD symptoms in battered women living in domestic violence shelters', *Violence Against Women*, vol. 18, 2012, pp. 102-17.

261 K.M. Devries et al., 'Intimate partner violence victimization and alcohol consumption in women: A systematic review and meta-analysis', *Addiction*, vol. 109, no. 3, 2014, pp. 379-91.

262 M. Devries et al., 'Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies', 2013.

263 R. Wirihana and C. Smith, 'Historical trauma, healing and well-being in Māori communities', *MAI Journal*, vol. 3, no. 3, 2014.

264 Drugs and Alcohol Women Network, 'Promoting a gender responsive approach to addiction', *United Nations Interregional Crime and Justice Research Institute Publication no. 104*, Turin, 2013.

Victims who already have depression or major mental health disorders are more vulnerable to IPV victimisation and re-victimisation. Their mental health issues are exacerbated and perpetuated by the abuse they experience.

The importance of trauma-informed responses has been acknowledged within the MH&A sectors for many years. Such approaches are well developed in other countries.²⁶⁵ However, more explicit attention could be given to providing trauma-informed responses that address the current safety and health needs for those experiencing and perpetrating IPV.

Addressing women's experiences of violence is critical for their recovery from MH&A issues.²⁶⁶ Because IPV is an ongoing pattern of abuse, mental health treatment strategies that fail to address women's experience of violence may actually do harm. For example, Devries et al point out that if IPV is not suspected as a potential causative factor, 'patients who have attempted suicide may be encouraged to return to partners/relatives, which could increase the risk of further violence and eventual suicide'.²⁶⁷

In addition to trauma-informed treatment that responds to the current safety needs of victims, an approach that acknowledges the intersection of compounding forms of disadvantage (such as sexism and racism) is required for the planning and provision of care.²⁶⁸ In Aotearoa New Zealand, there is an increasing understanding within mainstream MH&A services of the importance of cultural and indigenous conceptual frameworks and responses – for example, Māori drug and alcohol teams that can offer marae-focused, whānau-centred and wairua-driven support.

5.4.2 Weaving family violence into MH&A services practice

The regional reviews identify that MH&A services²⁶⁹ can be one of the main service providers engaged with victims and abusive partners. In some regional reviews, practitioners referred abusive partners to mental health services because they believed the abusive behaviour originated in a mental health condition, or because of their suicidal ideation. Abusive partners were also referred to community drug and alcohol services, often as a special condition of a community-based sentence (frequently imposed due to IPV offending against a previous partner). Many victims were involved with community drug and alcohol services because they used alcohol to numb their multiple experiences of abuse.

Research has shown that health care interventions for IPV which only focus on empowering victims (including cognitive behavioural therapy, counselling to improve self-efficacy and self-esteem, and safety planning), are ineffective at addressing the health and safety issues faced by victims of IPV.²⁷⁰ This is not surprising. If there is no response to the person using violence, the violence will not stop.²⁷¹ Health care professionals are now recognising that in some contexts there is potentially 'a serious

265 E.L. Machtinger et al., 'From treatment to healing: The promise of trauma-informed primary care', *Women's Health Issues*, vol. 25, no. 3, 2015, pp. 193–97. K. Huckshorn and J.L. LeBel, 'Trauma-informed care', in K.R. Yeager et al. (eds.), *Modern Community Mental Health: An Interdisciplinary Approach*, New York, Oxford University Press, 2013. M.J. Endres et al., 'Toward a trauma-informed system of care in Hawai'i's adult mental health division', *Hawai'i J Med Public Health*, vol. 74, no. 6, 2015, pp. 213–17.

266 Davies et al state that in order to understand women's health (physical and mental), practitioners must ask about women's *cumulative abuse* experiences. This is because 'to only assess current or [the] most recent violence misses important earlier experiences that matter for current health outcomes, and controlling for other types of abuse does not adequately account for the interactive effects of multiple forms of victimization.' Davies et al., 'Patterns of cumulative abuse among female survivors of intimate partner violence: Links to women's health and socioeconomic status', 2015, p. 32.

267 K.M. Devries et al., 'Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies', 2013, p. 9.

268 There is both a definition of and principles for the development of gender-responsive treatment. Gender responsive: Creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of women's lives, and is responsive to the issues of the clients. S. Covington, 'Creating gender-responsive programs: The next step for women's services', *Corrections Today*, vol. 63, 2001, pp. 85–7. Donna, Mental Health Consumer Consultant and Dr Jacqueline Short, Consultant Forensic Psychiatrist, 'Meeting the mental health needs of women in acute and crisis settings', *The Journey Forward*, Capital & Coast District Health Board, November 2007.

269 Seven layers of care have been identified within MH&A services: primary care, social care, self-care, organised primary MH&A packages of care, community-based MH&A support, specialist MH&A support, and hospital inpatient and acute services support.

It is important to note that these layers are additive, as people are likely to be accessing more than just one layer of service at any one time. Platform Trust and Te Pou o Te Whakaaro Nui, *On Track: Knowing Where We Are Going*, 2015, p. 7.

270 K. Hegarty et al., 'Screening and counselling in the primary care setting for women who have experienced intimate partner violence (WEAVE): A cluster randomised controlled trial', *The Lancet*, 2013, vol. 382, pp. 249–58. R. Jewkes, 'Intimate partner violence: The end of routine screening', *The Lancet*, vol. 382, 2013, pp. 190–91.

271 The response to the abusive person does not need to be from the health practitioner.

mismatch between the types of interventions being tested and the complexity of the problem of intimate partner violence'.²⁷²

Because people's safety and health are intertwined aspects of their wellbeing, responses to their health and safety needs must also be intertwined. Multi-agency and multi-disciplinary responses are required to do this effectively.

The Committee notes the current Ministry of Health Violence Intervention Programme partner abuse response in DHB MH&A services is an appropriate response for other DHB services situated at Tier 2 (see Chapter 4). The focus at Tier 2 is on referring identified victims to family violence NGOs.²⁷³

However, DHB MH&A services²⁷⁴ are well positioned to offer a Tier 3 family violence response. Moving to a Tier 3 response would involve DHB MH&A services supporting victims' wellbeing and safety needs in *partnership* with specialist family violence advocacy services. Such a partnership approach requires integrating family violence into MH&A practice in relation to both victims and people perpetrating violence. This involves regularly discussing family violence (including histories of childhood abuse and IPV) in MH&A multi-disciplinary meetings and in the development and review of treatment plans.

A Tier 3 response would require MH&A practitioners to participate in family violence multi-agency forums with specialist family violence advocacy services. This could include contributing their specific skills and actions to multi-agency:

- case management processes
- safety strategies that protect partners and children who are at risk of harm from an MH&A client.

This would significantly improve health and safety outcomes. Currently, the Ministry of Health does not have a family violence guideline for the risk management of people in MH&A services who perpetrate IPV. However, the Ministry recognises this as an area that requires consideration.²⁷⁵

The 2011 Health Workforce New Zealand report *Towards the Next Wave of Mental Health & Addiction Services and Capability* recommended the 'adoption of a whole of system, person centric view that represents the large majority of MH&A needs, issues and opportunities as a guide for future MH&A development'.²⁷⁶ Similarly, the *On Track: Knowing Where We Are Going*²⁷⁷ report makes it clear the MH&A NGO sector is aware of the need to move towards holistic approaches that address other social issues and/or partner with services from other social systems. The Ministry of Health report *Supporting Parents, Healthy Children*²⁷⁸ calls for adult services to move towards a holistic family-focused paradigm, where children's safety and wellbeing is 'everyone's responsibility and everyone's business'.²⁷⁹ These statements provide support in principle for considering the integration of family violence within MH&A services.

272 S. Rees and D. Silove, 'Why primary healthcare interventions for intimate partner violence do not work', *The Lancet*, vol. 384, 2014, p. 229.

273 The Ministry of Health recommends a six-step response to victim's family violence (IPV and CAN) disclosures in DHB services. Ministry of Health, *Family Violence Guidelines*, 2002, p. 40.

274 DHB MH&A services are delivered and funded by the DHB. The Ministry of Health Violence Intervention Programme is the foundation from which MH&A services can strengthen responsiveness to family violence.

275 We note that the Ministry of Health Violence Intervention Programme IPV risk assessment has been strengthened to consider IPV lethality indicators in response to the FVDRC *Fourth Annual Report* findings.

276 Health Workforce New Zealand, *Towards the Next Wave of Mental Health and Addiction Services and Capability: Workforce Service Review Report*, Wellington, Health Workforce New Zealand, 2011, p. 9.

277 Platform Trust and Te Pou o Te Whakaaro Nui, *On Track: Knowing Where We Are Going*, 2015.

278 Ministry of Health, *Supporting Parents, Healthy Children*, Wellington, Ministry of Health, 2015.

279 *Ibid*, p. 1.

5.4.3 Promising practice in Victoria

The Victorian Branch of the Royal Australian and New Zealand College of Psychiatrists' (RANZCP) submission to the Victorian Royal Commission into Family Violence says the health system still responds to family violence as a marginal issue (notwithstanding its significant health impacts).²⁸⁰ This is so, despite the fact that health services offer significant pathways to early intervention, recovery and rehabilitation for victims and people perpetrating family violence. The RANZCP emphasises the need to scale up efforts to address family violence within health and other sectors. It suggests psychiatrists should engage with the mental health impacts of family violence and minimise the risk of further violence through timely identification and appropriate ongoing health system support for victims and people perpetrating violence.

In February 2015, the RANZCP hosted a round table²⁸¹ with the objective of enhancing the mental health response to family violence and aligning it with specialist family violence services. The RANZCP plans to establish a relationship between the Peak Mental Health Bodies and Men's Behaviour Change programmes in order to consider policy, research, training and service delivery.

5.4.4 Challenges to service integration

Currently, family violence services and substance abuse services are provided separately as single-issue interventions available to those perpetrating or experiencing IPV. Alcohol use can increase the severity of IPV,²⁸² so non-violence programmes need specialised responses to address the co-occurrence of substance abuse and IPV. Interventions that address both alcohol misuse and the attitudes and behaviours that promote violence will have the greatest impact on victims' safety. Such service integration can prioritise victim safety, which is unlikely to be the case when an abusive partner is only being treated, for example, for their alcohol dependency.

Integrated services for family violence and substance abuse are economical with participants' time and finances (attending a single programme rather than two separate programmes), and likely to encourage retention. Multiple studies have shown that where services are not integrated, there are high dropout rates for both victims attending alcohol treatment and alcohol-dependent abusive partners in IPV 'counselling'.²⁸³

Integration of services is challenging because of the different theoretical frameworks that inform the family violence and MH&A sectors. Historically, alcoholism was understood within a disease paradigm, caused by environmental and genetic factors. Thinking has now shifted towards a trauma-informed paradigm. In contrast, IPV is understood as intentional behaviour shaped by people's social and historical experiences of violence and supported by social norms.

The regional reviews demonstrate that dangerous practice occurs when practitioners misunderstand alcohol as the underlying cause of family violence. Stopping drinking does not stop people's use of violence. It is more helpful to think of alcohol misuse and IPV as 'co-occurring', with other factors influencing both drinking and the perpetration of IPV. This framework hypothesises that there is no direct causal relationship between the use of alcohol and the perpetration of IPV.

280 Royal Australian and New Zealand College of Psychiatrists Victorian Branch Submission to Royal Commission into Family Violence, 2015, SUBM.0395.001.0002, www.rcfv.com.au/Submission-Review

281 They drafted a document which outlined how they would incorporate mental health responses to family violence comprising assessment and treatment of victims and perpetrators, and preparation of the mental health system through training and education of psychiatrists.

282 It is well known that victims suffer more severe injuries when their partner has been drinking; alcohol exacerbates the severity of violence inflicted by the abusive partner. M.P. Thompson and J.B. Kingree, 'The roles of victim and perpetrator alcohol use in intimate partner violence outcomes', *J Interpers Violence*, vol. 21, no. 2, 2006, pp. 163-77.

283 R. Braaf, 'Elephant in the room: Responding to alcohol misuse and domestic violence', Issue Paper 24, University of New South Wales, Australian Domestic & Family Violence Clearinghouse, 2012.

The theory of co-occurrence comes from studies showing alcohol consumption to be strongly associated with IPV where a person using violence *already holds attitudes condoning violence*, and importantly, *attitudes condoning violence against women*.²⁸⁴ Braaf highlights that co-occurrence theory fits with what is known about the dynamics of IPV. Specifically, that:

- violence is a deliberate choice and not caused by factors such as stress or anger (or, in this case, alcohol consumption)
- there are relationships in which both partners drink but only one becomes abusive; relationships in which either or both partners drink and no one becomes abusive; and relationships in which abusive partners are violent when drinking and when sober
- an abusive partner's excessive drinking may compound the frequency and severity of IPV.²⁸⁵

Another dominant theoretical model of health behaviour change which has been influential for addiction services is Prochaska and DiClemente's 'stages of change'.²⁸⁶ The 'stages of change'²⁸⁷ model (trans-theoretical model of change) is based on developmental theory, and assumes people move through four major stages from less to more readiness to change and responsiveness to treatment.²⁸⁸ This theory posits that matching treatment to a client's readiness improves compliance and therapeutic outcomes. However, the stages of change model does not appear to work in men's non-violence programmes, as there is inconsistent and weak support of change stages.²⁸⁹

Bringing the family violence and MH&A sectors together will involve significant foundational work, including workforce development, culture change and process changes within services. However, there is precedent elsewhere for such work. In London, the Stella Project²⁹⁰ is the leading UK agency addressing the overlapping issues of domestic and sexual violence, drug and alcohol use and mental health. The Stella Project works to support the integration of services and sustained improvement in the way services are delivered to survivors, their children and people using violence.²⁹¹

284 H. Johnson, 'Contrasting views of the role of alcohol in cases of wife assault', *Journal of Interpersonal Violence*, vol. 16, no. 1, 2001, pp. 54-72: Alcohol consumption predicted male violence against women where it coexisted with cultural and societal norms that support such violence. However, when beliefs in male dominance were removed, the effect of alcohol on the occurrence of violence was neutralised.

285 R. Braaf, 'Elephant in the room: Responding to alcohol misuse and domestic violence', 2012.

286 Matua Raki, *Interventions and Treatment for Problematic Use of Methamphetamine and Other Amphetamine-Type Stimulants (ATS)*, Wellington, Ministry of Health, 2010. Alcohol Advisory Council of New Zealand, *Alcohol and Your Health: Helping with Problem Drinking*, 4th edn., Wellington, Alcohol Advisory Council of New Zealand, May 2012. See 'Stages of change', pp. 12-16, www.hpa.org.nz/sites/default/files/useruploads/Resourcepdfs/02856_Alcohol%26YourHealth_ALAC_%20Problem_drinkers_FA2_LR.pdf

287 J. Prochaska and C. DiClemente, 'Common processes of change in smoking, weight control, and psychological distress', in S. Shiffman and T. Wills (eds.), *Coping and Substance Use: A Conceptual Framework*, New York, Academic Press, 1985.

288 E. Gondolf, 'The weak evidence for batterer program alternatives', *Aggression and Violent Behavior*, vol. 16, 2011, pp. 347-53.

289 Gondolf refers to three studies of non-violence programme outcomes where, contrary to expectation, the change stage did not predict programme completion. The studies were conducted in very different settings: programme intake at an urban batterer programme in Canada (Brodeur, Rondeau, Brochu, Lindsay, & Phelps 2008, n=302), initial contact at a suburban programme in Maryland (Alexander & Morris 2008, n=210), and an urban domestic violence court in Texas (Eckhardt et al 2008, n=199). E. Gondolf, 'The weak evidence for batterer program alternatives', 2011. In an extensive 'stages of change' review of criminal offenders, Burrowes and Needs conclude: 'We demonstrate the problems that the Stages of Change Model has with its predictive accuracy, internal coherence, and explanatory depth. Consequently the Stages of Change Model may not be an adequate model for measuring 'readiness to change' with offending behaviour, and may not provide a useful basis for developing interventions to improve readiness to change.' N. Burrowes and A. Needs, 'Time to contemplate change? A framework for assessing readiness to change with offenders', *Aggression and Violent Behavior*, vol. 14, 2009, pp. 39-49.

290 During 2002, discussions between the Greater London Domestic Violence Project (GLDVP) and the Greater London Alcohol and Drug Alliance (GLADA) identified gaps in the current service provision for both survivors and perpetrators of domestic violence who use substances problematically. GLDVP and GLADA created the Stella Project in order to find positive and creative ways to work towards more inclusive service provision. www.avaproject.org.uk/our-projects/stella-project.aspx

291 They provide best practice guidelines on domestic and sexual violence, drugs and alcohol, training, resources, policy briefings, consultancy, support and advice. [www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/complicated-matters-stella-project-toolkit-and-e-learning-\(2013\).aspx](http://www.avaproject.org.uk/our-resources/good-practice-guidance--toolkits/complicated-matters-stella-project-toolkit-and-e-learning-(2013).aspx)

5.5 Conclusion

The justice system, child protection system and MH&A services were not designed with family violence in mind. Currently these systems tend to fragment:

- long patterns of harm into individual incidents
- patterns of abuse into different 'types' of abuse
- families into individual clients
- the complexities of people's lives into separate issues to be dealt with separately.

This inhibits the ability to work together and differently in order to address victim safety. Consequently, in their current iterations these systems are not well equipped to respond to the complexities of family violence – a cumulative pattern of harm with multiple victims (child and adult), or provide the range of responses required for multiple family members (child and adult victims, perpetrators and whānau) with multiple co-occurring issues.

Siloed and fragmented interventions are fundamentally unsafe. New configurations of collaboration and integration across the whole system would encourage the emergence of innovative ways of thinking and practising – particularly in responding to people perpetrating violence.

CHAPTER 6: CONCLUDING COMMENTS ON PREVENTION

In this chapter, the notion that prevention can be tackled in discrete linear stages (primary, secondary and tertiary) is challenged. Also challenged is the idea that prevention can be approached as though it is *solely* an issue of educating individuals about how to build healthy relationships (although, clearly this is significant work).

The Integrated Safety System outlined in Chapter 4 is not built on a primary, secondary and tertiary prevention framework. This is because the regional reviews demonstrate that for many families and whānau there is no primary prevention space to claim. With respect to Māori whānau, Kaupapa Māori conceptual models of family violence prevention offer transformative opportunities based on connecting with and strengthening Māori cultural traditions.

In acknowledgement that people are impacted by what has gone before, what is currently occurring and what can (re)occur, the Committee has located prevention with restoration work (Tier 1) in its tiered safety response framework. However, as explained in this chapter, prevention is also intertwined with both restorative and safety responses.

The overall aim of an integrated family violence system is prevention – to prevent family violence from (a) occurring and (b) re-occurring and to prevent the harm it causes to all those involved. Opportunities for prevention are therefore embedded in every response to family violence, not just those normally restricted to primary prevention.

Our collective prevention focus should be on creating ‘waves of preventative effects’ in all our responses to family violence.²⁹²

6.1 Thinking differently about prevention – ‘waves of preventative effects’

6.1.1 Prevention is intertwined with safety and restoration

Whakapapa denotes the intrinsic interconnection of past, present and future generations. When responding to family violence, it is vital to consider what has already happened – and to appreciate the past does not disappear if it is not understood and addressed.²⁹³

For many families and whānau in Aotearoa New Zealand the absence of a pre-violence or primary prevention space is significant.²⁹⁴ Children are born into families and whānau already experiencing intergenerational violence and trauma, and are exposed to violence in multiple family contexts, including the relationships of their parents and grandparents. Prevention for these families and whānau is about interrupting intergenerational patterns of violence and the associated transmission of trauma. For Māori whānau, this will require Kaupapa Māori approaches, just as culturally responsive services and initiatives will be essential for everyone who requires help and healing.

If we intervene effectively with people who are using violence, then we prevent further family violence and can curtail the intergenerational transmission of trauma. In other words, a successful safety and protection response has potential preventative effects for current, hidden and future victims.

292 Victorian Government, *Royal Commission into Family Violence: Victorian Government Submission*, 2015, p. 11.

293 As outlined in Chapter 4, a consequence of colonisation was the profound alteration of the role, structure and functioning for many Māori whānau. The dispossession of land, language and traditional cultural values and practices have negatively impacted on many whānau – these important cultural imperatives promoted necessary connections, relationships and functions that served to protect women and children. An outcome is the increased vulnerability of many whānau to IPV, CAN and intrafamilial violence – destructive effects that have become normalised in those whānau and in some cases transmitted from generation to generation.

294 Findings from Ministry for Women research undertaken with Māori women about the concept of primary prevention raised a potential challenge of how to situate intergenerational violence (as seen from a Māori women's perspective) within the Western primary prevention framework. Ministry for Women, *Wāhine Māori, Wāhine Ora, Wāhine Kaha*, 2015.

Conversely, what is thought of as primary prevention work – for example, education programmes and public awareness-raising activities – will produce disclosures of violence that necessitate effective safety and restorative responses.²⁹⁵ Preventative work is intertwined with the need for intervention and restorative responses informed by the complex and pervasive impact of trauma and violence on victims and people using violence.

6.1.2 Prevention – addressing entrenched belief systems and structural inequity

Family violence cannot be prevented if it is understood as a psychological or relationship issue – the result of poor individual choices or deficit. A shift of focus to the social aspects that condone violence against women and children, and contribute to the entrapment of victims is required. Prevention involves:

- the development of strategies for addressing family violence at a societal level, including challenging the norms and practices that reinforce gender inequities and other forms of inequity²⁹⁶
- understanding how gender, race and class inequalities perpetuate family violence²⁹⁷
- understanding how a propensity to use violence as an adult can develop from exposure to adverse childhood experiences
- a critical examination of institutional structures that support dominant social norms and practices that make family violence acceptable.

A theme throughout this report is that the majority of those who are living with the most harmful levels of family violence and who experience the highest levels of entrapment are those sitting at the intersection of multiple axes of disadvantage – poverty, racism and sexism.

Those most at risk of finding themselves entrapped by abusive partners are marginalised Māori women and their children. Improving outcomes for these victims requires system transformation that incorporates Kaupapa Māori conceptual models of violence prevention.

Violence within Māori whānau is more than a coercive control issue – it remains entangled with the ongoing negative outcomes of colonisation. Achievement of whānau, hapū and iwi mauri ora²⁹⁸ requires rejecting the misconception that violence within whānau is normal and culturally acceptable. Early settlers' documentation reinforces an understanding by Māori of the importance of women and children in whānau and hapū, and the significant role men play in ensuring their safety and wellbeing. Moreover, values such as whakapapa, whanaungatanga, manaakitanga, tika, pono and aroha demand respectful interactions between people and children. Transformative practices based on Māori cultural traditions provide alternative and mana-enhancing ways of interacting with others. These are essential pathways for the prevention of violence and its intergenerational transmission.²⁹⁹

295 Those designing primary prevention programmes need to consider how disclosures can be encouraged and safely responded to.

296 World Health Organization, *Violence Prevention: The Evidence*, 2010.

297 L. Michau et al., 'Prevention of violence against women and girls: Lessons from practice', *The Lancet*, vol. 21, 2014, p. 3, [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)61797-9/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61797-9/abstract)

298 T. Kruger et al., *Transforming Whānau Violence – A Conceptual Framework. A Report from the Former Second Māori Taskforce on Whānau Violence*, 2004. T. Dobbs and M. Eruera, *Kaupapa Māori Wellbeing Framework*, 2014.

299 E Tu Whānau is a strengths-based Māori response to prevention. It urges communities taking responsibility and action to make changes and support whānau by reintroducing traditional values, like aroha, whanaungatanga, whakapapa, mana, manaaki, kōrero awhi and tikanga, to assist in strengthening whānau. The E Tu Whānau website offers a number of resources, including video links, that communities and whānau can refer to. The vision of E Tu Whānau, Te Mana Kaha o te Whānau, is 'Whānau are strong, safe and prosperous, living with a clear sense of identity and cultural integrity, and with control over their own destiny.' <http://etuwhanau.org/>

Pae Ora (healthy futures) for whānau, hapū and iwi require healthy and well whānau (whānau ora) together with healthy environments (wai ora) and individuals (mauri ora).³⁰⁰ This requires Māori to be a vital part of the transformation that informs culturally relevant service provision. While such services may be governed by Māori and delivered according to Māori cultural values and practices, they will be for the whole of the community and thus support community capacity for wellness and violence-free futures.³⁰¹

While Māori are over-represented with respect to family violence, family violence is experienced by many other women, children and men across our communities.

6.1.3 Government and community partnerships – building connected and protective communities

Communities are rightly considered a key site for the prevention of family violence. Family violence does not take place in a vacuum. It is a community problem, which needs a community response. Acknowledging community risks and protective factors is critical because the level of protection a person, family or whānau can access varies from community to community. Safety is impeded by inequities. Some communities experience an overwhelming number of risk factors without an equal balance of protective factors. These include low neighbourhood connectedness, lack of access to a range of health and social service resources (including MH&A services), high poverty and high indebtedness, unemployment and crime, making it more likely for members to experience multiple forms of violence, including 'institutional violence'.³⁰² These communities may not have the resources and capacity to take protective and preventative actions.

Many education campaigns are aimed at raising community awareness and mobilising communities to intervene and address family violence. A 'community-of-care approach'³⁰³ is required to enable the emergence of connected and protective communities who have the capacity to assist survivors, support abusive people in their journeys towards accountability, and provide safe and nurturing environments for children, women, men and whānau. Communities need resourcing in order to develop their capacity to take action.

The Government has a key role in collaborating with communities in order to build community capacity, provide wanted services and resources, and invest in education and skills development so people, especially non-abusive men, can take protective and preventative actions. Just as empowerment must be a collective endeavour, so must prevention.

300 Ministry of Health, *The Guide to He Korowai Oranga – Māori Health Strategy*, Wellington, Ministry of Health, 2014.

301 D. Grennell and F. Cram, 'Evaluation of Amokura: An indigenous family violence prevention strategy', *MAI Review*, vol. 2, Article 4, 2008.

302 See Appendix 1 for a definition of institutional violence as used in this report.

303 A 'community of care approach' is a holistic and encompassing way of working with victims of family violence that provides them with ongoing support from the community, as well as developing their awareness and skills for integrating back into the wider community. F. Pouesi., *Te Puawaitanga o te Ngākau: A case-study of Westside Counselling Services in West Auckland: A 'community of care' approach to working with Māori women and their whānau who have been impacted by domestic violence*, Master of Social Practice thesis, Unitec Institute of Technology, Auckland, 2011.

Example 10: Promising practice in the community

Developing community capacity through peer support

Informed by research with men and women with lived experience of overcoming the effects of family violence, Aviva's Purposeful Peer Support training programme develops the confidence and skills of women and men to provide effective informal support to others in their community. Informal peer support is an important source of guidance and hope.

www.avivafamilies.org.nz/Services/Peer-Support/

A community-accountability model to violence prevention³⁰⁴

Men Stopping Violence (MSV) in Atlanta has developed a community-accountability model for violence prevention and intervention.

MSV recognises that communities have been unwilling to own violence against women and children. Part of this denial has been the common strategy of sending individual violent men to non-violence programmes without attempting to examine and challenge the broader social context in which their violence takes place. MSV offers a six-month non-violence programme for men, but this programme represents only part of the larger work of the organisation. It advocates a paradigm shift from a primary focus on abusive men to one that provides all men with increased opportunities to work with women to make communities safer. This strategy has the greatest potential to increase the safety of women and children.

A significant proportion of MSV's work is focused on identifying, educating and organising male allies and potential male allies. This includes the following initiatives:

- The Because We Have Daughters initiative helps men look at life through their daughters' eyes, which heightens their awareness of the culture of violence and begins the dialogue necessary to create change.
- Community education and training: MSV provides community education presentations yearly to religious institutions, colleges, criminal justice organisations, non-profit organisations, corporations, government agencies and civic organisations.
- The Community Restoration Program provides a setting in which volunteers and men who have successfully completed the non-violence programme can give and receive support, complete community projects and educate the community about violence against women.
- The MSV Internship Program provides training for young men who are interested in becoming allies in the work to end violence against women. MSV provides mentors who demonstrate how to deconstruct long-held notions of manhood and support young men while they do the hard work of self-examination and advocacy.

MSV models a partnership approach between an organisation and the community. This approach offers a platform from which men can start to develop inroads into fostering community accountability.

www.menstoppingviolence.org

³⁰⁴ U. Douglas, D. Bathrick and P. Perry, 'Deconstructing Male Violence Against Women: The Men Stopping Violence Community-Accountability Model', *Violence Against Women*, vol. 14, no. 2, 2008, pp. 247-61, <http://www.menstoppingviolence.org/>

6.2 Conclusion – reframing family violence, a prerequisite for prevention

In this report, the Committee has discussed the need to change our collective story about family violence. Without change, we will continue to repeat inaccurate ways of thinking, which then contribute to potentially harmful ways of responding. We can, and must, interrupt this reinforcing and potentially fatal loop.

To do this we need to think differently about family violence. This includes reframing:

- family violence as a pattern of harm:
 - compounded by structural inequities
 - that is likely to have multiple victims – past, current and future
- IPV as a form of entrapment
- victims' responses to IPV as acts of resistance, not acts of empowerment
- IPV and CAN as entangled forms of abuse with entangled intervention opportunities
- safety and empowerment as collective endeavours, which are dependent on systemic responses to people using violence
- prevention as taking place in a pre-violence space, to being intertwined with restorative and safety responses.

If we are to prevent family violence, we need to stop asking what victims are doing to keep themselves and their children safe, and urgently start working in a myriad of ways with the people using violence. It is these people who perpetuate patterns of harm across generations.

A commitment to prevention is underpinned by investing in specialist family violence advocacy services and specialist services for people using violence. Kaupapa Māori services are essential.

We must also support practitioners struggling to respond safely and holistically within the current system, by developing integrated approaches. The complexities of people's lives affected by family violence require the development of multifaceted responses. Organisations and practitioners need to be part of an integrated family violence system.

To assist system integration, we have:

- suggested a reconfiguration of the current family violence workforce across four tiers of safety responses (supported by the necessary infrastructure)
- set out the shifts in thinking about the systemic response to family violence that would support such a movement
- identified how organisational responsiveness in the justice, child protection and MH&A sectors can be strengthened to contribute to victims' safety
- emphasised that opportunities to prevent family violence are embedded in every response to family violence.

Changing our collective story about family violence is a prerequisite to system reform and integration. Powerful strategies for prevention are transformations in the everyday conversations and actions of whānau, practitioners and community members. Regional reviews suggest the cumulative effect of seemingly small everyday responses can have profound effects on children's and adults' safety and wellbeing for generations.

Ultimately, the quality of our collective conversations uphold what is acceptable (and unacceptable) in our society and the actions we take in response. These conversations and responses will determine whether we effectively address family violence in Aotearoa New Zealand. We can lay the foundations today for interrupting the spiral of violence across generations. There is unprecedented will to make this a reality. Now is the time to act.

APPENDIX 1: GLOSSARY OF TERMS

The following is an explanation of key terms used in this document.

Child abuse and neglect (CAN)	CAN includes all forms of physical and emotional ill-treatment, sexual abuse, neglect and exploitation that actually or potentially harms a child's health, development or dignity. Within this broad definition, five sub-types can be distinguished – physical abuse, sexual abuse, neglect, emotional abuse and exploitation. ³⁰⁵ Children's exposure to intimate partner violence (IPV) is defined in section 3 of the Domestic Violence Act 1995 as psychological (emotional) abuse of the child and is therefore included in the definition of CAN.
Conflict	Conflict consists of disagreements within relationships. Conflict can be part of any relationship. Conflict is not abuse.
Deprivation	A lack of the socioeconomic resources necessary for positive health and social outcomes. The New Zealand Deprivation Index is commonly used to measure deprivation in neighbourhoods or geographical areas. It uses census data to calculate the degree of deprivation in geographical areas of approximately 81 people (referred to as meshblocks) using the following dimensions: access to internet at home; income derived from benefits; income; employment; qualifications; owned home; support (eg, single-parent family); living space; and access to a car. ³⁰⁶
Diagnostic change approach	An approach to change directed at diagnosing the problems and proposing a specific solution to those problems.
Dialogic change approach	An approach to change that focuses on changing how people think about an issue. Such an approach is thought to facilitate new ways of responding to the issue. ³⁰⁷
Entrapment	<p>The manner in which IPV inhibits a victim's resistance to, or escape from, the abuse. The use of coercive and controlling tactics (including isolation, threats and violence) by abusive partners entraps victims, preventing them from keeping themselves and their children safe (prior to or post-separation) or, in some instances, from leaving the relationship.</p> <p>Entrapment can also have social and structural dimensions. The quality of agencies' responses to victims' help-seeking and the inequities victims may be living with can compound their entrapment.</p> <p>Entrapment can be experienced individually and collectively.</p>
Equality	<p>An attempt to ensure responses to individuals are fair by assessing the sameness of either treatment or outcome for all people. Equality is a sameness measurement.</p> <p>Formal equality means treating everyone in exactly the same manner, regardless of their different circumstances.</p> <p>Substantive equality means treating people with different circumstances differently in order to arrive at the same outcome.</p>

305 World Health Organization at www.who.int/topics/child_abuse/en/

306 J. Atkinson, C. Salmond and P. Crampton, *NZDep2013 Index of Deprivation*, 2014, www.otago.ac.nz/wellington/otago069936.pdf

307 H. Bevan and S. Fairman, *The New Era of Thinking and Practice in Change and Transformation: A Call to Action for Leaders of Health and Care*, 2014, pp. 26-7.

Equity	Equity is founded in social justice and human rights, and is evident when all people have fair and reasonable access to opportunities to reach their full potential. ³⁰⁸ Equity acknowledges that disparities between groups in accessing essential resources and services are structural, rather than the result of individual or group deficit or choice. Equity requires different responses to groups that are differently placed. It also requires responses that acknowledge differences in culture, values and aspirations.
Family violence workforce	Those working in the multi-agency family violence system who have the opportunity and/or responsibility to prevent, identify and respond to individuals, families and whānau experiencing or perpetrating family violence. This includes both those working in specialist family violence advocacy services and those working in universal services, such as health or education.
Hidden and future victims	Hidden victims are those people who are affected by family violence (such as children living in a home where they are exposed to an abusive partner's behaviour) but whose experiences of abuse have not been identified by the agency or practitioner who is responding to violence within the family and whānau. Future victims are future partners or children (such as those in future relationships or the next generation) of a person who has a known history of perpetrating family violence.
Historical trauma	Trauma caused to groups and communities because of major historical events. For example, the processes and actions associated with the colonisation of indigenous people. If unaddressed, such trauma is transmitted from generation to generation, resulting in contemporary lifetime trauma, chronic stress, discrimination and family violence. ³⁰⁹
Inequity	The presence of socially unwarranted, avoidable or remediable differences among populations or groups defined socially, economically, demographically or geographically. Inequities result from unjust social structures that lead to the exclusion and marginalisation of some groups. ³¹⁰
Institutional violence	Discriminatory behaviours in the delivery of resources and services by institutions responsible for providing those resources or services to people who need and qualify for them.
Integrated system	A whole-of-system approach, supported by infrastructure, that enables agencies to respond as a single system when a family violence episode is reported to any one agency. ³¹¹ The infrastructure of an integrated system includes a shared understanding of family violence national and regional governance structures, shared practice principles, nationally consistent information-sharing processes, organisational and professional accountabilities, investment that builds capability and sustainability, and common risk assessment and response frameworks that enable safe and culturally responsive practice.
Integrative practice	Non-hierarchical and interdisciplinary practice that is person-centred and/or whānau-centred. Collective practice that seamlessly meets the multiple needs of individuals and whānau affected by family violence.

308 P. Braveman and S. Gruskin, 'Defining equity in health', *Journal of Epidemiology and Community Health*, vol. 57, no. 4, 2003, pp. 254-8.

309 K.L. Walters et al., 'Bodies don't just tell stories, they tell histories: Embodiment of historical trauma among American Indians and Alaska Natives', *Du Bois Review: Social Science Research on Race*, vol. 8, no. 1, 2011, pp. 179-89.

310 L. Reutter and K. Kusher, "'Health equity through action on the social determinants of health": Taking up the challenge in nursing', *Nursing Inquiry*, vol. 17, no. 3, 2010, pp. 269-80.

311 R. Herbert and D. Mackenzie, *The Way Forward*, 2014.

Intergenerational abuse	A pattern of interpersonal violence, abuse and/or neglect that, if unaddressed, is repeated from one generation to the next.
Intersectionality	The understanding that different forms of disadvantage combine to produce unique forms of disadvantage. For example, the experience of racism and sexism <i>in combination</i> produce experiences for Māori women that are both qualitatively and quantitatively different from those experienced by Pākehā women or Māori men.
Intimate partner violence (IPV)	<p>Coercive and controlling behaviours³¹² within an intimate relationship (including current and/or past live-in relationships or dating relationships).</p> <p>Coercion involves the use of force or threats to intimidate or hurt victims and instil fear. Control tactics are designed to isolate the victim and foster dependence on the abusive partner. Together these abusive tactics inhibit resistance and escape.</p> <p>Coercion tactics:</p> <ul style="list-style-type: none"> • Violence – assaults, severe beatings, strangulation, sexual violence and use of weapons and objects to inflict injury or death. • Intimidation – threats, jealous surveillance, stalking, shaming, degradation and destruction of property. This can include violence directed at children and pets/animals. <p>Control tactics:</p> <ul style="list-style-type: none"> • Isolation – restricting the victim’s contact with family, whānau, friends and networks of support, monitoring their movements and restricting their access to information and assistance.³¹³ • Deprivation, exploitation and micro-regulation of everyday life – limiting access to survival resources (such as food, money, and cell phones) or controlling how victims dress.
Kaupapa Māori family violence service	Family violence services in which Māori worldviews, tikanga (cultural processes and practices) and concepts (such as whakapapa, mana, wairua, and manaaki) inform whānau violence prevention and Whānau Ora strategies. These services primarily work with Māori wāhine (women), tāne (men), and tamariki and taiohi (children and young people), and their whānau, hapū and iwi affected by family violence.
Predominant aggressor	The person who is the most significant or principal aggressor in an IPV relationship, and who has a pattern of using violence to exercise coercive control.
Prevention	Stopping the occurrence and re-occurrence of violence within intimate relationships, families, whānau and communities.
Primary prevention	The prevention of family violence before there is any evidence of violence having occurring in families or whānau. This would include supports for parents, addressing stressors like poverty and initiatives that support the development and maintenance of healthy family relationships.
Primary victim	The person who (in the abuse history of the relationship) is experiencing ongoing coercive and controlling behaviours from their intimate partner.

312 E. Stark, *Re-presenting Battered Women: Coercive Control and the Defense of Liberty*, paper prepared for Violence Against Women: Complex Realities and New Issues in a Changing World Conference, 29 May to 1 June 2011, Montreal, Québec, Canada, Québec, Les Presses de l’Université du Québec, 2012.

313 E. Krug et al. (eds.), *World Report on Violence and Health*, Geneva, World Health Organization, 2002.

Regional review	A subset of all family violence deaths is selected for in-depth review. Reviews are undertaken by regional panels comprising representatives from the key agencies involved in the family violence response, along with family violence and cultural experts.
Resistance	IPV victims employ a range of strategies to counter the abuse that they experience. These strategies may be overt (such as 'fighting back' to protect themselves and children) or covert (eg, using alcohol to block out the experiences of abuse). A victim's resistance does not stop the abusive partner's use of violence.
Response-based practice	<p>Practice focused on examining people's social interactions in their social context. Response-based practice specifically looks at the microanalysis of social interaction; for example, examining the way language is used by practitioners to frame family violence. Language can:</p> <ul style="list-style-type: none"> • conceal the extent of the abuse • minimise the abusive person's responsibility for the abuse • blame and pathologise victims • conceal a victim's resistance to abuse.³¹⁴ <p>This, in turn, produces practice responses that do not adequately respond to the harm caused and the danger presented by the person using violence. It also produces practice responses which hold the victim responsible for the abuse.</p> <p>Language can be used more judiciously to:</p> <ul style="list-style-type: none"> • reveal the abuse • clarify the abusive person's responsibility for the abuse • contest the blaming and pathologising of victims • elucidate victims' responses and resistance.
Specialist family violence advocacy service	A non-governmental organisation (NGO) whose core focus is family violence and which offers wrap-around services that address the safety needs of children and youth, adults and/or families/whānau experiencing violence. Managers and advocates have knowledge, skills and expertise in family violence. Service provision can include working with abusive partners/parents or working in partnership with services engaged with those using family violence.
Structural inequity³¹⁵	Structures that promote unequal, inequitable or discriminatory responses to people belonging to groups that are socially disadvantaged.

314 L. Coates and A. Wade, 'Language and violence: Analysis of four discursive operations', *Journal of Family Violence*, vol. 22, no. 7, 2007, pp. 511-22.

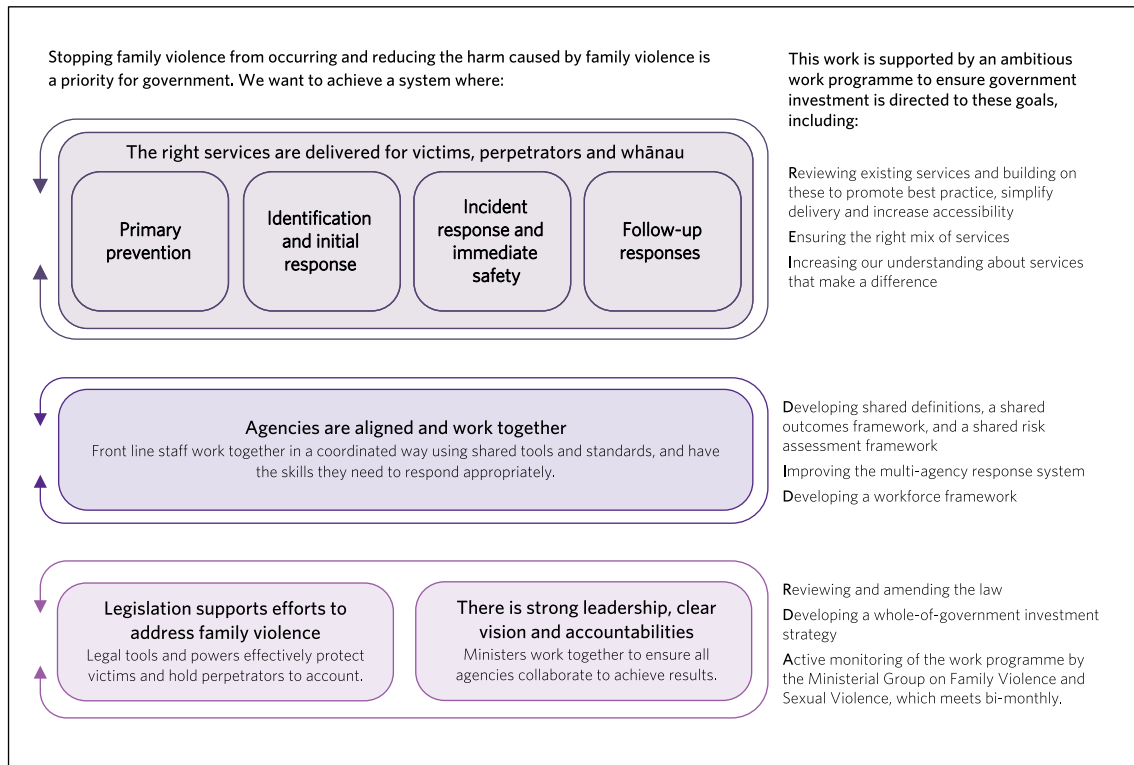
315 Structural inequity is also sometimes referred to as structural violence

<p>Torture</p>	<p>An act intended to inflict severe pain or suffering, whether physical or mental, on a person for one of the following purposes:</p> <ul style="list-style-type: none"> ▪ obtaining from her/him or a third person information or a confession ▪ punishing her/him for an act she/he or a third person has committed or is suspected of having committed ▪ intimidating or coercing her/him or a third person ▪ for any reason based on discrimination of any kind. <p>Such pain or suffering must be inflicted by, at the instigation of, or with the consent or acquiescence of a public official or other person acting in an official capacity.³¹⁶ An agency may be considered to have ‘acquiesced’ in the infliction of pain and suffering on the victim when they are aware of the abuse but fail to respond.</p>
<p>Victim empowerment</p>	<p>A philosophy directed at supporting individual adult victims of IPV to take action to address their partner’s use of violence.</p>
<p>Whānau Ora</p>	<p>A holistic approach to the provision of services that is grounded in Māori cultural concepts and practices. Whānau Ora focuses on the aspirations of the whānau and achieving wellbeing and the best outcomes for the whānau as a collective and its members. Whānau Ora requires tailored approaches that draw on a range of services and strategies; for example, involving health, education, housing and work and income to assist whānau in meeting their employment, relationships and wealth aspirations and needs.</p> <p>The principles of Whānau Ora include:</p> <ul style="list-style-type: none"> ▪ recognising the whānau as a collective entity ▪ endorsing the whānau’s capacity for self-determination ▪ having an intergenerational dynamic ▪ building on a Māori cultural foundation ▪ asserting a positive role for whānau within society ▪ involving a wide range of social and economic sectors.

316 United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

APPENDIX 2: CROSS-GOVERNMENT FAMILY VIOLENCE WORK

Whole-of-government work programme to reduce family violence³¹⁷



New Zealand Police Internal Family Violence Change Programme

The New Zealand Police Internal Family Violence Change Programme began in March 2015. The programme focuses on assessing and improving New Zealand Police's response to and investigation and resolution of family violence. This includes improving existing initiatives and introducing innovations within New Zealand Police to reduce family violence harm in communities, delivering better services and outcomes for victims and their families.

Initiatives New Zealand Police has progressed in 2015 include the following:

- **Family violence summary report** – New Zealand Police and the Ministry of Justice have developed this report for use in all family violence-related bail hearings. The report improves the information provided to judges and registrars when they make bail decisions in family violence cases. A three-month pilot in two courts commenced 1 September 2015. The pilot will be reviewed after three months and, if successful, rolled out nationally in 2016.
- **Improved practice initiatives** on the ground, including Waikato's Family Safe Network. This is testing a family intervention team, with co-location with community agencies and a new model of operation.

³¹⁷ Ministry of Justice, *Strengthening New Zealand's Legislative Response to Family Violence: A Public Discussion Document*, 2015, p. 8.

- Advancing a technology trial to look at **capturing video evidence** on mobility devices at the scene of family violence incidents, with the aim of providing better services for victims, increased efficiencies and better-quality information.
- **Quality Assurance and Improvement Framework** – building in a culture of quality investigation, through integrating assurance, improvement and monitoring across all stages of the family violence investigation process, commencing January 2016.
- **Training** for all sergeants and senior sergeants designed and successfully piloted. This fosters a positive mindset to ensure all New Zealand Police employees carry out effective responses and interventions to reduce family violence harm. National implementation will be completed in 2016.

Eight further projects in the change programme are also underway.

APPENDIX 3: STRENGTHENING NEW ZEALAND'S LEGISLATIVE RESPONSE TO FAMILY VIOLENCE

The Committee's submission on the Ministry of Justice's *Strengthening New Zealand's Legislative Response to Family Violence: A Public Discussion Document* suggested the inclusion of principles in the Domestic Violence Act 1995. These principles could support the practice shifts required to provide an integrated response that is focused on victim safety.

The principles follow:

- Children's safety is paramount. Children exposed to family violence require support.³¹⁸
- The autonomy of the victim is respected but the protection and safety of the adult victim is paramount.
- Curtailing the perpetrator's ongoing abuse is central in achieving safety for child and adult victims.
- Practitioners are not responsible for the abuse; however, they are responsible for maximising the safety and wellbeing of victims.
- Practitioners need to be able to ensure culturally responsive practice.
- Responses to Māori should recognise cultural needs and offer a whānau-based delivery model grounded in tikanga.
- Practitioners must respond to family violence as an ongoing pattern of harm.
- Practitioners must work together to curtail perpetrators' abuse and maximise victims' safety.
- Practitioners must utilise evidence-based risk assessments to inform their responses and risk management strategies.
- Agencies must integrate their responses to family violence and ensure their workforce is capable of responding safely and appropriately.

318 FVDRC regional death reviews indicate this is not taking place.

APPENDIX 4: CRIMINAL JUSTICE ISSUES

Prosecutorial decisions

When victims' interests are mentioned in the Solicitor-General's Prosecution Guidelines for Crown Law 2013, they feature solely in terms of the 'impact of the offending' on the victim.³¹⁹ The victim's ongoing safety does not receive mention.³²⁰

When making decisions about plea arrangements, prosecutors are required to give victims the opportunity to make their views known where 'practical and appropriate' (18.5). However, 'while victims' rights are an integral part of the criminal justice system, ultimately the prosecutor should make decisions based on the broader public interest and interests of justice' (18.5). Plea arrangements can be contemplated when the charges filed are 'clearly supported by evidence' (18.6). The overarching consideration is 'the interests of justice' (18.6). Relevant considerations are whether the charges 'adequately reflect the essential criminality of the conduct' and 'provide sufficient scope for sentencing to reflect that criminality' (18.6.1-2).

The New Zealand Police guidelines³²¹ for prosecuting family violence are more detailed and provide greater scope for considering victim safety when deciding whether prosecution is in the public interest and what the offender should be charged with. For example, when considering what charges would properly reflect the nature of the offending, the prosecutor is directed to 'locate the behaviour within the family violence battering cycle' and consider whether the charges reflect 'the continuing risk they pose to their victims'. No plea bargaining is permitted for protection order breaches, but otherwise considerations similar to those set out in the Solicitor-General's Prosecution Guidelines for plea bargaining are contained in the New Zealand Police guidelines for prosecuting family violence cases.

Bail

Section 7(2) of the Bail Act 2000 gives the defendant an automatic right to bail if they are charged with an offence for which the maximum punishment is less than three years' imprisonment. There is an exception to this rule where the offence is against section 194 of the Crimes Act 1961 (assault on a child, or by a male on a female) or section 49 of the Domestic Violence Act 1995 (contravention of a protection order). There is no exception for common assault (section 196). As a result, if a defendant is charged with common assault rather than 'male assaults female', he is automatically entitled to bail.

If the defendant does not have a right to bail, there is still a presumption that he will get bail unless 'there is just cause for continued detention' (section 7(5)). If a defendant is charged with an offence under section 49 of the Domestic Violence Act 1995 (breach of a protection order), when deciding if there is just cause to deny bail, 'the court's paramount consideration is the need to protect the victim of the alleged offence'. It is not clear why this provision does not extend to other family violence offences (such as interpersonal violence offences that are not accompanied by charges for the breach of a protection order).

If the offending involves a sexual assault, a serious assault or another kind of offence that has led to the victim 'having ongoing fears, on reasonable grounds for his or her physical safety or security' then the prosecutor is required to make all reasonable efforts to ascertain the victim's views on whether bail should be granted.³²² The court is required to take these views into account³²³ when deciding whether

319 When making decisions whether or not to prosecute, the impact of the offending on the victim is a relevant consideration (5.8.11, 5.8.12) and the prosecutor is obliged to assist the sentencing court by providing 'The impact on any victims of the offending' (21.2.3). Crown Law, *Solicitor-General's Prosecution Guidelines*, Crown Law, 2013.

320 Although note that whether the offending is likely to be continued or repeated, particularly when there is a history of recurring conduct, and the offender's past convictions, diversions or cautions is a public interest consideration in deciding whether or not to prosecute under 5.8.3 and 5.8.5.

321 New Zealand Police, *Prosecuting family violence policy*, New Zealand Police, 2014.

322 Section 30, Victims' Rights Act 2002.

323 Section 29, Victims' Rights Act 2002.

to release the defendant on bail. Unfortunately, this places responsibility on the victim to express opposition to bail if she does not feel safe having the defendant in the community, something it may not always be safe to do. It is not clear why victim safety is not a mandatory consideration in all family violence cases, with an obligation to take reasonable steps to seek the victim's views. This would give victims the opportunity to express their opinions without bearing all the responsibility for articulating safety concerns.

In all cases, when deciding if there is reason to deny bail, the court is directed to consider whether the defendant may 'interfere with witnesses' or 'offend' whilst on bail (section 8(1)(a)(iii)). And, when considering this, the court is entitled to take into account 'the character and past conduct or behaviour, in particular proven criminal behaviour of the defendant' (section 8(2)(d)). Arguably, this entitles the court to consider the defendant's past patterns of coercive and controlling behaviour in relation to those he is in a relationship with when making a decision as to whether his abusive behaviour is likely to continue if he is permitted to remain in the community prior to trial. If a particular judge has an incident-based understanding of family violence and does not understand the concept of coercive control, this is not guaranteed. The implication is that past abusive behaviour which has not resulted in a criminal conviction may be considered, but does not have the same weight as that which has resulted in a conviction.

There are specific provisions in the Bail Act 2000 dealing with repeated proven criminal offending. Under section 10, if a person is charged with a 'serious offence' and has a prior conviction for a 'serious offence' (as specified in section 10(2), including serious violence offences under sections 167, 168, 171, 173, 188, 189 and 191 of the Crimes Act 1961), the defendant must establish that they will not, whilst on bail, commit any offence involving violence against another person. Furthermore, the 'need to protect the safety of the public, and where appropriate, the need to protect the safety of the victim or victims of the alleged offending are primary considerations' for the judge. Section 12 applies to an offender who is charged with an offence that carries a maximum sentence of three years and was either:

- at the time of the offending remanded on bail or awaiting trial for previous such offence and had previously received a sentence of imprisonment; or
- had previously been convicted of an offence that was committed whilst they were on bail or remanded at large carrying a maximum sentence of three years and had previously received 14 or more sentences of imprisonment.

In such instances, the defendant has the burden of satisfying the judge that they will not whilst on bail commit an offence involving violence against or danger to the safety of another person. The 'need to protect the safety of the public, and where appropriate, the need to protect the safety of the victim or victims of the alleged offending are primary considerations' for the judge.

Sentencing

Under the Sentencing Act 2002, victim safety is not a mandatory consideration when sentencing in family violence cases. As a result, whilst individual judges who are knowledgeable about family violence can use aspects of the legislation to give expression to victim safety, this will not automatically occur in all cases. There is also a range of other (potentially countervailing) considerations set out in the Act.

Section 7 of the Sentencing Act 2002 describes the 'purposes' for which a court *may* sentence or otherwise deal with an offender. Most of these deal with reacting to past harm.³²⁴ Three are relevant to victim safety (although none is specifically directed at family violence or mandatory for judges to consider). The court may 'provide for the interests of the victim of the offence' (section 7(c)). The interests of the victim arguably include her ongoing safety. The court may sentence to 'deter the offender ... from committing the same or a similar offence' (section 7(f)). Preventing the offender from continuing harmful patterns of relating in respect of current or future family members would clearly

³²⁴ Holding the offender to account (section 7(a)), getting the offender to take responsibility for or acknowledge the harm that they have done (section 7(b)), providing reparation for harm done (section 7(d)) and denouncing the offending (section 7(e)).

enhance victim safety. Finally, the court may 'protect the community from the offender' (section 7(g)). Current and future victims of the offender's family violence offending are presumably included within the 'community' that needs protection.

Section 8 of the Sentencing Act 2002 sets out the 'principles' which the court *must* consider when sentencing an offender. Most of these relate to the gravity and seriousness of the offence which has taken place (including consistency with other similar cases) (section 8(a)–(e), (g)), matters personal to the offender (section 8(h)–(i)) or the outcomes of any restorative justice processes that have occurred (section 8(j)). Only one concerns victims: the court 'must take into account any information provided to the court concerning the effect of the offending on the victim' (section 8(f)). This is directed at considering the impact on the victim of the offending that has already taken place – not her future safety.

Section 9 requires the court to take into account a number of aggravating factors (if they are relevant to the facts). The majority of these are concerned with aspects of the offending that has taken place (section 9(a)–(i)). Victim vulnerability because of age (section 9(g)), or the offender's position of authority or trust (section 9(f)) or violence involved in the offending (section 9(a)) and harm caused by the offending (section 9(d)) can be considered. The offender's overall pattern of offending can only be considered if it consists of 'previous' or concurrent 'convictions' (section 9(j)). Patterns of past behaviour that have not resulted in convictions or the need to protect the victim from future harm are not aggravating factors at this point.

Mitigating factors that the court is obliged to consider 'if they are relevant' include 'any remorse shown by the offender' (section 9(2)(f)).

Restorative justice at sentencing

In all cases before the District Court where there has been a guilty plea, section 24A of the Sentencing Act 2002 requires proceedings to be adjourned so inquiries can be made by a 'suitable person' to 'determine whether a restorative justice process is appropriate in the circumstances of the case, taking into account the wishes of the victims'. As noted above, it is mandatory under section 8(j) for the court to consider the outcome of any restorative justice process when sentencing the offender.

Concerns have been expressed that, in a situation involving ongoing offending, victims may feel implicitly pressured to agree to participate in a restorative justice process in order to minimise the consequences for the person using violence at sentencing. Concerns have also been expressed that, in the absence of skilled support, they will be given responsibility for holding him to account or feel pressured to agree to an outcome during the restorative justice process that results in a more lenient sentence.

Whilst there might be value in carefully designed restorative justice interventions in relation to one-off or historical offending, there may be the need for stronger evidence of improved outcomes, in terms of victim safety and satisfaction, and reduced recidivism, before restorative justice responses are routinely used in situations that involve ongoing offending.³²⁵ Such interventions are a concern in family violence cases where remorse and apology can be part of the abuse process and where offender programmes in Aotearoa New Zealand do not accord with international standards of safe practice.

325 J. Stubbs, 'Gendered violence and restorative justice', 2014.

APPENDIX 5: CHILD PROTECTION ISSUES

The specific parenting domains used to direct practice responses to IPV in the Tuituia framework are reproduced below (with emphasis added). These could be better supported by descriptors and practice triggers specific to the effects of IPV victimisation and perpetration.

Kaitiaki Mokopuna³²⁶ (assessing capacity to care) sub-domain scale descriptors

Kaitiaki Mokopuna involves determining whether or not a parent or usual caregiver is able or has the potential to safely care for the child or young person.

Safe parenting factors

Personal resilience

10	Recognises, believes in and uses own strengths to bring about change. Sets goals and is able to work towards achieving them. Has a philosophy that guides action and makes sense of life. Is helpful and hopeful, has trust and faith in others. Possesses a range of effective problem-solving skills and uses a variety of healthy ways to deal with stress.
5	Confidence in their ability to manage stress and bring about change is increasing. There is evidence that they manage stressful situations appropriately but this is inconsistent.
1	Does not recognise or believe in own strengths or ability to bring about change. Unable to set and achieve goals. Has no hope/positive outlook/ability to see the positive side, does not trust or have faith in others. Uses predominantly unsafe and risky mechanisms to deal with stress or refuses/avoids dealing with problems.

Safety and basic care

Protecting from harm & risk

10	Fully protective and capable of identifying risk. Actively encourages safe behaviour amongst children, young people and adults. Actively supports the child or young person in their care and takes responsibility for supporting healthy, safe, pro-social behaviour.
5	Is protective and supportive some of the time.
1	Is or has been abusive and/or neglectful towards the child or young person or other children/young people. Does not protect them from others and/or situations that pose a risk. Has had a child/children removed from their care. Does not support the child or young person in their care and takes no responsibility for supporting healthy and safe behaviour. Condone and/or supports offending behaviour.

Partner relationships

10	Relationships are violence free, supportive, stable and capable of dealing with crises and the challenges of parenting.
5	Frequency and severity of conflict and/or violence is reducing. There is recognition that problems exist and help has been sought. Change is beginning to occur but is inconsistent and ongoing support is required.
1	There is frequent and severe conflict, and mutual support is rarely exhibited. Violence occurs on a regular basis and this has impacted the adult's ability to interact warmly and predictably, problem solve, deal with stress, care for self and meet the wellbeing needs of the child or young person in their care. There may be frequent changes of partner.

326 www.practicecentre.cyf.govt.nz/policy/assessment-and-decision-making/key-information/assessing-kaitiaki-mokopuna.html#WhatguidesaKaitiakiMokopunaassessment1

Safe and Together domestic violence informed continuum of practice

David Mandel³²⁷ has developed a continuum of domestic violence practice for child welfare services. The continuum is designed to support organisational responsiveness to adult and child victims, and perpetrators of domestic violence. Mandel's work focuses on supporting child welfare and other systems to develop their capacities and competencies to intervene more effectively with family violence perpetrators.

	Domestic Violence Destructive	Domestic Violence Neglectful	Domestic Violence Pre-Competent	Domestic Violence Competent	Domestic Violence Proficient
DEFINITION	Primarily defined by identifiable policies and practices that either actively increase the harm to adult and child survivors of domestic violence and/or make it harder for them to access support and assistance.	Primarily defined by identifiable policies and practices that reflect a lack of willingness or ability to intervene with domestic violence and/or fail to acknowledge how domestic violence's distinct characteristics impact children and families.	Primarily defined by an identifiable gap between the stated relevance and prevalence of domestic violence to the safety and wellbeing of families and child welfare's actual domestic violence policy, training practices, and services infrastructure.	Primarily defined by identifiable policies and practices that use a child-centered perpetrator pattern and survivor strength-based approach to domestic violence. Domestic violence isn't perceived as an add-on, but instead as a core part of child welfare practice.	Primarily defined by identifiable policies and practices that ensure that domestic violence policies and practices are consistent, dependable, and used throughout the child welfare system.
STATEMENT	"Regardless of the cost, the adult domestic violence survivor must make sure that the children are protected from the violence."	"Domestic violence is only relevant to the children if they see it or hear it. If the couple separates, there are no more domestic violence-related concerns."	"We don't want to re-victimise adult survivors, but our job is child safety" or "We know we need to do a better job with domestic violence cases, but we don't know how to do it."	"The perpetrators' behavior patterns and choices are the source of the child safety and risk concerns" and "Our goal is to keep children safe and together with the domestic violence survivor."	"We cannot achieve our mission around safety, permanency, and the wellbeing of children without being informed about domestic violence throughout our child welfare system."

327 The *Safe and Together Model Suite of Tools and Interventions* is a perpetrator pattern-based, child-centred, survivor strengths approach to working with domestic violence. <http://endingviolence.com/our-programs/safe-together/safe-together-overview/>

	Domestic Violence Destructive	Domestic Violence Neglectful	Domestic Violence Pre-Competent	Domestic Violence Competent	Domestic Violence Proficient
POTENTIAL OUTCOMES	<p>The risk of harm to adult and child domestic violence survivors from the domestic violence perpetrator is increased.</p> <p>The willingness of adult and child survivors to reach out for assistance, e.g. calling the police if there is a new incident of violence, is reduced.</p> <p>The power that domestic violence perpetrators have over their families is increased.</p> <p>Children may be removed unnecessarily from domestic violence survivors.</p> <p>Child welfare systems expend resources for the unnecessary placement of children.</p> <p>Poor families and families of color are more likely to experience unnecessary economic and family stress due to a focus on resolving the violence by “ending the relationship.”</p> <p>Children who attempt to protect one parent from another become caught in the delinquency system.</p>	<p>Assessments of families are incomplete and/or inaccurate and often focused on substance abuse and mental health issues instead of domestic violence.</p> <p>Domestic violence interventions with families do not occur until the violence escalates.</p> <p>When they do occur, these interventions are more likely to be inappropriate and/or ineffective, e.g. a referral to an anger management program when the correct referral is to a men’s behavior change program.</p> <p>Decisions made in court can be based on incomplete or incorrect information.</p> <p>Partnerships with adult domestic violence survivors that focus on the safety and wellbeing of the children are weakened by poor practice.</p> <p>Poor women and women of color are more likely to suffer from inadequate or incomplete legal representation or evaluation.</p>	<p>The commitment to improve current practice is weak because it is driven by outsiders encouraging/expecting/demanding improvements.</p> <p>Token change results in no or little real change in paradigm or practice.</p> <p>Child welfare workers are made more aware of the impact of domestic violence on children, but they are not fully equipped to help, resulting in anxiety and unpredictable decisions.</p> <p>Tensions remain between domestic violence agencies and child welfare, interfering with their collaborative work to assist families.</p> <p>Domestic violence perpetrators continue to escape responsibility as parents.</p> <p>A lack of a perpetrator pattern-based approach increases the likelihood that domestic violence perpetrators with privilege will gain dangerous access to children.</p> <p>Fatherhood programming might increase the unsafe access of some domestic violence perpetrators to their children and families.</p>	<p>Child welfare interventions with domestic violence cases are based on more comprehensive and accurate assessments.</p> <p>Children are more likely to remain safe and together with adult domestic violence survivors.</p> <p>Unnecessary out-of-home placements are reduced, resulting in stronger families and communities and more costs saved by child welfare systems.</p> <p>Dependency courts may experience a reduction in domestic violence-related cases.</p> <p>Men of color and poor men who are domestic violence perpetrators may experience more support to improve their parenting and remain safely engaged with their children and families.</p> <p>Child welfare workers and others may experience more workplace satisfaction due to a new paradigm that allows them to practice in ways that are consistent with their social work values.</p>	<p>Cross-system collaboration is improved when stakeholders use common frameworks and languages.</p> <p>Domestic violence and child welfare agencies may experience a reduction in tension and/or improved collaboration.</p> <p>There may be a reduction in domestic violence-related child deaths.</p> <p>Initiatives such as trauma-informed practice and differential responses are more likely to be successful.</p> <p>Adult and child domestic violence survivors are more likely to see the child welfare system as a resource and a support.</p> <p>Vulnerable new parents and delinquent youths are more likely to receive support and assistance for domestic violence issues.</p> <p>The commitment to a perpetrator pattern-based approach may reduce biases in cases involving women’s use of violence, same sex relationships, and vulnerable populations.</p>

APPENDIX 6: FAMILY VIOLENCE DEATH REVIEW COMMITTEE MEMBERS

Current membership

Name	Position	Organisation
Julia Tolmie (Chair)	Associate Professor of Law	University of Auckland
Dawn Elder (Deputy Chair)	Professor of Paediatrics and Child Health	University of Otago, Wellington
	Paediatrician	Capital & Coast DHB
Denise Wilson (Deputy Chair)	Professor Māori Health	Auckland University of Technology
Jane Koziol-McLain	Professor of Nursing	Auckland University of Technology
Fiona Cram	Director	Katoa Ltd
Pamela Jensen	Barrister & Solicitor	Jensen Law
Paul von Dadelszen	Retired District and Family Court Judge	
Miranda Ritchie*	National Violence Intervention Programme Manager	Health Networks Ltd

*Miranda Ritchie resigned from the Committee in November 2015.

Past members

Fia Turner, Ngaroma Grant (Deputy Chair), Barry Taylor, Wendy Davis (Inaugural Chair), Brenda Hynes, Patrick Kelly, George Ririnui, Alison Towns, Rob Veale and Vaoga Mary Watts.

Advisors

The Committee is also supported by advisors from Coronial Services, Department of Corrections, Ministry of Health, Ministry of Justice, Ministry of Social Development, New Zealand Police, the Office of the Children's Commissioner, Ministry of Education, the National Collective of Women's Refuges, the National Network of Stopping Violence Services and Jigsaw.

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**Family Violence Death
Review Committee**



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