

THE WAY FORWARD

An Integrated System for Intimate
Partner Violence and Child Abuse and
Neglect in New Zealand

JULY 2014

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Citation: Herbert, R. and Mackenzie, D. 2014. *The way forward - an Integrated System for Intimate Partner Violence and Child Abuse and Neglect in New Zealand*. Wellington, The Impact Collective.

Published July 2014.

Available at www.theimpactcollective.co.nz



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This document has been developed by The Impact Collective, a consultancy focused on intimate partner violence and child abuse and neglect, in partnership with Violence Free Network Wairarapa (VFNW), an interagency network of providers working to eliminate family violence in the Wairarapa region.

The authors¹ have been partially funded by a grant VFNW received from the Working More Together Fund - He Pūtea Mahi Tahī,² a fund set up by leading philanthropic trusts in New Zealand to promote interagency collaboration, but have also contributed a significant amount of their time voluntarily to produce this document. The extent of the analysis contained in the document is therefore limited. Further work to more fully develop the model would require additional funding.

We propose the establishment of a new evidence based model to better address the epidemic of intimate partner violence and child abuse and neglect in New Zealand and provide a business case to support this proposal. However this does not mean it is the only model that could work. We would like this document to help people 'come to the table' with a shared understanding of why a change in approach is needed, why we need to act now and how an integrated system would help us effect long term, sustainable change.

A cornerstone of the concept of 'collective impact' is that input from many sources is encouraged when designing solutions and initiatives. We hope that our proposal will help prompt a collective conversation among funders, policy makers, service providers, service users and local communities that can help shape the model as it is developed and implemented.

The authors are neither economists nor financial experts - we would welcome a critique of our calculations by those who are.

We acknowledge that a vast amount of impressive work is being done every day by many dedicated individuals, organisations and communities and we hope that our proposal will show them how their efforts can have more positive results in reducing intimate partner violence and child abuse and neglect in New Zealand.

¹ Refer to Appendix 1 for a bio of each author.

² <http://www.workingtogether.org.nz/>

Acknowledgements

We wish to thank the following people whose input has been integral to the design of the new model and the compilation of this document.

Kirsty Peel for her critical thinking and for helping to bring our ideas to life in this document; in particular for taking so many complex details and portraying them so effectively in diagrammatical form.

Gerry Brooking, Jeremy Logan and the Violence Free Network Wairarapa for embracing our vision of an Integrated System and their commitment to walking this journey with us.

Jessica Trask for her ideas and enthusiasm in the months of planning and preparation that preceded the writing of the document and the moral support she gave while on maternity leave as we wrote the report.

Bill Ryan for his input, wisdom, guidance and support throughout the journey; from concept through to the final stages of producing this document.

On 2 August 2006, retiring Governor-General Dame Silvia Cartwright used her farewell speech to contrast New Zealand's peaceful image abroad with the 'nightmare' of violence at home. She said she hoped New Zealand's '*dark secrets*' would never become known internationally.

She said New Zealand needed *'to focus for a while on the problems at home, and concentrate our world-class skills on resolving these issues that are our nightmare in the otherwise beautiful and peace-loving country we live in'*.

Eight years on and Dame Silvia's words are just as relevant. It is now time to concentrate our collective efforts to implement a new model to enable us to address this nightmare.

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Executive Summary

New Zealand has an epidemic of intimate partner violence (IPV) and child abuse and neglect (CAN). This fact is well known and there is widespread acceptance that IPV and CAN are among New Zealand's biggest social issues.

Over the past 20 years there have been countless formal groups, meetings, conferences, strategies, reviews, and investigations into the prevalence and problem of IPV and CAN in New Zealand undertaken by government, non-government agencies and academics. There have been hundreds of reports identifying the problem and areas that need to be addressed. There have been action plans containing an endless stream of largely one-off initiatives or new developments.

Yet despite the plethora of documents, a strong legislative framework and the efforts of successive governments and many NGOs that have strategised and delivered services to try and 'fix' the problem, real improvements seem to remain elusive. New Zealand has not made significant traction in responding to or reducing the problem.

It is time to think and act in a new way

In this document we are taking a fresh approach - we do not want to relitigate the problem or make recommendations for yet more remedial 'quick fixes'. We don't want this document to be yet one more report for the filing cabinet.

We want to talk about what needs to be done to see real long term sustained change happen. The Integrated System model proposed in this document is not a strategy or a new service initiative - it focuses on the infrastructure needed in order for sustained and long term change to happen. We do not provide options or recommendations; rather, we provide a proposal for the way forward and we believe this is New Zealand's only option if we want to successfully deal with the problem of IPV and CAN.

When we started out independently to design the Integrated System model we were not associated with the Wairarapa Violence Free Network. As part of our desire to test our ideas at the local level, we approached them, aware that they are seen as one of the most progressive regions in New Zealand with respect to IPV and CAN. They jumped on board, embraced our ideas and made a commitment to work with us to show government what needs to be done. We are now jointly engaged in showing New Zealand the way forward.

In order to present our proposal for change we firstly need to examine the issue - but we do that in order to show the scale and the complexity of the problem and why efforts to date have not made a difference.

In New Zealand the epidemic of IPV and CAN and its negative effects are spreading rapidly - from one person to another and from one generation to another like an infectious disease. However, with IPV and CAN, transmission is more complex than a typical infectious disease - it doesn't only spread

to become more abuse and violence. The trauma caused by experiencing chronic and repeated victimisation over time has a cumulative or snowballing effect that frequently manifests in many other social issues.

New Zealand ranks worst in the western world for IPV and amongst the worst for CAN. Local and international evidence shows that IPV and CAN directly contribute to many of the other complex social issues that are at epidemic levels in New Zealand. It is therefore not surprising we are also amongst the worst in the world for these connected issues including youth suicide, bullying, youth violence, teen births, sexual violence, young people not in education, employment or training to name a few. We believe it is time New Zealand started looking through a new lens at many social issues - poverty, alcohol and drug abuse, mental illness - seeing them not as the cause of IPV and CAN but the consequence. Until we do this we will be continuing to put a band-aid on the problem - spending vast amounts of money treating the symptoms that manifest themselves while leaving the underlying issues unresolved.

The collective and cumulative effect of IPV and CAN is placing a heavy burden on individuals, our society and the New Zealand economy and every day, every week, and every year things get worse as the effects continue to spread.

The full extent of the social and economic costs resulting from the high levels of IPV and CAN in New Zealand are not well understood, but the evidence we provide suggests, they are much greater than currently appreciated. We have applied various scenarios to existing but outdated economic assessments and concluded that IPV and CAN currently cost the New Zealand economy at least \$8.326 billion per annum.

IPV and CAN are currently costing every man, woman and child in New Zealand \$1,833 per year - every year.

This makes IPV and CAN everyone's problem and everyone's responsibility. Until we address these issues New Zealand society will be poorer and each and every New Zealander will be less well off.

Only about 20 percent of IPV and CAN is currently reported to the New Zealand Police. It is unrealistic to expect to create significant change to the prevalence and impact of IPV and CAN if our efforts and responses are focussed only on the 20 percent of reported cases. Similarly we will never address the impact IPV and CAN is having on so many other social issues or the intergenerational transfer of the problem if we are not reaching 80 percent of cases.

To reduce the burden on individuals, society and the economy we need to design a system that makes the greatest impact on as many cases as possible, ensuring an early and more effective response and encouraging the unreported cases to seek and gain help. In doing so we would not only reduce the incidence of IPV and CAN but reduce the incidence of many other linked social issues and reduce the economic costs.

IPV and CAN are complex problems. One-off, 'quick fix' remedial solutions do not work for complex problems – in fact they can easily make matters worse.

An integrated system is identified in the leading New Zealand and international literature and practice experience as being the best model to meet the challenges faced in preventing and responding to IPV and CAN. Other countries are already taking steps to adopt an integrated system approach. New Zealand is fortunate to be in a position to learn from their experiences - to draw from all possible sources and build the optimal system.

A fully integrated system is the missing piece of the puzzle in New Zealand's current response to IPV and CAN.

A well-recognised example of a complex but fully integrated system is the London Underground. There are multiple entry points and multiple companies operating different lines on the network but all services are connected. A traveller can enter at any point and travel, often via multiple connected routes, to the required destination. The system works because there are clear pathways, consistent safety standards, and agreements between the many different agencies providing services as part of the system. There is local autonomy; all stations (entry points) are different and serve different communities. In the London Underground no matter which station you use to enter 'the system' you can travel to any point around the vast city and to many surrounding suburbs without ever leaving the complex network of stations, platforms and lines.



The Underground provides us with a way to explain 'system thinking'. It is the process of understanding how each part within the whole system influences other parts. We can translate the idea of system thinking to an 'integrated system' response to a social problem like IPV and CAN.

An integrated system is a formal and proactive response whereby all agencies will deliver consistent and safe services. Complex problems such as IPV and CAN involve multiple agencies and individuals, each with differing responsibilities and working on different parts of the problem. An integrated system for IPV and CAN is where all agencies and individuals who are either directly or indirectly involved at all levels operate as one system.

When IPV or CAN is disclosed (to any agency), in effect, it is reported to the one system and mechanisms are in place to ensure seamless and effective service provision regardless of the entry point. There are clear referral pathways between all agencies in 'the system'; entering through any door leads into a broad system of community-wide support. This means anyone entering the system can access services via what might seem unlikely routes. It also means that when someone is being treated in the mental health system, the youth justice system (or the many other connected systems) and it is found that they are suffering from cumulative trauma of IPV or CAN, they can efficiently be 'linked up' with specialist IPV or CAN provider(s).

The New Zealand and international evidence is clear that in a high proportion of families IPV and CAN and sexual violence are all occurring. The system that responds to CAN must be integrated with the system that responds to IPV. Strategies aimed at addressing CAN are less likely to be successful unless any current or past IPV is also addressed and vice versa.

The current system is broken - fragmented and inconsistent, with gaps and overlaps - there is no infrastructure to hold all the various parts together.

There have been endless reports showing that the current system is unfit to provide a 'one door – right door' response to victims/survivors or abusers seeking help for IPV and CAN. In the current IPV and CAN system, leadership, governance and coordination activities do not adequately reflect the complexity of the issue. There are multiple agencies working at multiple layers. There are over 200 - largely disconnected leadership, governance and multi-agency groups, networks and coordinators trying to address the problem nationally and regionally. There is no shared understanding of IPV and CAN. This has resulted in government departments, non government (NGO) agencies and frontline workers holding different understandings of the 'problem' and different ideas about the appropriate responses.

There are very few lines connecting the stations, there are no maps or signage to guide people around the system, many stations are overcrowded with people, some people are lost between stations trying to navigate for themselves, some stations are missing all together and only a few of the staff running the system have been fully trained. The Family Violence Interagency Response System (FVIARS) is the primary means of inter-agency case management – but it is not a system – it is a discrete series of meetings happening in an isolated way throughout New Zealand.

Organisational practice is inconsistent. There is no standardised approach for identifying and managing high risk cases. There are no clear lines of accountability, no mechanisms to repair parts of the system when things go wrong and no evidence-based and standardised safety planning

processes to ensure all those travelling the system are safe. Services are fully stretched and there is no way we can keep loading more cases into the current system. Meanwhile we focus on temporary repairs - minor adjustments and short-term initiatives, thinking that if we just did one or two more things we could fix the problem.

We must stop trying to fix individual parts of the existing system.

Attempting to identify and respond to more cases more effectively with the current system would be akin to building a new story on a house that has poor foundations. It would simply not hold up; money would be wasted and in time, the cost of fixing it would be much greater than if the job had been done properly in the first place.

The Integrated System infrastructure we propose as the way forward would consist of a national backbone agency and approximately 32 regional hubs – for the purposes of this proposal we are assuming that Wairarapa would be the first regional hub – the demonstration region where the model would be established, evaluated and modified as need be before being systematically rolled out to the other 31 regions.

Establishing the Integrated System is not about replacing what already occurs, stopping and starting again, or taking random remedial actions. That would only exacerbate the situation. The approach we are proposing builds on what works, incorporates the existing networks, agencies and multi-agency processes, fills gaps and removes overlaps and inconsistencies. However the Integrated System would also provide the infrastructure and the processes to link and support all parts of the system to work together. The system would provide processes to ensure continuous improvement so that all parts of the system operate as effectively and equitably as possible.

To date most of the family violence initiatives have been top-down, designed by central government agencies with little or no input from the community, local service providers or victims/survivors. New initiatives have been implemented in a predominant single-agency culture. Moving to an Integrated System means we would need to start thinking locally, acting locally and resourcing locally to build this new system. Local service providers and service users would be engaged in ensuring the system is working effectively in their area. Local communities, government and non government agencies and researchers would work hand in hand towards common goals, harnessing the collective effort.

The Integrated System would take responsibility for keeping victims/survivors safe by wrapping a joined-up response around them, doing everything possible to reduce the immediate and long term effects of the abuse and for containing, challenging and changing the abuser's behaviour.

The Integrated System would improve the way inter-agency coordination operates; offer multiple doorways into the system and clear referral pathways around the system. The system would be continually evaluated and monitored and findings of those evaluations would inform future

development. If continuous improvement processes were put in place from the outset and continued in a consistent and sustained way – with continual learning to improve the system – over time, the incidence of IPV and CAN, the social consequences and the intergenerational transmission would be reduced.

However, there is no way that could be achieved within current service capacity. The model must be scalable so the required high quality standards are maintained at all parts of the system while expanding to accommodate more and more cases.

We have to start and not stop until major change has been achieved.

There are no ways to cut corners with an ambitious initiative such as this. Achieving long term sustainable outcomes would require careful planning, widespread community engagement and staged implementation. These problems took generations to create. They will require a well managed, sustained effort over the long term to be reversed.

It is vital that the Integrated System be implemented in a considered manner that takes time to meet the challenges, builds on existing practice and the innovative work beginning to take place within New Zealand communities, aligns with government priorities and new contracting initiatives, incorporates international findings and provides the best possible response to the needs of those affected.

New Zealand will have to spend in order to save, but like any investment it will only produce good returns if we invest wisely in a high quality system that continually collects evidence and makes improvements, that becomes more and more effective over time. To continue investing our scarce public dollars in an ad hoc way with no evidence of any return would be as the saying goes, 'throwing good money after bad'.

Investing in this Integrated System will produce a 15-fold diminishing return on investment. The greater the investment in a strong, effective, equitable and scalable system, the greater will be the social and economic savings.

There is a lot of work ahead of us to achieve the change the Integrated System can bring. This proposal shows that the Integrated System is the way forward. The cost of not taking this step is too great in every sense.

Addressing IPV and CAN in New Zealand will take vision, political commitment and a concerted effort.

Introduction to the document

This document details a proposed new Integrated System to address the epidemic of intimate partner violence (IPV) and child abuse and neglect (CAN) in New Zealand. It will be used to:

- provide the business case for government to fund the development and implementation of the Integrated System model
- influence the policy and political agenda to align government agency thinking with the key concepts of the Integrated System
- introduce and socialise the model to IPV and CAN agencies and networks throughout New Zealand so they can start preparing for implementing the model in their region over time
- show philanthropic trusts and businesses how they could make a valuable social contribution.

The document introduces the Integrated System and shows how it would build on and strengthen existing activity in New Zealand. It also outlines the reasons why fundamental reform and a radical new approach are required for New Zealand to achieve long term outcomes in addressing IPV and CAN.

Chapters 1-4 collectively provide the evidence for the need for change. We start by examining the nature, size and scale of the issue so our readers are all looking at the problem through a common lens as they read through the document. In Chapter 2 we explain the interconnectedness of IPV and CAN, show the effects of each and how they impact negatively on the individuals concerned and are manifested in multiple other violence, health and social issues, all of which have a long term impact on New Zealand society and the economy.

In Chapter 3 we show that New Zealand needs to radically change the way it has traditionally approached policy and service development in this area. In Chapter 4 we examine a number of international examples that provide important guidance about the key components necessary for a joined-up system to be effective.

Chapter 5 shows the overwhelming disarray in New Zealand's current system response to IPV and CAN. We conclude that the system is broken, fragmented and inconsistent, has gaps and overlaps and no infrastructure to hold together all the services and outcomes. It is not only failing to keep victims safe and hold abusers to account but also failing to have a positive impact on preventing further IPV and CAN. All indications are that we cannot continue to try and fix individual parts of the existing system in the absence of a strong infrastructure.

Chapter 6 describes the new Integrated System model that we believe needs to be established if New Zealand wants to achieve safety, accountability, earlier intervention, a reduction in the number of people affected and the long term damage, and economic savings to the country as a whole.

Chapters 7-11 collectively form the business case for the Integrated System. These five chapters are

based on the 'Five Case Model' mandated for the public sector in the United Kingdom³ and advocated by New Zealand Treasury (Better Business Cases) for capital investment projects.⁴ It is the same model used by KPMG recently in its business case for the development of the Social Bonds model.⁵ We believe that the background, context and complexity of IPV and CAN provided in the preceding chapters make the Five Case Model more relevant when considering the merits of major social reform.

We assess the strategic fit and economic benefits of the Integrated System model, its commercial and financial implications and viability in Chapters 7-10 respectively. We show that the model aligns well with our international and domestic treaty obligations, national policies, strategies and other initiatives. We also show that the implementation of the Integrated System model can bring significant savings to the New Zealand economy and provides a very attractive return on investment. We conclude in Chapter 11 by providing more details about specific elements of the model, how it would need to be implemented and managed, commencing with the establishment of a national backbone agency and a demonstration regional hub in, for example, Wairarapa.

For the following reasons we have elected to use the specific terms intimate partner violence (IPV) and child abuse and neglect (CAN), except where we are commenting on programmes, initiatives or services that use alternative terms:⁶

- a) IPV and CAN are the most common forms of interpersonal violence and hence we believe need to be the focus of the system response.
- b) IPV and CAN are inter-connected and co-occurring forms of violence and to be effective our response to them needs to be part of a single integrated system.
- c) The international evidence is clear that children's exposure to IPV needs to be accepted as a form of CAN.⁷ For this reason all references to CAN throughout this document should be read as including exposure to IPV.
- d) The notion of 'family' excludes violence happening between couples who are only dating or in the early stages of a relationship. Their experience is definitely 'violence among adult partners' (or IPV) but these victims/survivors don't see themselves as in a 'family' situation with their partner.⁸ As a result this vitally important component of IPV is often overlooked by the system response.

³ HM Treasury 2013. Public Sector Business Cases Using the Five Case Model. Green Book Supplementary Guidance on Delivering Public Value from Spending Proposals. UK

⁴ <http://www.infrastructure.govt.nz/publications/betterbusinesscases>

⁵ KPMG Social Bonds Business Case for the Ministry of Health. July 2013

⁶ For example 'family violence', 'domestic violence', 'violence against women and children'

⁷ This aligns with section 3 (3) of New Zealand's Domestic Violence Act 1995. Wherever we refer to CAN in this document it should therefore be taken to include children's exposure to IPV as one form of CAN

⁸ Research in New Zealand has shown that young women in dating relationships do not identify with the 'It's Not OK' campaign as they do not understand their relationships as falling under the 'family' umbrella. See Towns, A; Scott, H. The culture of cool: getting in early to prevent domestic violence. Wellington, N.Z.2008

In this document we refer to IPV victims/survivors in the female gender and IPV abusers in the male gender for the following reasons:

- a) Whilst there are both male and female abusers and female and male victims/survivors in all forms of IPV, and IPV also occurs in same sex relationships, the evidence is clear that that the vast majority of IPV is male violence towards female partners or ex partners. Those who perpetrate the most severe and lethal cases of IPV are predominately male, and the victims/survivors of the most severe and lethal cases of IPV are predominately women and children.^{9,10,11}
- b) Most westernised countries - including our closest neighbour, Australia - have understood the gender gendered nature of IPV for some time. ¹² That is, their documentation and IPV reform efforts are based on understandings of gender based structural inequality.
- c) While both women and men can be violent towards their children, the severity of the abuse and the long term negative outcomes are generally worse where the abuser is male, ie there is a gender bias in the effects of the abuse against children.¹³

When we refer to victims/survivors in this report we are referring to those currently being abused or who have recently left an abusive relationship; but we also acknowledge the importance of understanding that many abusers have themselves been victims/survivors earlier in their lives.

Appendix 2 contains a full glossary of terms used.

There will be a lot of work ahead of us all if we are to establish the most effective and efficient Integrated System possible. However, the cost of not doing this and continuing with the status quo is too high in every sense. This document shows it is time to take a new approach and that the Integrated System is 'the way forward'.

⁹ The Taskforce for Action on Violence Within Families. First Report 2006

¹⁰ Murphy, C., Paton, N., Gulliver, P., Fanslow, J. (2013). *Understanding connections and relationships: Child maltreatment, intimate partner violence and parenting*. Auckland, New Zealand: New Zealand Family Violence Clearinghouse, The University of Auckland.

¹¹ NZFVC; Family Violence and Gender Factsheet. October 2007 . Available at <http://www.nzfvc.org.nz/sites/nzfvc.org.nz/files/factsheet-gender-1.pdf>

¹² Some governments have shown a commitment to wide training initiatives to help create a shared understanding that IPV is gender based. For example in a Scottish Government high level strategy document responding to family violence *Safer Lives: Changed Lives. A shared approach to tackling violence against women in Scotland-2009* the message is very clear that violence against women is a consequence of continued inequality between men and women and is a barrier to achieving equality. They state that tackling violence against women is essential in terms of their gender equality duty and that securing a shared understanding (definition, impact etc.) provides the cornerstone for a comprehensive response to violence against women and the commitment to preventing it.

¹³ Murphy, C., Paton, N., Gulliver, P., Fanslow, J. (2013). *Understanding connections and relationships: Child maltreatment, intimate partner violence and parenting*. Auckland, New Zealand: New Zealand Family Violence Clearinghouse, The University of Auckland.

1. What is the problem we need to address?

Despite widespread acceptance that IPV and CAN are not OK there is no shared understanding about the dynamics, types of abuse and the lived experience of those involved. It is therefore important that we start this document by examining the issue so our readers are all looking at the problem through a common lens.

In this chapter we discuss the nature, size and scale of the problem and explain that although it is often responded to as a single event, IPV and CAN are actually experienced as part of an ongoing pattern of abuse. There are many widely held myths and misconceptions about IPV and CAN. The lack of shared understanding about the problem means these often go unchallenged and lead to unsafe interventions.

We provide evidenced information about the experience of IPV and CAN and show that it is serious, pervasive, prevalent, underreported, and experienced more often in New Zealand than other countries. Our discussion moves on to show how certain groups are more vulnerable to IPV and CAN and therefore interventions must be particularly responsive to these groups. The background provided in this chapter makes clear the urgent need to better address IPV and CAN in New Zealand because of their devastating and intergenerational consequences.

1.1 Defining and understanding the problem

IPV and CAN are never just one-off episodes. They involve a pattern of behaviour or a pattern of relating within an interpersonal relationship. One person (usually a man) repeatedly uses a range of abusive strategies in order to gain power and control over another (usually a woman and/or child). The perpetrator uses various 'tools' of abuse to create an environment of fear and uses this fear to control his victim(s). All aspects of their lives are infused with the power imbalance and abuse can happen at any time.

Physical violence is only one 'tool' in a range of strategies which may include psychological abuse and threats, financial abuse, and sexual abuse, usually within a context of domination and fear. Abuse physically harms, arouses fear, prevents a person from doing what they want, or compels them to behave in ways they would not freely choose. The tactics used by abusers to psychologically abuse their partners are complex and multiple.¹⁴ Many victims/survivors say that the emotional and psychological abuse is worse than the physical abuse and that it is harder to recover from.¹⁵ An abuser's ability to control his partner and children by manipulation and threats mean that he can maintain control when he is not present and even after separation - their lives are literally in his hands. The use of 'coercive control'¹⁶ is often difficult for others to comprehend and this dominance

¹⁴ <http://www.speakoutloud.net/>

¹⁵ <http://www.2shine.org.nz/introduction#what%20is%20domestic%20abuse?>

¹⁶ E. Stark, *Coercive Control. How Men Entrap Women in Personal Life*, New York: Oxford University Press, 2007. Stark says that coercive control captures three aspects of women's experience that are not present in the violence model – firstly, that it is ongoing rather than episodic and resulting harm is cumulative, second, that it is multi-faceted and, third, that it involves rational and instrumental behaviour. Stark considers IPV to be less about the physical assaults than what he describes as 'the cumulative deprivations of a woman's

may not be observable to those outside of the relationship because abusers are usually adept at choosing with whom and when they will exert their need for power and control.

The effect of IPV and CAN is that victims/survivors live in fear of the abuser, become traumatised from repeated acts of abuse and become entrapped in the relationship. Therefore women and children can never 'just leave'. Leaving involves fundamentally challenging the abuser's power and control – the very thing he wants most to hold on to. Leaving is both dangerous and difficult.

When women and children do leave, many abusive men will use new tools to further abuse and exert control.¹⁷ In many cases the very institutions that are meant to improve women's and children's safety such as the Family Court become the abuser's new tools of abuse; for example, they make applications for contact orders or non-removal orders. Control and fear often continue for women and children for years afterwards.

We know that many IPV abusers have themselves been victims/survivors earlier in their lives. Boys who grow up in a family where there has been IPV and CAN are more likely to use IPV and CAN in their adult relationships; this is known as the intergenerational transmission of violence. Although this is not always the case; many men who abuse their partners and children did not grow up with IPV or CAN. The single most common factor shared between men who use violence against their partners and children is their belief in rigid gender roles and their position as 'head of the household' – that they are the one in charge. In New Zealand there is strong element of macho in our culture that is deeply embedded and celebrated at all levels of our society. As a result, violence and abuse occurs in all neighbourhoods.

Women are equally likely to find themselves in an abusive relationship but women who have grown up in a home with IPV and CAN may find it harder to get out of abusive relationships early on; the same messages that influence men to use IPV and CAN tell girls/women that men have a right to have control over them. Many women in New Zealand who experience IPV have had no previous exposure to it. Women do not choose to be with abusive men. Unfortunately, abusive men do not usually reveal their controlling and abusive behaviours until sometime into the relationship once the woman has already committed to him through marriage, pregnancy or living together. The experience is shocking and repugnant for women but their ability to leave the relationship is undermined by the abuser's control, society's expectations and an absence of resources and support. There is lack of information available about coercive control and so, for women, their experience of abuse can seem confusing and hard to classify – particularly if they are not experiencing physical abuse.

personhood'. In other words, IPV is a crime against self-determination – the deprivation of rights and resources that are critical to personhood and citizenship, such as liberty and autonomy and connectedness to others. To appreciate the harms of IPV there is a need to focus not only on what the abusive partner has done to the victim, but on what the victim has been prevented from doing for themselves.

¹⁷ This often involves economic abuse for example withholding child support payments.

However, abuse usually increases slowly in severity over time and so continued acts of abuse become normalised; it becomes harder to make sense of the abuse, and therefore harder still to reach out for help. Because IPV is such an isolating experience for women it is vital that primary prevention and early intervention responses address the societal norms that continually tell women that the abuse is their fault, if they just try harder the problem will go away and that their job in a relationship is to rescue and forgive. Instead women need to be reassured that they are not alone, that abuse is not 'normal' in relationships and that help is available and the earlier she reaches out for it the better.

The impact of IPV and CAN also includes the intergenerational transmission of the effects of the trauma on children later in their lives. In Chapter 2 we discuss the effects of IPV and CAN and show how IPV and CAN are connected to a range of other serious social issues.¹⁸

There is no shared understanding

Although there has been legislation that defines IPV and CAN in New Zealand since 1995,¹⁹ there appears to be no shared understanding at a public level, across government departments or in the sectors that work in these areas about the dynamics, types of abuse and the lived experience of those involved. For example IPV is often understood to be about anger and a loss of control whereas IPV is about power and control, ownership and entitlement; the IPV perpetrator is fully 'in control', choosing when and how to abuse. Hence, IPV almost always happens behind closed doors and not in public.²⁰

The absence of a shared understanding means that the many widely held myths and misunderstandings regarding IPV and CAN are left to flourish among the public and among many personnel working in the current system. This can and does result in unsafe responses to both victims/survivors and abusers. Unsafe beliefs include:

- abuse in relationships is usually caused by both people, that partners allow it to happen, and therefore, both must change for the abuse to stop
- children need fathers, even violent ones
- victims/survivors exaggerate the level of abuse; if it was really that bad, they would leave
- victims/survivors provoke the violence
- abuse is caused by drinking, stress and poor impulse-control
- some people need the violence, enjoy it or are addicted to it
- IPV does not happen in gay and lesbian relationships

¹⁸ When used in this report the term 'social issues' should be seen as including justice, health, and education issues.

¹⁹ In 1995 New Zealand enacted legislation to guide responses to domestic violence. The Domestic Violence Act 1995 encompasses all forms of domestic violence across all people as long as the violence occurs within a close personal relationship. The Act recognises a range of abuse in both type and severity and defines 'domestic violence' as: '*in relation to any person, means violence against that person by any other person with whom that person is, or has been, in a domestic relationship*'. The object of the Act is 'reduce and prevent violence in domestic relationships.' See Appendix 3 for a more extensive extract from the Act.

²⁰ See <http://www.2shine.org.nz/myths-and-facts> for more detail about the realities of domestic violence

- IPV abusers are monsters and their violence is a pathological problem.²¹

These, together with the fact that there is no nationally consistent training or accreditation process for those who work in the IPV and CAN sectors in New Zealand, mean that individuals within government departments and NGO agencies hold different understandings about the 'problem' and different ideas about the appropriate responses. Consequently policy, planning, funding and service delivery have become increasingly generalised and less specifically tailored to those experiencing violence. Policy makers through to frontline workers are left to base their decisions on their own personal understandings, unchallenged. Workers from different areas of specialisation often hold different understandings about the families they are working for, resulting in fractured and unsafe responses.

The recent Glenn Inquiry People's Report²² made the same point, saying: *'New Zealand's public, professionals and frontline workers generally lack knowledge about child abuse and domestic violence'* and noted that this is having a negative impact and serious consequences for victims/survivors:

'People, especially victims, are faced by frontline workers and people around them whose attitudes and behaviours expose them to further abuse and trauma'

'Victims are generally not believed, and perpetrators' manipulative behaviours mean that they remain unaccountable for their abuse and violence.'

Victims often reported feeling abused again when they come into contact with services they needed to interact with to get help.

A comprehensive integrated system response requires those working at all levels – government, service agencies and departments, policy makers, funders and volunteers – to have a shared understanding about IPV and CAN, to look at the issue through the same lens. Once all those in the system have a shared understanding, it can be clearly conveyed to the New Zealand public. We have successfully told New Zealand 'It's Not OK'. Now we need to ensure everyone has a clear understanding of what 'it' is.

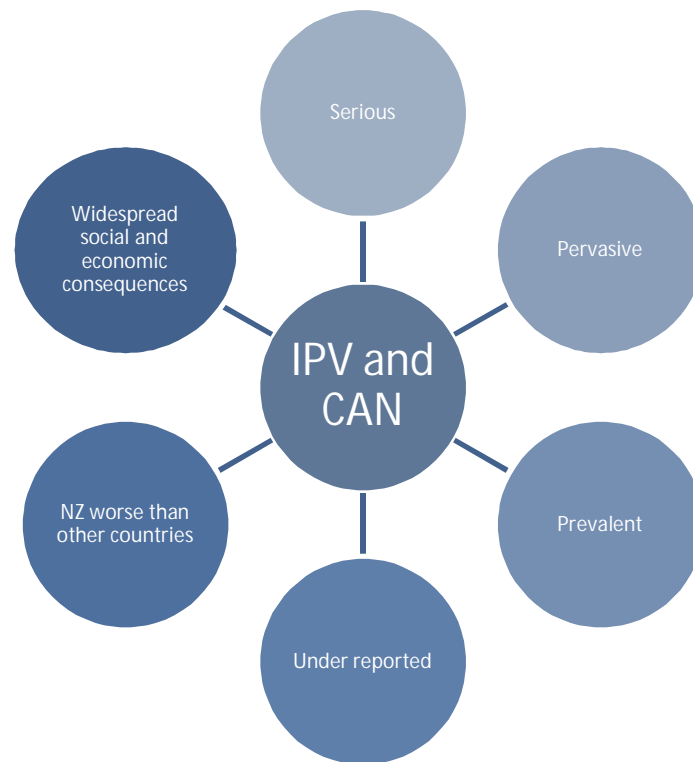
1.2 The extent of the problem

IPV and CAN are significant problems in New Zealand and deserve society's utmost attention to developing world-leading solutions. Figure 1 shows the key aspects of IPV and CAN that are discussed in the following sections.

²¹ See <http://whiteribbon.org.nz/act/get-help/nine-common-myths-and-misconceptions/> for more detail about the common myths and misunderstandings

²² https://glenninquiry.org.nz/uploads/files/The_Peoples_Report_-_full_document.pdf

Figure 1: The extent of the problem



Serious

IPV and CAN are among the most complex, multifaceted and poorly understood issues in western society and the New Zealand Government has shown that it takes these issues seriously. On 27 January 2014 New Zealand's Minister of Justice, the Hon. Judith Collins told the United Nations Human Rights Council:²³ *Women and children experience an unacceptably high rate of family violence in New Zealand. We remain steadfast in our determination to eradicate this problem that causes great personal and social harm.*

The Minister's concerns are well placed as IPV and CAN make up approximately 50 percent of all violent crime in New Zealand and can be fatal.

The Family Violence Death Review Committee's (FVDR) *Fourth Annual Report*²⁴ shows that in the four year period from 2009 to 2012, an average of 47 percent of all homicides and related offences each year were family violence deaths and family violence related deaths. During these four years there were 63 IPV deaths and 37 CAN deaths (Table 1). Three-quarters of offenders were men and almost three-quarters of the deceased were women. Among the 46 female deceased, 44 (96 percent) were killed by their male intimate partner. Two women (four percent) were killed by women. One of these killings occurred in a same-sex relationship.

²³<http://webtv.un.org/watch/new-zealand-review-18th-session-of-universal-periodic-review/3111258233001/> (approx 20.20 into the recording)

²⁴ Family Violence Death Review Committee, 2014. Fourth Annual Report: January 2013 to December 2013. Wellington: Family Violence Death Review Committee. Available at <http://www.hqsc.govt.nz/assets/FVDR/Reports/FVDR-4th-report-June-2014.pdf>

Table 1: Family violence deaths by type, New Zealand, 2009–12²⁵

CATEGORY	Family violence deaths n=126	
	n	%
Intimate partner violence (IPV)	63	50
Child abuse and neglect (CAN)	37	29
Intrafamilial violence (IFV)	26	21

All IPV and CAN deaths are preventable if the system responds effectively to the notion of risk. It is important for all service providers to understand and assess the level of risk in each IPV and CAN case they are working with. Well-established risk screening tools are available that can assess the risk of re-assault and/or lethality. 'Red flags' such as threats to kill, strangulation, stalking and separation are key indicators of high risk. In other countries high risk cases are targeted for more intensive intervention by Police and advocates. For many women and children who live in high risk situations the line between living and dying is very fine. Those who are murdered represent the tip of the iceberg. Many more women and children each year are seriously injured and live in extreme ongoing fear of their abusive ex/partner.

Prevalent

IPV and CAN are all too common in New Zealand. We know that one in three New Zealand women will experience being physically and/or sexually abused by a partner or ex-partner at some stage in her life.²⁶ The data available on reported cases shows that New Zealand Police (Police) respond to one 'family violence' call out every six minutes. In 2013, there were 95,080 family violence notifications made to Police.²⁷ Approximately 70 percent of these call outs are IPV, 20 percent are CAN and 10 percent are IFV.²⁸ In 59,137 of these cases there was at least one child aged 0-16 years linked to these investigations and therefore exposed to a history of abuse.

Our rates of child abuse are shocking.²⁹ In the year ending June 2013 Child Youth and Family (CYF) received 148,659 notifications regarding care and protection concerns for children, including those involved in family violence cases reported to Police. CYF determined that 61,877 (42 percent) of these required further action and emotional, physical and/or sexual abuse. Neglect was substantiated in 22,984 cases.³⁰ In 2011, 113 children and young people were hospitalised for a

²⁵ Ibid.

²⁶ Fanslow, JL et al. (2011). Sticks, Stones, or Words? Counting the Prevalence of Different Types of Intimate Partner Violence Reported by New Zealand Women. *Journal of Aggression, Maltreatment & Trauma*, 20, 741–759.

²⁷ New Zealand Family Violence Clearinghouse. Data Summaries 2014: Snapshot. Available at <http://nzfvc.org.nz/data-summaries/snapshot>

²⁸ Family Violence Process Comparison provided by Police on 14 March 2012 at Family Violence Process Changes - Stakeholder Update Meeting

²⁹ According to Youth '12, the third national health and wellbeing survey of secondary school students in New Zealand 14% of students reported being physically harmed on purpose by an adult in their home. This was more common among male students and younger students. Twenty percent of female and 9% of male students had ever been touched in a sexual way or been made to do unwanted sexual things. Among students who had experienced this, 37% reported it was severe (pretty bad, really bad or terrible) and 57% had told no-one about it. Available at http://www.fmhs.auckland.ac.nz/faculty/ahrg/_docs/2012-overview.pdf

³⁰ <http://www.cyf.govt.nz/about-us/who-we-are-what-we-do/information-for-media-backup.html>

serious non-fatal assault perpetrated by a family member.³¹

Sexual violence is not uncommon; 16.8 percent of New Zealand women report having experienced sexual violence by an intimate partner in their lifetime, two percent in the last 12 months.³² Children and young people experience high rates of sexual abuse with one in four women in New Zealand and one in six men (international research) reporting having been sexually abused in childhood.³³

Under reported

There is a gap between cases of IPV and CAN that are reported and those that are not. It is difficult to know the real, actual levels. Estimates are that around 91 percent of sexual violence³⁴ and approximately 80 percent of IPV and CAN goes unreported.³⁵ These figures say the real numbers of instances are significantly greater than those the authorities hear about.

Pervasive

IPV and CAN occur in all types of relationships and families, all cultures, classes, backgrounds, socio-economic groups and neighbourhoods. A common myth exists in New Zealand that IPV and CAN occur only in poor families and particular ethnic groups, whereas in reality they transcend socioeconomic status, affecting all levels of income, education, occupation, and all ethnic groups. Victims/survivors come from all walks of life ranging from doctors, clergy, stay-at-home parents, service providers, to factory workers. Likewise abusers can be judges, labourers, lawyers, truck drivers, teachers or your next-door neighbour. We know very little about the make-up of the IPV and CAN cases that are not reported and there are no grounds for assuming that these cases are the same demographic mix as the cases that are reported.

New Zealand situation worse than other countries

IPV and CAN are global problems and international bodies track individual countries' levels of IPV and CAN and rate them against other countries. New Zealand shows high levels of IPV, CAN and sexual violence compared to other countries. Of the OECD countries who provided data to UN Women regarding sexual violence, New Zealand reported a higher rate than any other, with 14 percent of women reporting having experienced sexual violence during 2000 and 2010.³⁶ Figure 2 shows New Zealand is the worst in the world for physical and sexual IPV.

³¹ National Health Board Business Unit. (2011). National minimum dataset (Hospital events): Data Dictionary. Wellington: Ministry of Health. Cited in NZFVC Data Summaries: Snapshot June 2013
<http://www.nzfvc.org.nz/data-summaries/snapshot>

³² Fanslow, JL et al. (2011). Sticks, Stones, or Words? Counting the Prevalence of Different Types of Intimate Partner Violence Reported by New Zealand Women. *Journal of Aggression, Maltreatment & Trauma*, 20, 741–759.

³³ <http://toah-nnest.org.nz/what-is-sexual-violence/prevalence>

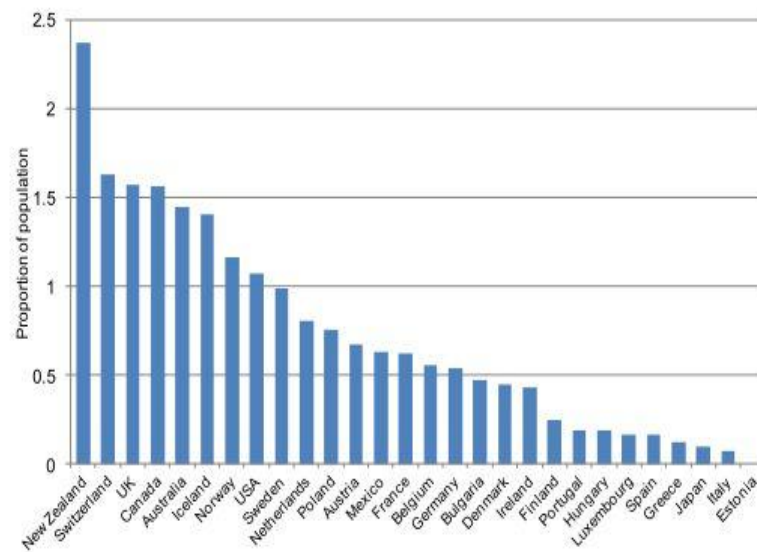
³⁴ Sexual violence is the fifth most common offence in New Zealand, but the crime least commonly reported to New Zealand Police. Most victims/survivors do not report sexual violence because of fear, shame and beliefs they will be blamed. Cases in the criminal justice system are a fraction of all sexual violence occurring. The judicial process is widely acknowledged as re-traumatising for victims of violence and fewer than 10% of reported SV cases lead to a conviction levels for sexual violence. Please see <http://toah-nnest.org.nz/what-is-sexual-violence/prevalence> for information regarding low SV reporting rates.

UK research found that less than one in thirty victims of rape can expect to see his or her attacker brought to justice. Available at <http://www.independent.co.uk/news/uk/crime/100000-assaults-1000-rapists-sentenced-shockingly-low-conviction-rates-revealed-8446058.html>

³⁵ According to the New Zealand Family Violence Clearinghouse (NZFVC) 2009, p 1. New Zealand Police estimate they see only 18% of all violence within homes. <http://www.nzfvc.org.nz/sites/nzfvc.org.nz/files/factsheet-statistics-2009-1.pdf>

³⁶ UN Women (2011), In pursuit of Justice, Progress on the World's Women, United Nations. Available at <http://progress.unwomen.org>

Figure 2: Prevalence of partner physical or sexual assault, women and men, around 2005

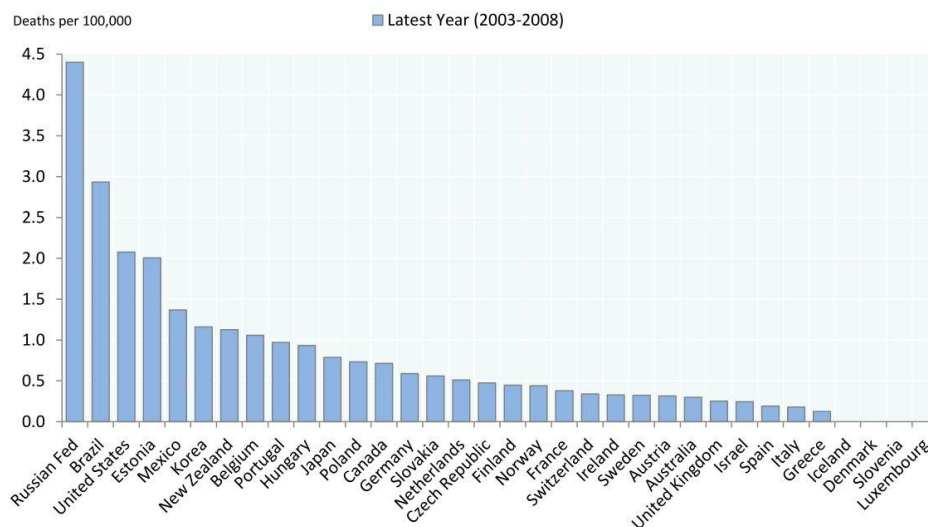


Note: Data refers to 2004 for Australia, Bulgaria, Canada, Estonia, Japan, Mexico, New Zealand, Norway, Poland and the US. For the rest data refer to 2005.

Source: International Crime and Victim Survey (2004-2005) and European Crime and Safety Survey (2005).

New Zealand's rate of child deaths resulting from intentional injuries is also among the highest in the world and well above Australia, our closest neighbour, as shown in Figure 3.

Figure 3: Deaths due to intentional injury, death rates per 100 000 children aged 0-14



Source: WHO Mortality database, 2010.³⁷

³⁷ Cited in a presentation by Maria del Carmen Huerta Social Policy Division, OECD.
http://srsg.violenceagainstchildren.org/sites/default/files/consultations/better_data/presentations/maria_del_carmen_huerta_cross_national_data_on_child_maltreatment.pdf

To examine this further we compared New Zealand's statistics for all forms of family violence to those of the state of Victoria (Australia) and Scotland (both with similar populations to New Zealand).³⁸ As shown in Table 2 indications are that our rates are worse than both Scotland and Victoria.

Table 2: Comparative levels of Family violence 2012 - New Zealand, Victoria and Scotland

	New Zealand	Victoria	Scotland
Total population	4,433,000	5,354,000	5,295,000
Family Violence cases reported to Police in 2012	87,622 ³⁹	60,829 ⁴⁰	60,080 ⁴¹
Rates reported to Police per 100,000 population	1,977	1,136	1,135
FV cases deemed to be an offence	41,187 (47%)	25,574 (42%)	30,259 (51%)
Rates of offences per 100,000 population	929	478	571

1.3 Dynamics of the problem

Unlike other types of violent crime (one off violence incidents against strangers), IPV and CAN have particular dynamics that mean patterns of harm become cumulative for individuals, families and communities.⁴² Any failure to fully understand the dynamics of the abuse and to establish the wider context and history of what is happening in a community and family/whānau severely limits how successful any prevention or intervention initiatives will be. Figure 4 shows the complex dynamics of IPV and CAN.

³⁸ The data provided in the table below was not collected for comparative purposes and evidence is not available to confirm whether the percentage of all family violence cases that are not reported is comparable, indications are that the under-reporting rates are very similar.

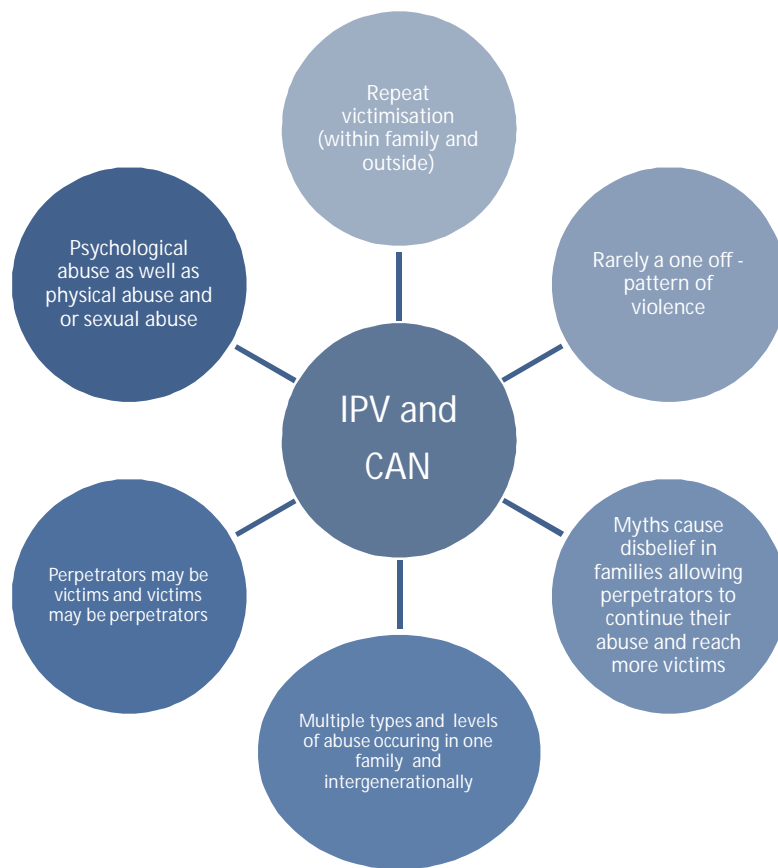
³⁹ http://www.nzfvc.org.nz/sites/nzfvc.org.nz/files/DS2-Violence-Against-Women-2013_0.pdf

⁴⁰ http://www.police.vic.gov.au/content.asp?a=internetBridgingPage&Media_ID=72311

⁴¹ <http://www.scotland.gov.uk/Topics/Statistics/Browse/Crime-Justice/TrendDomesticAbuse>

⁴² The inter-connectedness and the inter-generational cycle of abuse and violence means that any one individual can be both a victim/survivor and a perpetrator, of the same or different types of abuse at different times in their life i.e. a woman may be a victim of IPV and the perpetrator of CAN.

Figure 4: Complex dynamics of IPV and CAN



1.4 One size does not fit all

IPV and CAN are common experiences in New Zealand and research has shown that they can occur across all ethnicities, socio economic groups, ages and abilities. However, some people show a greater vulnerability to IPV and CAN or face particular obstacles in seeking help. Some groups show unique dynamics in terms of their experience. It is necessary to ensure responses to IPV and CAN attend to these particularities and needs.

Māori whānau/family violence

Māori whānau/family violence is a complex issue to address. It occurs within the historical context that reshaped the foundations of Māori society through the process of colonisation. Whānau violence is a serious and prevalent problem within Māori society. Each year in New Zealand Māori are negatively over-represented in statistics of reported cases of both IPV and CAN as victims/survivors and as abusers. The FVDRC's *Fourth Annual Report*⁴³ states that the rates per year of Māori victims and offenders in IPV and CAN homicides were significantly higher than for those of non-Māori and non-Pacific peoples.

⁴³ Family Violence Death Review Committee, 2014. Fourth Annual Report: January 2013 to December 2013. Wellington: Family Violence Death Review Committee. Available at <http://www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC-4th-report-June-2014.pdf>

The Second Maori Taskforce on Whānau Violence identified that whānau violence has been 'normalised' in modern Māori society and is tolerated to a high degree in many whānau. The Taskforce highlight that whānau violence is certainly not embedded in tikanga Māori.⁴⁴ Instead the concept of whānau violence as part of the process of colonisation, has taken several generations of learned behaviour and practice to become entrenched in Maori society. It will therefore take time to be unlearned. A recent issues paper⁴⁵ produced by the New Zealand Family Violence Clearinghouse (NZFVC) says:

'Māori are over-represented in family violence statistics as both victims and perpetrators. The causes of whānau violence are acknowledged as complex and as sourced from both historical and contemporary factors. The impact of colonisation needs to be considered in order to respond effectively to whānau violence.'

'Western approaches have not curbed the epidemic of whānau violence. Multi-level approaches to whānau violence prevention and intervention are more likely to achieve the best results.'

Pasefika communities

The Pacific Conceptual Framework Nga Vaka o Kāiga Tapu⁴⁶ is a cultural framework for addressing family violence in seven Pacific communities in New Zealand. It is informed by, and aligned with, ethnic specific cultural frameworks for Cook Islands, Fijian, Niuean, Samoan, Tuvaluan, Tongan, Tokelauan people. The 2012 Nga vaka o kāiga tapu research plan⁴⁷ states that Pasefika peoples are over-represented both as victims/survivors and as abusers of family violence. The research plan explains that it is important to appreciate that Pasefika peoples are not one homogenous culture but include many distinct cultures. The authors say that there is an urgent need for information, evidence and research on families and family violence from Pasefika nations. The plan emphasises that violence in Pasefika families is not part of traditional ways of being and that its prevalence indicates the effects of migration and situational factors on families such as, socio-economic disadvantage, gender roles, the place of the church, geographical location, employment type (including prostitution), and education. It is vital that Pasefika women and children have easy access to culturally diverse and appropriate services that are grounded in best practice.

Ethnic and migrant communities

Women and children living in New Zealand from ethnic and migrant communities and from different religious backgrounds can face additional challenges in accessing services. These challenges may be due to language barriers, different community expectations of the role of women and children and concerns that reporting IPV and CAN may affect their right to residency, amongst other things. These women and children may also be experiencing intergenerational trauma and a sense of isolation and

⁴⁴ Second Māori Taskforce on Whānau Violence. Tamati Kruger (Chair), Mereana Pitman, Di Grennell (formerly Pitama), Tahuaroa McDonald, Dennis Mariu, Alva Pomare, Teina Mita, Matehaere Maihi, Keri Lawson-Te Aho

⁴⁵ Dobbs, T. & Eruera, M. (2014). *Kaupapa Māori wellbeing framework: The basis for whānau violence prevention and intervention*. Auckland, New Zealand: New Zealand Family Violence Clearinghouse, University of Auckland.

⁴⁶ <http://www.familyservices.govt.nz/working-with-us/programmes-services/pasefika-proud/pacific-cultural-frameworks.html>

⁴⁷ Taskforce for Action on Violence within Families. Nga vaka o kāiga tapu : Pasefika Proud family violence research plan 2013 – 2018. Ministry of Social Development. 2013

alienation.⁴⁸ However, there is evidence that tolerance of IPV and CAN is being challenged from within certain communities. In 2012 for example, Faith Communities against Violence released a statement in which they refuse to tolerate violence within families. Signatories from forty four different faith groups pledged to make a stand against family violence and provide a place of safety for women and children and hold abusers accountable.⁴⁹

People with disability

Disability increases women and children's vulnerability to violence. In her paper exploring services and refuge accommodation for disabled women, Hager notes that: '*statistics on prevalence vary depending on the research methodology, but it could be as high as, or higher than, 1 in 2 disabled women (with a slightly lower figure for disabled men)*'.⁵⁰ Disability can be a significant barrier to accessing support. Barriers may include access to information and relevant services, physical access to services and isolation from wider society.

Disabled women are more likely to experience abuse and may also find it more difficult to end an abusive relationship because of their economic dependency or fear of being ostracised from their families. Women with a diagnosed mental illness or a mental health issue are less likely to seek or access help due to fear of how they will be perceived and not being believed. Many current mainstream services do not understand that the psychological impact of IPV on women can result in mental illness (depression and/or anxiety) and therefore services risk identifying the victim/survivor as responsible for the abuse rather than the perpetrator.

Disabled children are also at a greater risk of being victims/survivors of violence than non-disabled children and are less likely to be able to communicate or have the abuse recognised.⁵¹ The research into prevalence of violence for children with disabilities is limited. However, an Australian article highlights some reasons why interventions may fail to recognise the violence against a disabled child including:

- *'the social exclusion of families with either a child with a disability or domestic violence*
- *workers with expertise in disability but not with domestic violence may not recognise problems and may, therefore, not comply with mandatory reporting requirements*
- *children may be unable to disclose abuse or domestic violence because of inability to communicate or lack of technology*
- *non-violent carers may be unable to leave a violent situation due to the financial and time burdens of caring for a child with a disability*

⁴⁸ Levine, M, and Benkert, N (2011) *Case Studies of Community Initiatives Addressing Family Violence in Refugee and Migrant Communities: Final Report*, Ministry of Social Development and Ministry of Women's Affairs, Wellington

⁴⁹ http://nzfvc.org.nz/sites/nzfv.org.nz/files/Faith_Communities_Against_Violence_National_Statement.pdf

⁵⁰ Hager, D., *Finding Safety*. Provision of specialised domestic violence and refuge services for women who currently find it difficult to access mainstream services: disabled women, older women, sex workers and women with mental illness and/or drug and alcohol problems as a result of domestic violence. 2010

⁵¹ Jones, Lisa; Bellis, Mark A; Wood, Sara; Hughes, Karen; McCoy, Ellie; Eckley, Lindsay; Bates, Geoff; Mikton, Christopher; Shakespeare, Tom; Officer, Alana. Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies In: *The Lancet*, 2012, 380: 899-907

- *responses of children and young people to trauma may be confused with the effects of a particular impairment.*⁵²

Elder abuse

Abuse of elderly people can be financial, physical, psychological or emotional and can involve deprivation of basic rights. Elder abuse occurs in the context of a relationship of trust between the older person and the person abusing them. The majority of elder abuse victims/survivors are women. Age Concern state that, '65% to 70% of abused older people are women. Even taking account of the fact that there are 6 women over the age of 65 for every 5 men, women are over-represented as victims of elder abuse'.⁵³ Most of the abuse is perpetrated by family members even if the older person is residing in residential care. Older people are vulnerable to ongoing abuse because they may fear that if they complain, they will experience more abuse or poorer care. Elder abuse is not only an issue of age and may be the continuation of a lifetime of IPV. When not perpetrated by the victim's/survivor's partner and/or carer, it is most commonly perpetrated by the victim's/survivor's adult children.⁵⁴

GLBTIQ⁵⁵

GLBTIQ relationships can be affected by IPV and there are some unique features of abuse that appear in these relationships including:

- threatening to 'out' the victim/survivor to family or employers
- refusing to use the victim/survivor's preferred pronoun
- hiding hormones or anti retro viral drugs
- saying that abuse is a heterosexual problem, so what is happening in the GLBTIQ relationship could not possibly be abuse.

Available research about the particular dynamics of same sex IPV is increasing and shows that there are some similarities between opposite-and same-gender IPV in prevalence, types of abuse, and various dynamics. There are also some differences including, help-seeking behaviours. The differences signal to us that GLBTIQ cases require a different set of services and policy considerations.

Women in rural communities

Living in a rural community can bring extra barriers to women seeking help for IPV. These women may face isolation, limited access to services, lack of services in their area, difficulties in getting help in a confidential way in a small tight knit community and a lack of specialist services. Women in rural

⁵² Baldry, Eileen; Bratel, Joan; Breckenridge, *Domestic violence and children with disabilities: working towards enhancing social work practice. Australia. 2006.*

⁵³ <http://www.ageconcern.org.nz/safety/elder-abuse/key-statistics-about-eanp>

⁵⁴ 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.

⁵⁵ The acronym GLBTIQ is used to refer broadly to gay, lesbian, transgender/transsexual, bisexual, intersex, and queer individuals and communities.

communities can be at greater risk of serious harm because guns are often more readily available.⁵⁶

Upper socioeconomic women

As noted above, IPV and CAN occur in all socio-economic levels, but little is understood about the particular difficulties upper socioeconomic women face. We know from the many upper socioeconomic women we have worked with that they typically experience a prolonged and complex array of psychological, sexual and financial abuse - they often have no access to money, fear social embarrassment and their friends and acquaintances are less likely to understand the problem.⁵⁷

Upper-educated and upper-income women rarely report abuse to Police and these cases are not portrayed in the media. Hence they are more invisible in our statistics, policies and programmes. This results in the system that is less likely to recognise upper socioeconomic abuse, lacks a frame of reference, ignores the signs and is more lenient on these abusers who are seen publicly as successful, respected, powerful and often very charming. The Glenn Inquiry People's Report⁵⁸ says:

'We also heard from a number of middle to upper socio-economic status Pākehā women about the difficulty of leaving abusive situations. They wanted the people of New Zealand to know that domestic abuse affected their part of society too. Disclosing the violence they lived with was exceptionally difficult for them, often because of their partner's position in the community, their connections and financial wealth.'

Summary

Throughout this chapter we have provided background information regarding IPV and CAN. They are devastating issues that affect many New Zealanders and commonly held misunderstandings can lead to unsafe responses. We believe it is time to stop responding to IPV and CAN as one-off incidents and instead collectively understand the true nature, scope and scale of the problem and adjust our response accordingly.

⁵⁶ 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.

⁵⁷ Upper socioeconomic women frequently talk of the financial power imbalance - the abuser has tight control over the finances and therefore has the ability to 'starve' the women and children out of the family home and to deny her access to legal assistance. These abusers have powerful connections and are able to 'buy' a large team of lawyers and 'experts' to file an endless stream of legal applications thereby further psychologically and financially abusing the woman.

⁵⁸ https://glenninquiry.org.nz/uploads/files/The_Peoples_Report_-_full_document.pdf

2. What are the connections and consequences?

In this chapter we explain the interconnectedness of IPV and CAN and explore the co-occurrence of IPV, CAN and sexual abuse. We show the effects of each of these forms of abuse and how they impact negatively on physical health, personal and social well-being, intimacy and relationships, mental and emotional health and other areas in both the short term and the long term. The cumulative impacts from a combination of abuse types, the interconnectedness, and continued abuse over time, has a snowball effect that results in widespread social harm. The impact on women and children from IPV and CAN is catastrophic both at the time it occurs and well into the future.

Governments and public policies have not yet made the connections between IPV and CAN or fully appreciated its widespread impacts. We believe it is essential this happens so we can clearly understand and quantify the social and economic costs arising from IPV and CAN (which are discussed in Chapter 8) and the opportunities to respond more effectively.

2.1 The co-occurrence and inter-connectedness

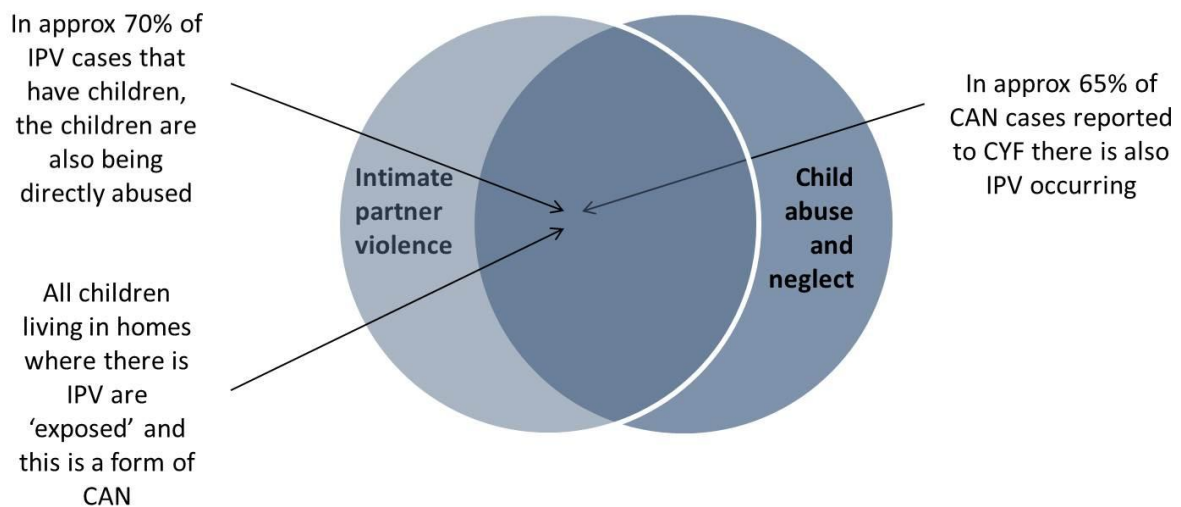
The considerable overlap or co-occurrence between IPV, CAN is not well understood in New Zealand. The New Zealand and international evidence is clear that in a high proportion of families IPV and CAN and sexual violence are all occurring. Activities that respond to CAN must be integrated with those that respond to IPV. Strategies aimed at addressing CAN are less likely to be successful unless any current or past IPV is also addressed and vice versa.⁵⁹

Police report that in approximately 70 percent of family units where IPV exists, the children are also direct victims/survivors of some form of violence.⁶⁰ The relationship between IPV and CAN should also be understood as occurring in reverse; where there is one form of abuse there is likely to be the other as shown in Figure 5.

⁵⁹ Humphreys reports that recent policy and practice developments around the world now emphasise the importance of separate but linked services for women and children. These two very different intervention systems (statutory child protection and specialist, community-based, domestic violence services) have needed to find ways of working together, as have the other services involved in domestic violence intervention to recognise that the safety and well-being of children is tied closely to the safety and well-being of their mothers. http://www.adfvc.unsw.edu.au/documents/IssuesPaper_13.pdf

⁶⁰ <http://www.nzfvc.org.nz/issues-papers-3>

Figure 5: The co-occurrence of IPV and CAN



There is emerging evidence of the potential severity of the co-occurrence of IPV and CAN:

- Murphy et al⁶¹ note that: *'Both New Zealand and international researchers have highlighted the relative severity of violence in a household when IPV and child maltreatment co-exist.'*
- In 47 percent of the fatal inflicted injury CAN deaths (where the offender was known), the father/step-father, or the male partner of the female caregiver was known to the Police for abusing the mother of the child or the female caregiver.⁶²
- Australian child death reviews highlight similar frequency with which child maltreatment fatalities occur against a backdrop of IPV.⁶³

Children's exposure to IPV is a form of CAN

Alarmingly high numbers of children and young people are affected by IPV and this is a widespread, chronic and serious social problem.

The Youth '07 study surveyed 9107 secondary school students throughout New Zealand.⁶⁴ They found that in the previous 12 months in their homes:

- 48.2 percent had witnessed adults yelling or swearing at each other
- 10.4 percent had witnessed adults hitting or physically hurting each other.

⁶¹ <http://www.nzfvc.org.nz/issues-papers-3>

⁶² Family Violence Death Review Committee, 2014. Fourth Annual Report: January 2013 to December 2013. Wellington: Family Violence Death Review Committee. Available at <http://www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC-4th-report-June-2014.pdf>

⁶³ <http://nzfvc.org.nz/sites/nzfvc.org.nz/files/issues-paper-3-2013.pdf> referencing to New South Wales Child Death Review Team. 2001-2001 Annual Report. Sydney: NSW Commission for Children and Young People; 2002 and O'Hara M. Child deaths in the context of domestic violence: Implications for professional practice. In: Mullender A, Morley S, eds. Children living with domestic violence. London: Whiting and Birch; 1994 reports that in nine of the 19 cases of fatal non-accidental injury (children aged 0-4 years), there was evidence of ongoing, severe IPV. In 13 of these cases, there was evidence of prior abuse of children

⁶⁴ http://www.fmhs.auckland.ac.nz/faculty/ahrg/_docs/2007-violence-report-2010a.pdf

Children's exposure to IPV has long been recognised as a form of CAN in New Zealand. Our Domestic Violence Act defines a child seeing or hearing the physical, sexual, or psychological abuse of a person with whom the child has a domestic relationship as child abuse.⁶⁵ The FVDRC *Fourth Annual Report*⁶⁶ says: *'It is well known that exposure to IPV is a form of child abuse.'*

The international evidence is clear that:

- Children do not need to see the violence occurring to suffer the negative effects. The international literature shows that there is little differentiation between the harm caused by direct abuse and that caused by exposure to IPV.⁶⁷
- All children are affected by the presence of IPV or other forms of domestic violence in their family, regardless of the nature of the violence.
- As with children and young people who are directly abused, for children who are exposed to IPV, the impacts affect all aspects of their lives.
- In particular, boys who are exposed to IPV are more likely to become IPV abusers later in life.⁶⁸

The multiple short and long term effects of children directly abused and those exposed to IPV are discussed later in this chapter. Three government funded reports in recent years have reflected the effects:

1. The Social Sector Forum's 2011 Briefing⁶⁹ to the Incoming Minister advised the Minister: *'Children who are exposed to intimate partner violence are more likely than other children to have behavioural, social and emotional problems. They also experience long-term impacts such as higher rates of adult depression and trauma symptoms and increased tolerance for and use of violence in relationships. In addition, they are at increased risk of child maltreatment'*.
2. The FVDRC *Fourth Annual Report*⁷⁰ notes: *'While violence perpetrated by mothers is not without its negative effects, exposure to violence by fathers appears to have more pervasive developmental effects on children. Exposure to more severe IPV was associated with a*

⁶⁵ Refer Appendix 3 for the relevant section from the Act.

⁶⁶ Family Violence Death Review Committee, 2014. Fourth Annual Report: January 2013 to December 2013. Wellington: Family Violence Death Review Committee. Available at <http://www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC-4th-report-June-2014.pdf>

⁶⁷ In fact some studies, such as the meta-analysis of 118 studies by Kitzmann et al., (2003), which evaluated the psychosocial outcomes of children living with IPV (but not directly abused themselves) showed significantly poorer outcomes on 21 developmental and behavioural dimensions for the children exposed to IPV than those not exposed to any IPV and that the outcomes for those exposed to IPV were similar to those where children were also directly physically abused. These findings are now supported by multiple other studies and widely reported in the literature.

⁶⁸ Flood, M & Pease, B 2006, The factors influencing community attitudes in relation to violence against women: a critical review of the literature, Victorian Health Promotion Foundation, Melbourne

⁶⁹ <http://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/corporate/bims/social-sector-forum-2012.pdf>
The briefing cited Carlson, B E (2000). Children exposed to intimate partner violence: Research findings and implications for intervention. *Trauma, Violence, and Abuse*, 1(4), 321–340; Edleson, J L (1999). The overlap between child maltreatment and woman battering. *Violence Against Women*, 5(2), 134–154; Rossman, B B (2001). Longer term effects of children's exposure to domestic violence. In Graham-Bermann, S A and Edleson, J L (Eds.). *Domestic violence in the lives of children: the future of research, intervention, and social policy* (pg 35 to 66). American Psychological Association, Washington, DC.

⁷⁰ Family Violence Death Review Committee, 2014. Fourth Annual Report: January 2013 to December 2013. Wellington: Family Violence Death Review Committee. Available at <http://www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC-4th-report-June-2014.pdf>

corresponding significant increase in the childhood risk of sexual abuse and regular use of physical punishment by a caregiver'.

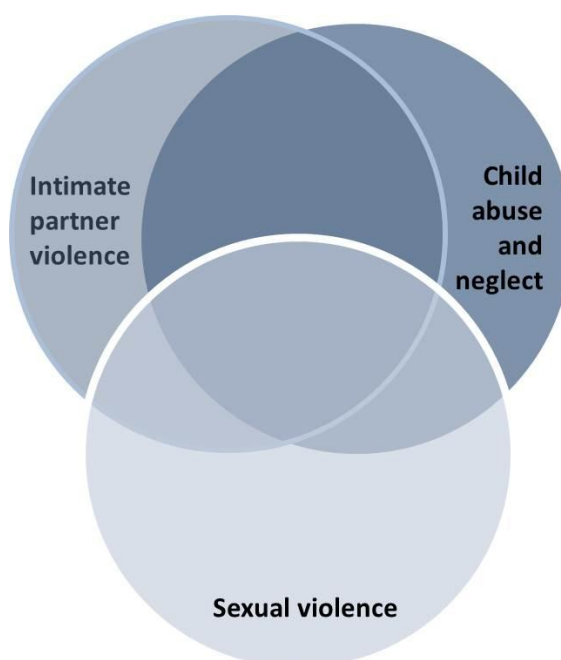
3. The NZFVC Issues Paper #3:⁷¹ 'the links between child maltreatment and IPV , the detrimental effects of children's exposure to IPV , the disruption to mother-child relationships due to IPV and poor fathering can accompany perpetration of IPV'.

This local thinking is also reflected throughout the international evidence.

Co-occurrence of IPV, CAN and sexual violence

New Zealand has traditionally taken a separate approach in planning, policy and service delivery for sexual violence than other forms of IPV and CAN. However sexual violence is frequently part of the experience of IPV and CAN. There is no single source of data on the rate at which sexual violence occurs within IPV and CAN but indications are that 40 to 70 percent of the sexual abuse and assault of children and adults occurs within IPV or CAN as shown in Figure 6.⁷²

Figure 6: Sexual violence as one form of IPV and CAN



⁷¹ <http://www.nzfvc.org.nz/issues-papers-3>

⁷² Partners (and ex-partners) and other family members were cited as the perpetrator in 41 percent of all sexual offences against women in one report (Family Violence Statistics Report. Families Commission. 2009 (pg 162). Available at <http://www.familiescommission.org.nz/publications/briefs-and-statistics/family-violence-statistics-report>) and Partners, ex-partners, current or previous boy/girlfriends and other family members were cited as the perpetrator in 73 percent of all sexual violence against women in another report (Mayhew, P. Reilly, J. L. (2009) The New Zealand Crime and Safety Survey. In Family Violence Statistics Report. Families Commission. Wellington, August). Family or other household members or primary caregiver were cited as the perpetrator in 50 percent of all sexual abuse of children and young people in 2006 (in Family Violence Statistics Report. Families Commission. 2009 (pg 162). Available at <http://www.familiescommission.org.nz/publications/briefs-and-statistics/family-violence-statistics-report>). Murphy et al report that: 'There are few studies investigating the overlap between IPV and child sexual abuse. However one of the publications that addressed this issue found that over half of 111 children who had been sexually abused and were attending a children's support centre had also been living with IPV'. Available at <http://www.nzfvc.org.nz/issues-papers-3>

A significant number of sexual violence victims/survivors do not disclose their abuse at all. Researchers have found that it takes victims/survivors of sexual violence an average of sixteen years to disclose their experience to another individual, hence reported levels to the Police are the tip of the iceberg.⁷³

Abusers with previous IPV complaints [against them] were much more likely to inflict sexual abuse on an intimate partner.⁷⁴ Lundy Bancroft⁷⁵ has done some illuminating work and found that men who use IPV are four to six times more likely to sexually abuse than non-abusive men and seven times more likely to physically assault their children than non-abusive men. In addition, evidence is emerging that a significant group of children suffer child sexual abuse within a wider atmosphere of fear created through IPV.⁷⁶

New Zealand needs to recognise the overlap between IPV, CAN and sexual violence and reflect this understanding at all levels of policy and practice.

2.2 The immediate damage caused

IPV and CAN have widespread consequences for the people involved that can last a lifetime. The trauma caused by experiencing chronic and repeated victimisation over time has a cumulative or snowballing effect that frequently results in many other social issues.⁷⁷

Direct effects of IPV, CAN and sexual violence

The negative impacts of IPV, CAN and sexual violence are serious, complex and often long term. Victims/survivors typically experience frequent, sustained and repeated acts of abuse over long periods of time (physical, sexual and psychological). Studies have shown a link between the experience of abuse and mental health impacts on victims/survivors.⁷⁸ Victims/survivors may experience anxiety, depression or post-traumatic stress disorder complaints.

Many of the negative impacts are a consequence of the cumulative effect of trauma arising from the ongoing nature of the abuse. Each episode of abuse may induce very high levels of fear in the victim/survivor and this builds on the trauma and hurt of previous experiences (much like the experience of painfully grazing a knee; healing starts and a scab forms but which breaks off in a subsequent injury causing even more pain than the initial injury).

⁷³ <http://toah-nnest.org.nz/images/pdfs/ChildSexualAbuseFactsheet.pdf>

⁷⁴ Robinson, A.L. (2006) „Reducing repeat victimisation among high risk victims of domestic violence; the benefits of a co-ordinated community response in Cardiff, Wales. *Violence Against Women*, 12(8),761-788. Cited in Ministry of Women’s Affairs. *Lightening does Strike Twice*. preventing sexual revictimisation. September 2012.

⁷⁵ <http://www.lundybancroft.com/articles/the-connection-between-batterers-and-child-sexual-abuse-perpetrators>

⁷⁶ A study that asked 164 young people (7-19 years old) at a sexual abuse clinic about domestic abuse (Kellogg and Menard, 2003) - over half the children reported living with violence, 58% of child sex offenders lived at their home and physically abused the child’s mother - the significant difference for children who also suffered domestic abuse was that they were more likely to delay disclosure because of fear of the sexual/domestic abuse offender.

⁷⁷ The economic implications of these far reaching social consequences are outlined in Chapter Eight.

⁷⁸ Fanslow, Janet L. Violence against women in New Zealand: prevalence and health consequences. In: *The New Zealand Medical Journal* 117(1206) 2004 and Gulliver, P. and Fanslow, J. (2013), Exploring risk factors for suicidal ideation in a population-based sample of New Zealand women who have experienced intimate partner violence. *Australian and New Zealand Journal of Public Health*, 37: 527–533

Victims/survivors therefore require a specialist intervention that can respond to both the physical impacts of the abuse and their experiences of trauma and the associated life impacts of that trauma. In the following diagrams we show the effects for each type of abuse separately. However, it is important to consider that the interrelatedness of the three forms of abuse (IPV, CAN and sexual violence) mean that the impacts will often be occurring concurrently and cumulatively.

IPV effects

IPV almost always involves psychological abuse of the victim/survivor.⁷⁹ Psychological abuse can have a serious and long term effect on a survivor. Physical and sexual abuse can also be part of the experience of IPV and these both have serious effects also. Figure 7 provides an overall picture of the impacts of IPV.

Figure 7: Immediate effects of IPV

Physical Health	Personal and Social Wellbeing	Intimacy and Relationships	Mental and Emotional Health	Other Impacts
<ul style="list-style-type: none"> • death • physical injury • permanent disability (blindness, deafness, epilepsy, loss of mobility) • hospitalisation for physical injuries of gynaecological problems • sexually transmitted infections (STIs) • unwanted pregnancies • chronic, long-term illness • losing an unborn baby, or having a baby with birth defects • infertility • treatment for broken teeth, cuts, headaches, concussion • bruises, pain, trauma 	<ul style="list-style-type: none"> • feeling worthless • loss of community and culture • self-blame • hurting others that are close • copying controlling and violent behaviour • withdrawing from family and friends • bad relationships with children • feeling whakama/shame, guilt or embarrassment • feeling out of control • a distorted sense of reality • low self-esteem and loss of confidence • loss of energy, feeling apathetic • isolation (staying home so people don't see the bruises; being avoided by others) • hating or being ashamed of your body • sexual promiscuity 	<ul style="list-style-type: none"> • living in constant fear • not being able to have healthy sexual relationships 	<ul style="list-style-type: none"> • mental illness • anxiety and worry • eating and sleeping disorders • depression • feeling suicidal/committing suicide/self-harm • violent thoughts or actions • Post Traumatic Stress Disorder (PTSD) 	<ul style="list-style-type: none"> • alcohol and drug abuse • inability to hold down work

⁷⁹ Of the women who seek help at Women's Refuge in New Zealand, 90% report experiencing psychological abuse compared with 65% who report experiencing physical violence.

CAN effects

The effects of CAN on children can be immediate or show up later in life. Some children show an enormous amount of resilience in dealing with experiences of CAN (including exposure to IPV). Children utilise a complex range of coping strategies. A recent NZFVC issues paper explores the effects of CAN on children in more detail.⁸⁰ Figure 8 presents the range of effects of CAN.

Figure 8: Immediate effects of CAN

Physical Health	Personal and Social Wellbeing	Intimacy and Relationships	Mental and Emotional Health	Other Impacts
<ul style="list-style-type: none"> bruising, cuts, burns, fractures and in severe cases -death 	<ul style="list-style-type: none"> disrupted mother child attachment poor academic attainment have alcohol and drug issues as they get older 	<ul style="list-style-type: none"> more likely to continue the intergenerational cycle of violence or victimisation boys exposed to IPV are more likely to later perpetrate violence against their female partners 	<ul style="list-style-type: none"> depression, anxiety and self-harm behaviour and are more likely to commit suicide 	<ul style="list-style-type: none"> come to the attention of youth justice be involved in bullying and truancy

Sexual violence effects

The effects of sexual violence vary among victims/survivors but they may be severe and long term. Research undertaken by the Ministry of Women's Affairs found that victims/survivors experienced a number of different effects including those shown in Figure 9.⁸¹

Figure 9: Immediate effects of sexual violence

Physical Health	Personal and Social Wellbeing	Intimacy and Relationships	Mental and Emotional Health	Other Impacts
<ul style="list-style-type: none"> disruptions to sleep, such as insomnia and nightmares physical ailments, such as migraines, auto-immune diseases, gynaecological issues, digestive problems, and eating problems 	<ul style="list-style-type: none"> changes in personality withdrawing socially becoming isolated and reclusive feeling unable to sustain a social life alcohol or substance use/abuse increase in self-doubt, self-blame and self-hatred 	<ul style="list-style-type: none"> a loss of trust in men confusion around sexuality a feeling of loss of safety which affected everyday relationships and communication 	<ul style="list-style-type: none"> generalised feelings of fear and anxiety and also feeling anxious or afraid about specific events, such as the perpetrator returning depression; flashbacks; anger, dissociation; self-harming behaviours; and symptoms associated with post-traumatic stress disorder 	<ul style="list-style-type: none"> disruptions to work and study patterns loss of motivation reduced concentration overworking to distract from feelings a loss of self-esteem and confidence

⁸⁰ Murphy, C., Paton, N., Gulliver, P., Fanslow, J. (2013). *Understanding connections and relationships: Child maltreatment, intimate partner violence and parenting*. Auckland, New Zealand: New Zealand Family Violence Clearinghouse, The University of Auckland.

⁸¹ http://mwa.govt.nz/sites/public_files/pathways-to-recovery-pdf_0.pdf

2.3 The long-term damage caused

IPV and CAN are leading contributors to multiple other social issues. New Zealand and international evidence shows a strong link between IPV and CAN and many other health, education, violence, social and behavioural issues. These connections are frequently commented on. For example:

- Twenty seven years ago, the Report of Ministerial Committee of Inquiry into Violence⁸² (the Roper Report) noted that violence in the home could account for up to 80 per cent of all violence in New Zealand society:

'Family violence is the cradle for the perpetuation of violence in the community' - children who grow up experiencing violence in their families/whānau are more likely to develop severe cognitive and behavioural problems; become violent as adolescents; and in due course continue the cycle of family violence with their own partner and children.'

- More recently Principal Youth Court Judge Andrew Becroft followed a similar theme in his foreword to 'Young People and Violence' which is part of the Youth '07 series:⁸³

'In the Youth Court, we believe that all roads lead back to the family environment, especially the critical early years. It ought to be a cause for real concern that nearly 17% of students report witnessing family violence in the home, and over 12% of young people report being kicked, hit or punched in their home. Violence begets violence. As Youth Court Judges we see the consequences of family violence every day.'

- The Prime Minister's Chief Science Advisor reported:⁸⁴

'... the seeds of many adolescent difficulties are sown very early in development. For example, many adolescent problems are associated with a history of early neurological and biological factors, low cognitive ability, school failure, childhood antisocial behaviour, family violence, parental drug and alcohol use, physical abuse, neglect and poor parenting practices.'

These sentiments are also echoed by Dr. Gary Slutkin,⁸⁵ a physician trained in infectious diseases who was engaged to find innovative approaches to addressing general community violence in the USA. His starting point was to get people to see violence as a contagious disease – an epidemic – whereby the greatest predictor of a case of violence is a preceding case of violence (just as in the case of flu; if someone gets a dose of flu it's because someone gave it to them). The abuse of one individual has an effect on many others as shown in Figure10.

However, with IPV and CAN transmission is more complex than with an infectious disease – it does not only spread in the form of more abuse and violence. The cumulative trauma experienced by IPV and CAN victims/survivors also spreads to multiple health and social issues affecting the individual, others around them and the next generation.

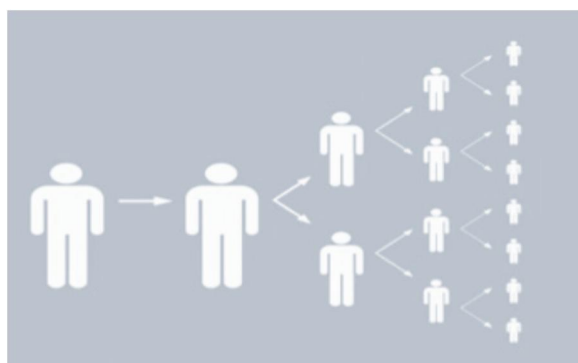
⁸² Roper, C. (1987). Report of Ministerial Committee of Inquiry into Violence. Presented to the Minister of Justice March 1987. Wellington, N.Z. Ministry of Justice.

⁸³ http://www.fmhs.auckland.ac.nz/faculty/ahrg/_docs/2007-violence-report-2010a.pdf

⁸⁴ <http://www.pmcsa.org.nz/improving-the-transition/>

⁸⁵ http://www.ted.com/talks/gary_slutkin_let_s_treat_violence_like_a_contagious_disease

Figure 10: Transmission of the effects of IPV and CAN



To complicate the picture further, evidence shows that nearly two thirds of those who experience either IPV or CAN will experience more than one type of violence over the course of their life (revictimisation). Experiencing chronic and multiple forms of abuse results in chronic and multiple health and social problems - the more abuse and violence one person experiences, the more severe and multi-layered their resulting violence, health and social problems will be. For example the USA Adverse Childhood Experiences (ACE) study⁸⁶ in which 17,000 participants provided detailed information about their childhood experience of abuse, neglect, and family dysfunction, found that male children with an ACE Score of 6 or more (having six or more adverse childhood experiences) had an increased likelihood of more than 4,000 percent of using intravenous drugs later in life (Felitti & Anda, 2009).⁸⁷

We have not found any studies that have brought together all the evidence regarding the multiple long term effects of IPV and CAN and such an exercise is outside the scope of this document. While no single study can be seen as 'proof' of a causal link, it is common in social science research to triangulate the evidence; data from multiple sources is brought together to make up a picture. Figure 11 brings together some of the New Zealand and international evidence of the far reaching effects of IPV and CAN. It is not a meta-analysis but is provided as background information to show that:

- IPV and CAN directly contribute to multiple other violence, health and social issues.
- IPV and CAN have a significant long term impact on the New Zealand society and economy.
- Early intervention or reduction in IPV and CAN cases would in turn reduce these many other social problems.
- Individuals presenting with any of these related problems should be considered as a possible red flag of current or past IPV or CAN and therefore an opportunity for early intervention.

⁸⁶ <http://www.cdc.gov/violenceprevention/acestudy/>

⁸⁷ https://www.childwelfare.gov/pubs/factsheets/long_term_consequences.pdf#page=3&view=Physical Health Consequences

Figure 11: Far reaching effects of IPV and CAN

Violence and justice	NZ Evidence	International Evidence
Youth violence	Youth CAN victims/survivors 3-4 x more likely to attack someone with a weapon	CAN victims/survivors 9-11 times more likely to offend and be arrested for criminal behaviour in adolescence
Violent crime including homicides	Family violence contributes to about ½ of all violent crime in NZ All prisoners learning to read have been abused as children	84% of all prison inmates had been abused as a child
CAN/IPV/SV abusers	CAN victims/survivors are more likely to grow up to become IPV and CAN abusers or victims The majority of adolescent sexual offenders are found to have a history of sexual and/or physical abuse	Single biggest predictor of becoming perpetrator or victim of IPV or SV is growing up in home with IPV, in particular boys exposed to IPV are more likely to become abusers later in life
Revictimisation	Child sexual abuse victims/survivors twice as likely to experience sexual and/or physical violence as adults, perpetrated by partners and non-partners Exposure to more severe IPV associated with a corresponding significant increase in the childhood risk of sexual abuse and regular use of physical punishment by a caregiver	Women who have a history of child sexual abuse are at least twice as likely to experience adult sexual victimisation
Animal abuse	Abusers' use of overt threats and actual harm to animals as a 'tool' of control of their family. 36.5% of IPV victims/survivors report a pet or animal had been injured or killed	Similar results found in international studies
Bullying	Students who had witnessed or experienced violence at home twice as likely to be bullied	Children exposed to violence in home more likely to bully other children Children and young people who bully 5.63 times more likely to become IPV abusers
Health and wellbeing		
Poor health	Victims/survivors of moderate to severe physical IPV significantly more likely to have consulted a healthcare provider within the previous 4 weeks	IPV is the highest risk factor to physical health of women under 45 CAN doubles the odds of children having poor physical health at 6 years of age
Alcohol and drug	The psychological effects of CAN may lead to alcohol and drug abuse problems in adolescence and adulthood	Male and female adults CAN victims/survivors twice as likely to abuse drugs or alcohol IPV victims/survivors are more likely to abuse alcohol and drugs as a method of coping or self-medicating
Eating disorders	Higher rates of eating disorders in women who have experienced childhood sexual abuse	Relationship between eating disorders and violence against women and girls
Teen pregnancy and Sexually transmitted infections	Adverse consequences of teenage pregnancy and risky sexual activity associated with experiences of abuse and neglect	Young women exposed to child sexual abuse have significantly higher rates of teen pregnancy and increased rates of sexually transmitted infections
Poor mental health	Youth 2 - 3 time more likely to have mental health issues	35-70% of female mental health patients report CAN in childhood 62% female and 16% male IPV victims/survivors have at least one PTSD symptom
Suicide	Youth 3-3.65 times more likely to have attempted suicide	Young people sexually abused as children 2-11 times more likely to have suicidal thoughts, attempt or commit suicide Women who experienced severe physical IPV 8 times more likely to attempt suicide
Social, education and financial		
Homelessness	Women became homeless due to escaping abuse Violence at home increases risk that young people will become homeless	IPV is major driver of homelessness, especially for women with children Adult victims/survivors of CAN 26x more like to be homeless as adults
Welfare dependency		Majority of women on welfare in US studies are current or past victims of IPV
Poverty	Despite the clear link between poverty, parental stress and negative outcomes for children, there is still an unresolved question about the direction of causality	Experience of IPV contributes to poverty, financial risk and hinders recovery sometimes long after they have left the relationship
Not in employment, education or training	Approx 2/3rds of 13-15 year olds in alternative education experienced CAN (incl exposure to IPV) in their homes CAN victims/survivors more at risk of long-term educational failure	CAN or exposure to IPV strong risk factors for young people not being in education, employment or training Substantial rates of unemployment among women who reported IPV
Behavioural issues	Cognitive and neurodevelopment can be substantially impaired in CAN victims/survivors Violence initiated by fathers associated with an increased risk of conduct disorder in children and young people	Survivors of child sexual abuse may be at greater risk of risky behaviours as adults CAN associated with behaviour problems in childhood and adolescence

Notes:

1. CAN victims/survivors includes those exposed to IPV.
2. References for this information are available upon request.

To explain this further we conclude this chapter by examining one example more closely - the relationship between CAN (including children's exposure to IPV) and youth suicide. Repeated studies in New Zealand and overseas have shown that CAN (including exposure to IPV) increases the risk of self-harm, attempted or actual suicide. The Australian Institute of Family Studies report 'Effects of child abuse and neglect for children and adolescents'⁸⁸ sums up the evidence thus:

'Research suggests that abuse and neglect doubles the risk of attempted suicide for young people (Brodsky & Stanley, 2008; Brown et al., 1999; Evans, Hawton, & Rodham, 2005). The systematic review by Evans and colleagues found a strong link between physical/sexual abuse and attempted suicide/suicidal thoughts occurring during adolescence.

Perkins and Jones (2004) found that 31% of a physically abused group of adolescents had suicidal thoughts compared to 10% of a non-abused group.

Brodsky and Stanley (2008) found that risks of repeated suicide attempts were eight times greater for youths with a sexual abuse history.'

The New Zealand Youth '07 study⁸⁹ found that both male and female students who had experienced or witnessed violence in their home were much more likely to have attempted suicide than students who had not experienced or witnessed violence in their home; 3.65 times for male students and 3 times more likely for female students.⁹⁰ Given the evidence, it is somewhat puzzling that the New Zealand Suicide Prevention Strategy 2013-2016⁹¹ makes no mention of IPV, CAN, or sexual violence.

In Section 1.2 we showed that New Zealand has some of the highest rates on IPV and CAN in the developed world. Once we understand the link between IPV, CAN and youth suicide it stands to reason we would also have the highest youth suicide rates internationally - this is confirmed in the OECD data shown in Figure 12.

Figure 12: New Zealand has the highest rates of youth suicide in the OECD



Source: New Zealand Country Highlights OECD (2009), Doing Better for Children.⁹²

⁸⁸ <http://www.aifs.gov.au/nch/pubs/sheets/rs17/rs17.html>

⁸⁹ http://www.fmhs.auckland.ac.nz/faculty/ahrg/_docs/2007-violence-report-2010a.pdf

⁹⁰ *ibid*

⁹¹ <http://www.health.govt.nz/publication/new-zealand-suicide-prevention-action-plan-2013-2016>

⁹² <http://www.oecd.org/social/family/doingbetterforchildren.htm>

Whilst IPV and CAN are not the only experiences that contribute to youth suicide, it is easy to see that if New Zealand had a system that could intervene earlier and more effectively in IPV and CAN cases we would be able to reduce the short and long term consequences - including youth suicides. The same works in reverse - we would see many of these consequential social issues as red flags to help identify where IPV and CAN maybe happening and can intervene. An expert counsellor, Margaret Mourant notes: '*Every [suicide] attempt is a cry for help and when help is denied or is unavailable, the desperation increases and further attempts may follow.*'⁹³ Attempted suicides should be seen as potential flags of IPV or CAN and responded to accordingly. This is already happening in Wairarapa where attempted suicide cases are reviewed by their Family Violence Intervention Group; a significant percentage are found to be underpinned by IPV, CAN or sexual violence.

Similar arguments could be put for the other consequential social issues. Evidence suggests that for many of the linked social issues New Zealand ranks among the worst in the world:

- 2nd to worst out of 35 countries for bullying^{94,95}
- 3rd to worst out of 152 countries for ecstasy and amphetamine type drug use⁹⁶
- 5th to worst out of 30 countries for rates of teen births⁹⁷

By intervening earlier and more effectively in IPV and CAN cases we can expect to see a reduction in bullying, teen births, welfare dependence, mental health conditions, alcohol and drug abuse and youth violence and more. Likewise by seeing attempted suicides, bullying, women with mental health conditions, young people not in employment, education or training as red flags for people suffering the effects of IPV or CAN, effective intervention could lead to a reduction in the multiple consequential social effects.

In light of the information provided in this chapter we provide two fictitious (but typical) case studies in the hope they help the reader to look at the issue through a new lens. In both these stories the victim/survivor is female not because this is always the case but to be consistent with the approach used throughout this report.

Case 1

Maria is 10 years old - her Dad died when she was five and now her Mum has a new partner. He seems to love Maria, pays her a lot of attention, takes her out for treats and tells her she is special. Maria is not sure when the abuse started. Was it when he would hug her too often, or when he used to come in when she was in the bath while her Mum was at work? Or was it when he started to sneak into her room at night and tell her if she told anyone about 'their special secret' that she would be taken away from her mother and put in a home for naughty girls. Maria had been a bright capable child who loved school. No

⁹³ <http://www.life.org.nz/suicide/suicidekeyissues/nz-statistics-on-attempted-suicide>

⁹⁴ <http://www.stuff.co.nz/the-press/761221/NZ-schools-lead-world-in-bullying>

⁹⁵ http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11118484

⁹⁶ <http://www.unodc.org/wdr2014/>

⁹⁷ <http://dx.doi.org/10.1787/711401746455>

one seemed to notice when she turned into a sullen teenager. She started sleeping over at friend's places to try and avoid home life. Then she found her problems seemed much less if she got drunk and later if she took drugs. She was withdrawn and was failing at school. Other kids picked on her, bullied her. She starts self harming and at 17 she attempts suicide. Maria is a mother by 19 but the authorities say unless she stops drinking and gets somewhere permanent to live they will take her child away from her.

What is the issue here? Does she need a parenting programme? Does she need a re-entry course to get her back into schooling? Does she need alcohol or drug counselling? Does her school need to introduce a programme to address bullying? Does she need help from a suicide counsellor? Or does she need someone to listen to what happened to her, to get her the specialist therapy she needs for the effects of years of sexual abuse, to help her re-build her life?

Case 2

Kiri was raised in a good loving home with no abuse. She succeeds at school and gets a university degree. At age 27 she meets a charming, fun loving man two years older. He dotes on her, treats her like a princess, makes her laugh and says she is the centre of his universe. His parents are separated but she doesn't know the details of their relationship and the father now lives overseas. The young couple get married and set up house together - they are in love and all seems right with their world. Kiri learns she is pregnant - she is delighted, he appears less so - he is concerned that having a child will 'cramp' his fun loving lifestyle. She thinks he just needs time to get used to the idea. The abuse starts late in the pregnancy - after the first time he assaults her he pleads with her to forgive him and promises her he will never hit her again. He tells her how he, his brothers, sisters and mother were all assaulted by his father, how as he got older he used to intervene to try and protect his mother, how he wants things to be so different for Kiri and their children. But the abuse doesn't stop and he becomes more and more controlling. Kiri says she will leave him but he says he can't live without her, couldn't bear to think of her with another man - again and again he promises to get help and stop the abuse. Kiri becomes depressed. She now has two small children, he controls every part of her life and now threatens that if she ever left him he would kill her and the children - she is trapped. The children are unsettled, they are clingy - they don't sleep much and neither does she.

After leaving and returning several times she decides to leave him for good. But Kiri is so afraid of what he will do to her that she leaves while he is at work, taking the children to a refuge. In the months and years that follow she struggles to get her life back together - she is homeless, not mentally well enough to work has no money and he is stalking her so she keeps moving between family and friends to try and avoid him. The children are more and more unsettled and she is trying to survive on a minimal welfare benefit. Then there are the long drawn out court cases - he is claiming Kiri is not mentally well enough to have custody of the children - he has a job and rents a nice house - says he should have sole custody of the children.

What is at issue here? Kiri's presenting problems are homelessness, lack of money, mental ill health and transience. But who sits behind all of these problems? If the presenting problems are addressed but not the violence behind them all – what will the outcome be for Kiri and the children?

Summary

In this chapter we have shown how the co-occurrence and interconnectedness of IPV, CAN and sexual violence create serious and ongoing impacts for victims/survivors. The snowball and transmission effects of violence and the short and long term impacts shows how urgent it is that New Zealand responds more effectively to IPV and CAN. We have found no evidence of any work being done at government level to consider the policy and practice implications of the complexity of the co-occurrence and the impacts, but believe it is critical to understand the issue in its widest sense in order to:

- assess and respond to the social and economic implications IPV and CAN has on New Zealand (see Chapter 8)
- appreciate that any reduction in IPV and CAN will have a flow on effect in reducing the incidence of all these other social problems.

We need to design a system that intervenes earlier and more effectively and identifies cases where IPV and CAN are manifesting in other social issues - in doing so we would be able to reduce the incidence of IPV and CAN, reduce the incidence of many other linked social issues and reduce the social and economic costs.

3. What are the relevant models and concepts?

In order to determine what the most effective system for New Zealand would be we need to consider what the literature⁹⁸ says. We start by examining two relevant theoretical concepts and show that IPV and CAN are what are referred to in the literature as 'complex' and 'wicked' problems and as such are not solvable using traditional approaches.

We examine four international models – ecological, prevention continuum, 'three planets' and collective impact – that can help us to conceptualise an appropriate answer to the questions raised by IPV and CAN. We then outline the Mauri Ora model that uses a Māori conceptual framework for considering responses to whānau violence and is therefore particularly relevant in Aotearoa New Zealand. We introduce a number of relevant practice and structural elements that need to be considered, in particular the issues of coordination and collaboration, and show that a fully integrated system approach would meet these concerns. An Integrated System would require radical shift in the way this country currently responds to IPV and CAN - it would require decentralisation, more decision making at a local level, community engagement, the involvement of service users, the development of a backbone agency, support and resources to communities and a continuous improvement framework.

3.1 Conceptual considerations

Complex problems

Western governments are grappling with many complex social issues such as crime, youth suicide, bullying, mental health, IPV and CAN – the list goes on. However, there are a number of commonalities between these sorts of issues.

- They are often highly visible.
- They have a direct or indirect effect on society.
- They are multi-dimensional, inter-related, and often multi-generational.
- There is often only minimal evidence to guide planners and hence designing and implementing solutions is difficult.
- They require change at multiple levels - society, government, service provision, local community and individual levels.

Complex problems tend to be non-linear and difficult to understand, and attempting to remedy one aspect of the problem can reveal or create unexpected further problems elsewhere. A complex problem is not solvable by reductionist or sequential approaches. As the business case for Social Bonds prepared by KPMG for the Ministry of Health⁹⁹ notes:

'Part of the complexity of the most intractable social issues is that they are cross-sector and cross-agency. This means that a number of levers need to be pulled to address a particular social issue and usually a variety of agencies will be responsible for pulling the different levers. The two main problems

⁹⁸ In this context we use the term literature in its broadest sense - and include relevant practice and social change concepts

⁹⁹ KPMG Social Bonds Business Case for the Ministry of Health. July 2013

created by the cross-cutting nature of social issues are coordination of efforts and poor incentives where benefits accrue to an agency which does not have influence over the necessary levers.'

Is the problem tame or wicked?

An increasingly popular and useful lens through which to better understand how to respond to complex social problems is to think of the problems as falling under two distinct categories with two distinct responses required.

Tame problems – are well defined, with a stable description of the problem, a defined stopping point, where you will know that success has been achieved. Tame problems are not necessarily simple—they can be technically very complex—but the problem can be tightly defined and a solution fairly readily identified or worked through. Rational policy making is designed to work towards the remedy of tame problems.

Wicked problems – the concept of wicked problems dates back to the 1970s when Rittel and Webber¹⁰⁰ coined the phrase to describe a class of problem that defy solution in the context of social planning.

Figure 13 shows five distinctive ways that wicked and tame problems can be differentiated.

Figure 13: Five distinctions of wicked problems

No clear definitive definition	Definitions vary among organisations and there is disagreement about the nature and solution to the problem.
No stopping rule	Efforts to solve the problem are reliant on resources to continue rather than on reaching a solution.
A symptom of another problem	There is an inherent interconnectedness between wicked problems which makes it difficult to see where one ends and another begins.
Solutions that are neither right or wrong	Because there are many perspectives about the problem the solutions can be defined as 'better' or 'worse', 'good enough' or 'not good enough'.
Every solution is a 'one shot' operation	You have to try the solution to see if it works to solve the problem.

IPV and CAN are both highly complex and typical wicked problems but are not beyond effective intervention. The complex and wicked nature of these issues demands that we stop responding as if they were tame problems. They require a different approach than the simplistic ones we have used to date. As detailed in Chapter 2, IPV and CAN are inextricably linked with other key social issues like homelessness, suicide and poor educational attainment. Given the interconnectedness of these issues, attempting to remedy one in isolation of the other can have unintended negative consequences for these related issues.

The Australian Public Service has taken a progressive approach and developed guidelines for their staff working on wicked problems.¹⁰¹ They have recognized that approaches taken to date have not achieved significant social change or return on investment for the money spent and they urge policy and decision makers to approach things differently. The Australian Public Service suggests the

¹⁰⁰ Rittel, H., & Webber, M. (1973). Dilemmas in a General Theory of Planning Policy Sciences, vol. 4. (pg 155–169).

¹⁰¹ <http://www.apsc.gov.au/publications-and-media/archive/publications-archive/tackling-wicked-problems>

following are key requirements of a strategy to address a wicked problem:

- Working in collaboration.
- Bottom up perspective.
- Flexibility and innovation.
- Long term approach.
- Interagency working.
- Developing a framework of accountability.

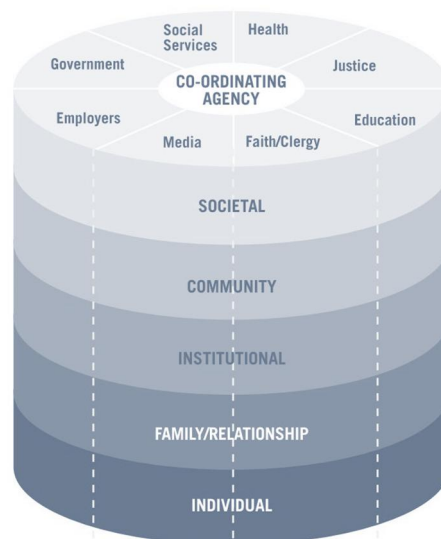
3.2 Relevant models

There are a number of models, concepts and ways of working that are well suited to improve our approach to addressing complex and wicked social problems such as IPV and CAN. It is useful to consider these when conceptualising and planning for a more effective system.

Ecological model

Fanslow, in her 2005 report on addressing family violence in New Zealand,¹⁰² noted that as the complexity of family and domestic violence has become clear, frameworks for conceptualising, identifying and addressing the wide range of diverse contributing factors have been developed. She combined the ecological model of Krug et al in the World Report on Violence and Health¹⁰³ and the co-ordinated community response model developed by the Domestic Violence Institute of Michigan to come up with the ecological model shown in Figure 14.

Figure 14: Ecological model



Source: Beyond Zero Tolerance (2005, p 78).

¹⁰² Fanslow, J. (2005) Beyond zero tolerance: key issues and future directions for family violence work in New Zealand. Families Commission, Wellington. Available at <http://www.nzfamilies.govt.nz/research/beyond-zero-tolerance>

¹⁰³ Krug, E., Dahlberg, L., Mercy, J., Zwi, A., & Lozano, R. (2002). World report on violence and health. World Health Organization, Geneva. www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf

As we discuss in later chapters, effectiveness in addressing IPV and CAN demands a comprehensive collection of initiatives, interventions and processes are occurring at all levels of the ecological model in a collaborative and integrated way.

Prevention continuum model

In addition to the levels of the ecological model, interventions to IPV and CAN must work across the prevention continuum shown in Figure 15.

Figure 15: Prevention continuum model

Primary prevention	Taking action before it occurs – awareness campaigns, education.
Early intervention	Taking action as early as possible before the violence escalates to crisis - including screening and voluntary disclosures to reduce harm and provide early and co-ordinated interventions.
Crisis response	Intervention immediately following an episode - including risk assessment, safety planning, securing refuge, gaining protection orders and care of children orders.
Rebuilding lives	Long-term follow-up, care, counselling, protection and rehabilitation.

International evidence makes clear that we need to have a ‘system’ that provides an optimal response at all levels from prevention, early intervention, crisis intervention, to rebuilding lives free from violence to reduce the long term social effects and intergenerational transference of IPV and CAN and ensure lasting change.

A health care example of this continuum would be the epidemic of type 2 diabetes. Our government has a range of national and local primary prevention initiatives largely based around programmes to reduce diabetes risk factors, such as reducing overweight/obesity, stopping smoking and increasing physical activity. Every day 50 people are newly diagnosed with diabetes.^{104,105} It is estimated that in New Zealand an estimated 50 percent of people with type 2 diabetes have not been identified¹⁰⁶ and the health sector tries to identify those most likely at risk, testing them and intervening early before the disease causes long term harm. Many people are only diagnosed when they reach the 'crisis' stage and by then have severe complications (kidney failure or damage to sight) which are very expensive to treat. The equivalent 'rebuilding lives' stage is the long term care and management of the condition aiming to minimise long term damage to the individual and economic costs. It is easy to see that addressing the epidemic of diabetes needs to occur at all four levels of the prevention continuum and the same is the case with IPV and CAN. Intervening earlier reduces harm and costs.

¹⁰⁴ http://www.diabetes.org.nz/about_diabetes

¹⁰⁵ In comparison every day on average 238 cases of family violence are reported to New Zealand Police

¹⁰⁶ This compares to 80 percent of IPV and CAN cases not identified.

Three Planets model

In addition to responding at different levels of the ecological model and across all four stages of the prevention continuum, we need to consider the 'three planet' model created by Marion Hester.¹⁰⁷ Hester explains that the intervention sector for IPV and CAN is divided into three 'planets'. Each planet has its own assumptions and beliefs, culture, laws, policies and practices and the workers on each of the different planets pull in different directions. She explains how detrimental the division is to successful response to IPV and CAN and argues that unless we have a unified approach where practitioners across planets team up and work together, unsafe practice and harmful interventions can occur. Figure 16 shows the key elements of the three planets model.

Figure 16: Three planet model

Three Planets	Domestic Violence Planet	Child Protection Planet	Child Contact Planet
Who lives on this planet?	Those working specifically with IPV, such as refuges and providers of advocacy developed with adult victim/survivor as their main focus, domestic violence programme providers and criminal justice agencies that intervene with abusers.	Statutory child protection social workers with the child as the focus of their work.	Family Court and other professionals who are focussed on parents and their residence and contact arrangements in relation to children.
How is IPV and CAN understood	The problem is male violence toward mainly female victims/survivors. Trying to build a coordinated response with more focus on high risk cases. Criminalising IPV/CAN important. Good mother safety is good child safety.	Child focus - see family as problem (dysfunction) not the perpetrator.	Presumption is that contact between a child and the non-resident parent is desired and indeed an inevitable outcome of any court proceedings -whatever the history of the relationship.
Response	Pro arrest policies, increases in prosecution and conviction, domestic violence courts. Male seen as perpetrator and female victim/survivor in need of protection and support. Not so much focus on children –but the recognition of the impact on children of exposure to IPV started on this planet.	General approach is partnership with parents rather than prosecution. Emphasis on mothers to protect children but difficult to protect children unless their own safety is assured. Punitive approach –leave him or we will take the children. Does not hold abusers accountable.	Focus on private rather than public law with the assumption that the state should not have to intervene and parents should make agreements through mediation.
Differences	On CP and DV planet the ethos is intervene to protect (deal with risk) in child contact planet intervention is not required - should be a private matter dealt with in families.	CP and DV planet think about past behaviour but child contact focus is on future behaviour.	Knowledge of dynamics of IPV and CAN is not shared.

¹⁰⁷ Hester M. British journal of Social Work . Vol 41. Issue 5. July 2011 (pg 837 – 853).

Collective impact model

The Collective Impact approach is particularly applicable to thinking about ways to respond to complex wicked problems. The term 'collective impact'¹⁰⁸ recognises that organisations must coordinate their efforts and work in collaboration if they are to achieve transformative, large-scale social change to which they all contribute. Figure 17 shows the five conditions identified by Kania and Kramer¹⁰⁹ that, together, lead to meaningful results.

Figure 17: Collective impact model

Common agenda	All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.
Shared measurement	Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.
Mutually reinforcing activities	Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.
Continuous communication	Consistent and open communication is needed across the many players to build trust, assure mutual objectives and create common innovation.
Backbone support	Creating and managing collective impact requires a separate organisation(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organisations and agencies.

Mauri Ora model

The four models above are international models - all are relevant to the matters being considered in this proposal. However, given that Māori are negatively over-represented in both IPV and CAN statistics as victims/survivors and as abusers, it is particularly relevant for us also to consider a New Zealand model.

The Mauri Ora framework¹¹⁰ is a model that uses a Māori conceptual framework for considering responses to whānau violence from a Maori world view and achieving transformation in the area of whānau violence. Mauri Ora (well-being) is the overall goal of the framework for whānau, hapū, iwi and individual Maori. Mauri Ora refers to well-being created by the maintenance of balance between wairua (spiritual wellbeing), hinengaro (intellectual wellbeing), ngakau (emotional wellbeing) and tinana (physical wellbeing). Mauri ora is sustained and restored by experiences of ihi (being enraptured with life), wehi (being in awe of life) and wana (being enamoured with life). The six constructs shown in the diagram below¹¹¹ should be applied to practice to increase Mauri Ora enabling transformative changes that can stop violent behaviour.

¹⁰⁸ A term coined by Kania and Kramer. See Kania and Kramer (2011), 'Collective Impact,' *Stanford Social Innovation Review*. Available at http://www.ssireview.org/blog/entry/rereading_collective_impact_three_lessons?utm_source=Enews&utm_medium=Email&utm_campaign=SSIR_Now&utm_content=Read_More

¹⁰⁹ Kania and Kramer (2013) 'Embracing Emergence: How Collective Impact Addresses Complexity'. *Stanford Social Innovation Review* Available at http://www.ssireview.org/blog/entry/embracing_emergence_how_collective_impact_addresses_complexity

¹¹⁰ Kruger T., Pitman M., Grennell D., McDonald T., Mariu D., Pomare A., Mita T., Maihi M., Lawson-Te Aho K. Transforming Whānau Violence: A Conceptual Framework. An updated version of the report from the former Second Maori Taskforce on Whānau Violence. 2004

¹¹¹ These definitions were used by the Amokura Family Violence Prevention Consortium and cited in Dobbs, T. & Eruera, T. (2014). *Kaupapa Māori wellbeing framework: The basis for whānau violence prevention and intervention*. Auckland, New Zealand: New Zealand Family Violence Clearinghouse, University of Auckland. Available at <http://www.nzfvc.org.nz/issues-papers-6>

Figure 18: Mauri Ora model

Imperative	Mauri Ora framework working definition
Whakapapa	Kinship that determines the connectivity between whānau, hapū, iwi; collective consciousness.
Tikanga	The practice of Māori beliefs and values; collective practice.
Wairua	Spirituality expressed as awareness of wairua and passion for life; self-realisation.
Tapu	Brings us to a state of our own knowing; self-esteem.
Mauri	Inner values; sense of power, influence and identity.
Mana	Outer values; external expression of achievement, power and influence.

3.3 Structure and practice considerations

Having considered the overarching concepts of complex and wicked problems and a range of models to guide our thinking it is now important to consider a range of structure and practice considerations that must be built into a new and more effective approach to reducing IPV and CAN.

Collaboration or integration?

There has been considerable discussion in recent years, both internationally and in New Zealand, about the need for a more joined-up approach to address social issues that are both complex and wicked such as IPV and CAN, and to ensure victim/survivor safety and accountability of abusers by:

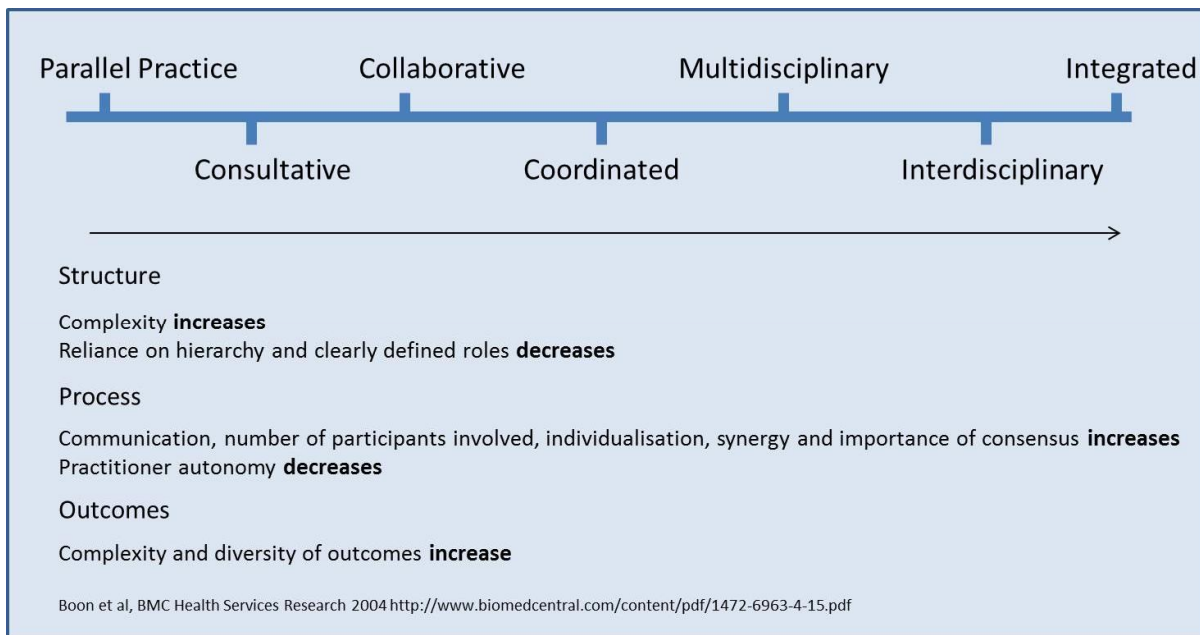
- maximising local efforts to intervene early and prevent violence from occurring
- helping create the longer-term changes needed to prevent violence from recurring
- enhancing service coordination and the ability of services to work in complementary ways
- enabling local communities to determine the most appropriate use of funding in their area.

Numerous terms and types of approaches have been used – amongst them, joined-up, whole-of-government, inter-agency, multi-agency, coordination, collaboration and partnership. Boon et al¹¹² identify seven different levels as shown in Figure 19. In a later paper they suggest¹¹³ that 'integration' rather than 'collaboration' needs to be the ultimate goal of teams working together to solve complex problems. They say collaboration can occur without integration but in order to take an integrated approach people need to collaborate.

¹¹² Boon, H.S., et al. Parallel practice to integrative health care: a conceptual framework. *BMC Health Serv Res* 2004;4:15.

¹¹³ Boon, H.S., et al. The Difference Between Integration and Collaboration in Patient Care: Results From Key Informant Interviews Working in Multiprofessional Health Care Teams *Journal of Manipulative and Physiological Therapeutics* Volume 32, Issue 9, November–December 2009, Pages 715–722

Figure 19: Collaboration and integration continuum



An Australian report¹¹⁴ commenting on the multitude of types of approaches in relation to IPV and CAN highlights the difficulties involved when there are so many different structures in practice:

'The fluid use of terminology in this field, however, does create difficulties when assessments of the success of collaborative practice are undertaken. How much coordination is required in order to resolve and address complex problems and complex needs? Partnerships can range from those with loose networks of interagency update meetings, through streamlined referral systems to more tightly woven, single integrated systems across a range of sub-unit services'.

For a truly integrated approach to be effective it needs to happen both horizontally and vertically; *'There is a need for both 'horizontal' integration (bringing the actions and priorities of different service areas and different regions into alignment) and 'vertical' integration (coordinating the actions and priorities of government departments and local services and agencies up and down the lines of accountability)'.*¹¹⁵

There are a number of examples of current IPV and CAN collaboration initiatives in New Zealand (see Chapter 5). The questions we now face are: 'Is collaboration enough?' 'What is the difference between collaboration and integration?' 'Do we need to integrate in order to achieve the results we are seeking?'

¹¹⁴ Healey, L., Humphreys, C., and Wilcox, K. (2003). Governance and interagency responses: improving practice for regional Governance – a continuum matrix. Australian Domestic and Family Violence Clearinghouse. Topic Paper 21

¹¹⁵ Matheson, C. 2000. 'Policy Formulation in Australian Government: Vertical and Horizontal Axes.' Australian Journal of Public Administration 59(2):44–55.

Integrating using a systems approach

Having determined that integration is the ultimate goal, it is timely to consider what happens if we bring the concept of integration together with that of taking a system's approach. The NZFVC issues paper¹¹⁶ says: '*international thinking is that 'the system matters' when it comes to eliminating and preventing family violence because the causes are deeply rooted at every level of the social ecological system*'.

System thinking is the process of understanding how each part within the whole system influences other parts. It can help join together the multiple organisations, agencies, sectors and individuals that work across the various levels of the ecological model and the prevention continuum to achieve collective impact. As such it lends itself well to the characteristics of complex problems.

Complex problems such as IPV and CAN involve multiple agencies and individuals, each with differing responsibilities and working on different parts of the problem. An integrated system for IPV and CAN is where all agencies and individuals who are either directly or indirectly involved at all levels, operate as one system. The FVDRC describe the multi-agency family violence system as a complex system with the following characteristics:¹¹⁷

- 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.¹¹⁸
- 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.¹¹⁹

At the local level of an integrated system Potito et al¹²⁰ describe integration as, '*Agencies forming shared arrangements at a strategic level, and intensive case management based on shared protocols and data sharing arrangements at the operational level for frontline workers.*' When a case is reported to any part of 'the system', mechanisms are in place to ensure there is a seamless and effective response regardless of the entry point. Agencies that have adopted the concept of an integrated system, with clear referral pathways between all agencies in 'the system', can offer an open door into a broader system of community-wide support. This means anyone experiencing or

¹¹⁶ <http://www.nzfvc.org.nz/issues-papers-1>

¹¹⁷ Family Violence Death Review Committee, 2014. Fourth Annual Report: January 2013 to December 2013. Wellington: Family Violence Death Review Committee. Available at <http://www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC-4th-report-June-2014.pdf> Wellington: Family Violence Death Review Committee citing D. Snowden and W. Boone, 'A leader's framework for decision making', Harvard Business Review, vol. 85, no. 11, 2007, pp. 68–76.

¹¹⁸ This is frequently referred to as emergence.

¹¹⁹ This means that we cannot forecast or predict what will happen.

¹²⁰ Potito C, Day A, Carson E & O'Leary P, 2009, 'Domestic Violence and Child Protection: Partnerships and Collaboration', Australian Social Work, vol. 62, issue 3, pp. 369-387.

using violence can access services via what might seem unlikely routes.

An integrated system approach is well aligned with the concepts described above under 'Collective Impact'. International practice examples of integrated system approaches are discussed in Chapter 4.

Decentralisation

Governments throughout the world are grappling with ways to reform their public services so they are more able to tackle big complex social problems, deal with complexity and work more collectively. The UK Institute for Public Policy Research has recently released a report¹²¹ advocating three steps to design and manage public services in a way that recognises they are complex systems: decentralise, pool funding and integrate. This report says that dealing with complex problems requires much greater integration of public service systems, and the fostering of deep relationships both among citizens and between service users and frontline professionals. They say the public management of the future is one where central government has to 'let go' and become an enabler rather than the manager.

'This is because complex challenges are not susceptible to standardised, one-size-fits-all blueprints; because services delivered in functional silos from Whitehall are unable to get a grip on the interconnected causes of complex problems; and because greater professional autonomy is required to allow for more innovative and relational approaches at the frontline.' 'Top-down initiatives and restructures tend not to work because, as complexity theory teaches us, the most effective change in a complex system comes about endogenously and incrementally, rather than externally and suddenly. Innovation comes about through learning over time'

Frontline personnel

Those who work on the frontline of service provision hold a lot of information regarding what is and is not working with the current system. The development of any response to IPV and CAN would benefit from engaging them to identify where services need to be developed and extended and how agencies can be better connected to affect successful referral pathways. Regardless of what part of the ecological model or prevention continuum they work in, frontline workers need to be involved in all levels of policy, planning, implementation, and service delivery.

The Secretary of Education, Peter Hughes is clearly advocating a move in this direction: *'The term 'sector leader' that is 'littered throughout' my job description isn't relevant any longer. The sector's leaders are actually those principals and teachers leading schools. Our role is as stewards of the education system, and I'm more of the view that we're supporting the sector leaders and providing them with the tools they need.'*¹²²

¹²¹ Muir, R and Parker, I. (2014), *Many to Many: How the relational state will transform public services*. Institute for Public Policy Research, London UK. Available at <http://www.ippr.org/publications/many-to-many-how-the-relational-state-will-transform-public-services>

¹²² <http://www.stuff.co.nz/national/politics/9144821/Educations-new-man-calls-for-rejig>

Service user involvement

Similarly, international best practice recommends that service user input is gathered for all planning, policy and service delivery initiatives to enhance the way that services best respond to their needs. The Better Public Services Advisory group¹²³ also identified 'weak customer focus' as one of the barriers to meeting the challenges ahead for the New Zealand state services: '*State services that understand customer needs well are more likely to do the things that matter most to their clients, in ways that make sense to users*'.

The Taskforce for Action on Violence within Families (the Taskforce) published a guide to involving service users to improve agencies' and the government's response to all forms of family violence.¹²⁴ The guide recommends a service user voice be at the table of any collaboration. The proposed benefits for organisations and service users are shown in Figure 20.

Figure 20: Benefits of involving service users

Benefits to Organisations	Benefits to Service Users
<ul style="list-style-type: none"> • Creating a service that better meets service users needs by being more inclusive, accessible and/or fulfilling the needs of service users more precisely • Improving the quality of the service provided and making it safer for users • Achieving the effective use of resources • Developing outcome measures that are meaningful and relevant to service users themselves • Improved accountability • Improved communication between providers and service users 	<ul style="list-style-type: none"> • Being empowered and having their voice heard • Building confidence, self esteem, skills and self-respect • Feeling included, valued and respected

Any major developments in the sector needs to be undertaken in a collaborative and collective way that involves and responds actively to service user voices, in particular from the groups we discussed in Chapter 1 as having unique dynamics in terms of their experience (see Figure 21). By involving service users in all levels of policy, planning, implementation, and service delivery, the developments are more likely to be equitable and accessible for all different service user groups.

¹²³ http://www.ssc.govt.nz/sites/all/files/bps-report-nov2011_0.pdf

¹²⁴ Taskforce for Action in Family Violence. *Incorporating the Voice of Experience*. Family Violence Service User Involvement Guide. July 2012. Available at <https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/initiatives/action-family-violence/voice-of-experience.pdf>

Figure 21: Multiple sources of service user voices



Community engagement

IPV and CAN are issues for individuals, families/whānau, communities and society but are too often labelled as a private matter. Community engagement does not involve simply passing responsibility of IPV and CAN over to the community; government agencies need to work collaboratively with service providers, community organisations, tangata whenua, businesses, service users and others. Citizens need to be involved in defining and resolving issues that affect them.¹²⁵

Positive outcomes for victims/survivors are best achieved through an integrated, whole-of-community approach to how we understand and respond to IPV and CAN.¹²⁶ One of the strategies identified in Australia's National Council to Reduce Violence against Women and their Children¹²⁷ to ensure that systems work together effectively was to: *'Support and/or establish community partnership planning mechanisms that enable communities and services to prioritise need, address gaps and unnecessary duplication in service provision, and contribute to the development of policy, planning and delivery at the local level'*.

¹²⁵ [http://www.dia.govt.nz/Pubforms.nsf/URL/ENGAGEMENT_GUIDE_FINAL.pdf/\\$file/ENGAGEMENT_GUIDE_FINAL.pdf](http://www.dia.govt.nz/Pubforms.nsf/URL/ENGAGEMENT_GUIDE_FINAL.pdf/$file/ENGAGEMENT_GUIDE_FINAL.pdf)

¹²⁶ http://www.women.nsw.gov.au/violence_prevention/Domestic_and_Family_Violence_Reforms

¹²⁷ <http://www.dss.gov.au/our-responsibilities/women/publications-articles/reducing-violence/national-plan-to-reduce-violence-against-women-and-their-children/time-for-action-the-national-council-s-plan-for-australia-to-reduce-violence-against-women-and-their-children-2009-2021>

Backbone agency

To function effectively an integrated system needs a backbone agency. Kramer and Kania identified backbone support as one of the five conditions to achieving 'collective impact' (see earlier section). The UK Institute for Public Policy Research report¹²⁸ identifies the development of collaborative backbone organisations in public services as one of seven key developments required for interconnected systems. Key functions they collectively identify for such organisations include:

- Coordinating participating organisations and agencies.
- Working with those involved in all parts of the system to ensure they understand and agree to uphold both the common agenda and rules for interaction.
- Generating and transferring knowledge around the system to ensure the system is constantly learning.
- Disseminating knowledge and offering opportunities for ongoing professional development.
- Acting as clearing houses for innovative practice and allow the system as a whole to learn.
- Tracking data, enabling adaptation, disseminating knowledge and improving motivation and morale among all participants.
- Enabling a high degree of transparency among all organizations and levels involved in the work.

Learning as we go - the continuous improvement cycle

In the sections above we have noted that when working to make change in complex social issues there is often only minimal evidence to guide planners and hence a continuous improvement framework is critical when addressing these issues. In 2011 the Prime Minister's Chief Science Advisor, Sir Peter Gluckman, produced a report¹²⁹ in which he identified a number of relevant matters including:

'Many decisions must be made in the absence of quality information, and research findings on matters of complexity can still leave large areas of uncertainty. In spite of this uncertainty, governments still must act.'

'Many policy decisions can have uncertain downstream effects and on-going evaluation is needed to gauge whether such policies and initiatives should be sustained or revised. But, irrespective of these limitations, policy formed without consideration of the most relevant knowledge available is far less likely to serve the nation well.'

These ideas also align with Kania and Kramer's¹³⁰ thinking with regard to addressing wicked problems:

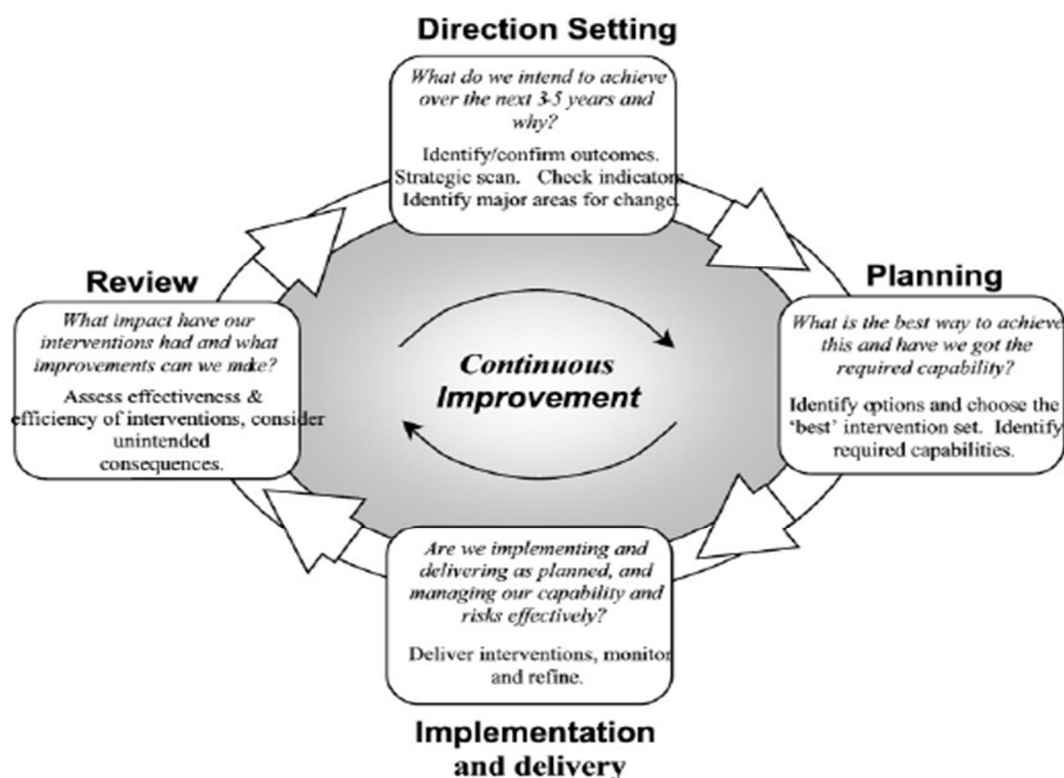
'There is no single solution for wicked problems and say that even if a solution were known, no one individual or organization is in a position to compel all the players involved to adopt it. Important variables that influence the outcome are not and often cannot be known or predicted in advance. Under these conditions of complexity, predetermined solutions rarely succeed.'

¹²⁸ Muir, R and Parker, I. (2014), *Many to Many: How the relational state will transform public services*. Institute for Public Policy Research, London UK. Available at <http://www.ippr.org/publications/many-to-many-how-the-relational-state-will-transform-public-services>

¹²⁹ Towards better use of evidence in policy formation: a discussion paper. Available at <http://www.pmcasa.org.nz/publications/>

¹³⁰ Kania and Kramer (2013) 'Embracing Emergence: How Collective Impact Addresses Complexity'. *Stanford Social Innovation Review* Available at http://www.ssireview.org/blog/entry/embracing_emergence_how_collective_impact_addresses_complexity

Figure 22: The continuous improvement cycle



Source: Steering Group for the Managing for Outcomes (2003, 2).¹³¹

All stages of the continuous improvement cycle, outlined in Figure 22, must operate effectively and all be linked with one another. This is what Rittel and Webber¹³² call the 'no stopping rule'. Particular attention needs to be paid to how knowledge regarding what works is generated and shared around the system, in order to facilitate ongoing learning and informed innovation. A responsibility should be put on all providers of public services to share their experiences. The need for the whole system to improve through the sharing of successful practice should override any concerns among private providers about commercial confidentiality.¹³³

For continuous improvement to work it needs to be part of an infrastructure by which all stages of the cycle can be co-ordinated in a continuous and ongoing manner. This should enable gathering of available evidence to inform innovation, strategy and planning, implementation at a local level, and then review and evaluation in order to build more evidence and feed that back into strategy and planning. Formal systems and processes need not stifle these activities but rather provide the framework for maximising opportunities while minimising risks. What is critical is that there are mechanisms to make changes as the learning occurs.

¹³¹ Steering Group for the Managing for Outcomes. (2003) *Managing for Outcomes: Guidance for Departments*. [Online]. Available from http://www.ssc.govt.nz/display/document.asp?navid=253&docid=3530&pageno=1#P12_245.

¹³² Rittel, H., & Webber, M. (1973). Dilemmas in a General Theory of Planning *Policy Sciences*, vol. 4. (pg 155–169).

¹³³ Muir, R and Parker, I. (2014). *Many to Many: How the relational state will transform public services*. Institute for Public Policy Research, London UK. Available at <http://www.ippr.org/publications/many-to-many-how-the-relational-state-will-transform-public-services>

Summary

In this chapter we have shown that IPV and CAN are complex and wicked problems and we will be unsuccessful in solving them by continuing to respond as if they are tame problems. Designing an integrated system would involve changing the way that policy and service development for IPV and CAN have traditionally happened in New Zealand. To create this new system we would need to think locally, act locally and resource locally and provide backbone support to local communities. Most importantly we would need to listen to the voices of service users and service providers and ensure that the system is continually improving as learning occurs.

4. What are other countries doing to tackle the problem?

In our quest to identify the most effective system for addressing the epidemic of IPV and CAN in New Zealand it is important to examine what other countries are already doing so we can learn from their experiences. Although New Zealand has very high rates of IPV and CAN, other Western countries are also grappling with the problem and are seeking to make reforms to their systems to respond safely and effectively.

In this chapter we show that the other comparator countries have already started to join-up their efforts from policy through to service delivery recognising that national, regional and local levels need to be operating as one system. As discussed in Chapter 3 there is a continuum of joined-up responses ranging from parallel processes to integrated systems. The examples discussed below fall on different parts of that continuum. Some of these examples provide a collaborative and coordinated approach, while others are working towards providing an integrated response. Most assume there are two critical objectives – victim/survivor safety and perpetrator/system accountability.

4.1 Victoria, Australia

Before the Australian state of Victoria implemented reforms they had a response system to IPV and CAN much like the current New Zealand situation. There was no 'family violence service system' or unifying, cohesive policy framework. Ten years ago Victoria began to implement a series of reforms to build an integrated response to violence against women and children.

Their first undertakings were engaging the sector in a collaborative process to create a shared understanding of the problem, developing a common philosophical and policy framework and setting up governance structures to oversee the reforms. At its heart the integrated response aims to ensure women and children are made safer no matter what their individual circumstances are and how they come into the system.¹³⁴ The integrated response has four key guiding principles that are central to their continuing efforts of reform:

1. women's and children's rights
2. safety, wellbeing and empowerment
3. accountability
4. accessibility and inclusion.

The Victorian model has taken a collaborative approach in the development of their integrated response. Strong leadership from the government and non-government sectors has led to support for the reforms at regional and state level. The Victorian government has invested in the Police, courts, and the services sector so they can work together and this has been central to the new

¹³⁴ See http://www.whealth.com.au/documents/health/fv-a_right_to_respect.pdf for the 10 year prevention plan, http://www.dhs.vic.gov.au/__data/assets/pdf_file/0004/643072/ARighttoSafetyandJustice.pdf for the most recent 10 year intervention plan and http://www.dpcd.vic.gov.au/__data/assets/pdf_file/0018/35523/Final_10_Year_Plan_Oct08_2nd_Edition.pdf for the Indigenous plan.

reforms. In addition, the Family Violence Risk Assessment and Risk Management Framework are helping to create system-wide capacity to ensure that women can access highly skilled help and support anywhere in the system, that they are assessed properly for risk and therefore receive the right service at the right time. Training standards have also been introduced in key sectors to ensure staff are appropriately skilled. Referral pathways have also been strengthened. Government agencies continue to undertake research and evaluation and develop effective monitoring and accountability mechanisms. They are also working towards improving their data collection and systems so that they can measure their progress against the family violence reform priority outcome areas. Part of the focus for future development is in broadening the reach of the integrated response to related sectors and areas such as the acute health system. The Victorians have identified that because most cases of IPV and CAN are not reported to the Police, the integrated response system is now required to build linkages with mainstream services to broaden its capacity to identify and respond to more cases of family violence.

One challenge they have faced is to integrate child protection services with the integrated response. As Humphreys explains in the 'Issues Paper on Child Protection Services in Australia',¹³⁵ every state in Australia is making progress in developing an integrated response particularly with regard to criminal justice, but has struggled to integrate Child Protection Services. In 2009 a National Framework regarding child protection was released by the Council of Australian Governments.¹³⁶ The framework sets out ways that nation-wide and state-wide efforts can ensure children and young people are safe and argues that 'major system reform is necessary to bring earlier intervention and child protection sectors together, and link them to early childhood services to form a coordinated system'. The plan states that reforms in Victoria have led to building a more integrated service system across the levels of child, youth and family services and has resulted in a service system that is 'localised, better coordinated and that is responsive to family needs'. The plan explains that there has also been a boost to earlier intervention and prevention. This involves community-based intake, assessment and referral when families first show signs of difficulty, and targeting family support services at the most vulnerable groups and communities. This work has involved referrals from the statutory child protection agency to community service providers.

Victoria appears to be making headway in integrating two very different 'response systems' (family violence and child protection) by trying to strengthen the relationship between Child Protection Services and other workers in the sector. In Victoria there are partnership agreements between family violence services, Child FIRST/Family Services and Child Protection. These agreements set out joint practice approaches that are based on three overarching aims, namely, the safety and wellbeing of children, the safety and empowerment of victims/survivors of family violence, and the

¹³⁵ Humphreys C. Issues Paper 13. Domestic Violence and Child Protection: Challenging directions for practice. Australian Family Violence Clearinghouse. May 2007

¹³⁶ Protecting Children is Everyone's Business. National Framework for Protecting Australia's Children 2009 – 202. An initiative of the Council of Australian Governments

responsibility and accountability of perpetrators of family violence. In 2012 a good practice guide was released using case studies to help show how multi-agency partnerships can work to improve child safety.¹³⁷

4.2 New South Wales, Australia

New South Wales (NSW) has recently released a strategy document to better guide its system response to 'family and domestic violence'.¹³⁸ Two government reports were critical of the way the system in NSW was responding to domestic violence. The reports made a range of findings including:

- agencies trying to work together to prevent and respond to domestic and family violence are doing so without a common framework for their activities, and without common goals or objectives
- organisations do not identify or assess risk in a common way – which means that victims/survivors of violence can fall through gaps between the agencies
- there are significant barriers to sharing information between agencies which must be addressed if we are to help people stay safe from violence
- there are few programs that seek to change behaviour in abusers.¹³⁹

In response, NSW began a year-long public consultation process with a wide range of individuals, agencies and service users to gather evidence about what changes were needed in order for the system to be more integrated and to work better. The strategy being adopted has 10 principles in place that will guide all policy and practice reforms.

1. The safety of victims/survivors, particularly women and their children, is paramount.
2. Domestic and family violence is acknowledged as a violation of human rights.
3. Domestic and family violence is predominately but not exclusively perpetrated by men against women and their children.
4. Support for victims/survivors is empowering and focused on long-term recovery.
5. Responses to children exposed to violence prioritise the safety and long term wellbeing of children.
6. Perpetrators of domestic and family violence are held to account.
7. Victims/survivors can choose to remain safely at home, free of violence.
8. Strong leadership and good governance supports government and non-government organisations to work together in an integrated, multi-agency approach.

¹³⁷http://www.dhs.vic.gov.au/__data/assets/pdf_file/0009/729423/1_good_practice_working_together_support_children_young_people_family_violence_0812.pdf

¹³⁸ NSW Government - It Stops Here. Standing together to end domestic and family violence in NSW The NSW Government's Domestic and Family Violence Framework for Reform.2014

¹³⁹ NSW Auditor General 2011, 'New South Wales Auditor-General's report – performance audit: Responding to domestic and family violence', Audit Office of New South Wales, Sydney

9. Information sharing is consent-based wherever possible.
10. Services, programs and practice models are evidence-based and continuously improved through evaluation.

New South Wales has built a domestic violence framework which aims to allow agencies to work together. Like Victoria they have created shared policy definition of domestic and family violence and guiding principles applicable for all agencies in the sector. They have also created a set of minimum standards applicable to all services, invested in strategic approaches such as building the evidence base through monitoring, evaluation and research, and developed and invested in exemplar projects and strategies. A new referral pathways model has been established to help improve integration and coordination of services. Part of the new referral pathway has meant the implementation of a new Risk Identification Tool and a Central Referral Point. This is an electronic referral mechanism that provides real-time data on domestic and family violence referrals and services provided to victims/survivors and their children operating 24 hours a day, seven days a week. Local Coordination Points are also part of the new system which will provide a centralised way of case managing cases. The New South Wales plan is clear that victims/survivors of domestic violence require a comprehensive response including support for:

- protection from further violence through the criminal justice system
- physical health issues associated with the violence they have experienced
- the emotional and psychological effects of violence
- practical safety and security concerns (eg replacing locks)
- financial, transport and accommodation support.

Improvements to the way that the child protection system and the domestic violence sector work together have occurred in NSW. In 2006 the State released Interagency Guidelines for Child Protection Intervention. The guide recognised that child protection cannot be achieved by one government agency and that interagency partnerships were vital to a successful intervention in terms of child safety. It set out processes for agencies to effectively work together to help children, young people be safe and promoting the idea of agencies sharing information, resources and expertise to improve overall practice.

In 2008 a Special Commission of Inquiry into Child Protection Services in NSW¹⁴⁰ was released. One of the findings of the report was that some institutional barriers prevented agencies from working together. The Inquiry resulted in the release of a five-year action plan that aims to build a stronger, more effective child protection system in NSW.¹⁴¹ Creating an integrated system that supports children, young people and their families is a central objective of the plan. The use of new reporting and referral arrangements to allow families to access appropriate services from government

¹⁴⁰ The Hon James Wood AO QC. Report of the Special Commission of Inquiry into Child Protection Services in NSW Executive Summary and Recommendations. 2008.

¹⁴¹ Keep Them Safe: a shared approach to child wellbeing 2009-2014

agencies and non-government services without having to come in contact with the statutory child protection system is one such way the integrated ways of working are being promoted.

4.3 United Kingdom

The United Kingdom has a number of integrated response initiatives in place at a local level. England, Wales and Northern Ireland now have over 250 MARACs (high risk multi-agency risk assessment case management meetings), a number of specialist domestic violence courts and many funded Independent Domestic Violence Advisers (IDVAs) who work with victims/survivors including representing them in MARACs and the courts. While these elements might not be an 'integrated system' as such, they share common elements with the Victorian and NSW's approach; ie agencies have a shared understanding and shared training and documentation. Moreover, while not formalised in the way we envisage an integrated system would be, they do represent a broad, consistent 'systemised' approach to IPV and CAN.

A national strategy was released in March 2011 outlining a wide range of actions the UK government would be taking towards its strategy of ending violence against women and girls.¹⁴² The strategy is clear; government needs to work in partnership with communities and agencies to respond effectively, and decentralising services to local communities is the key to developing services that are best suited to local contexts. Training is also seen as fundamental to the overall development of a better system.

In Scotland, a high level strategy was produced in 2009 to help implement a shared understanding regarding violence against women.¹⁴³ The document was at a policy level rather than that of an action plan. However, this year (2014) work commenced at the government level to develop an overarching strategy to guide the country's response to violence against women. It includes but is not limited to commercial sexual exploitation; female genital mutilation; forced marriage; rape and sexual assault, as well as domestic abuse. A consultation process which involves engagement and collaboration with frontline agencies and services will gather information to ensure the strategy provides for better services and prevention of violence against women. The strategy is due to be published in July/August 2014.

Scotland (which has a similar population to New Zealand) has 32 Multi Agency Partnerships (MAPS) in place. These partnerships focus on prevention, protection, provision and participation and are seen to be essential in any response to violence against women. In Scotland the MAPS are designed with an outcomes based approach whereby the Scottish government and local authorities have a single outcome agreement. The local authorities decide what their local priority will be and allocate the funding accordingly as long as priority is consistent with the national government's ten year programme of national outcomes. A cornerstone of the MAPS is shared understanding with training provided through specialist consortia to ensure there is a common definition and high level

¹⁴² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118153/vawg-action-plan.pdf

¹⁴³ Safer Lives: Changed Lives. A shared approach to tackling violence against women in Scotland-2009

knowledge regarding violence against women. In addition, monitoring and evaluation is key to gathering information and exploring what is happening locally in order to target their efforts and engage meaningfully with local partners. A toolkit is available for communities wishing to develop an outcomes approach.¹⁴⁴

In terms of integration with the child protection services, reforms are already underway. In Scotland the links between IPV and CAN are made very clear in documentation guiding policy and practice relating to child protection. The two systems of child protection and family violence intervention appear to be more aligned than in, for example, Australia. For example, since 2003 the government has provided funding to have one dedicated children's worker in every Women's Aid group in Scotland. Concern was expressed in a 2004 report that services were not consistent throughout Scotland.¹⁴⁵ A subsequent guide for policy planners encouraged local agencies to ensure they adopt integrated approaches to meet the needs of children affected by IPV and CAN. Further effort was made a couple of years later to improve the integrated response. A multi-agency group (Delivery Group and Ministerial Task Force) set up a 'Getting it Right for Every Child National Practice Model' including domestic abuse pathfinder sites in four pilot areas to test and implement practice change¹⁴⁶ focussing on:

- initially removing need for automatic referrals to Child Protection Services
- making the child's needs and wants central to planning
- joint working with other agencies
- protection strengthened by taking into account the needs and views of non-abusive parent
- taking measures to address the actions of the perpetrator.

There is an expectation that these pilots will be 'scaled up' once there is adequate infrastructure, protocols and resources. Scotland has found that treating every case of IPV as a child protection case for automatic referral is not helpful. Instead they have found that protecting the mother may be the best way to protect the children. In 2008 the Scottish Government also released a literature review to help promote good practice in terms of services for children and young people affected by IPV and CAN in recognition that cross government and cross agency action can and must improve.¹⁴⁷ The report explores the ways multi-agency forums can work to make child protection a focus of domestic violence forums like MARAC. The key principles of the approach are:

- no one organisation is responsible for keeping children safe
- effective multi-agency collaboration is required
- protective action needs to focus on intervention with the perpetrator
- the protection of children is separate but linked to the protection their mothers.

¹⁴⁴ www.scotland.gov.uk/publications/2009/04/23084349

¹⁴⁵ Children and Young People Experiencing Domestic Abuse. Guidance Note for Planners Scottish Executive, Edinburgh 2004

¹⁴⁶ <http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright/publications/dap-review/review>

¹⁴⁷ Literature Review: Better Outcomes for Children and Young People Experiencing Domestic Abuse – Directions for Good Practice. COSLA, Scottish Govt, 2008

4.4 Duluth USA

The Duluth Domestic Abuse Intervention Project (DAIP) model, developed in the 1990s in Minnesota, USA, is one of the founding models of a 'coordinated community response' on which many international models are based. This model comes mid-way on the continuum of joined-up approaches discussed in Chapter 3. Again common elements including shared understanding, training and protocols are foundations of the approach – although not as formalised as would be the case in a fully integrated system.

The Duluth model has victim/survivor safety as its central goal and incorporates perpetrator programmes to provide an integrated response. Resources have been developed for agencies working in the domestic violence sector including best practice policies and protocols. Emphasis is placed on providing support and safety planning for women who experience abuse, prompt and appropriate referral to other agencies, and collaborative approaches between different agencies such as child protection services, alcohol / drug and mental health treatment. Monitoring and tracking of cases has been built into the system and the response is evaluated from the standpoint of victim safety.

The development of the criminal justice response is well documented and includes an emphasis on offender accountability through the use of case tracking, arrest policies and sanctions against non-compliance to court orders.^{148,149}

While the primary focus in Duluth is on the criminal justice sector, limited integration of child protection services is evident. A guideline document is available for child welfare workers to provide direction when responding to situations in which child maltreatment and domestic violence are both occurring.¹⁵⁰ The guide provides information and tools for screening, risk and lethality assessments, safety planning and how to work with the non-abusive parent and children.

4.5 Common components and activities of successful international integrated approaches

The international examples discussed above provide a set of common components and activities of successful integrated responses. Figure 23 provides a snapshot.

¹⁴⁸Pence, E (1997) A coordinated community response to domestic violence. The National Training Project, Duluth, Minnesota

¹⁴⁹Australian Domestic and Family Violence Clearinghouse (2010) Understanding Domestic Violence and Integration in the NSW Context: A Literature Review for NSW Department of Community Services. Prepared on behalf of UNSW Global Pty Limited.

¹⁵⁰<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3490-ENG>

Figure 23: Common components and activities of successful international integrated approaches

Component	Activities
A shared understanding and commitment and common goals	<ul style="list-style-type: none"> • Policy is underpinned by violence against women and children being intolerable
Shared training and workforce development	<ul style="list-style-type: none"> • Shared organisational training to enable shared understanding • Workforce up-skill to increase understanding and capacity necessary • Accommodate diverse perspectives
Resources to guide and support local integration	<ul style="list-style-type: none"> • Minimum service standards • Templates to help build regional or local governance structures • Funding for a local coordinator • Written resources that support and guide local groups working together • Common risk assessment tool • Guides to assist development of referral pathways
All agencies, structures, processes, initiatives operate as one system	<ul style="list-style-type: none"> • Multiple entry points to the one 'system' • Connected vertically and horizontally • Collective or shared outcomes • Communication, coordination, collaboration
Continuous improvement	<ul style="list-style-type: none"> • Developmental, formative, outcome evaluations • Services, programs and practice are evidence-based and continuously improved • Openness and trust to enable inquiry and thinking • Emergent solutions adopted • Flexible and consultative with service users • Continuous feedback loops
Vertical and horizontal connections	<ul style="list-style-type: none"> • Formal mechanisms to connect horizontally between local areas and vertically to connect national activities to local
Strong leadership	<ul style="list-style-type: none"> • Strong leadership supports organisations to work in an integrated way • Leaders aligned as to the nature of IPV • Integrated leadership all levels political, institutional and local • Leadership at a national (or state) level establishes the mandate for all levels to integrate (horizontally and vertically)
National framework or strategy to guide activity	<ul style="list-style-type: none"> • Consistent and commonly understood set of principles and practices. • Core principles commonly include placing the survivor at the centre of the response, ensuring survivor safety, holding abusers accountable, service user involvement, the independent rights and needs of children exposed to violence and taking into account the needs and experiences of people from diverse backgrounds

Backbone agencies

The international models show that integration works best at a local level if there are resources to support collaboration, coordination or integration. In some countries independent backbone agencies have been established to perform many of the functions outlined in the table above. There are two standout examples in the UK of local communities being resourced by national backbone agencies to work in a more integrated ways and informed by best practice. These agencies are CAADA and Respect.

CAADA (Co-ordinated Action Against Domestic Abuse) is a UK national charity that works to support a strong multi-agency response to domestic abuse by helping to create a consistent, professional and effective response to all victims/survivors of domestic violence, and in particular those at high risk of harm. CAADA understand that the best ideas for supporting domestic abuse victims/survivors

are most often generated by local non-government agencies. Accordingly, they work to ensure that effective ideas are scaled up and shared at a national level, and that local evidence is used to shape national policy and practice. They use evidence of improved safety outcomes for victims/survivors and their children to shape the attitudes and skills of those working in the sector, those funding the work and those developing policy in the area to encourage the allocation of resources to this work. Some of the CAADA's services and resources include:

- providing accredited learning, development and practical tools
- facilitating a multi-agency response: saving lives, saving money
- sharing and embedding best practice
- gathering evidence to shape national policy and local practice.¹⁵¹

Respect is a further UK example of a coordinated response to domestic violence that promotes consistency and best practice in local communities via a national agency through provision of national resources and services.¹⁵² Respect is a membership organisation that develops, delivers and supports effective services for, male and female perpetrators of domestic violence, young people who use violence and abuse at home and in relationships and men who are victims/survivors of domestic violence. Some of those services and resources include:

- support, resources and training for members including providing safe minimum practice assessments
- managing accreditation of perpetrator programmes so that members of the public, funders, commissioning agencies and other professionals can be assured of a high quality, safety-focused service from organisations accredited by Respect
- promoting knowledge of research about domestic violence and collaboration between researchers, practitioners and policy makers
- influencing public policy and providing a national voice on men's violence against women.

Summary

New Zealand is fortunate to be in a position to learn from developments undertaken in other countries with respect to IPV and CAN. Some of these models have been evaluated and findings have helped to shape what is now understood internationally to be good practice in terms of creating and implementing a joined-up approach. The two examples of backbone agencies (CAADA and Respect) show what is possible when an independent body is resourced to provide services to improve sector-wide knowledge, skills and consistency.

The key components necessary for a successful joined-up approach drawn from these case studies can be used to guide the design of the new Integrated System for New Zealand – although none of the examples examined are providing as yet the fully integrated system approach we propose for New Zealand in Chapter 6.

¹⁵¹ To learn more about the work CAADA do visit <http://www.caada.org.uk/aboutus/what-we-do.html>

¹⁵² To learn more about the work RESPECT do visit <http://respect.uk.net/>

5. What is the current situation in New Zealand?

In the previous four chapters we examined the issues of IPV and CAN and the need to collectively understand the nature, scope and scale of the problem and adjust our response accordingly. We examined the serious and ongoing impacts for IPV and CAN victims/survivors and how the effects snowball and then transmit to others and become widespread social problems. We showed the need for an integrated system to reduce the incidence of IPV and CAN and the many other linked social issues.

The proposed new Integrated System would involve changing the way that policy and service development for IPV and CAN have traditionally happened in New Zealand. To create this new system we would need to think locally, act locally and resource locally and provide the support of a national backbone agency. We have also examined several international examples that provide important guidance about the key components necessary for a joined-up system to be effective. Before we pull all this information together and outline what the ideal integrated system would be – ‘where we need to be’ – we need to look at the current situation in Aotearoa New Zealand – ‘where we are now’. From there we can see how much needs to change.

This chapter describes how the current system for IPV, CAN and sexual violence is organised. We detail the national and regional infrastructure, services and relationships. What is evident is that we have a system that is complicated, fragmented and not operating as one system. We have many different initiatives, groups and networks and yet we have no national register and no formal overarching national or regional infrastructure linking all these together horizontally at a regional level – or vertically to the national bodies which are meant to provide infrastructure and governance. The current system is overly confusing.

This chapter shows that it is unfit to provide a ‘one door – right door’ response to victims/survivors or abusers seeking help for IPV and CAN. Three recently released reports have also commented on the parlous state of the current ‘system’, relevant quotes from which are shown in Figure 24.

Figure 24: Media comments

Report	Comment
The FVDRC's <i>Fourth Annual Report</i> ¹⁵³	<i>'The Committee has documented system failures in many of the regional reviews. It is worth noting that these failures have not occurred just in respect of the abusive episode that resulted in death. In most of the reviews problematic practice can be observed over many years.'</i>
The Glenn Inquiry People's Report ¹⁵⁴	<i>'Most people told the Inquiry that New Zealand's current system for addressing child abuse and domestic violence is generally not working. Sometimes the things that were meant to help didn't – they just made it worse'. 'People talked extensively about the amount of time they spent navigating the ins and outs of 'the system', making it difficult to become, or stay, safe which left little time for 'healing'.'</i>

¹⁵³ Family Violence Death Review Committee, 2014. Fourth Annual Report: January 2013 to December 2013. Wellington: Family Violence Death Review Committee. Available at <http://www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC-4th-report-June-2014.pdf>

¹⁵⁴ https://glenninquiry.org.nz/uploads/files/The_Peoples_Report_-_full_document.pdf

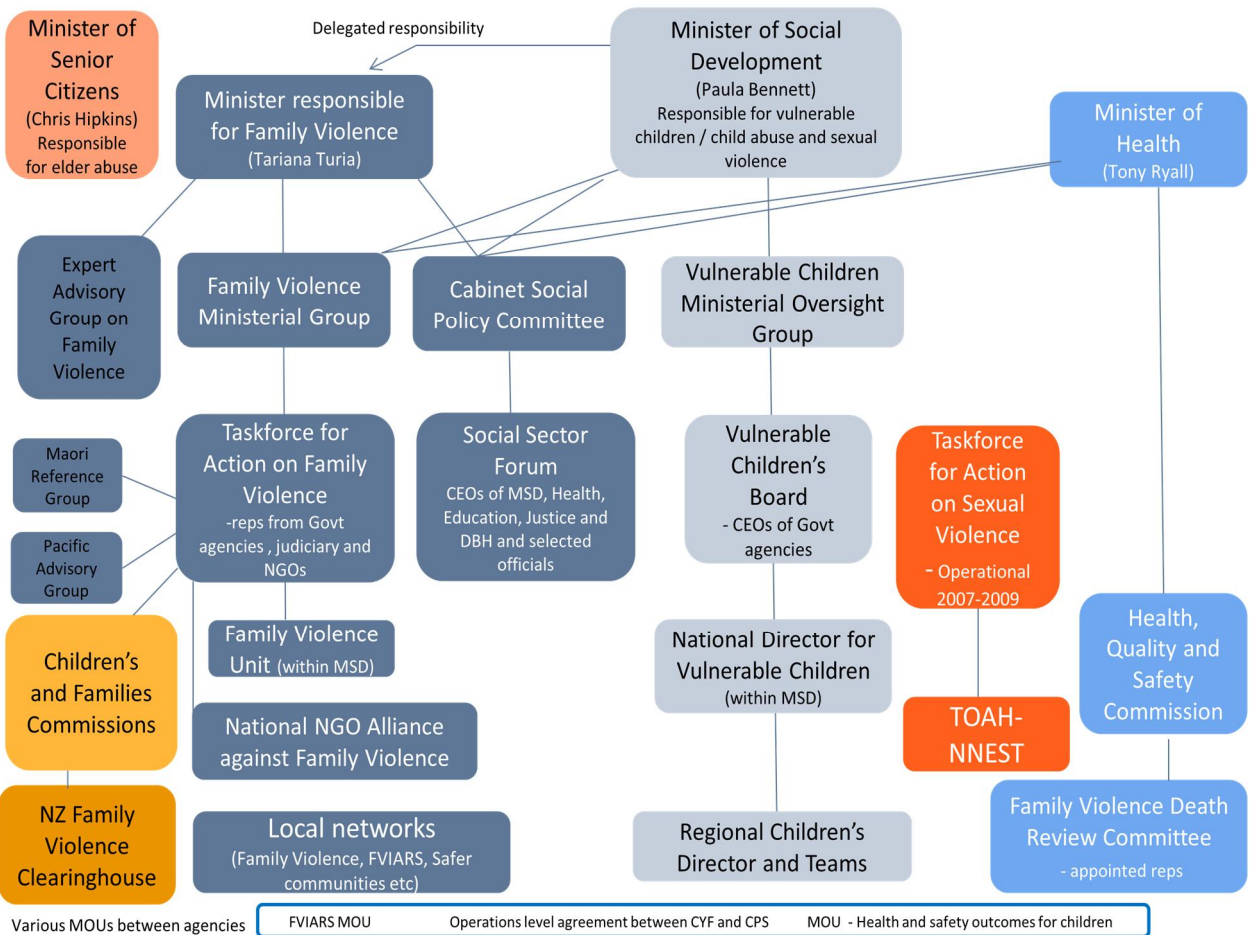
The Expert Advisory Group's report¹⁵⁵

'To maximise the prospect of reducing the rate of family violence and dealing more effectively with victims and perpetrators of family violence the current systems and structures need to change.' 'It results in the current system having a multiplicity of service providers, but no overall service. If there is to be genuine integration there will need to be systemic change.' 'While many reports have been written approximating the scale of the problem, successive attempts to address it have not been sustained and we have not taken opportunities to learn from previous successes and failures.'

5.1 National infrastructure

The importance of recognising and reflecting the overlap and interconnectedness between IPV and CAN in all levels of policy and practice was outlined in Chapter 2. Currently however, governance and leadership arrangements for these are managed quite separately and in complex ways at a national level (Figure 25).

Figure 25: Current national infrastructure - as at July 2014



¹⁵⁵ http://beehive.govt.nz/sites/all/files/Report_of_the_Expert_Advisory_Group_on_Family_Violence.pdf

Family violence

The Taskforce for Action on Violence within Families (the Taskforce)¹⁵⁶ was established in June 2005 to advise the Family Violence Ministerial Team on how to improve the way family violence is addressed, and how to eliminate family violence in New Zealand. The Taskforce's current Terms of Reference¹⁵⁷ state the role of the Taskforce is to:

- identify and prioritise actions to strengthen government and NGO initiatives to prevent family violence, including the abuse and neglect of children and older persons
- identify policy, legislative and service gaps and opportunities for alignment
- ensure that key actions are integrated across the government and NGO sectors
- commission information, analysis and advice as required
- provide advice on emerging issues.

There has not been a national strategy for family violence since the Te Rito strategy in 2002. Instead the Taskforce governance and leadership activities are based on producing and overseeing the implementation of annual Programmes of Action.¹⁵⁸ These are not designed to be either strategic or long-term but rather contain a variety of more short-term initiatives that are instigated by the Taskforce and then either completed, not progressed or passed to an individual agency to manage in an ongoing way with no subsequent oversight from the Taskforce.

There is no dedicated budget attached to the Taskforce's Programme of Action. Annual initiatives are planned, funded and implemented via 'lead' Ministries. The Taskforce has no governance or leadership responsibility for the sector as a whole or for developments occurring in the sector outside their Programme of Action.

The Māori Reference Group¹⁵⁹ and the Pacific Advisory Group¹⁶⁰ provide strategic advice to the Taskforce and review progress on its Programmes of Action. Each group has one member on the Taskforce.

Current status

- The Taskforce has not met since 25 September 2013.
- There have been no updates on the Taskforce website of meetings and achievements since December 2012.¹⁶¹
- The last annual Programme of Action expired on 30 June 2013¹⁶² and has not been replaced with a current one.
- The most recent report monitoring progress on implementation of the Taskforce's initiatives is

¹⁵⁶ <http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/action-family-violence/>

¹⁵⁷ Available at: <http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/action-family-violence/taskforce-info.html>

¹⁵⁸ There was an 'Ongoing Programme of Action' that spanned the years 2007-2010

¹⁵⁹ <http://www.familyservices.govt.nz/working-with-us/programmes-services/whānau-ora/Māori-reference-group.html>

¹⁶⁰ <http://www.familyservices.govt.nz/working-with-us/programmes-services/pasefika-proud/profiles-of-pag.html>

¹⁶¹ <http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/action-family-violence/taskforce-work.html>

¹⁶² Available at: <http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/action-family-violence/reports.html>

dated June 2011.¹⁶³

- The Māori Reference Group's E Tu Whānau Programme of Action sits alongside the work undertaken by the Taskforce but in contrast it is a comprehensive five year strategy. Between the two documents, particular initiatives are not necessarily reflected or aligned.
- The Pacific Advisory Group's programme of action 2008 and beyond¹⁶⁴ now appears to be out of date. More recently the group produced the Pasefika Proud Family Violence Research Plan.¹⁶⁵

Other family violence activities

Social Sector Forum

On 3 July 2014 the government advised¹⁶⁶ that family violence had been added as one of the Social Sector Forum's priority areas to '*help to improve the integration of government's family violence activity and ensure synergies and duplication in programmes and services are identified early*'. The Social Sector Forum¹⁶⁷ works to all social sector Ministers. It is not clear what the links are between the Social Sector Forum, the Taskforce and the many other governance and leadership arrangements shown in Figure 25.

Expert Advisory Group

On 1 October 2013 the Associate Minister for Social Development, Tariana Turia announced the establishment of an Expert Advisory Group on Family Violence in New Zealand,¹⁶⁸ saying: '*The Expert Advisory Group on Family Violence is being formed to provide independent strategic advice to assist Government to determine key priority actions to address family violence in New Zealand*', and '*The Group has a range of expertise and experience in this field and will work towards solutions by the end of 2013*'. The Expert Advisory Group met twice in October and November 2013 and government released the group's report along with the government's response on 3 July 2014.¹⁶⁹

Elder abuse

Elder abuse is one of the five forms of 'family violence' and hence comes under the Taskforce. The operationalisation of elder abuse initiatives is managed via the Senior Services team at the Ministry of Social Development (MSD)¹⁷⁰ and reports to the Minister of Senior Citizens.

Family Violence Death Review Committee

The FVDRC is an independent committee that advises the Health Quality & Safety Commission (HQSC) on how to reduce the number of family violence deaths. The FVDRC's *Fourth Annual*

¹⁶³ Available at: <http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/action-family-violence/taskforce-work.html>

¹⁶⁴ <http://www.familyservices.govt.nz/documents/working-with-us/programmes-services/whānau-ora/programme-of-action-for-pacific-peoples-2008-and-beyond.pdf>

¹⁶⁵ <http://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=4255>

¹⁶⁶ http://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&cad=rja&uact=8&ved=0CDMQFjAD&url=http%3A%2F%2Fwww.beehive.govt.nz%2Fsites%2Fall%2Ffiles%2FA_stronger_response_to_family_violence_Q_A.pdf&ei=yiy2U-3WHsXGkwXBr4D4Dw&usq=AFQjCNHpoHF1m-IMSSuoTYZKK0iuFzE9nw

¹⁶⁷ <http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/corporate/annual-report/2010-11/leadership.html>

¹⁶⁸ <http://www.beehive.govt.nz/release/new-expert-advisory-group-family-violence-announced>

¹⁶⁹ <http://www.nzfvc.org.nz/node/1778>

¹⁷⁰ <http://www.msd.govt.nz/what-we-can-do/seniorcitizens/positive-ageing/progress/goal-5.html>

*Report*¹⁷¹ was released in June 2014. They made eight specific recommendations and note, 'Throughout this report the Committee identifies opportunities to strengthen the system's resilience and enable organisations and practitioners to better respond to those living with family violence'. The FVDRC has no formal links with the Taskforce and indications are it is left up to individual ministers and ministries to decide how implementation of the FVDRC's findings and recommendations will be managed.

New Zealand Family Violence Clearinghouse

The NZFVC is operated by the University of Auckland, under a contract funded by the Families Commission to provide accessible, comprehensive and up-to-date information on family and whānau violence. Researchers from the Leitner Centre¹⁷² reported: 'Despite the large number of resources contained in the website, it is not clear whether it was created to share information with NGOs or with the government or to monitor and follow-up the situation and studies on domestic violence in New Zealand.'

National NGO Alliance against Family Violence¹⁷³

This alliance is a group of national NGOs. Member organisations discuss and take action on domestic and family violence, elder abuse, sexual violence and child abuse in New Zealand. The alliance group has three representatives on the Taskforce.

Memoranda of Understanding (MOU) between agencies

We understand that for some years there has been a national MOU in place between Police, CYF and the National Collective of Independent Women's Refuges (NCIWR) with respect to the management of Family Violence Inter Agency Response System (FVIARS) but neither the details or the status of this document appear to be publicly available.

Vulnerable children

Although CAN has been defined in government documentation as one of the five forms of 'family violence' for over 10 years, it is now being managed separately under the Vulnerable Children's initiative. The Taskforce's Terms of Reference state: 'In October 2012, government recognised that a whole-of-government response to family violence must continue [SOC Min (12) 22/2 refers]. It sought to ensure that work to address family violence is strongly linked with other strategic priorities, particularly the White Paper for Vulnerable Children, the Better Public Services result areas, and Whānau Ora'. However, the Terms of Reference are silent on how these linkages will be achieved.

¹⁷¹ Family Violence Death Review Committee, 2014. Fourth Annual Report: January 2013 to December 2013. Wellington: Family Violence Death Review Committee. Available at <http://www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC-4th-report-June-2014.pdf>

¹⁷² Fenrich, J. & Contesse, J., (2009), *It's Not OK New Zealand's Efforts to Eliminate Violence Against Women*, Leitner Centre for International Law and Justice. New York City. (pg 17)

¹⁷³ <https://womensrefuge.org.nz/WR/Get-help/Useful-links.htm>

The White Paper for Vulnerable Children¹⁷⁴ is, in essence, the government's strategy for CAN and the Children's Action Plan is a high level plan of how these strategic changes will be implemented. Interestingly, the White Paper for Vulnerable Children includes no mention of the evidence summarised in Chapter 2 on the inter-connectedness between IPV and CAN or how these two 'entangled' issues should be addressed together, thereby creating further fragmentation in planning, policy and service delivery. The White Paper for Vulnerable Children (pg 167)¹⁷⁵ shows the governance arrangements as outlined in Figure 25. Our understanding is this governance structure only pertains to the work being done under the Children's Action Plan, not all work being done for CAN or vulnerable children.

Current status

- Implementation of the Children's Action Plan is being managed by a dedicated team within the Ministry of Social Development.¹⁷⁶ The Children's Action Plan¹⁷⁷ has 56 recommendations that were due to be implemented by the end of 2013. There appears to be nothing on the website detailing the progress of this work.
- In May 2014 the New Zealand Government formally responded to the United Nations Human Rights Council second Universal Periodic Review (UPR) of New Zealand, accepting the 'vast majority' of the 155 recommendations. However, it is concerning that our government has rejected the recommendation that they take into account the relationship between child abuse and contributing factors such as domestic violence and poverty.¹⁷⁸ The reason given is, 'The Children's Action Plan aims to protect vulnerable children from maltreatment. New Zealand has other programmes to address intimate partner violence and child poverty.' This response intimates that the government is confident that addressing IPV and CAN separately is appropriate despite the evidence to the contrary, as discussed in Chapter 2.
- The government has announced that by June 2015 eight new Children's Teams will be established.¹⁷⁹

Other vulnerable children activities

Parliamentary inquiry

In November 2013 parliament's Health Select committee reported on an inquiry they had conducted into improving child health outcomes and preventing child abuse, with a focus on pre-conception until three years of age.¹⁸⁰ Recommendation 90 is: 'We recommend to the Government that it

¹⁷⁴ Two volumes available via <http://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/policy-development/white-paper-vulnerable-children/white-paper-for-vulnerable-children-volume-1.pdf> and <http://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/policy-development/white-paper-vulnerable-children/whitepaper-volume-ii-web.pdf>

¹⁷⁵ <http://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/policy-development/white-paper-vulnerable-children/whitepaper-volume-ii-web.pdf>

¹⁷⁶ <http://childrensactionplan.govt.nz/>

¹⁷⁷ <http://childrensactionplan.govt.nz/action-plan/>

¹⁷⁸ Recommendation 113 in the report available at <http://www.hrc.co.nz/wp-content/uploads/2013/03/New-Zealand-Government-Response-to-2014-UPR-recommendations.pdf>

¹⁷⁹ Horowhenua, Marlborough, Clendon/Manurewa/Papakura, Hamilton City, Gisborne, Whanganui, Christchurch, Whakatane <http://childrensactionplan.govt.nz/resources/childrens-teams-factsheet/>

¹⁸⁰ http://www.parliament.nz/en-nz/pb/sc/documents/reports/50DBSCH_SCR6007_1/inquiry-into-improving-child-health-outcomes-and-preventing

evaluate the case for further investment in the development of multi-disciplinary teams including paediatricians, social workers, behavioural psychologists, and family support workers, to provide an integrated system of assessment and evidence-based services for families with a high-risk or history of child abuse'. The government's response to the committee's recommendations¹⁸¹ is silent on the concept of an integrated system.

Memoranda of understanding (MOUs) between agencies

We are aware of the following MOUs between agencies with respect to CAN.

Figure 26: Memoranda of understanding

Partnership between CYF, Police and each DHB ¹⁸²	MOU between the three agencies focused on health and safety outcomes for children and young people signed in August 2011, focused on a collaborative working relationship. It is unclear how this three-way relationship links to the work of the VIP coordinators.
MOU CYF and Ministry of Education ¹⁸³	Details how the two agencies will work together to ensure the safety and education of vulnerable children. Child protection training for identifying at-risk children and potentially dangerous situations is included, along with who to work with and what action to take.
MOU between CYFs and CPS	In August 2012, an 'Operational Level Agreement: Requests for information from Child, Youth and Family by Community Probation Services (CPS)' was agreed. This agreement assists CPS to request and receive information from Child, Youth and Family to assist its assessment of an offender.

Sexual violence

Sexual Violence has no whole-of-government oversight. The Taskforce on Sexual Violence operated for two years 2007 to 2009 but was then disbanded. The Sexual Violence Taskforce was a partnership between government and Te Ohaakii a Hine – National Network Ending Sexual Violence Together (TOAH-NNEST).¹⁸⁴ The partnership approach recognised the considerable subject matter expertise and knowledge of the sector alongside the knowledge and resources of government. TOAH-NNEST was involved at every level of the taskforce from leadership and work programme design, through to working with officials to develop an information and evidence base and find solutions.

Current status

Since the Sexual Violence Taskforce was disbanded there has been no joined-up national leadership by government and the NGO sector has only had informal arrangements to get their voices heard by the multiple ministers and government agencies involved in some way with sexual violence. The 71 recommendations contained in the final report from the Sexual Violence Taskforce have yet to be fully implemented.

¹⁸¹ <http://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=4372>

¹⁸² http://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=0CCMQFjAB&url=http%3A%2F%2Fwww.cyf.govt.nz%2Fdocuments%2Fworking-with-others%2Fmicrosoft-word-final-mou-cyf-police-dhbs-august-2011.pdf&ei=VHCWU8jZFMXCKQWY7IHYAQ&usg=AFQjCNE6NLhTom6nF_GLbEroEcor-Ios-w

¹⁸³ <http://www.cyf.govt.nz/working-with-others/mou-with-education.html>

¹⁸⁴ TOAH-NNEST is a network of specialist sexual violence response and prevention services, representing about 40 specialist not for profit organisations (NGOs) and many individual specialists working throughout Aotearoa New Zealand in whānau/ families, hapu, iwi and communities. <http://toah-nnest.org.nz/>

In February 2013 Social Development Minister Paula Bennett took ministerial responsibility for sexual violence.

Other sexual violence activities

On 21 August 2013 parliament’s Social Services Select committee initiated an inquiry into the funding of specialist sexual violence social services.¹⁸⁵ On 30 April 2014, Social Development Minister Paula Bennett said she could not wait for the outcome of the inquiry¹⁸⁶ and the government announced additional funding for sexual violence services over the next two years (see Section 5.5).

5.2 Related initiatives

Having shown that IPV and CAN are directly linked to multiple other social issues (Chapter 2) it is appropriate to consider the infrastructure, governance and national initiatives for those related issues. Figure 27 contains by no means an exhaustive list but shows how much more complicated things become when these are also considered.

Figure 27: Related initiatives

Related governance and inter-agency groups	Related initiatives
<ul style="list-style-type: none"> • NZ Injury Prevention Strategy Chief Executives Forum • Crown-iwi Whānau Ora governance group with three NGO commissioning agencies • Social Sector Trials Joint Venture Board • Inter-agency committee on drugs • Expert advisory committee on drugs • The Ministerial Committee on Suicide Prevention • Ministerial sub-group of the Cabinet Social Policy Committee • Crown-Iwi Whānau Ora Partnership Group • Ministerial Committee on Poverty • Ministerial Committee on Drug Policy • Expert Advisory Group on Vulnerable Children’s Information System 	<ul style="list-style-type: none"> • Better Public Services groups • Youth Crime Action Plan • Disability Strategy • Crime Reduction Strategy • Te Punanga Haumarū bullying prevention initiative¹⁸⁷ • Injury Prevention Strategy • Ministry of Youth Development • Fresh Start Youth Justice reforms • Prime Minister’s Youth Mental Health project • NZ Injury Prevention Strategy secretariat • Drivers of Crime project • Welfare Reform Group • Whānau ora unit at Te Puni Kōkiri • Dept. of Corrections Drug and Alcohol strategy • NZ Drug detection agency

5.3 Regional service provision and infrastructure

Service provision

Current service responses to IPV and CAN include:

- dedicated IPV and CAN services e.g. stopping violence programme services
- Kaupapa Māori services
- mainstream services e.g. mental health or alcohol and drug services
- legal and statutory services e.g. Police and Courts.

¹⁸⁵ http://www.parliament.nz/en-nz/pb/sc/business-summary/00DBSCH_INQ_12392_1/inquiry-into-the-funding-of-specialist-sexual-violence

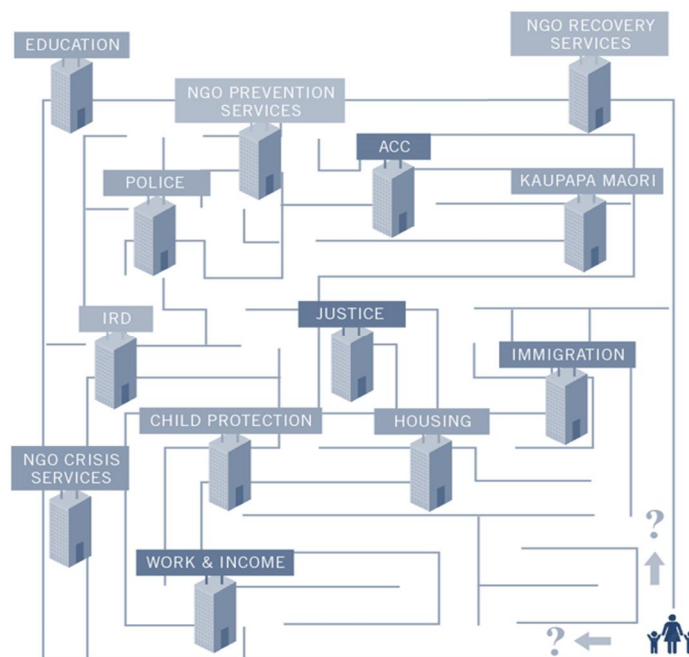
¹⁸⁶ <http://www.nzfvc.org.nz/node/1692>

¹⁸⁷ <http://www.tph.org.nz/>

These services are provided by a large number of IPV and CAN specific and mainstream organisations, either directly by government departments or via contracted arrangements with NGOs. There is no publicly-available master list of all family violence services provided or purchased by government. According to MSD's Family and Community Services website¹⁸⁸ they contract with 774 different providers for family violence services. In addition, family violence services are contracted via CYF (eg differential response services), Ministry of Justice (eg stopping violence programmes), and other government agencies. There are no consistent national service accreditation specifications or practice standards but rather isolated examples of guidelines pertaining to individual groups of services that are purchased.¹⁸⁹

Across the country, community level responses are inconsistent and fragmented, with gaps and duplications. Victims/survivors, abusers and families often find it difficult to navigate their way through a complex maze of disconnected services and systems each with different policies and processes. Agencies operate as silos and invariably do not know what other agencies can offer and hence are unable to make appropriate referrals. Therefore some victims/survivors struggle to access the current system at all. Others find themselves in a never ending cycle, lost within the maze (Figure 28) or stuck within specific parts of the system. They cannot get out and move on with their lives (eg because of endless hearings in the family court): *'The numerous organisations and agencies do not work well together, communicate with one another, or share information. This left those seeking help and support ill-informed, confused, or feeling lost in the chasms between the silos.'*¹⁹⁰

Figure 28: Current service provision maze



¹⁸⁸ <http://www.familyservices.govt.nz/directory/searchresultspublic.htm?cat1=966&searchTerms=&search=Search&azServices=false>

¹⁸⁹ For example Family Violence Response Co-ordination Funding Agreement Practice Guidelines. Available at <http://www.familyservices.govt.nz/working-with-us/funding-and-contracting/practice-guidelines/family-violence-response-co-ordination-pg-2012.html>

¹⁹⁰ https://glenninquiry.org.nz/uploads/files/The_Peoples_Report_-_full_document.pdf

There is no central point of contact that oversees and understands the needs of individuals experiencing IPV and CAN. As a result those affected are often sent back and forth between different service providers, which means that they have to 'battle the system'. They fall between the cracks in the system response and in many instances return to their abuser as leaving is just too hard.

*'When various organisations and agencies – government, non-government and community – involved in child abuse and domestic violence work in isolation, it makes it difficult for people and families under stress, especially those in crisis situations, to navigate them. People spoke about getting the "run around" when they needed help, especially when agencies did not communicate and work together.'*¹⁹¹

There are no clear lines of accountability, no mechanisms to repair parts of the system when things go wrong and no evidence-based and standardised safety planning processes to ensure all those travelling the system are safe.

As previously stated, unfortunately sexual violence services are largely silo-ed from IPV and CAN services even though there is a significant overlap between the issues (see Chapter 2). The silo-ing of services is largely a result of a funding environment that historically has pitted the sectors against each other to compete for scarce resources. Few communities have specialist sexual violence services and screening for sexual violence is not a standard part of work with victims/survivors of IPV despite the evidence being clear that there are high rates of sexual violence experienced in families where there is IPV.

Current infrastructure

Some attempts at coordinated ways of working have already been implemented throughout the country to try and organise national initiatives to respond to, and end IPV and CAN. However significant factors such as the highly competitive funding environment, increasing competition from other agencies to provide similar or identical processes or services, a shortage of highly trained professional staff and a lack of time to determine how collaborative work could be achieved, often serve to reinforce local agencies working in isolation from one another.

Figure 29 summarises the regional initiatives, networks and inter-agency groups with more detail provided in Appendix 4. There are 218 groups, networks and coordinators either directly or indirectly working on 'family violence'. There is no national register of all these groups and no formal over-arching national or regional infrastructure linking all these initiatives together horizontally at a regional level or vertically to the Taskforce and no formal mechanisms (other than those mentioned above) to link the various groups and networks together.

¹⁹¹ https://glenninquiry.org.nz/uploads/files/The_Peoples_Report_-_full_document.pdf pg 73

Figure 29: Multiple local co-ordination mechanisms



The DHB Violence Intervention Programme (VIP) appears to be the only one that has national leadership and governance arrangements providing oversight of all regional/local activities. The Family Safety Teams (FSTs) have a Police National FST Coordinator and a national steering group;¹⁹² however, we are told that while the national steering group's charter requires the group to meet every two months, there have been fewer meetings in recent times.¹⁹³

No-one has responsibility for keeping an overview of how these various multi-agency arrangements are working in each region or local area. We know that in some regions many of these groups and networks work collaboratively together and have in essence formed an informal network-of-networks or inter-agency groups. In other areas everything is fragmented with all these different groups/activities working independently of one another.

Despite collaborative efforts being made, there is evidence that these efforts appear to be falling short. Many have not been well implemented and are not achieving measurable or sustainable outcomes. Further, because in most regions these initiatives are not integrated in any way, they add

¹⁹² Which includes representatives from Police, CYF, National Collective of Independent Women's Refuges, National Network of Stopping Violence Services, the Taskforce's Māori Reference Group and Pacific Advisory Group and an NGO representative of the six FSTs

¹⁹³ Advice received in response to an OIA request

to the fragmentation, inefficiencies, confusion and competition for scarce resources.

Family Violence Inter-agency Response System

The Family Violence Inter-Agency Response System (FVIARS) - an initiative designed to manage cases of family violence reported to the Police - is the primary inter-agency initiative in each local region or area. A key objective of FVIARS is to enable collaborative, coordinated interagency responses to family violence via regular local interagency meetings aimed at assessing the risk level of reported cases of family violence, plan responses and monitor cases. Despite its aims FVIARS lacks the infrastructure, governance and national consistency to effectively manage cases of family violence.

FVIARS is compromised by its very structure; it is not a system. It is a discrete series of isolated meetings happening throughout New Zealand. Each of the 62 FVIARS operates autonomously from the others. There is wide variation in the form of each FVIARS meeting, in the number of agencies involved, the volume of cases each FVIARS considers and how the meeting is conducted. In six regions there is also a Family Safety Team (a joint initiative between Police, Ministry of Justice, and the Department of Child, Youth and Family, in collaboration with the community sector) with similar aims but it is not clear how many of those teams are aligned to their local FVIARS.

In essence each FVIARS operates similar to a hospital emergency department waiting room with cases flooding in and the FVIARS meeting triaging each case to determine what action needs to be taken by which agency(ies). All or most of the 90,000+ family violence cases reported to Police each year are referred into one of the 62 FVIARS 'waiting rooms' around the country. Information regarding each case is shared between participating agencies and agreement reached as to which exit door is most appropriate for each case. Some cases relate to multiple exits and therefore the agencies concerned need to reach agreement on how they will work together on that case. Some of the multiple exit doors are shown in Figure 30 as examples only.

Figure 30: Family Violence Inter-agency response System waiting room



Particularly, in the larger regions with high volumes in the waiting room each week, the process can be very demanding on the resources of individual agencies. In some areas, two levels of meetings are held; one for high-risk cases (lower volumes) and the second for lower-risk cases (higher volumes). There are no nationally consistent practice standards guiding these meetings, documented referral pathways or integrated risk assessment framework for use by all FVIARS and participating agencies (although some FVIARS have developed their own). The current FVIARS system expects the victim/survivor to take responsibility to achieve safety for herself and her children. The FVDRC commented¹⁹⁴ as follows:

'In the regional reviews it was evident that frequently the well-intentioned focus of the Family Violence Inter-Agency Response System (FVIARS) meetings was on empowering the victim to make their own choices, which in effect resulted in a list of actions the victim would take to make herself and her children safe (ie go into refuge, separate from her abusive partner, get a protection order, etc). This individualist approach to safety planning had the unintended and dangerous consequence of placing the responsibility to stem the abusive partner's violence and initiate safety plans solely on the victim – someone who was extremely vulnerable, with limited resources and social supports and in a state of considerable trauma.' (pg 83)

In most, if not all, instances the FVIARS processes are not linked to the Courts processes. Most FVIARS do not have formalised linkages with agencies focused on associated social issues and it is not yet known how the new Children's Teams will link with the FVIARS meetings. The Glenn Inquiry People's Report¹⁹⁵ indicates widespread dissatisfaction with the current inter-agency system, *'Many people spoke about a widespread lack of inter-agency collaboration in New Zealand....time and again the Inquiry heard from victims, perpetrators and frontline workers that numerous organisations and agencies did not work well together, communicate with one another, or share information.'* (pg 73)

In their report for the period December 2011 to December 2012¹⁹⁶ the FVDRC reported an urgent concern about the use of the FVIARS system to respond to IPV and made three FVIARS-specific recommendations. Twelve months later the FVDRC's *Fourth Annual Report*¹⁹⁷ notes that in the past 12 months CYF has made little or no progress implementing those recommendations. It is concerning that according to the government's announcement on 3 July 2014, it will be a further 12 months before any progress is made: *'The Ministry of Social Development and New Zealand Police will lead work to develop advice on how to enhance the current multi-agency system for responding to family violence incidents. They will report to the Family Violence Ministerial Group within the next year on what is needed to ensure that victims of domestic violence get the support they need to stay safe and build independence'*.¹⁹⁸

¹⁹⁴ Family Violence Death Review Committee, 2014. Fourth Annual Report: January 2013 to December 2013. Wellington: Family Violence Death Review Committee. Available at <http://www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC-4th-report-June-2014.pdf>

¹⁹⁵ https://glenninquiry.org.nz/uploads/files/The_Peoples_Report_-_full_document.pdf

¹⁹⁶ Family Violence Death Review Committee, *Third Annual Report: December 2011 to December 2012*. Wellington, Health Quality & Safety Commission, 2013. Available at <http://www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC-3rd-Report-FINAL-locked-June-2013.pdf>

¹⁹⁷ Family Violence Death Review Committee, 2014. Fourth Annual Report: January 2013 to December 2013. Wellington: Family Violence Death Review Committee. Available at <http://www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC-4th-report-June-2014.pdf>

¹⁹⁸ http://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&cad=rja&uact=8&ved=0CDMOFjAD&url=http%3A%2F%2Fwww.beehive.govt.nz%2Fsites%2Fall%2Ffiles%2FA_stronger_response_to_family_violence_Q_A.pdf&ei=yiy2U-3WHsXGkwXBr4D4Dw&usq=AFQjCNHpoHF1m-IMSSuoTYZKK0iuFzE9nw

There is no standardised approach around the country for identifying and managing high-risk cases. Seven of the nine deaths¹⁹⁹ the FVDRC reviewed in depth in 2012 had been managed via the FVIARS process at some point and the FVDRC noted: *'In its current form, the FVIARS process was not able to provide a multi-agency response sufficient to address the imminent or longer-term safety issues of these particular high-risk cases'*. Once again it is of concern that 12 months after that report was released the government has now announced: *'An intensive case management approach will be tested for feasibility and effectiveness in two locations over two years. The Ministry of Justice and New Zealand Police will work with key stakeholders to design how it will be tested'*.²⁰⁰ *Much more urgency is required?*

5.4 The voices of service users and frontline workers

In 2010 a group of service users released a report outlining what they saw as the barriers domestic violence 'survivors' are facing in the current system and possible solutions.²⁰¹ In a subsequent magazine article the group's spokeswoman, Lisa Close, said, *'We are trying to highlight shortcomings in the system and facilitate change'*.²⁰² While Close and her group attracted considerable media attention and were invited to speak at some central government policy and planning meetings, there has never been any formalised, ongoing or systematic way for service users to be involved in all levels of policy, planning, implementation, and service delivery.

Frontline service providers hold enormous amounts of information and experience regarding the limitations and potential for our service system but their knowledge is not currently utilised. Representatives from national NGO agencies are usually invited to speak on behalf of frontline workers in central government strategy and planning forums, for example, by the Taskforce or specific advisory groups. The Glenn Inquiry People's Report²⁰³ expresses a similar view: *'Importantly, the development of a strategy must be informed by the voices of those affected by child abuse and domestic violence, and by frontline workers. The current reliance on policy-makers with little or no insight into, or understanding of, child abuse and domestic violence and its impacts does not work.'*(pg 115)

There are no formalised complaints processes for victims/survivors, *'Those affected by child abuse and domestic violence had no genuine right of redress, as their complaints and questions about the quality of the services they received often went unheard or unaddressed'*.²⁰⁴

¹⁹⁹ These seven cases came from seven different FVIARS groups in large metropolitan areas.

²⁰⁰ http://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&cad=rja&uact=8&ved=0CDMQFjAD&url=http%3A%2F%2Fwww.beehive.govt.nz%2Fsites%2Fall%2Ffiles%2FA_stronger_response_to_family_violence_Q_A.pdf&ei=yiy2U-3WHsXGkwXBr4D4Dw&usq=AFQjCNHpoHF1m-IMSSuoTYZKK0iuFzE9nw

²⁰¹ <http://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=2498>

²⁰² <http://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=1826>

²⁰³ https://glenninquiry.org.nz/uploads/files/The_Peoples_Report_-_full_document.pdf

²⁰⁴ *Ibid.*

5.5 Funding

In July 2014 Minister Tariana Turia said government currently funds nearly \$70m to NGOs for family violence services²⁰⁵ but it is not possible to determine the total government spend on 'family violence' services. Government has had a history of short term funding arrangements; in many cases new initiatives have been funded for short periods, often only in the pilot stage. Regardless of the results achieved from the pilot, sustainable funding is not forthcoming and many promising initiatives have been forced to stop. Service providers have expressed frustration and concern that the government has 'preferred' to fund short term projects rather than provide sustainable funding to existing services.²⁰⁶

Frontline service providers have reported being under-resourced and stretched to full capacity with increasing demand for their services. Specialist sexual violence services have been severely underfunded and are greatly reduced in numbers as a result. Many NGO agencies rely on volunteers to deliver their frontline services. The Glenn Inquiry People's Report²⁰⁷ includes numerous comments from frontline workers about problems with funding and capacity of the services they provide, including:

'In fact, most frontline workers who talked about community-based organisations said they were only partially funded by government contracts, and some received no government funding at all. It was clear from frontline workers that programmes supporting victims and perpetrators of child abuse and domestic violence must be adequately and sustainably funded.' (pg 71)

However, we do know that even without an overall strategy, the government is investing heavily in IPV and CAN services in particular arenas.

- In 2011 the government established a new \$10.535 million initiative called the Family-Centred Services Fund which aims to foster Māori and Pacific wellbeing by enabling providers to respond holistically to the broad range of needs of families and whānau experiencing violence.²⁰⁸
- In May 2013 Associate Minister for Social Development Tariana Turia announced an additional \$8m over four years for the E Tu Whānau programme.²⁰⁹ This is to help address family violence within Māori whānau, Pasifika, migrant and refugee communities.
- The government's 2014 budget which provides \$33.2 million in operating funding for the initiatives arising from the Children's Action Plan in 2014/15.²¹⁰
- In June 2014 government announced:

²⁰⁵ <http://beehive.govt.nz/release/breaking-family-violence-cycle>

²⁰⁶ Fenrich, J. & Contesse, J., (2009), *It's Not OK New Zealand's Efforts to Eliminate Violence Against Women*, Leitner Centre for International Law and Justice. New York City. (pg 44)

²⁰⁷ https://glenninquiry.org.nz/uploads/files/Section_3_-_The_Peoples_Report.pdf

²⁰⁸ http://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CB0QFjAA&url=http%3A%2F%2Fwww.familyservices.govt.nz%2Fdocuments%2Fworking-with-us%2Ffunding-and-contracting%2Fapplication-forms%2Foverarching-fact-sheet-1-april-2011.pdf&ei=mu21U9HTDYemkQW1_ICYcw&usg=AFQjCNHMTjv7G764XJ3m3fPQYCiChFHEzQ

²⁰⁹ <http://www.nzfvc.org.nz/?q=node/1267>

²¹⁰ \$16.4 million to continue developing new ways of working together, \$3.2 million for the implementation of the Vulnerable Children's Bill and \$13.7 million of new funding to CYF. See: <http://beehive.govt.nz/release/investing-protect-our-most-vulnerable-children>

- A \$10.4 million funding boost for sexual violence services over the next two years.²¹¹
- An additional \$9.4m funding package for three new family violence justice sector initiatives over the next four years.²¹²

5.6 Past reports

There have been numerous reviews, research exercises, inquiries and retrospective deaths reviews regarding IPV and CAN (see Appendix 5) as well as periodic reviews of our international treaty obligations (see Appendix 6). All have added to the body of evidence of what is working and not working in New Zealand responses to IPV and CAN. All have included recommendations for changes that need to occur. Many of these reports have criticised the current 'system' for its failure to:

- hold the safety of victims/ survivors at its heart
- hold abusers accountable
- respond appropriately to Māori service users
- have a cohesive framework to link all the agencies, organisations and initiatives together
- work in a collaborative and consistent way across the country to ensure the first two goals
- monitor and evaluate practice
- have practice that is informed by evidence
- involve input from victims/survivors including a robust complaints process
- have standardised IPV and CAN training or qualifications which promotes a good understanding of the dynamics of IPV and CAN
- have national guidelines for IPV and CAN violence intervention
- have practice standards for domestic violence intervention.

We have a track record in New Zealand of being good at identifying the issues and problems with our current system. Many people have worked tirelessly, whether on a government taskforce or advisory group or via reviews or evaluations, and produced many excellent reports. The analysis of the hundreds of recommendations contained in these reports is beyond the scope of this document but we can report that there is no centralised tracking of these recommendations or the action that has been taken regarding them.

It is clear that many (if not the majority) of the recommendations of past reports have not been actioned. There is a clear pattern of failing to implement recommendations as we see evidence of the same/similar recommendations appearing over and over again in subsequent reports. A 2008 review of the implementation of three of New Zealand's family violence strategies²¹³ noted:

²¹¹ This money is being allocated between harmful sexual offender treatment services, male victim services and medical forensic services (\$1.7million pa for two years) and for some existing specialist sexual violence crisis services chosen by the government (\$3.5 million pa for two years). See: <http://www.nzfvc.org.nz/?q=node/1743>

²¹² http://www.google.co.nz/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=0CB8QFjAB&url=http%3A%2F%2Fbeehive.govt.nz%2Fsites%2Fall%2Ffiles%2FA_stronger_response_to_family_violence_Q_A.pdf&ei=f-y1U_7-DIPGkAXAilEo&usq=AFOjCNG6Db0TPbza5Sb3b08_jhRw74EjA

²¹³ <http://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=2577>

'There is a systematic pattern whereby when around half the actions in each strategy are not fully implemented or have had no action taken, a new strategy is developed that supposedly picks up the outstanding actions from the earlier strategy. The evidence suggests that some of the incomplete actions are picked up by the subsequent strategy, but many appear to have fallen off the radar and have never been completed. The time and resources spent on partially implementing actions that are not progressed to completion is a waste of public resources.'

We assume this is because there is no continuous improvement framework for considering the evidence arising from these reports, deciding what changes are required, overseeing the implementation of the changes into practice and monitoring and evaluating to ensure the same failures do not re-occur. These reports, and leading international material, simply accumulates into an ever growing stockpile of material for individual agencies (national and local) to draw on as they see fit, exacerbating the inconsistencies and fragmentation in policies and practice.

5.7 Monitoring and evaluation

There are virtually no routine outcome monitoring, evaluation or audit activities currently undertaken in the sector. Almost no new initiatives have been evaluated. There are no formal accreditation processes for NGO service providers and no independent audits undertaken of those services. Furthermore there is only patchy quantitative (often output) monitoring undertaken. Our current data collection system in New Zealand is under developed and not equipped to collect data that can be used comparatively. In addition, we have no baseline data from which to track whether or not the interventions we are spending money on are actually making a difference in people's lives. It is unclear why monitoring, evaluation and audits are not a priority in this sector in New Zealand.

One limitation is clearly the lack of reliable quantitative data. A recent report from the Families Commission says: *'New Zealand has an appalling record for family violence, with high rates of domestic murders, and high rates of child maltreatment. But a common issue is a lack of quality information on family violence in New Zealand'*.²¹⁴ The Taskforce website says: *' However, there are gaps and limitations to the data that is currently available. These gaps and limitations affect our ability to tell a story about the big picture of violence that occurs within families. Our view of different aspects of family violence is highly variable, partial and fragmented'*.

Concerns have repeatedly been raised about the situation, for example: *'Annual crime statistics released by Statistics New Zealand have again raised concerns over how family violence is measured. Despite calls for more comprehensive statistics by NGOs, Police have not provided data specifically on family violence'*.²¹⁵

²¹⁴ Gulliver, Pauline; Fanslow, Janet L; New Zealand. SuPERU . *Family violence indicators: can administrative data sets be used to measure trends in family violence in New Zealand?* For Families Commission. December 2013.

http://www.familiescommission.org.nz/sites/default/files/downloads/family-violence-indicators-2013_1.pdf

²¹⁵ <http://www.nzfvc.org.nz/?q=node/1487>

Researchers from the Leitner Centre²¹⁶ noted: *'The lack of complete and reliable data affects the implementation and evaluation of effective domestic violence policies because such policies are not based on comprehensive research. For instance, there is no data available to assess the effectiveness of men's stopping violence programs'*. They recommended:

'The government should produce, collect and disseminate data on domestic violence (including, for example, research on the prevalence, causes and consequences of violence against all groups of women, enforcement of protection orders, effectiveness of stopping violence programs, the number of convictions for domestic violence incidents, evaluation of best practices and culturally appropriate approaches to domestic violence) in full coordination with all relevant governmental and non-governmental agencies.'

One of the concluding observations of the Committee on the Elimination of Discrimination against Women (CEDAW) about New Zealand in 2012 was: *'The Committee notes with concern insufficient statistical data on violence against women'*. One of their recommendations was: *'To ensure systematic collection and publication of data, disaggregated by sex, ethnicity, type of violence, and by the relationship of the perpetrator to the victim; to collect data on the number of women killed by partners or ex-partners; and to monitor the effectiveness of legislation, policy and practice relating to all forms of violence against women and girls.'*

The FVDRC *Fourth Annual Report*²¹⁷ says:

'The regional reviews have raised many questions about the safety and quality of family violence services and have highlighted the gap in family violence service providers' quality assurance processes. The regional reviews have also found evidence of significant variability (excellent to problematic) in the quality and safety of the work being done by specialist family violence services and non-specialist family support NGO service providers contracted to deliver family violence work.'

'The multi-agency family violence system is largely reliant on NGO service providers ensuring that their service is safe. In the absence of a national framework, different agencies are developing different and potentially conflicting practice standards and/or response pathways.'

Summary

The bird's eye view of our current system provided in this chapter highlights the need to create a new model to better address the issues of IPV and CAN. We have shown the overwhelming disarray in our current response system to IPV and CAN. It is obvious that our approach in New Zealand is broken, fragmented, and inconsistent, has gaps and overlaps in service provision and has no infrastructure to hold all the services and outcomes together. Other western countries have faced similar challenges and yet have made the move towards significant reform to create a more joined-up, evidence-based and evaluated system (see Chapter 4). It's time to ask ourselves if an integrated system model would provide a better platform and response to IPV and CAN in this country.

²¹⁶ Fenrich, J. & Contesse, J., (2009), *It's Not OK New Zealand's Efforts to Eliminate Violence Against Women*, Leitner Centre for International Law and Justice. New York City. (pg 17)

²¹⁷ Family Violence Death Review Committee, 2014. *Fourth Annual Report: January 2013 to December 2013*. Wellington: Family Violence Death Review Committee.

6. Would an Integrated System model have greater impact?

In the previous chapter we showed that our current response system in New Zealand is fragmented and the various parts of the system are disconnected, leading to a silo effect. This is not only failing to keep victims safe and hold abusers to account but is also failing to have a positive impact on preventing further IPV and CAN. In this chapter we ask the question 'would an integrated system model have greater impact?' Our answer is that if New Zealand wants to achieve safety, accountability, earlier intervention resulting in fewer people affected, a reduction in the long-term effects, and economic savings to the country as a whole, then an integrated system is 'the way forward.'

It would not be possible or sensible to consider establishing only part of a system, therefore the two options we believe New Zealand must consider are:

1. Continue with the status quo (as detailed in Chapter 5) with incremental changes [to what end?].
2. Invest in a new Integrated System model (as detailed in this and following chapters).

Throughout this chapter we draw on our discussions in previous chapters to show the rationale for change to the new Integrated System. We provide an outline of a unique New Zealand Integrated System model. We discuss the particular challenges this would bring and describe and introduce the key principles, components, and structure of the new model.

6.1 The rationale for change

In New Zealand, successive governments and many NGOs have tried to 'fix' the problem of IPV and CAN – responding as if it was a 'tame' problem. Up until now our approach has been to look for straightforward solutions based largely on 'best guesses' and practical experience. In the absence of robust evidence base, solutions to issues are just 'good ideas'; a new thought, or approach that someone believes has merit but based on everyday assumptions. As Daveney and Spratt observe, '*current practice and conventional wisdom are often poor guides to what works*'.²¹⁸ As explained in Chapter 5, this approach has not been successful in addressing IPV and CAN in New Zealand and has led to fragmented policy decisions, silo-ed ministries, limited long-term planning and no infrastructure to join-up the various processes and services or to steward the implementation of new initiatives.

The lack of an integrated approach has meant that in New Zealand we have a fractured landscape of hundreds of agencies planning and delivering social services on behalf of government. This can be attributed to the new public management model introduced throughout the New Zealand public sector in the 1980s. The model placed a strong emphasis on breaking public sector activities down into stand-alone business units, and a competitive funding process for NGOs to provide services previously delivered by government departments. These changes created a separation between policy, service delivery and, in some cases, funding. The resulting multiplicity of service providers and the range of services with no overarching strategy to guide their work, has created unnecessary

²¹⁸ Daveney and Spratt. 2008 see <http://intl-jpubhealth.oxfordjournals.org/content/31/3/453.full.pdf+html>

overlaps, inconsistencies, gaps along with misunderstandings and funding competitiveness between agencies. We cannot continue to try and fix individual parts of the existing system in the absence of a strong infrastructure to hold everything together. We need a new approach.

6.2 Overview of an integrated system

An integrated system is identified in the leading New Zealand and international literature and practice experience as being the best model to meet the challenges faced in preventing and responding to complex, wicked problems in general, and IPV and CAN in particular. The Integrated System model detailed in this chapter is not a strategy or a new service initiative, but instead is the infrastructure upon which strategic considerations and service development conversations and changes take place.

An integrated system is much more than a collection of agencies working together. It involves:

- all activities directly or indirectly involved in or impacting on IPV and CAN being connected via clear pathways and linkages between different points in the system
- a national infrastructure equipped to broker the multiple relationships between the agencies and local and national bodies
- all policy makers, service providers, individuals and society as a whole having a shared understanding of IPV and CAN; everyone looking through the same lens and everyone understanding their place in the system.

A well-recognised example of a complex but fully integrated system is the London Underground. There are multiple entry points and multiple companies operating different lines on the network – but all services are connected. A traveller can enter at any point and travel, often via multiple connected routes, to the required destination. The system works because there are clear pathways, consistent safety standards, and agreements between the many different agencies providing services as part of the system. There is local autonomy - all stations (entry points) are different and all serve different communities.

Figure 31: Map of the London Underground system



Although the lines are managed separately – like the various social issues – the overall system ensures the lines connect, work in similar ways to similar standards and 'talk' to each other. When IPV and CAN is disclosed (to any agency), it is, in effect, being reported to the one system. Regardless of the point at which they enter the system, the individual(s) can be easily connected to multiple other parts of the system, to services that can carry them through to the stage of recovery and rebuilding their life.

Similarly the IPV and CAN Integrated System will need to connect the multitude of related social issues. The different coloured lines in the Underground graphic can correspond metaphorically to the different social issues identified in Chapter 2 (eg homelessness, youth violence, teen pregnancy, unemployment, health difficulties, mental health issues). When someone is being treated in the mental health system and it is found that they are suffering from cumulative trauma of IPV or CAN, the mental health service provider can readily 'link up' with specialist IPV or CAN provider(s).

In the current IPV and CAN system there are not many lines connecting the stations; there are no maps or signage to guide people around the system; many stations are overcrowded with people; others are lost between stations trying to navigate for themselves; some stations are missing all together and only a few of the staff running the system have been fully trained. More and more people try and gain entry, many suffering serious harm or dying because the system failed them. Meanwhile, we focus on minor adjustments and short-term initiatives, thinking that if we just did one or two more things we could fix the problem.

The last thing we need in New Zealand is another 'quick fix' reaction to increasing levels of IPV and CAN. We believe a fully integrated system is the missing piece of the puzzle in New Zealand's current response to IPV and CAN. It is vital that the Integrated System be implemented in a considered manner that takes time to meet the challenges, builds on existing practice and the innovative work beginning to take place within New Zealand communities. It must also align with government priorities and new contracting initiatives, incorporate international findings, and provide the best possible response to the needs of those affected.

6.3 The challenge to design our own Integrated System model

Our challenge in New Zealand is to develop a system that holds abusers accountable for their violent/abusive behaviour and keeps victims safe by wrapping a joined-up system around them to do everything possible to reduce the immediate and long-term effects of the violence/abuse. We start by asking:²¹⁹

1. How could we create an integrated system focused on safety and accountability?
2. How could we shift responsibility from individuals to the system - so that agencies within the system are collectively responsible for ensuring the safety and long-term recovery of victims/survivors and at the same time place responsibility for containing, challenging and changing the abusers behaviour collectively with the system?

²¹⁹ These questions are a modification of three overarching questions used in the Victorian reforms to help guide them through the challenges that lay ahead in their effort to design and implement reforms.

3. How could we engender an integrated system response that is more consistent and powerful than the abuser?

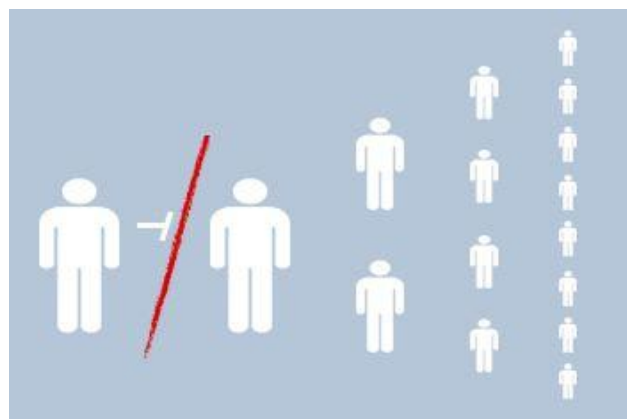
The principles of the proposed Integrated System model, outlined later in this chapter, guide our responses to these questions and the challenges discussed here.

Prevention continuum

One of the challenges in designing and implementing the Integrated System model is creating a system that recognises and responds to all four stages which collectively form the prevention continuum shown in Figure 15 (Chapter 3). It is definitely worthwhile for our society to stand up with a clear message that IPV and CAN are not acceptable and will not be tolerated. But we must also ensure our primary prevention initiatives are aligned with efforts at the other three stages of the prevention continuum, namely, early intervention, crisis response and the longer-term rebuilding lives stage. That way, when victims/survivors or abusers respond to the primary prevention messages and reach out for help there is an effective system with sufficient capacity available for them. There would be little point in encouraging the public to use the London Underground if they weren't able to get where they wanted to go, safely and efficiently. This is even more important given that there is no clear separation between the four stages of prevention continuum for IPV and CAN.

Prevention of IPV and CAN – stopping violence before it starts – presents a challenge to any model seeking to address such a complex and wicked problem. As explained in Chapter 1, a significant proportion of the perpetration of IPV and CAN is intergenerational and in Chapter 2 we suggested we think about this as a contagious disease – an epidemic – that passes from one person to many people – leaving us with the question, where and when is the point 'before it starts'? Because of this effect, primary prevention is often actually early intervention; that is, intervening as early and as effectively as possible at the first signs of abuse to heal the trauma and prevent further spread in this generation and the next (as shown in Figure 32), continuing to work long-term at all stages of the prevention continuum with the people affected.²²⁰

Figure 32: Stopping the transmission of the effects of IPV and CAN



²²⁰ This concept was introduced by Dr. Gary Slutkin and has now become a movement across USA to reduce community violence. Learn more at http://www.ted.com/talks/gary_slutkin_let_s_treat_violence_like_a_contagious_disease

Two further factors complicate the picture:

- Two thirds of those who experience either IPV or CAN will experience more than one type of violence over the course of their life (revictimisation) and may therefore over time, enter the system at different points of the prevention continuum with respect to different experiences of IPV or CAN.
- Evidence shows that IPV victims/survivors attempt to separate from an abusive partner on average four to seven times before finally escaping the abusive relationship and therefore do not move through the prevention continuum in a linear way.²²¹

No quick fixes

One of the main challenges will be for New Zealand to accept that there is no 'quick fix' and the Integrated System would not instantly reduce numbers of IPV and CAN. However, once the Integrated System model was fully operational we could expect to see a reducing number of high-risk cases requiring crisis intervention. The Integrated System would provide a more effective response sooner thereby reducing the immediate and long-term effects, interrupting the intergenerational spread of violence resulting in fewer people affected. Change is possible but it would take time.

Identify more cases

The prevalence of IPV and CAN remains unclear as reporting rates are low. We explained in Chapter 1 that most IPV and CAN remains unreported in New Zealand; only about 20 percent is reported to the Police.²²² It is unrealistic to expect to create significant change to the prevalence and impact of IPV and CAN if our efforts and responses are focussed only on the 20 percent of reported cases. Similarly we will never address an intergenerational epidemic when we are only responding to 20 percent of all cases.

Our focus and response to IPV and CAN must widen so that rather than only addressing the numbers we know about, we are finding out about more cases (as New South Wales are attempting to do) and intervening earlier before the violence escalates and the trauma accumulates. We need to respond in the most effective way possible to keep victims safe and hold abusers to account, thereby reducing the immediate and long-term effects. In order to do this we need to respond more effectively when cases of IPV and CAN are reported and we need to encourage more cases to be reported (ie a measure of success would be an increase in reporting rates).

Life and death

IPV and CAN deaths are all preventable. In order to reduce the number of deaths, the Integrated System would need to identify those at highest-risk and tailor an intensive response to those cases. The system would need to intervene as early as possible (as outlined above) but also ensure resources are channelled to those most at-risk. Other countries have found that risk of re-assault or lethality is best identified via integrated multi-agency assessment processes as different agencies

²²¹ <https://womensrefuge.org.nz/WR/Domestic-violence/Why-doesnt-she-leave.htm>

²²² Some cases are reported to other agencies but not to Police. However, Police data is the only accurate data available regarding the proportion of all cases that are reported to agencies.

hold different pieces of information relevant to the assessment. The importance of sharing information in a consistent and controlled way cannot be overstated but this process also relies on a shared understanding of the dynamics of risk (that can change over time), knowledge of the indicators of dangerousness and lethality, and common risk assessment tools. A shared way to manage safety to reduce deaths and harm can then be adopted. Other countries like Australia and the Multi-Agency Risk Assessment Conferences (MARACs) in the UK already have well established processes for high-risk case management.

Current system is at capacity

In Chapter 5 we showed that we currently have a fragmented system that is failing to meet demand. It is at capacity even though it currently only responds to approximately 20 percent of all IPV and CAN. There is no way we can keep loading more cases into the current system.

To achieve its objectives the Integrated System model must be strong enough, safe enough and flexible enough to make the greatest impact on as many cases as possible. This could be achieved by ensuring early and more effective responses, encouraging unreported cases to seek and gain help, while at the same time ensuring those at highest risk are identified and that the system works together to ensure safety. It demands we build a system that is scalable so we could maintain the required high quality standards at all parts of the system while expanding to accommodate more and more cases. There would be financial implications of scaling up the system (see Chapter 10) but these would be offset many times over by the economic savings achieved by the reduction in the short and long-term effects (Chapter 8).

Retaining focus on different specialities

We see that while all those responding to IPV and CAN need to be linked together as part of the Integrated System, it is also vital that specialities within each sector are maintained. We would need to recognise the similarities, overlaps and the differences of the following related areas and ensure they are closely aligned and linked into the Integrated System model. Specifically:

- Elder abuse is a specialised area and needs a focused response.
- Sibling abuse and parental abuse are not well understood and further work needs to be done in these areas to determine the most appropriate response.
- A 'whole of family or whānau' approach needs to be built into all parts of the system where appropriate – particularly for Māori and Pacific communities.
- Sexual violence is one important form of IPV and CAN and a significant proportion of sexual violence occurs within interpersonal relationships. The system response needed for sexual violence victims/survivors is often different.
- Systems responding to the many related social issues (for example, mental health, substance abuse and drug, youth justice) need to retain their own specialist focus but be linked into the IPV and CAN Integrated System.

6.4 Principles

There are seven key principles that we believe should provide the heart of the model. Figure 33 shows how these principles would be implemented.

Figure 33: Integrated System principles

Principle	Description	How Achieved
One problem, one system, many solutions	Everyone has a shared understanding of IPV and CAN and the multiple connections and works together as part of one system to focus on collective outcomes across the system response.	Moves away from the idea of outcomes being achieved by individual agencies and towards collective impact. Gaps and overlaps are minimised. There are consistent core elements that are replicated in each region to ensure consistent high quality at all levels.
Local leadership, national support	Relevant agencies work together on local solutions to local problems building on existing strengths supported by a nationally consistent framework.	A bottom-up approach empowers local communities to take leadership. The national backbone agency provides support to ensure national consistency and safety that is attentive to local need, autonomy and ownership.
Those affected are at the centre of the system	The system is designed to respond to the needs of those affected by IPV and CAN.	Victims/ survivors are made safe through the implementation of structural policies and local services which work to remove an individual survivor's responsibility to keep herself safe and place that responsibility on the system instead to ensure both survivor safety and recovery.
Perpetrator and system accountability	The system is designed to hold the perpetrator to account and ensure that he no longer has the ability to abuse.	Promoted through shared understanding and a collaborative system ensures abusers are visible, understood and responded to appropriately. Ongoing monitoring and evaluation ensures the system is accountable.
Primacy of rights of Māori as tangata whenua	Te Tiriti o Waitangi is the founding document for relationships between Tangata whenua and Tauīwi within Aotearoa.	The treaty principles of governance, sovereignty and equality are reflected at all levels of the integrated system. Working collaboratively with Māori to ensure that Māori are supported to deliver and have access to kaupapa Māori services.
Equitable outcomes for all	Regardless of the individual characteristics or living conditions of victims/survivors or abusers the system offers equitable access to services, resulting in safety and recovery. No exceptions.	The system accommodates diverse perspectives, reflects that there is no 'one-size-fits-all' and ensures safety, accessibility and inclusion irrespective of background, situation, experience, geographical location.
Evidence based and learning culture	A nationally consistent framework that is evidence based and provides innovation, reflective practice and continuous improvement.	Builds on strengths of existing systems and services and provides a framework for strengthening systematic changes over time. A formal continuous improvement process identifies and alters the practices, processes and/or policies that need change early on. Facilitates horizontal learning - sharing of what works and doesn't work between regions based on collective experience.

6.5 Objectives

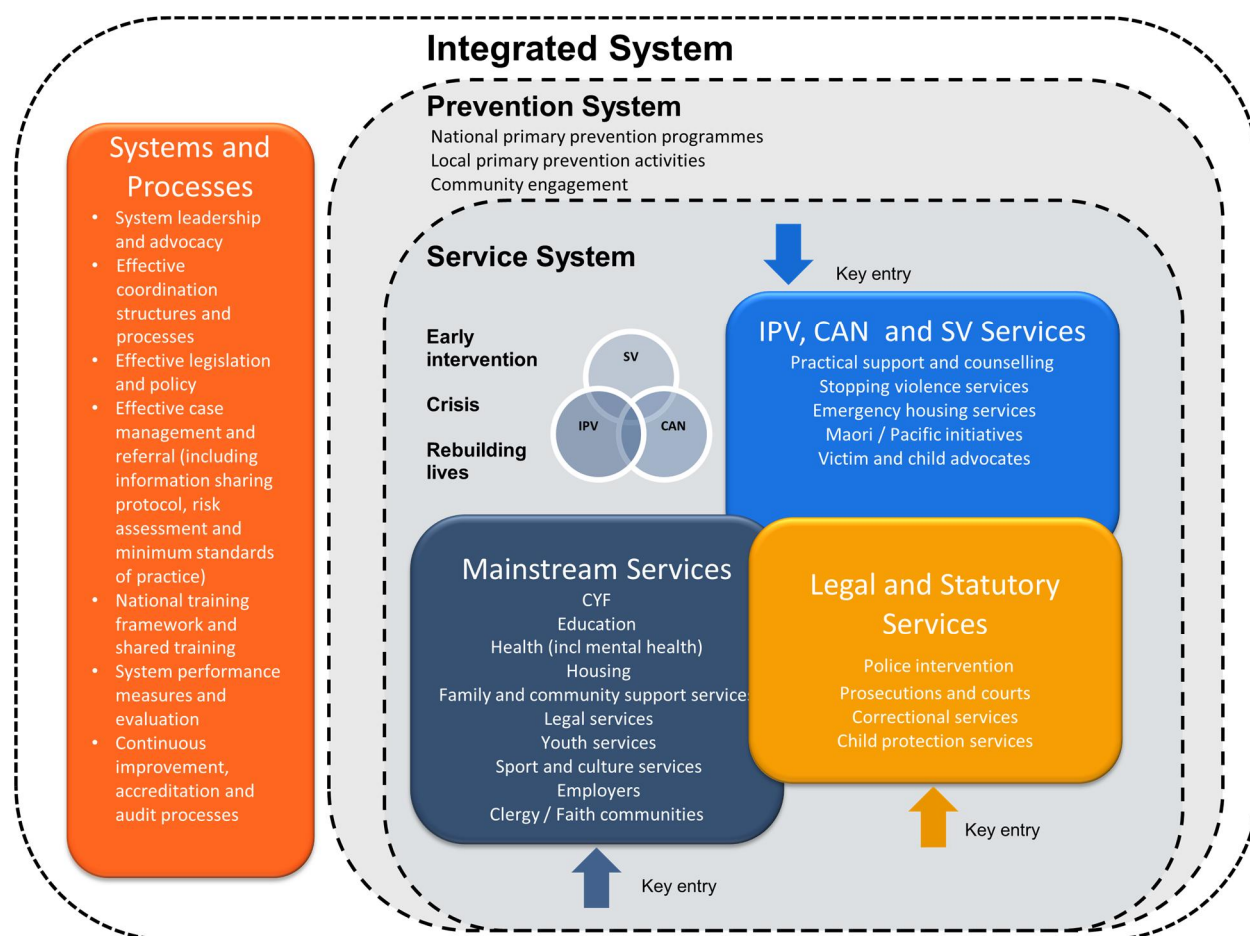
We believe the new Integrated System should aim to:

1. change societal norms, bust the current myths and establish a widespread shared understanding
2. be more effective at ensuring safety of victims/survivors and accountability of abusers
3. intervene earlier and provide more joined up accessible intervention to more effectively reduce the short and long-term effects
4. identify more of the currently unreported cases
5. proactively manage high-risk cases to reduce the number of deaths
6. over time reduce the incidence of IPV/CAN
7. reduce the heavy burden IPV and CAN have on the New Zealand economy.

6.6 Features of the New Zealand Integrated System model

The Integrated System model builds on the theoretical models for addressing complex and wicked problems, international practice examples and the existing local and national infrastructure in New Zealand. Figure 34 outlines the collection of agencies and structures that would make up the Integrated System model for IPV and CAN.

Figure 34: The Integrated System model for IPV and CAN

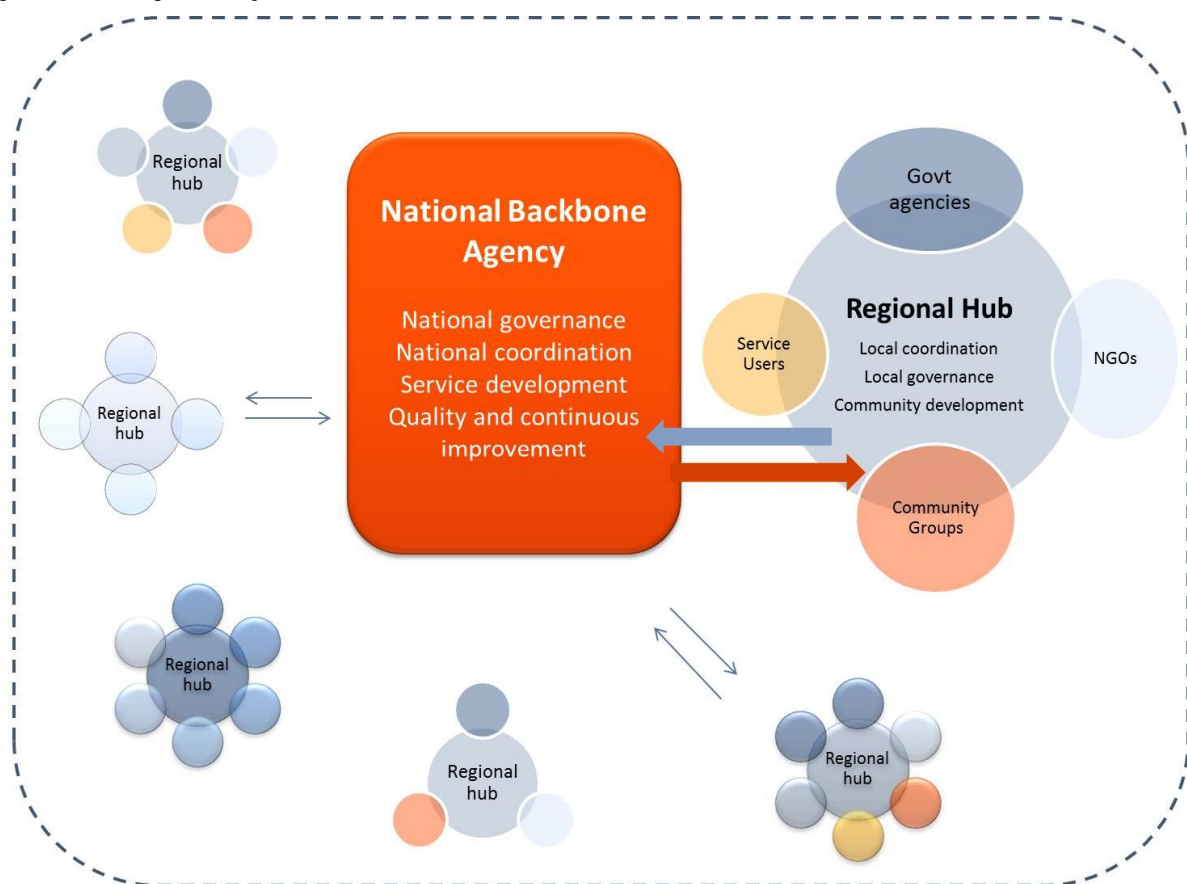


6.7 Structure

The Integrated System would have the following infrastructure (see Figure 35):

- Regional hubs²²³ - to oversee and coordinate the Integrated System infrastructure in each region by connecting all local agencies, structures and processes together, linking existing local interagency networks, undertaking regional service mapping and population needs assessment, maintaining and strengthening local referral pathways, facilitating the development of local solutions, community engagement and building on existing networks. Once fully operational the regional hubs would be well placed to trial new initiatives.
- National backbone agency - to oversee and coordinate the national Integrated System infrastructure, support the regional hubs and be responsible for all components of the Integrated System that need to be nationally consistent, for example processes and mechanisms to develop a shared understanding (such as training frameworks), governance mechanisms, leadership and national consistent resources including shared policies, practice standards, processes, risk assessment tools and referral pathways.

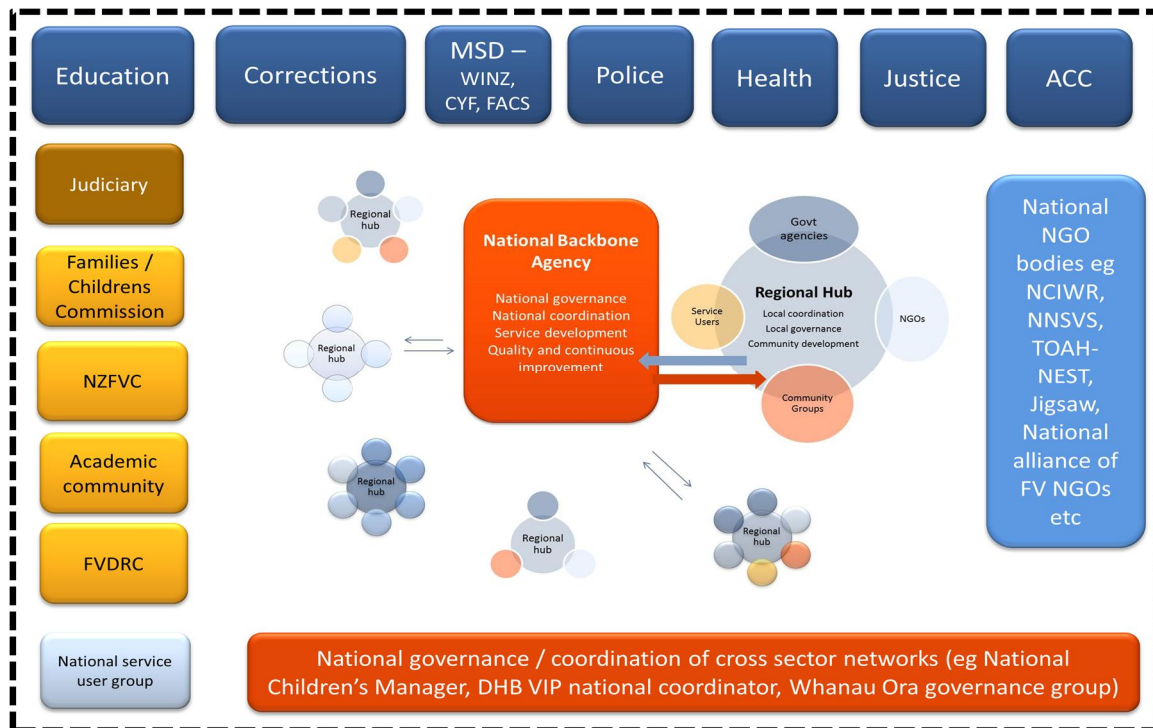
Figure 35: Integrated System infrastructure



²²³ Regional hubs are in essence local backbone agencies but to avoid confusion over the terms we have chosen to refer to the local backbone agencies as 'regional hubs'

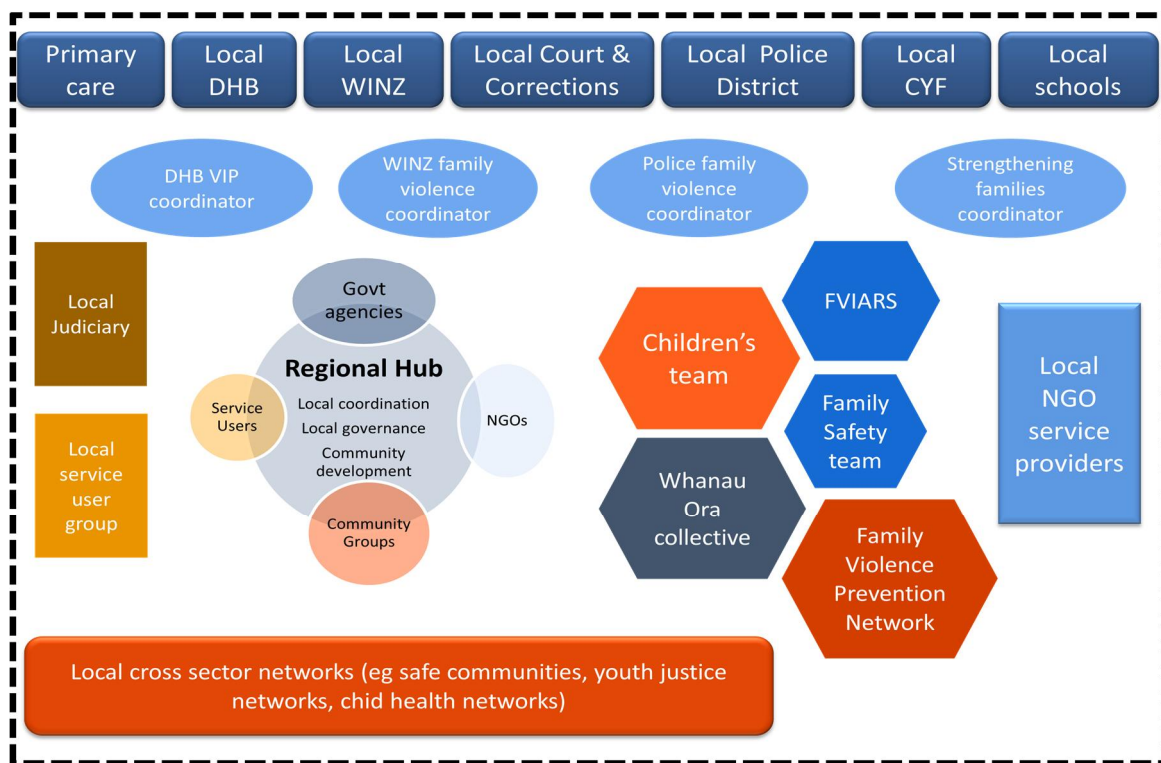
The model would incorporate and build on the existing infrastructure, linkages and multi-agency processes, not seek to replace what already occurs. The national Integrated System infrastructure would need to comprise all agencies, processes, initiatives and inter-agency activities nationally and in all regions as shown in Figure 36. The national backbone agency would be the glue that ensures central government agencies, national governance groups are linked with regional hubs (vertical integration) and that regional hubs are linked together (horizontal integration).

Figure 36: National Integrated System infrastructure



The mix of networks and initiatives differs between each region. The regional Integrated System infrastructure (Figure 37) would need to comprise all agencies, processes, initiatives and inter-agency activities at a regional level. Each regional hub would be the glue that supports and links these together while enabling them to each retain their specialist focus. The whole would be greater than the sum of its parts.

Figure 37: Regional Integrated System infrastructure



Implementation of the new Integrated System model would require the establishment of a national backbone agency and one initial demonstration regional hub. Other regional hubs would be developed over time as learning occurs; when the model is further refined and as other regions are ready to adopt the new approach. Chapter 11 provides details of the implementation process.

6.8 Key roles and responsibilities

The expected core roles and responsibilities of the national backbone agency and regional hubs are summarised in Figure 38 and outlined in more detail in Chapter 11.

Figure 38: Integrated System roles and responsibilities




	National backbone agency	Regional hubs
Leadership and governance	<ul style="list-style-type: none"> • Governance and leadership • Relationship management • Socialisation of the concept • Shared understanding • Assisting to establish regional hubs 	<ul style="list-style-type: none"> • Governance and leadership • Relationship management • Socialisation of the concept • Shared understanding • Community engagement
Co-ordination and communication	<ul style="list-style-type: none"> • Ensuring all parties understand the common agenda • Enabling transparency • Conduit for information and collective contributions 	<ul style="list-style-type: none"> • Ensuring all parties understand the common agenda • Enabling transparency • Linkages between regional agencies • Local referral pathways

Documentation	<ul style="list-style-type: none"> • National system specification and strategy • Organisational practice standards²²⁴ • Service accreditation standards and processes • Quality management framework 	<ul style="list-style-type: none"> • Local components of referral pathways • Local written resources
Service development	<ul style="list-style-type: none"> • National needs assessment • Implementation assistance to regional hubs • National system development (via national agencies) 	<ul style="list-style-type: none"> • Regional needs assessment • Regional service mapping and gap analysis against system specification • Preparation of individual agencies
Funding	<ul style="list-style-type: none"> • Funding models / arrangements • Alternative sources of funding 	<ul style="list-style-type: none"> • Regional funding decisions • Alternative sources of funding
Training and workforce development	<ul style="list-style-type: none"> • Training and workforce development framework • Disseminating knowledge 	<ul style="list-style-type: none"> • Regional training and workforce development • Identifying opportunities for additional training and professional development
Information management	<ul style="list-style-type: none"> • National information management system 	<ul style="list-style-type: none"> • Local information management system
Building evidence and knowledge	<ul style="list-style-type: none"> • New evidence regarding best practice • Transferring knowledge around the system • Clearing houses for innovative practice 	<ul style="list-style-type: none"> • Disseminating new evidence and knowledge locally
Quality and evidence management	<ul style="list-style-type: none"> • Performance and outcome monitoring • System quality assurance and evaluation • National complaints process • Findings of death reviews • Continuous improvement framework 	<ul style="list-style-type: none"> • Baseline evaluation • Ongoing evaluations • Disseminating knowledge and improving motivation and morale among all participants

6.9 Key differences between current system and Integrated System model

Figure 39 lists the key requirements, components and activities for successfully addressing complex and wicked problems and maximising collective impact via integrated responses that we identified in Chapters 3 and 4. A traffic light system has been used to show that most of the required elements are currently either missing or only partially operating, and that the proposed Integrated System model would contain all required elements.

The following codes have been used in these tables:

 Not evident	 Partially evident	 Evident
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²²⁴ Including policies, procedures, referral pathways, standardised risk assessment and safety planning tools and integrated assessment response processes, templates and quality assurance processes.























Figure 39: Differences between current system and integrated system

Key elements identified in Chapters 3 and 4	Current system	Integrated System model
All agencies structures, processes, initiatives operate as one system	☐	😊
Strong leadership	☐	😊
Working in collaboration	●	😊
Interagency working	●	😊
Mutually reinforcing activities	☐	😊
Backbone support	☐	😊
Vertical and horizontal connections and continuous communication	●	😊
National framework or strategy to guide activity	●	😊
Long-term approach	☐	😊
Bottom up perspective	☐	😊
Decentralisation	☐	😊
Community engagement	●	😊
Service user involvement	☐	😊
Frontline service personnel involvement	☐	😊
A common agenda - shared understanding and common goals	☐	😊
Collective or shared outcomes/measurement	☐	😊
Framework of accountability	●	😊
Continuous improvement framework	☐	😊
Flexibility and innovation	●	😊
Shared training and workforce development	☐	😊
Resources to guide and support local integration	☐	😊

Victims/survivors and frontline workers who spoke to the Glenn Inquiry made suggestions for doing things differently, including the need for a systematic solution that builds on what works and mechanisms for measuring, evaluating and improving services. The key elements required to meet the needs of those impacted by IPV and CAN that were identified in the Glenn Inquiry People's Report²²⁵ are listed in Figure 40 to show the Integrated System model accommodates all these.

²²⁵ https://glenninquiry.org.nz/uploads/files/The_Peoples_Report_-_full_document.pdf

Figure 40: Key elements identified by Glenn Inquiry

Key elements identified in the People's Report	Current system	Integrated System model
Documentation to eliminate inaccuracies, fragmentation and errors		
Early intervention in particular:		
Reviewing the ways the government allocates funding		
Improving early identification processes		
Providing information to those affected		
Monitoring agency or service delivery and outcomes		
Bringing together services via 'single points of access'		
Skilled workforce		
Prevention via education		
Equitable approaches		
Community action		
Inter-agency collaboration		

6.10 Practice implications of these changes

FVIARS and other local multi-agency initiatives

In Chapter 5 we discussed the current inter-agency approach (FVIARS) and explained that FVIARS is not a system. It is a discrete series of meetings happening in an isolated way throughout New Zealand. It cannot serve as the only mechanism through which people access help for IPV and CAN. Unfortunately FVIARS has been relied upon throughout the country as 'the' response to IPV and CAN even though it lacks any national framework, consistency of practice, delineation of risk for intervention purposes, evaluation and monitoring system, and is not linked with a body to oversee and share best practice examples. FVIARS meetings are currently stretched beyond capacity and represent an entry point into the system only for those people whose cases come to the attention of the Police and it is often unable to safely respond to high-risk cases.

FVIARS would become be one part of the Integrated System. The Integrated System would improve inter-agency coordination in response to IPV and CAN by offering multiple entry points for many more people affected by IPV and CAN; more doorways through which they can enter the system and access help from the full range of interventions identified in the system specification, including clear referral pathways to ensure they get the right help at the right time (see Chapter 11). FVIARS would form part of the Integrated System but would no longer be forced to assume the responsibility for being the only process for co-ordinating interventions.

Frontline service personnel

The Integrated System would have a positive impact on frontline service personnel. Having an overarching national strategy to address IPV and CAN would support frontline agencies to work together towards a common goal with support and resources to help them get there. The decentralisation necessary to address wicked problems (as discussed in Chapter 3) would enable frontline service

personnel to be more engaged in developing the Integrated System model in their area than previous 'top-down' approaches. The Integrated System would give local service personnel a voice to discuss gaps, inconsistencies and resource requirements which can be followed up by the regional hub and national backbone agency. The 'learn as we go' continuous improvement approach which enables more 'on the ground' feedback, would ultimately result in a more responsive system for local service users. In turn frontline service personnel would be able to share their experiences with those in other regions via the horizontal links between all regional hubs facilitated through the national backbone agency. Local agencies would work together in a more enhanced way aided by delivery of training and workforce development to frontline service personnel, a shared understanding of IPV and CAN and evidence-based ways to respond most effectively (risk assessment and screening tools, referral pathways, resources such as emergency housing, income support etc).

Service Users

There are three key implications for service users.

Safety

Currently, many IPV and CAN victims/survivors are not made safer when they approach 'the system' for help. We believe the Integrated System would enable them to expect and experience much more responsiveness. They would be safer because workers would have a shared understanding of IPV and CAN and be better placed to respond safely and effectively. The Integrated System would enable more effective referral pathways between agencies resulting in the right service at the right time with fewer delays and greater safety sooner for victims/survivors. The Integrated System would strengthen the relationships and protocols between different sectors resulting in a multi-agency response that works together for a common goal – the safety of women and children experiencing IPV and CAN.

Accountability

A critical aspect of the Integrated System would be its ability to increase abuser and system accountability. This would be achieved via a shared understanding among workers, better referral systems to ensure abusers receive the right support to change their behaviour early on, agencies working closer together to minimise the likelihood of collusion with the perpetrator and a system that works hard to minimise re-offending in the future.

Participation

Service users (victims/survivors, abusers and their families) would be encouraged to have input into the design and implementation of the Integrated System model to ensure it best meets their needs. There would also need to be clear complaint mechanisms and other means by which they can hold the Integrated System accountable and be part of affecting change if the system is failing in any way.

Community engagement

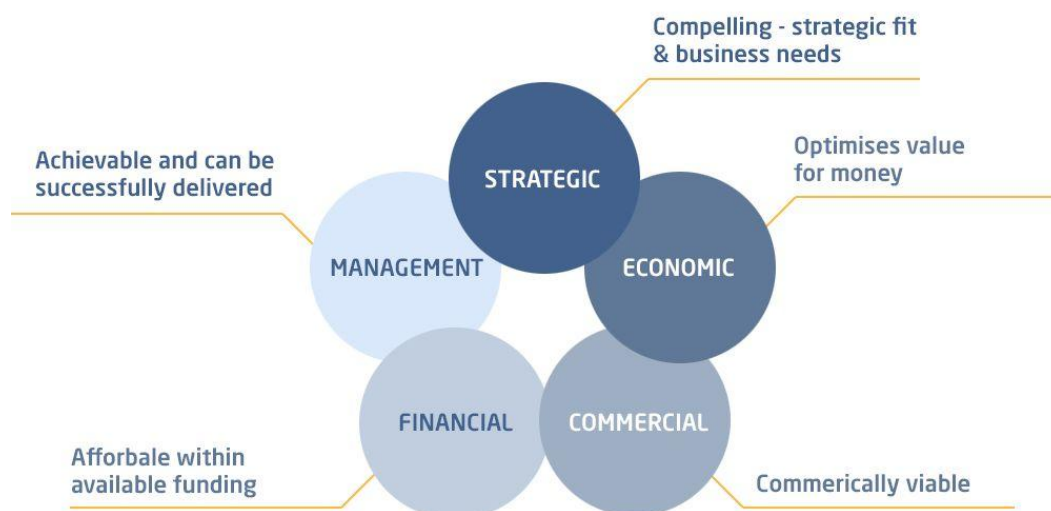
We explained in Chapter 3 that having 'collective impact' on wicked social problems requires organisations (government and non-government) to coordinate their efforts and work in collaboration. We see huge potential under the Integrated System for communities to be directly involved in the design, development and implementation of the Integrated System model in their community. Historically this has not been possible due to the 'top down' approach of government with respect to funding services and developing policy nationally to be implemented locally. A

unique strength of the Integrated System model would be the combination of a nationally consistent and prescribed set of evidence based tools for intervention – risk-assessment tools, training and workforce development, ‘must-haves’ for successful responses – with communities having flexibility in the way that the structure is brought to life locally to ensure it fits local needs. The community would become a key part of the system and the system would rely on the connections between community groups, agencies and members to work well. The community would be empowered to share leadership with government agencies, although it would not be forced to hold the whole responsibility for fixing IPV and CAN.

Summary

In this chapter we have shown that an integrated system is 'the way forward' for New Zealand to effectively respond to IPV and CAN. All indications are that continuing with the status quo is unlikely to lead to any significant reduction in IPV and CAN in New Zealand. We cannot continue to try and fix individual parts of the existing system in the absence of a strong infrastructure or backbone to hold everything together. We have introduced the Integrated System model and shown the way the model would operate for those affected by IPV and CAN and those who would work to help them. We have detailed the key features, objectives, principles and structures of the Integrated System model. We are confident that the Integrated System would enable us to have the greatest impact on the greatest number of cases by identifying more of the currently unreported cases, intervening earlier, and providing greater safety and accountability. As a result there would be a reduction in the immediate and long-term effects on individuals and those around them. In the following chapters we provide the business case for the Integrated System using Treasury's 'Better Business Case' model²²⁶ as shown in Figure 41.

Figure 41: Better business case model



²²⁶ <http://www.infrastructure.govt.nz/publications/betterbusinesscases>

7. How does the Integrated System model fit strategically?

Chapters 1 to 4 collectively provided the evidence of the need for change. Chapter 5 outlined our current response system in New Zealand and Chapter 6 explained the features of the new Integrated System model that we believe needs to be established in order for New Zealand to have greater impact in addressing IPV and CAN. In this chapter we analyse how well the model fits strategically with our international and domestic treaty obligations, national policies, strategies, and other initiatives.

7.1 Alignment with treaty obligations

International treaty obligations²²⁷

IPV and CAN are human rights violations and a form of prohibited discrimination under international law. New Zealand is a signatory to most major international human rights treaties and is bound to the provisions of international human rights law that obligates our government to act with due diligence to prevent, investigate or punish such acts and to provide effective remedies to the victims/survivors. It is beyond the scope of this report to examine these conventions in detail but it would be essential to consider New Zealand's international obligations when planning and implementing new initiatives to address IPV and CAN.

New Zealand has signed and ratified the U.N. Charter,²²⁸ the Universal Declaration of Human Rights,²²⁹ the International Covenant on Civil and Political Rights,²³⁰ and the International Covenant on Economic, Social, and Cultural Rights,²³¹ the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,²³² the Convention on the Rights of the Child (UNCROC),²³³ and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).^{234,235}

²²⁷ In this section we draw on two primary sources:

- Fenrich, J. & Contesse, J., (2009), *It's Not OK New Zealand's Efforts to Eliminate Violence Against Women*, Leitner Centre for International Law and Justice. New York City. This was a year-long project undertaken by the Leitner Center for International Law and Justice at Fordham Law School to study violence against women in New Zealand in light of our international commitments.
- A memorandum entitled 'New Zealand's Obligations under International Law to Prevent, Protect and Punish Domestic and Sexual Violence against Women' from Professor Bonita Meyersfeld, one of the world's leading experts in Domestic Violence and International Law. Dr Meyersfeld is Associate Professor of International Law, School of Law, the University of Witwatersrand, Johannesburg, Head of Gender at the Centre for Applied Legal Studies; author of *Domestic Violence and International Law* (Hart Publishing, 2010); former legal advisor, House of Lords, UK. This communication is available upon request.

²²⁸ U.N. Charter. The Charter was signed on June 26, 1945, and entered into force on October 24, 1945.

²²⁹ Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. Doc. A/180, at 71 (1948).

²³⁰ International Covenant on Civil and Political Rights, 999 U.N.T.S. 171 [hereinafter ICCPR]. The Covenant was adopted on December 19, 1966, and entered into force on March 23, 1976.

²³¹ International Covenant on Economic, Social and Cultural Rights, 999 U.N.T.S. 3 [hereinafter ICESCR]. The Covenant was adopted on December 19, 1966, and entered into force on January 3, 1976.

²³² Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1465 U.N.T.S. 85. The Convention was adopted on December 10, 1984, and entered into force on June 26, 1987.

²³³ Convention on the Rights of the Child, 1577 U.N.T.S. 3. The Convention was adopted on November 20, 1989, and came into force on September 2, 1990.

²³⁴ Convention on the Elimination of all Forms of Discrimination Against Women, G.A. Res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc.

A/34/46 (1980) [hereinafter CEDAW]. The Convention was adopted on December 18, 1979, and entered into force on September 3, 1981.

These various treaties impose positive obligations upon New Zealand to eliminate IPV and CAN and to protect against and punish such acts. If New Zealand fails to take positive steps to protect women and children from high levels of IPV and CAN, our government is in violation of international law.

The test to determine whether states parties have fulfilled their obligations is referred to as the 'due diligence test'. The test asks whether a state reasonably ought to have taken a more active and efficient approach to eliminate these issues and takes into account:

- the degree of protection required under the particular circumstances
- the practical factors required to render such protection possible or impossible
- the frequency of a State's failure to assist victims/survivors.

Although in instances of IPV and CAN the abusers are typically non-state actors – spouses, partners, parents or step-parents – under international human rights law, the state may also be accountable for human rights abuses by private actors if it fails to take positive steps to promote and protect rights.

'States may also be responsible for private acts if they fail to act with due diligence to prevent violations of rights or to investigate and punish acts of violence, and for providing compensation. The standard of due diligence is one of reasonableness, it requires a state to act with the existing means at its disposal to address both individual acts of violence against women [and children] and the structural causes so as to prevent future violence.'^{236,237}

New Zealand is required to report periodically to the various treaty bodies and in turn to respond to recommendations they make.²³⁸ Of particular relevance when considering the merits of the Integrated System are recommendations specific to New Zealand's response to IPV and CAN from: The Human Rights Council, UNCROC and CEDAW. Following the most recent reviews by these three committees the following overall observations were reported:

CEDAW²³⁹

- The committee notes that many of the recommendations in the report of the Taskforce for Action on Sexual Violence have not yet been implemented.
- The Committee is concerned about the continued high and increasing levels of violence against women and the low rates of reporting and conviction, particularly relating to sexual violence.
- The Committee notes with concern insufficient statistical data on violence against women, especially on violence against Māori women, migrant women and women with disabilities.
- The Committee is concerned at the lower level of representation among the members of the Taskforce for Action on Violence within Families.

²³⁵ In 1992, the CEDAW Committee passed General Recommendation 19, requiring States Parties to take positive measures to eliminate violence against women, including sexual violence. Refer UN Committee for the Elimination of All Forms of Discrimination against Women, 'General Recommendation 19: Violence against Women' (1992) UN Doc A/47/38. 19.

²³⁶ In-depth study on all forms of violence against women, Report of the Secretary General, U.N. Doc. A/61/122/Add.1 (2006), at para. 257.

²³⁷ This paragraph refers specifically to domestic violence/violence against women but the same situation is expected to apply to violence toward and abuse of children

²³⁸ <http://www.ohchr.org/EN/countries/AsiaRegion/Pages/NZIndex.aspx>

²³⁹ <http://www2.ohchr.org/english/bodies/cedaw/cedaws52.htm>

UNCROC²⁴⁰

- The Committee remains alarmed at the high prevalence of abuse and neglect of children in the family and at the lack of a comprehensive nationwide strategy in this regard.
- The Committee regrets that there is still no comprehensive system of recording and analysing abuses committed against children and that mechanisms for physical and psychological recovery and social reintegration of victims/survivors are not sufficiently available across the State party.

Human Rights Council²⁴¹

- A number of member countries noted concern over continued high levels of violence against women, particularly Māori, Pacific and minority women and the need to do more to address violence against women through measures to empower women and improve women's rights.

The most recent recommendations for action agreed between our government and these three committees with respect to IPV and CAN in New Zealand are summarised in Appendix 6. Implementing an Integrated System in New Zealand would serve to meet our international treaty obligations and provide an infrastructure to implement the current and future recommendations from these bodies.

Aotearoa treaty obligations

Researchers from the Leitner Centre for international Law and Justice reported with respect to our obligation to uphold the Treaty of Waitangi (internationally and at a domestic level) regarding IPV.

*'Through different means, international law has proved crucial for the advancement and protection of indigenous peoples' rights.....But this obligation does not only derive from New Zealand's international obligations; at the domestic level, perhaps unlike most other countries with significant indigenous populations, New Zealand is bound by political and legal obligations, in particular, those set in Tiriti o Waitangi or the Treaty of Waitangi.'*²⁴²

To date, consultation with, and participation of, Māori in the development of mainstream responses to whānau violence has been extremely limited. Recent reports written by Māori discussing possible responses to whānau violence recognise that western approaches using a mainstream framework have failed to achieve good results. They have:

- failed to recognise the negative impact of colonisation on whānau, hapū and iwi
- endorsed interventions focused on concepts of individual harm, as opposed to whānau, hapū and iwi development and well-being
- created barriers to flexibility within programme provision
- failed to recognise the importance of addressing issues such as systemic violence and the endemic nature and acceptance of family and whānau violence within communities

²⁴⁰ <http://www.ohchr.org/EN/countries/AsiaRegion/Pages/NZIndex.aspx>

²⁴¹ The most recent review of New Zealand by the Human Rights Council' Working Group on the Universal Periodic Review (UPR) was held on 27 January 2014. The final report pertaining to this review is not yet available and hence the summary points have been extracted from the working group's draft report dated 29/1/14. Available at <http://www.hrc.co.nz/international-human-rights-new/upr-1314-nzs-second-universal-periodic-review/>

²⁴² Fenrich, J. & Contesse, J., (2009), *It's Not OK New Zealand's Efforts to Eliminate Violence Against Women*, Leitner Centre for International Law and Justice. New York City. (pg 17)

- failed to value prior learning amongst Māori providers
- not recognised the value of Māori methods and models.²⁴³

There has also been criticism of the ways that government has responded to the problem of whānau violence by taking a silo-ed approach and not sharing information across sectors and setting up providers to compete against each other for limited funding opportunities.²⁴⁴ Two documents are particularly relevant in ensuring the Integrated System would have direct relevance and application for Māori. Firstly, a recent NZFVC issues paper on whānau violence²⁴⁵ argues that multi-level approaches to prevention and intervention are more likely to achieve the best results for whānau. The paper highlights that Māori frameworks and research point towards the importance of working collaboratively to achieve results. Collaborative ways of working are strengthened by a holistic or ecological approach which works at a policy level, a community level, a whānau level and an individual level.²⁴⁶

The second report that shows that the Integrated System would have relevance for Māori, is the Taskforce on Violence within Families' Māori Reference Group's (MRG) recently released 'E Tu Whānau' strategy for addressing whānau violence²⁴⁷ which builds on the concepts of Whānau Ora and the Mauri Ora framework. This states that the responsibility and accountability for positive change lies with both iwi and the government and '*requires a range of strategies and interventions and a continuum of short – term and long-term priorities and responses*' (pg 20). Fundamentally at the heart of the framework is a commitment to Māori designing and implementing strategies that respond to Māori needs and ways of being. The E Tu Whānau strategy expresses a commitment to continue to work with key agencies to provide support and input to any projects aimed at improving systems and processes related to family violence (pg 30). We see many synergies between the E Tu Whānau framework and the Integrated System model.

7.2 Alignment with national policies, strategies and initiatives

General government priority areas

There are a number of government priority areas to be considered when assessing the strategic fit of the Integrated System model (see Figure 42). Common themes that flow through these government initiatives are:

²⁴³ Dobbs, T. & Eruera, T. (2014). *Kaupapa Māori wellbeing framework: The basis for whānau violence prevention and intervention*. Auckland, New Zealand: New Zealand Family Violence Clearinghouse, University of Auckland

²⁴⁴ Inquiry into the determinants of wellbeing for tamariki Māori Report of the Māori Affairs Committee Fiftieth Parliament (Hon Tau Henare, Chairperson) December 2013 Presented to the House of Representatives

²⁴⁵ Dobbs, T. & Eruera, M. (2014). *Kaupapa Māori wellbeing framework: The basis for whānau violence prevention and intervention*. Auckland, New Zealand: New Zealand Family Violence Clearinghouse, University of Auckland. Available at <http://www.nzfvc.org.nz/issues-papers-6>

²⁴⁶ Similarly, a 2013 inquiry into the wellbeing of Māori tamariki²⁴⁶ found that collaboration and partnership between whānau, community agencies, iwi, local and central government, non-government organisations, and other stakeholders is central to empowering relationships for delivering effective service. See Inquiry into the determinants of wellbeing for tamariki Māori Report of the Māori Affairs Committee Fiftieth Parliament (Hon Tau Henare, Chairperson) December 2013 Presented to the House of Representatives.

²⁴⁷ E Tu Whānau Programme of Action for Addressing Family Violence 2013 – 2018 The Māori Reference Group for the Taskforce for Action on Violence within Families.

- a recognition that no one agency can itself achieve long-term outcomes
- the need for government and NGOs to work more closely together and organise themselves around results that make a difference to New Zealand
- sharing functions and services, purchasing goods and services, and developing systems together
- making use of technology to improve access to government services
- improving how agencies measure and report on performance
- greater responsiveness within the public sector to the needs and expectations of New Zealanders, and a commitment to continuous improvement
- identifying opportunities to expand a number of innovations and good practices already underway.

Figure 42: Strategic fit with government priority areas

Government initiative	Strategic Fit with Integrated System model for IPV and CAN
Better Public Services (BPS) - the central platform for the government's public sector reforms is focused on getting the system working to deliver better results and improved services for New Zealanders.	The Integrated System model is expected to have a positive impact on seven of the 10 Better Public Services priority result areas - see Appendix 7.
Investing in Services for Outcomes (ISO) - an MSD initiative aiming to achieve better outcomes through more effective engagement with community service providers.	The Integrated System model is well aligned with the ISO model and is specifically designed to ensure better outcomes.
Strategic Investment Framework ²⁴⁸ - an MSD initiative to provide the sector with a comprehensive picture of what social services they will purchase, to meet government priorities and community need.	Key functions of the national backbone agency and the regional hubs (see Chapters 6 and 11) are directly aligned with this approach.
Whānau ora - has a strong focus on working with whānau as a collective and requires multiple community and government agencies to work together with families rather than separately with individual family members.	The Integrated System model proposed is similar in design and objectives to Whānau ora.
Social Sector Trials (the Trials) ²⁴⁹ - the most relevant local example of a new way of working to address a complex wicked social problem.	There are strong synergies between the Trials model and the Integrated System model.

National IPV and CAN strategies

Having shown close alignment between various government priority areas, Figure 43 shows there is also close alignment between the Integrated System model and various governance arrangements and strategies for IPV and CAN currently in operation.

²⁴⁸ <http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/investing-in-services-for-outcomes/strategic-investment-framework.html>

²⁴⁹ <https://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/social-sector-trials/>

Figure 43: Strategic fit with national IPV and CAN strategies

Government initiative	Strategic Fit with Integrated System model for IPV and CAN
White Paper on Vulnerable Children and Children's Action Plan (CAP) ²⁵⁰	The Integrated System model provides an opportunity to build on the work being done under the CAP and 11 of the objectivities and action areas in the CAP align with the principles and the functions of the national backbone agency and regional hubs for the Integrated System model.
The Taskforce for Action on Violence within Families (the Taskforce)	The national backbone agency will be ideally placed to coordinate the local implementation and continuous improvement of many of these types of initiatives.
Te Toiora Mata Tauherenga - Report of the Taskforce for Action on Sexual Violence ²⁵¹	We see the development and sustainability of the sexual violence sector as critical in order to ensure the needs of all of those who have experienced sexual violence within IPV and CAN.
E Tu Whānau strategy	There are many synergies between the Integrated System model and the E Tu Whānau strategy.
Family Violence Programme of Action for Pacific Peoples	The principles of this strategy align well with the principles of the Integrated System model.

Summary

In this chapter we have highlighted an extensive range of international and domestic treaty obligations, national policies, strategies and other initiatives and shown strong alignments between these and the Integrated System model.

²⁵⁰ <http://childrensactionplan.govt.nz/>

²⁵¹ Available at <http://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=3615>

8. What are the economic benefits of the Integrated System model?

Having established that the Integrated System is the most appropriate model to address IPV and CAN and that it is a good fit strategically, in this chapter we explore the extent to which the costs of establishing and operating the new Integrated System would be justified in terms of reducing personal harm and the long-term social and economic impacts. Do the benefits outweigh the costs?

An absence of robust quantitative and qualitative data on the costs and effectiveness of current arrangements in New Zealand means we have had to rely on a range of estimates and proxy measures to inform this cost benefit analysis. As is typical when assessing the economic benefits of a complex social issue, we have used a mix of qualitative and quantitative measures to build up a picture of the expected costs and benefits associated with the new model, namely:

- Direct annual costs for the fully established Integrated System model - as calculated in Chapter 10.
- Quantitative benefits - economic savings as calculated in Section 8.3 below.
- Qualitative benefits arising from the new model.

8.1 Limitations

The scope of this document has not permitted a full economic analysis to be undertaken and there are a number of limitations in the analysis contained in this chapter including:

- The social benefits delivered under the current arrangements are not measured.
- Information is not available about the true levels or geographical spread of IPV and CAN in New Zealand. The evidence shows that they occur in all socio demographic groups and hence for the purposes of this proposal and the supporting business case we have assumed rates of IPV and CAN are equal in all regions and that benefits would be achieved equally by all regions.
- There is currently insufficient evidence to determine the extent to which greater financial savings and economic benefits would come from investing in each of the stages; namely, primary prevention, early intervention, crisis intervention or rebuilding lives (to reduce the immediate harm, long-term social effects and intergenerational transference). In reality investment is needed at all levels. The optimal mix of service responses and related costs cannot be known until the system specification has been developed and tested and more specific data has been gathered over time.

Once the first regional hub was established and evaluated we would expect the following information to be available to allow a more robust cost benefit analysis:

- Costs and social value - costs incurred in establishing and operating the national backbone agency and the demonstration region and the social benefits that are possible.
- Baseline information - a baseline evaluation and population needs assessment would be undertaken in the demonstration region in the early stages of development. Government would need to be asked to assist in establishing a clear baseline of the current costs of services and a full review of international research to establish baseline social measures.

- Results framework - realistic immediate, intermediate and long-term objectives and outcome or results measures would need to be agreed with government - the number and scale of these should be informed by international research, practice examples from integrated system developments in other countries, views of front-line providers and service users.

8.2 Calculating the economic cost of IPV and CAN

In Chapter 2 we detailed the social costs of IPV and CAN – the interconnectedness between the different forms of violence – the immediate and long-term damage caused to individual victims/survivors, the way this transmits from one individual to many others as further violence and multiple other health and social issues. The full extent of the social costs resulting from the high levels of IPV and CAN in New Zealand are not well understood, but the evidence we provide in Chapter 2 suggests they are much greater than currently appreciated. We believe the Integrated System would reduce the costs to individuals and the New Zealand society and economy.

The Ministry of Social Development's Are you OK website says:²⁵² *'The economic cost of family violence was estimated at \$1.2 to \$5.8 billion per year by Economist Suzanne Snively in 1994. In today's figures that would rise to \$8 billion p.a.'* indicating that the government accepts \$8 billion as the annual economic cost of family violence in New Zealand. Rather than merely accepting this figure as a given we have attempted to calculate a more precise figure, one we feel comfortable justifying in our arguments around potential economic savings.

International studies

Since the late 1980s, the literature reflects an increasing interest in augmenting social, psychological and criminological perspectives with an economic perspective as a way of gathering government and community support for efforts to prevent and overcome the effects of IPV and CAN. There is also growing awareness of the need to ensure limited resources are targeted most effectively.²⁵³ A 2005 study undertaken for the United Nations concluded: *'All of the economic costing literature indicates that the whole of society pays for the costs of not addressing this [violence against women] pressing social concern.'*²⁵⁴

The economic costs of IPV and CAN are borne by individuals, families, communities and societies. Individuals pay out of pocket expenses, and their families experience a change in their consumption choices as a result. Individuals and their families also bear the burden of reduced income, reduced savings and loss of household output. Employers bear a heavy burden due to lost productivity arising from the effects of IPV.²⁵⁵ Communities cover the costs of private services provided by the local agencies such as churches or volunteer workers in crisis centres. National, regional and local

²⁵² www.areyouok.org.nz/files/Updated_Stats_Final.pdf

²⁵³ Laing, L. and Bobic, N. (2002) Economic costs of domestic violence. Australian Domestic and Family Violence Clearinghouse . Available at www.adfvc.unsw.edu.au/pdf%20files/economic_costs_of_dv.pdf

²⁵⁴ Day, T., McKenna, K., and Bowlus, A (2005). The Economic Costs of Violence Against Women: An Evaluation of the Literature. The University of Western Ontario, London, Ontario, Canada. Available at www.un.org/womenwatch/daw/vaw/expert%20brief%20costs.pdf

²⁵⁵ Kahui et al recently published a study showing domestic violence is currently costing New Zealand employers \$368 million p.a. Kahui, S., Bryan, K and Snively, S. (2014) Productivity gains from workplace protection of victims of domestic violence. Commissioner by Public Services Association. Available at <http://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=4375>

governments bear the costs of public services offered within their jurisdictions, as well as supporting private initiatives through granting programs. Overall, the entire economy and the society nationwide are affected by the monetary losses resulting from this violence.²⁵⁶

The experts seem to agree that there is no one ‘best’ approach to estimating the economic costs of IPV and CAN given their complex nature, high levels of under-reporting, the diversity of agencies in contact with individuals and families affected by it, and high intangible costs. There are considerable differences in the findings of international studies of the economic cost of IPV and CAN (discussed further later in this chapter). This is largely because each study measures the different costs in different ways, in particular the long-term and diverse negative social consequences that arise. In Chapter 2 we included a table showing the multiple social issues that are directly impacted by IPV and CAN. None of the economic studies appear to have included any analysis of the full extent of these effects as new evidence regarding the relationship between these problems is continually emerging.

The WHO reviewed a total of 119 studies and documents discussing the costs of violence.²⁵⁷ The findings pertaining to CAN, IPV and sexual violence are in Appendix 8.²⁵⁸ They measured direct and indirect costs and benefits as shown in Figure 44.

Figure 44: Direct and indirect costs and benefits

Direct costs and benefits	Indirect costs and benefits
The effects resulting directly from acts of violence or attempts to prevent them.	The long-term effects of acts of violence on abusers and victims/survivors.
<ul style="list-style-type: none"> • Costs of legal services • Direct medical costs • Direct perpetrator control costs • Costs of policing • Costs of incarceration • Costs of foster care • Private security contracts • Economic benefits to abusers 	<ul style="list-style-type: none"> • Lost earnings and lost time • Lost investments in human capital • Indirect protection costs • Life insurance costs • Benefits to law enforcement • Productivity • Domestic investment • External investment and tourism • Psychological costs • Other non-monetary costs

Some of the costs that are commonly excluded from these studies are the:

- flow on costs associated with long-term effects, other than with respect to the specific issue of the intergenerational transmission of abuse
- cost of child victims/survivors who as adults are incarcerated or hospitalised for reasons arising as a consequence of child abuse

²⁵⁶Day, T., McKenna, K., and Bowlus, A (2005). The Economic Costs of Violence Against Women: An Evaluation of the Literature. The University of Western Ontario, London, Ontario, Canada. Available at www.un.org/womenwatch/daw/vaw/expert%20brief%20costs.pdf (pg 11)

²⁵⁷World Health Organisation (2004) The Economic dimensions of interpersonal violence. Geneva. Available at <http://whqlibdoc.who.int/publications/2004/9241591609.pdf>

²⁵⁸Because no systematically documented studies of the economic effects of abuse of the elderly were found, they dropped this category from the review but noted that elder abuse is common in countries of all income levels, indicating the urgent need for further research of this topic.

- social effects of child abuse and neglect from the perspective of the individual victim/survivor
- reduced earning capacity of victims/survivors who lack the self-confidence to pursue educational opportunities they might have had in the absence of the abuse.

Most studies recognise that accurately estimating the economic cost is particularly difficult given that only a relatively small proportion of IPV and CAN is reported to authorities. They are only able to estimate the economic costs related to the cases of violence that are reported and are therefore forced to assume that the nature and long-term impacts of the unreported cases are the same as the reported cases. However, there is no evidence to support that assumption. For example indications are that physical violence is reported and acted on by the state more often than cases of long-term psychological or sexual abuse and yet studies repeatedly confirm that psychological and repeated sexual abuse has the most far reaching damaging consequences.

Most recent studies apportion the costs in three main categories - individuals, state and wider society and employers. Most appear to be more successful in calculating the direct costs (such as the cost of crisis accommodation, legal services, income support, and health and medical services) than in calculating the indirect costs (such as the replacement of lost or damaged household items, and costs associated with changing houses or schools).²⁵⁹

However, different studies reach different conclusions about the percentages of total costs falling within each category. For example Professor Walby²⁶⁰ allocated 82 percent of costs per year to victims/survivors, 12.5 percent of the total costs to the state and five and a half percent to employers. In 1994 Suzanne Snively undertook a comprehensive analysis of the economic cost of all forms of family violence in New Zealand.²⁶¹ In contrast Snively allocated only 32 percent of costs per year to victims/survivors and 78 percent to the state and she noted: '*It is even more difficult to estimate the cost to the employer of lost productivity as employees attempt to maintain a 'normal' working life whilst suffering the consequences of family violence*'.

Methodology used for this analysis

Our starting point in finding a quantitative measure to use in analysing the costs and benefits was to consider the above methodological issues against four New Zealand-specific studies shown in Figure 45.

²⁵⁹ Laing, L. and Bobic, N. (2002) Economic costs of domestic violence. Australian Domestic and Family Violence Clearinghouse . Available at www.adfvc.unsw.edu.au/pdf%20files/economic_costs_of_dv.pdf

²⁶⁰ Cited in The National Council to Reduce Violence against Women and their Children (2009) *The cost of violence against women and their children*. Commonwealth of Australia. Available at <http://www.dss.gov.au/our-responsibilities/women/publications-articles/reducing-violence/national-plan-to-reduce-violence-against-women-and-their-children/economic-cost-of-violence-against-women-and-their-children?HTML#found>

²⁶¹ Snively, S. (1994) *The New Zealand Economic Cost of Family Violence* (1996) . Department of Social Welfare, Wellington. Available at <http://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=3469>

Figure 45: New Zealand specific economic studies

Study	Scope	Findings	Total economic cost adjusted to 2014
Snively, S. (1994) ²⁶²	All forms of Family Violence	Reported three scenarios of the economic cost of family violence (IPV and CAN) in NZ in 1993/94 year.	\$8.326 billion p.a. total ²⁶³
Infometrics Ltd (2010) ²⁶⁴	Child abuse and neglect	Used studies from USA and Australia and translated their findings into New Zealand terms.	\$2.220 billion p.a. total ²⁶⁵
Roper and Thompson (2006) ²⁶⁶	Sexual offences	Sexual violence as a component of violence crime: Intangible costs, lost output and total private sector.	\$1.365 billion p.a. ²⁶⁷
Tu Van Nguyen (2009) ²⁶⁸	Family violence	12,510 family violence related incidents reported to the Counties Manukau Police in 2008.	\$4,417 billion p.a. ²⁶⁹

None of the above studies are directly aligned. Snively's 1994 study²⁷⁰ was the most inclusive and is therefore adopted as the starting place for our calculations. Snively used three different prevalence rates and three different scenarios of scope as shown in Table 3.

Table 3: Economic cost of family violence for 1993/94 in New Zealand

	Prevalence Rate		
	1-in-10 \$B	1-in-7 \$B	1-in-4 \$B
Base Scenario*	1.187	1.235	1.352
Five Times Callout Scenario**	2.691	2.739	2.855
Income Foregone Scenario***	3.770	4.206	5.302

* Calculates direct costs for families who called out the Police.

** Calculates direct costs for five times the number who called out the Police.

*** Calculating income foregone as well as direct costs for five times the number who called out the Police plus the value of life.

²⁶² Snively, S. (1994) *The New Zealand Economic Cost of Family Violence* (1996) . Department of Social Welfare, Wellington. Available at <http://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=3469>

²⁶³ Refer Table4

²⁶⁴ The nature and economic costs from child abuse and neglect in New Zealand a report prepared by Infometrics Ltd. for Every Child Counts - June 2010. Available at <http://www.infometrics.co.nz/reports/ECC-Child-Abuse-Neglect-FULL-REPORT.pdf>

²⁶⁵ Adjusted by 8.2% - the New Zealand implicit GDP deflator 2010 to 2014

²⁶⁶ Roper, T. and Thompson, A. (2006) Estimating the costs of crime in New Zealand in 2003/04. New Zealand Treasury Working Paper 06/04. Available at <http://www.treasury.govt.nz/publications/research-policy/wp/2006/06-04/>.

²⁶⁷ Adjusted by 14.5% - the New Zealand implicit GDP deflator 2006 to 2014

²⁶⁸ Tu Van Nguyen/RAH for Tomorrow's Manukau Reducing Family Violence Group (2009). Available at

<http://www.tomorrowsmanukau.co.nz/files/Economic%20Cost%20of%20Family%20Violence%20in%20Counties%20Manukau.pdf>

²⁶⁹ Tu Van Nguyen's cost per case was adjusted by 10.6% - the New Zealand implicit GDP deflator 2009 to 2014 and multiplied by 95,080 (the number of family violence investigations by NZ Police in 2013. Data available at <http://nzfvc.org.nz/data-summaries/snapshot>

²⁷⁰ Snively, S. (1994) *The New Zealand Economic Cost of Family Violence* (1996) . Department of Social Welfare, Wellington. Available at <http://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=3469>

Although Snively's findings are now 20 years old, the methodology she used has generally stood the test of time. If a similar study was done today the scope is likely to be broader. For example Snively did not include any 'costs to others'.²⁷¹ We elected to use Snively's mid-prevalence range of 1-in-7 and her 'income foregone scenario' figure of \$4.206 billion as our starting point and adjusted this figure as follows.

Table 4: Estimated economic cost of IPV and CAN for 2014 in New Zealand

Snively's 1-in-7 income foregone scenario for 1993/94	\$4,206,000,000
Increased by 23.7 percent - population increase over the past 20 years ²⁷²	\$996,822,000
Sub total	\$5,202,822,000
Increased by 77.8% - the implicit GDP deflator over the past 20 years	\$4,047,795,516
Sub total	\$9,250,617,516
Decreased by 10 percent to remove the cost of IFV ²⁷³	\$925,061,752
Total projected cost in 2014	\$8,325,555,764

We then attempted to check our adjusted figure \$8.326 billion per annum against two international studies.²⁷⁴ However, neither included child abuse and neglect and both included different direct and indirect costs and were therefore not comparable. For three key reasons we believe our Snively-adjusted figure of \$8.326 billion per annum is not an over-estimate. Firstly, by Snively's own admission she did not include 'costs to others' and hence our total economic cost would be higher if these costs were included. Secondly, in Chapter 2 we showed that evidence is now available showing more long-term effects than were considered by Snively 20 years ago e.g. bullying and youth suicide related to experiencing CAN in childhood. Thirdly, Snively included the loss of earnings from the family violence homicides but did not include any costs of a statistical life for either family violence deaths or family violence related deaths (ie suicides occurring at, or soon after, the death event).

²⁷¹ Other services for those affected are provided by the voluntary sector and the cost incurred by 'others' ie employers were excluded.

²⁷² Statistics New Zealand population clock available at http://www.stats.govt.nz/tools_and_services/population_clock.aspx

²⁷³ Snively's figures included all types of family violence - IPV, CAN and IFV (see glossary of terms for details). Police report that of all family violence cases reported to them 70% are IPV, 20% CAN and 10% IFV (Family Violence Process Comparison provided by Police on 14 March 2012 at Family Violence Process Changes - Stakeholder Update Meeting). As this business case is focused on IPV and CAN we have reduced Snively's adjusted figure by 10% to factor these costs out of our calculations.

²⁷⁴ (1) The National Council to Reduce Violence against Women and their Children, 2009, *The Cost of Violence against Women and their Children*, p. 4, Canberra, Commonwealth of Australia. Available at http://www.fahcsia.gov.au/sites/default/files/documents/05_2012/vawc_economic_report.pdf and (2) Source data in S. Walby, 2004, *The Costs of Domestic Violence*, p. 12, Leeds, Women and Equality Unit and University of Leeds. As reported by UN Women at: <http://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures#sthash.kMifVHEH.FOfDPFTz.dpuf> As reported by UN Women at: <http://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures#sthash.kMifVHEH.FOfDPFTz.dpuf>

The Ministry of Transport calculates the value of statistical life in 2013 terms as \$3.85million.²⁷⁵ The latest FVDRC report²⁷⁶ says in the four years 2009 to 2012 there were an average of 35 family violence deaths and related deaths per year. If the cost of these statistical lives were included it would increase Snively's total by a further \$134.75 million per annum. An up to date economic analysis would be needed to reflect the latest evidence and confirm or adjust the economic savings estimates used in this chapter.

IPV and CAN are costing the New Zealand economy \$8.326 billion per annum
IPV and CAN are costing every man, woman and child in New Zealand \$1833 per annum.²⁷⁷

8.3 Estimating the potential economic savings

We believe there would be significant economic savings by establishing the Integrated System model in New Zealand. These would be achieved by responding more effectively to keep victims/survivors safe, identifying more cases, responding earlier before the violence and the resulting trauma escalates, by holding abusers accountable for their behaviour, and by all parts of the system wrapping around those affected and doing everything possible to reduce the immediate and long-term effects.

A matrix (Table 5) has been used to calculate a range of scenarios of possible savings using two variables:

1. The percentage of total cases (currently reported and unreported) the Integrated System could have a positive impact on.
2. The extent to which the Integrated System could reduce the immediate and long-term effects.

For example if the economic cost of 100 percent of current cases (reported and unreported) is \$8.326 billion, the cost of the 20 percent of cases that are currently reported will be \$1.665 billion. If the Integrated System could reduce the economic impact arising from these cases by just 10 percent this would result in an annual saving to the New Zealand economy of \$163 million (10 percent of the economic cost of 20 percent of all cases). If we could identify 30 percent of all cases and reduce the impact of these cases by 30 percent, the economic saving increases to \$749 million. If 50 percent of all cases were identified and we reduced the impact on these cases by 50 percent the annual saving to the economy is over \$2 billion and so on.

²⁷⁵<http://www.transport.govt.nz/research/roadcrashstatistics/thesocialcostofroadcrashesandinjuries/>

²⁷⁶ Family Violence Death Review Committee, 2014. Fourth Annual Report: January 2013 to December 2013. Wellington: Family Violence Death Review Committee. Available at <http://www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC-4th-report-June-2014.pdf>

²⁷⁷ According to Statistics New Zealand in 2013 the population of New Zealand was 4,542,137 on 7 July 2014.. See http://www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/NationalPopulationEstimates_HOTPA30Jun13.aspx

Table 5: Potential economic savings

Percentage of total cases the Integrated System would have a positive impact on	Percentage reduction in the economic cost arising from the immediate and long-term effects (\$ million)				
	10%	20%	30%	40%	50%
10% ²⁷⁸	83.26	166.52	249.78	333.04	416.30
20% ²⁷⁹	166.52	333.04	499.56	666.08	832.60
30% ²⁸⁰	249.78	499.56	749.34	999.12	1,248.90
40%	333.04	666.08	999.12	1,332.16	1,665.20
50%	416.30	832.60	1,248.90	1,665.20	2,081.50

Notes:

1. If all parts of the system did everything possible to ensure victim/survivor safety and perpetrator accountability, prevent the violence from continuing and minimise the harm done by living with such violence, economic savings would result from a reduction in the costs associated with the immediate and long-term social effects.
2. The earlier we intervened in each case and the more effective the Integrated System response is, the greater the economic savings would be.
3. The more cases we could identify and take action on the greater the economic savings would be ie a measure of success for reporting rates to increase.
4. The effort required to achieve such results in any one case would not all occur within one year and the savings would only be realised over time.
5. The investment required to rebuild lives following successful early intervention (before the violence has escalated and become entrenched) is expected to be significantly less than that required for the high-risk cases.
6. As the Integrated System effectively identifies and intervenes early we would expect to see a reducing number of high-risk cases requiring higher cost crisis intervention.
7. The cumulative effect of having even a relatively small positive impact on all new cases identified in any one year would build over time. Once the Integrated System was fully operational, we are confident that savings of these magnitudes would be achievable.
8. The calculations shown here are for example only to show the levels of economic savings that are possible. We recognise that a reduction in the impact on any one case would not be achieved in a year - in some cases the system would need to wrap around the individuals concerned for many years through the rebuilding lives phase of the prevention continuum.
9. We have not attempted to forecast the potential economic savings on an annual basis and appreciate there will be diminishing returns over time. To some extent these will be offset by decreasing costs.

²⁷⁸ Half the current 20% of cases reported to the integrated system (via Police) have improved outcomes

²⁷⁹ All the current 20% of cases reported to the integrated system (via Police) have improved outcomes

²⁸⁰ 10% more cases are reported to the integrated system (via any entry point) and all have improved outcomes

8.4 Appraisal of costs and benefits of the Integrated System model

To achieve the economic savings calculated above, New Zealand would have to invest more in addressing these problems. In order to calculate the potential return on investment, or costs versus benefits, we have estimated the costs of establishing and operating the Integrated System throughout New Zealand at a level that we believe could achieve a 20 percent saving in the economic costs arising from the 20 percent of all cases that are currently reported to Police. These costings are detailed in Table 8 (Chapter 10).

More work would be required to model the transitional dynamics of moving from the current system to a fully operational Integrated System. Financial experts would need to be engaged to review the estimates we have used and undertake a financial modelling exercise to more accurately project the costs, savings and expected annual rate of return. Once the model was operational in the demonstration site and the system specification and initial gap analysis completed, more realistic estimates of the wider consequences will be possible. For the purposes of this proposal we have used a moderate cost scenario and compared this to the economic saving in the highlighted cell in Table 5. The comparative costs and benefits of this scenario have been brought together in Table 6.

Table 6: Costs and benefits of Integrated System model

Annual costs ¹		National backbone agency	\$2.50 m
		Regional hubs	\$6.48 m
		Transactional	\$0.35 m
		Service provision	<u>\$12.00 m</u>
		Total	<u>\$22.37 m</u>
Quantitative benefits - economic savings ²		Total	\$333.04 m
Qualitative benefits ³	Individual	<ul style="list-style-type: none"> • reduction in the effects of trauma and personal short and long-term harm • reduction in transmission of harm to others • reduction in deaths due to improved high-risk case management • increased reporting of cases enabling increased positive intervention • increased safety for victims/survivors- they feel safer • increased levels of shared understanding and training of staff • more accountability for abusers to change their behaviour • increased sense of mana and self-esteem amongst victims/survivors • improved access to services and viable alternatives for living violence free • improved levels of job satisfaction for frontline staff if services are better resources 	
	Strategic	<ul style="list-style-type: none"> • improved quality • increased efficiency via targeted service provision aligned to need • reduced gaps, overlaps and duplications and inconsistencies • reduction in inequities • improved alignment of national and local initiatives • greater compliance with local and international treaty obligations • greater alignment with current government priority areas 	
	Economic	<ul style="list-style-type: none"> • reduction in bullying, youth suicides, mental illness, alcohol and drug abuse, disability, teen pregnancies and STIs, unwanted pregnancies, failure at school, truancy, chronic illness, risk taking behaviour, youth violence and multiple other social issues • more effective intervention the first time hence fewer cases re-entering into the system • more efficient use of resources by targeting services to work collaboratively 	

Notes:

1. Annual Costs: The medium scenario for the infrastructure, transactional and service provision costs that would be required over and above current funding levels as shown in Table 8 in Section 10.3.
2. Quantitative benefits: For the purpose of this analysis we assumed a 20 percent positive impact on the 20 percent of all cases currently reported to Police (this would be the same as having a 10 percent positive impact on 40 percent of all cases) from the table above. The economic savings on any individual case would not be fully realised in the first year ie there would be a diminishing rate of return.
3. Qualitative benefits: A range of individual, strategic and economic benefits achievable by the Integrated System model.

Return on investment

In principle, the more that is invested in a well managed Integrated System the greater the economic savings would be. The above analysis indicates that once the Integrated System was established and fully operational in all regions of New Zealand it would be possible to achieve a 15 fold diminishing return on the additional funding invested. Irrespective of the end point in the number of cases identified and the percentage reduction in the economic cost arising from the immediate and long-term effects (table 5), indications are that for every dollar invested the Integrated System can provide a positive rate of return in the form of savings to our economy.

Investing in the Integrated System would result in significant savings to the New Zealand economy and hence to New Zealand taxpayers.

If we assume that the average length of time the system will need to wrap around each case through the rebuilding lives stage of the prevention continuum is two and a half years there would be an average annual six fold return on investment. This contrasts with the two fold return on the taxpayer's investment in New Zealand's last challenge for America's Cup, *'The economic benefit from our investment in Team New Zealand is considerable. From a \$36 million taxpayer investment, the evaluation shows an estimated positive impact of \$87 million to the New Zealand economy'*.²⁸¹

Hump funding

As discussed in Sections 10.2 and 11.6 once the evidence based system specification had been prepared identifying all the components parts required to operate the most effective system, service mapping would be undertaken to identify and remedy any gaps, overlaps and regional variations. Whilst this would identify some savings by removing overlaps or services identified as not required (or not required at current levels) for the Integrated System, there would almost certainly be greater funding required to address service gaps and regional inconsistencies and to increase capacity. This would create a hump funding effect where resources would be required to establish the Integrated System, and increase the system's capacity to respond effectively to more cases. However, as soon as the Integrated System takes effect we would start to see economic savings.

²⁸¹ Minister Steve Joyce - see <http://www.scoop.co.nz/stories/PA1403/S00532/reports-show-benefits-of-americas-cup-to-nz.htm>

Scaling up

To maximise economic savings we would need to identify and respond effectively to far more cases than we currently do. If we only ever strive to identify 20 percent of all cases and reduce the damage caused by 20 percent (as portrayed in the scenario in Table 6), we will fall a long way short of slowing the transmission of the harm caused to this generation and the next. Hence the system would need to be sure it has the capacity to respond to more and more cases.

Once the Integrated System infrastructure was fully developed and operational throughout the country and the continuous improvement processes were in place to maximise opportunities and minimise risks; providing funding was increased and there was sufficient workforce capacity; it would be reasonably straight forward to systematically expand the system to have greater and greater capacity to respond to more and more cases. However, expansion would need to be carefully managed to ensure quality and effectiveness are not compromised by trying to expand too quickly too soon.

It is not possible at this stage to calculate with any degree of certainty the incremental costs required to expand the system.

Other considerations

Distributional analysis

It was not possible to undertake a distributional analysis to identify how the costs and benefits would accrue to different groups with any degree of accuracy at this time, primarily because the New Zealand public sector does not report accurate or up to date data on the gender, ethnicity, age, geographic location, disability or socio demographic status of cases of IPV and CAN.

Optimism bias adjustment

We acknowledge that we may have underestimated the cost of implementing and operating the Integrated System model and underestimated the percentage of all cases that are currently reported to agencies. It is also possible we have overestimated the savings possible by removing service overlaps or duplications and underestimated the extent to which additional services are needed to fill the service gaps and inconsistencies identified by the system mapping exercise.²⁸² If we adjusted the costs upwards by 25 percent and the annual savings down by 25 percent to adjust for any possible bias there is still a very attractive return on investment.

Sensitivity analysis

One possible scenario is that we have over-adjusted Snively's 1-in-7 income foregone scenario.²⁸³ We re-ran the calculations of projected economic savings using Snively's 1993/94 figure of \$4.206 million making no adjustments for population growth or inflation costs. This reduced our estimated

²⁸² The 'Map of Gaps' studies in the UK found there is a crisis in the funding and provision of specialised services that support victims of violence and that victims face a regional postcode lottery and in large parts of Britain provision of required services is scarce or non-existent. Map of Gaps 2: the postcode lottery of Violence Against Women support services in Britain. End Violence Against Women and Equality and Human Rights Commission (2009)

²⁸³ Snively, S. (1994) *The New Zealand Economic Cost of Family Violence (1996)*. Department of Social Welfare, Wellington. Available at <http://library.nzfvc.org.nz/cgi-bin/koha/opac-detail.pl?biblionumber=3469>

economic savings in the highlighted cell in Table 5 to \$151.40 million which is still just under a seven-fold diminishing return on investment.

Risk management

All possible risks that could impact negatively on these cost benefit projections would need to be identified and mitigation strategies developed throughout the establishment and operation of the new model. A risk register would need to be maintained throughout (see also Chapter 11).

8.4 The social and economic costs of retaining the status quo

The cost of doing nothing other than to continue with the status quo arrangements, relying on a mixed bag of one-off initiatives in the absence of any long-term strategy or a joined up system, would result in a continued escalation of economic costs over time. As we noted in Chapter 2, IPV and CAN need to be seen as contagious diseases. Every case affects multiple people thereby spreading over time to more and more people. As is the case with an infectious disease if we only ever intervene in 20 percent of cases and/or intervene after the violence has escalated to crisis point, the flow on costs to would continue to multiply over time.

Summary

We have shown that the social and economic cost to New Zealand of IPV and CAN in both qualitative and quantitative terms is extremely high. We have applied various scenarios to existing, but outdated, economic assessments and concluded that IPV and CAN are currently costing the New Zealand economy approximately \$8.326 billion per annum. The implementation of the Integrated System model could bring significant savings to the New Zealand economy. Although the cost of providing the Integrated System would initially increase the total expenditure on IPV and CAN, over time, significant economic savings would be achieved as a result. Any initiative that serves to reduce the burden of IPV and CAN to individuals, our society and our economy is worth consideration. The Integrated System makes good economic sense for New Zealand and continuing with the status quo is not a viable option.

9. What would the commercial arrangements need to be?

We have shown that IPV and CAN impacts on individuals and their families, communities, employers and society as a whole. Whilst primary responsibility for funding and providing the system response to IPV and CAN should rest with government, long-term sustainable progress in addressing the problem would be most effective if the whole of New Zealand society took responsibility for the problem.

In Chapter 3 we showed that IPV and CAN are both complex and wicked problems. One of the key features of wicked problems is the 'no stopping rule'. Achieving long-term sustainable change cannot be achieved via 'quick fixes'; efforts must continue overtime rather than aiming to 'reach a solution' and then stop. The success of the Integrated System would be totally reliant on long-term certainty in the respective funding, procurement and contracting arrangements - without this the Integrated System would fail.

In this chapter we examine the commercial implications; the funding, procurement and contracting arrangements needed for the national backbone agency, the regional hubs and individual services and initiatives that make up the Integrated System.

9.1 Partner funding models

Whilst government should be the primary funder for the Integrated System it would also be important to explore additional sources of funding including private business and philanthropic partners, local government and community members. The Integrated System model appears to fit well with a number of new funding approaches the government is exploring.

Figure 46: Potential funding models

Commercial model	Detail
Strategic Investment Framework ²⁸⁴	A funding allocation model being developed by the Ministry of Social Development that factors in where the highest need is (client group and location) and what service works best.
Social Bonds	An innovative approach used internationally being trialled by Ministry of Health for private and not for profit organisations to partner in delivering better social outcomes and being rewarded by government for doing so.
Social Enterprise	The government values the role of social enterprises as potential partners for a range of government agencies in achieving 'collective impact', and as contributors to Better Public Services goals involving third party service delivery. ²⁸⁵
Public Private Partnerships	PPPs can refer to many different kinds of relationships between the government and the private sector. Examples include the building of new schools and prisons.

²⁸⁴ <http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/investing-in-services-for-outcomes/strategic-investment-framework.html>

²⁸⁵ Government position statement released in February 2014. Available at <http://www.dia.govt.nz/Resource-material-Our-Policy-Advice-Areas-Community-Development-Policy#Social-Enterprise>

If any of these funding models were used alongside government funding it would be important to retain transparency in how public money is being spent. A commitment should be made to 'open-book accounting' across all public service providers, and NGOs and private companies delivering public services should be subject to the same transparency requirements as public bodies.

9.2 Community-led funding decisions

Funding and contracting the regional hubs and the various services in the Integrated System could continue via the current approach with government adding clauses to existing contracts to define how the regional hub and service agencies would work as part of the Integrated System.

In Chapter 3 we introduced the concept of decentralisation as one of the key approaches to deal with complexity and to enable people to work more collectively. The best example of a decentralised procurement, contracting and funding approach in the New Zealand social sector is the Social Sector Trials (the Trials) where in-scope financial contributions, including non-departmental and departmental funding, are transferred from multiple parties into a single appropriation, 'Trialling New Approaches to Social Sector Change' in Vote Social Development.

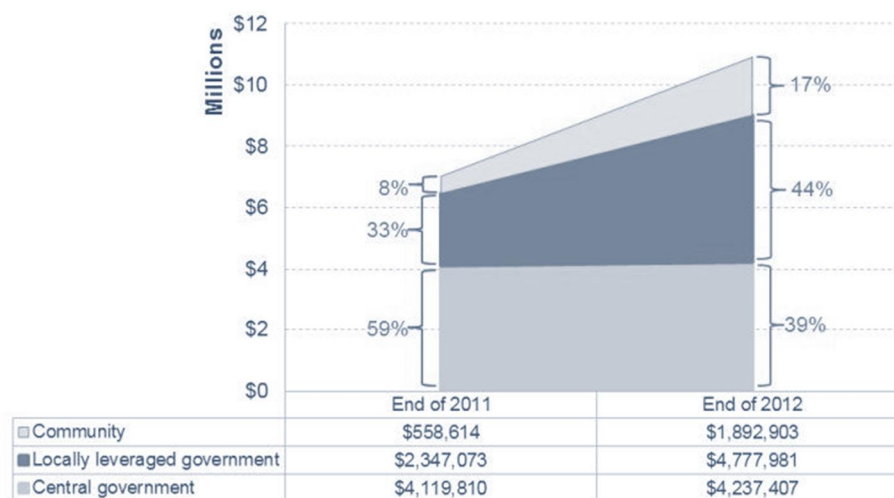
Each local community in which a Trial is being conducted is given the mandate, authority and flexibility to use the funding to best meet local needs. The Final Evaluation Report on the Trials²⁸⁶ says: *'The Trials are funded through cross-agency contributions of funding to support the administration of the Trials, the transfer of relevant contracts to the control of the Trial Leads, funding for new initiatives ('seed funding'), and through contribution of resources 'in-kind'.* Each Trial team is encouraged to secure additional financial support through government and community sources as shown in Figure 47.

'Initially, Trials locations were predominately funded by centrally allocated funding from partner agencies (including initial funding for setting up the Trials and transferred government contracts). By the end of 2012 the majority of contributions had been secured locally by the Trial leads from locally leveraged government sources²⁸⁷ (partner agencies and other government agencies) and from community sources (including district councils, businesses, schools, tertiary institutes, Primary Health Organisations, NGOs, iwi and members of the local community).'

²⁸⁶ <https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/initiatives/social-sector-trials/msd-social-sector-trials-evaluation-report-may-2013.pdf>

²⁸⁷ This is in addition to the centrally allocated funding that the Trials started with.

Figure 47: Social Sector Trials accumulated secured financial contributions at the end of 2012 by source type (Mar 2011 - Dec 2012)²⁸⁸



SOURCE: Ministry of Social Development, 2013

9.3 Contracting models

Government is developing and using some new approaches to contracting. Two worth noting are shown in Figure 48.

Figure 48: Contracting models

Contracting model	Detail
Streamlined contracting with NGOs ²⁸⁹	Being developed by Ministry of Business Innovation and Employment (MBIE) with a focus on achieving outcomes and greater consistency, increasing collaboration and reducing inconsistency and duplication.
Integrated services contract ²⁹⁰	Procuring service in an integrated manner whereby a coordinated group of named providers with relevant experience, qualifications and skills in a specialist area are contracted to deliver a full range of services to ensure that clients transitioning from one stage to another find the experience smooth, supportive, and safe.

9.4 Procurement and contracting considerations

One of the five requirements for achieving collective impact, listed in Figure 17 (Chapter 3), is a separate organisation with staff and a specialist set of skills to serve as the national backbone for the entire initiative to coordinate participating organisations and agencies. We are of the view that the national backbone agency for the Integrated System should be a specialist, 'fit for purpose', independent, not for profit agency in order to:

²⁸⁸ <https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/initiatives/social-sector-trials/msd-social-sector-trials-evaluation-report-may-2013.pdf>

²⁸⁹ <http://www.business.govt.nz/procurement/procurement-reform/streamlined-contracting-with-ngos/about-the-project>

²⁹⁰ For example Accident Compensation Commission (ACC) in its request for tender (RFT) for Integrated Services for Sensitive Claims. See <https://www.gets.govt.nz/Default.aspx?show=TenderDetail&TenderID=42353&returnTo=home>

- ensure impartiality and objectivity and avoid conflicts of interest and role confusion across the multiple levels involved – government and non government
- provide sufficient openness for the non government sector, academics and victims/survivors
- enable equal input and influence from each government agency
- enable a high degree of transparency among all organisations and levels involved in the work
- be answerable to its funders, those delivering the Integrated System at a regional level and to service users.

Ideally the agency managing and coordinating the regional hub in each area would also be independent of those agencies providing services for similar reasons, but this should be negotiated with key stakeholders in each region to ensure local ownership of the model. In many regions the local family violence network may be well placed to assume the role of the regional hub.

The national backbone agency would need to establish relationships with national bodies and central government departments in order to facilitate any changes that result from the service mapping and gap analysis process in each region and from the ongoing continuous improvement process. This would include brokering new or changed contracting mechanisms, along the lines of those being trialled by government already, in order to facilitate service changes that better meet the needs of the local community and as agreed by the regional hub.

There would be particular merits in trialing new partnered and community led funding, procurement and contracting arrangements as part of the stage one developments and as the Integrated System model is rolled out to other regions.

Summary

In this chapter we have advocated for a sustainable funding solution for the Integrated System model. Unless the Integrated System was fully funded over the long-term, it would fail. We have argued that the ultimate responsibility for funding the Integrated System should lie with government but we also see a role for private business and philanthropists to commit to investing in long-term social change – the returns are substantial (as shown in the previous chapter).

We have discussed three examples of new ways of government contracting/funding agreements that show the Integrated System model 'fits' commercially.

10. What would the Integrated System cost?

The primary purpose of the financial projections contained in this chapter is to enable us to consider the expected costs against the expected economic and social benefits as calculated in Chapter 8. To ensure alignment between the figures in this chapter with those in Chapter 8 we have estimated the costs of establishing and operating the Integrated System with capacity to achieve the 20 percent reduction in the economic costs relating to the 20 percent of cases currently reported to Police that we used as the basis for our discussions in Chapter 8.

As outlined in Chapter 6, the intention is to develop and implement the new model via regional hubs (see Appendix 9 for a breakdown of the population into 32 regions based on population size) and a national backbone agency. Rather than trying to introduce the model consecutively in all regions in a 'big bang' approach, we would recommend that implementation occurs region by region in a carefully staged manner whereby the model is strengthened as learning occurs.

The full costs of the model would be better understood once stage one developments were completed. This staged and systematic approach to implementation development means that the first regional hubs would have moved into 'ongoing operational' phase when others were just entering their development phase. The cash flow implications of this rolling development have not been undertaken at this stage.

This financial analysis focuses on service costs only and does not include any additional cost for additional primary prevention activities although we expect this would be required.

10.1 Limitations

The following variables limit the accuracy of any financial projections being undertaken for the Integrated System:

- Each case of CAN or IPV is unique and requires a different response - there is no 'one size fits all' in responding to IPV and CAN - the most effective response will be different for different cases. All figures used in the financial projections should be seen as estimates and averages as they have not been calculated on a 'cost per case' basis.
- The easiest cases to have a positive impact on are likely to be the less costly ones - it would be tempting for the new regional hubs to focus initially on the low hanging fruit to get some 'quick wins.' However, this would create greater safety risks for the more complex high-risk cases.
- In the early stages it would be important to invest more heavily in crisis intervention and rebuilding lives in high-risk cases at the same time as working in early intervention because the high-risk cases lead to the homicides and the most serious and long-term negative social outcomes (and hence the greatest economic costs).

10.2 Structure of the costing model

The financial estimates below have been calculated in four broad groupings.

National backbone agency

Details of the national backbone agency are contained in Chapter 6 and the implementation and management arrangements in Chapter 11. Development funding would be required for the national backbone agency until all regional hubs were fully established and operational (up to 10 years). Funding and staffing levels and the skill mix of staff would need to expand and change over time as more regions join the Integrated System and as the national backbone agency's functions transition to ongoing operations.

Detailed costings including the expected cost of office accommodation, information management systems, training, evaluation etc have not been calculated at this stage as some of these may be able to be provided from existing arrangements. More accurate projections of the ongoing operational cost of the national backbone agency would become clearer as the model evolves.

Regional hubs

Details of the regional hubs are contained in Chapter 6 and the implementation and management arrangements in Chapter 11. Each regional hub is expected to require development funding for up to two years before transitioning to ongoing operating funding. For this exercise we have based the funding on 32 hubs and assumed annual operating funding would be at the same level as the annual development funding.

Different levels of funding have been estimated for each of the three groups of hubs based on the size of the population they would serve (see Appendix 9). Detailed line by line costings have not been done at this stage and more accurate projections of the ongoing operational cost of the regional hubs would become clearer as the model evolves.

Transactional

The transactional costs of developing and managing the Integrated System are expected to be slightly greater than the costs of the current approach until all regional hubs are fully operational. This is due to the need to develop the tailored measurement framework, negotiate a robust payment mechanism and monitor outcomes. An estimate of the likely increase in transactional costs incurred by government funding agencies has been included. At this stage we have assumed that transactional costs incurred by the national backbone agency and regional hubs would be met from within their development and operating funding. Transaction costs incurred by individual service providers, due to any changes in funding or contracting arrangements, would be met from within the 'cost of additional services'.

The projections assume that the primary financial and contract management responsibilities would remain the responsibility of central government agencies. However, as detailed in Chapter 9, the Integrated System model would provide opportunities for new and innovative funding arrangements

to be adopted and these may shift the majority of the transactional costs from central funding agencies to the national backbone agency and/or regional hubs.

Service provision

According to a media statement from Minister Tariana Turia²⁹¹ the government currently funds nearly \$70m to NGOs for family violence services. However, the total cost of related services provided by government (for example CYF, courts, Police, probation) is not known. Hence the figures included here are only the marginal changes expected and not the total funding required for service provision.

As detailed in Chapter 11, service mapping would be undertaken in each region. Once completed we expect the relevant central funding agencies would:

- make adjustments to existing contracts to remove any identified service overlaps or duplications
- adjust existing contracts or establish new service contracts to address the identified inconsistencies, shortfalls and gaps.

These have been shown in two separate lines in the financial projections in Tables 7 and 8: saving on existing services and cost of additional services.

10.3 Financial estimates

The figures presented below are estimates only in order to provide an indication of the possible costs that would need to be considered by the government and other potential funders. More accurate financial projections would be possible once the stage one developments are underway. In order to estimate the financial costs, we have prepared two models.

Stage one financial estimates

Stage one would involve:

- establishing the first regional hub to demonstrate the new model
- establishing the national backbone agency, developing documentation and processes to guide the model; starting with the system specification to identify the services and processes required for the optimal system
- undertaking the baseline evaluations and the national and regional service mapping and gap analysis against system specification.

²⁹¹ <http://beehive.govt.nz/release/breaking-family-violence-cycle>

Table 7: Three year cash flow projections for stage one

	Year 1	Year 2
National backbone functions	\$500,000	\$600,000
First regional hub - Group A hub	\$230,000	\$230,000
Transactional	\$10,000	\$10,000
Service provision – Group A hub		
Saving on existing services		-\$50,000
Cost of additional services		\$300,000
Total	\$740,000	\$1,090,000

Notes:

- These figures are based on medium level scenario from the table below.
- The development costs of the first regional hub would be higher than subsequent regions therefore establishment costs have been increased by 20 percent over the base projections for the first region.
- The national backbone functions required to support the first regional hub would be transferrable to other regional hubs once findings have been incorporated into the model.
- As noted above some costs have not been factored into these projections (incl office accommodation, information management systems, training, evaluation)
- The figures in this table are high-level estimates only - detailed line by line financial costings have not been calculated at this stage.

Fully operational Integrated System financial estimates

Estimates of the cost of the model once fully operational have been prepared to inform the cost benefit analysis (see Table 6). These calculations assume all developments (32 regional hubs, the national backbone agency, and all service adjustments) were undertaken at the same time. In reality costs would be staggered over five to 10 years as regional hubs are systematically established.

Three scenarios (low, medium and high) have been calculated (Table 8). The medium scenario has been used in the economic analysis.

Table 8: Annual cost of full Integrated System operational throughout New Zealand

	Low	Medium	High
National backbone agency	\$1,500,000	\$2,500,000	\$3,000,000
Regional hubs			
18 x Group A hubs	\$2,880,000	\$3,420,000	\$3,960,000
10 x Group B hubs	\$2,200,000	\$2,500,000	\$2,800,000
4 x Group C hubs	\$1,400,000	\$1,600,000	\$1,800,000
Transactional	\$320,000	\$350,000	\$380,000
Service provision			
Saving on existing services	-\$1,800,000	-\$3,000,000	-\$4,200,000
Cost of additional services	\$10,000,000	\$15,000,000	\$20,000,000
Total	\$16,500,000	\$22,370,000	\$27,740,000

Note:

The figures in this table are high level estimates only - detailed line by line financial costings have not been calculated at this stage.

Summary

In this chapter we have provided financial projections to undertake stage one of the development of the Integrated System and to enable the cost benefit analysis to be undertaken (Section 8.4). The primary costs of the model are the development and operation of the national backbone agency and 32 regional hubs and the additional cost of service provision to enable a more effective service response in order to achieve the projected economic savings.

The full costs of the model would be better understood once stage one developments were completed. We are confident that the proposed 'learning as we go' and the staged implementation approaches will ensure that the Integrated System is cost efficient.

11. How would the Integrated System be implemented?

Once funding is secured, development of the Integrated System model could begin. It would be vital for the national and regional components to be implemented at the same time; neither could happen without the other – top-down and bottom-up must work in unison. Local interagency collaboration requires a national infrastructure to guide and support this work and national developments need to be implemented locally.

In this chapter we outline the implementation process and timeframes, together with the core components required to ensure optimal practice and the transition from implementation to ongoing operations is achieved.

11.1 Staged implementation

Planning and implementing a world leading model in such a complex environment cannot be rushed. In order for the new Integrated System to be high quality and sustainable, dedicated funding, robust project management and carefully staged implementation will be required. We believe it would take between five and ten years before the model was fully operational throughout the country. The national components would guide and underpin the local developments in each region and therefore need to be planned and implemented in tandem.

For the purpose of this proposal, we have estimated that there would be 32 regional hubs, based on the existing regional configuration of IPV and CAN services and networks. We have clustered these into three groups according to population size (see Appendix 9). Currently the regions range from 30,000 to 433,000 in population size. Some are densely populated urban regions whereas others cover a much larger geographical area. The demographic makeup in each region also varies considerably. The specific planning and implementation requirements of each region would be likely to vary considerably.

A range of planning and implementation steps would need to be taken to establish the national and regional Integrated System infrastructure. As the overall planning and implementation would take approximately ten years, the national backbone agency would be responsible for a mix of planning, implementation, evaluation and operational tasks over this period. We expect each region to take around two years to reach a point where the model is fully operational in that area. Each regional hub would be established once that region was ready to embrace this new approach - change of this nature would be unsuccessful if forced on a region from the top-down.

Implementation would occur in three broad stages:

- Stage one - Developing the national infrastructure, frameworks, documentation and processes, and establishing the demonstration region.
- Stage two - Fine tuning the model and systematically establishing it in all other regions.
- Stage three - National backbone agency and all regional hubs fully operational.

11.2 Selecting the demonstration region

The model would need to be demonstrated in one region so it could be established, evaluated and modified if need be, before being rolled out to the other 31 regions. We believe Wairarapa is the ideal demonstration region for a number of reasons:

Existing landscape

There is a solid collaborative foundation in the Wairarapa that has been built over the past 15 years with an existing network ready and willing to embrace this new approach. The Violence Free Network Wairarapa (VFNW) has 40 member agencies (see Appendix 10) and is recognised as one of New Zealand's leading networks for their efforts to work collaboratively to prevent and respond effectively to family violence.²⁹² Member agencies range from government organisations, specialist family violence service providers, non-specialist social service providers, drug and alcohol and mental health services, through to local government. The VFNW is one of the 38 Family Violence Networks currently operating in New Zealand. It was established with a vision of creating a violence free Wairarapa where all agencies working with family violence, collaborate cohesively and effectively to help reduce family violence in the Wairarapa. The collaboration is already having a positive impact.²⁹³

Widespread support to work more closely

The Impact Collective, as authors of this document, has already undertaken some work with VFNW to develop a plan to prepare them for being the first demonstration region. A survey of member agencies was undertaken in January 2014 to ascertain their willingness to extend their collaboration. Thirty seven survey responses were completed by member agencies and showed that:

- 100 percent believe they can make a bigger difference (have a bigger impact) by working more closely together.
- 94 percent want to take their collaboration to the next level and be actively involved in how that happens.

The Wairarapa community has a history of tailoring new initiatives to fit their local needs. Adopting the Integrated System approach requires a willingness to 'do things differently' which is a strong theme of the existing IPV and CAN collaborative efforts in the Wairarapa.

²⁹² The VFNW is recognised by government ministries and other family violence networks as one of New Zealand's leading networks for their efforts to work collaboratively to prevent and respond effectively to domestic violence. The recognition of the network's success has led to the VFNW regularly hosting visitors from other networks and central government.

²⁹³ In particular there has been a decrease in repeat incidents - up until 2010 up to 30 percent of all Police calls for family violence in Wairarapa were to addresses they had previously attended. The VFNW now estimate that repeat call outs have dropped to about 10 percent.

Logistically suitable

As well as being a tightly defined geographical area, the Wairarapa also contains the full range of social, health, education and justice sector agencies that would need to be connected to form the Integrated System. This makes it logistically a great place to demonstrate the model. We expect that the lessons learnt from Wairarapa would help the implementation in other regions. The findings from Wairarapa would be monitored and evaluated and used in the continual improvement of the system specification and other documentation.

11.3 Funding

As we noted in Chapter 6, it would not be viable or sensible to establish half a system. There are no ways to cut corners with an ambitious initiative such as this; achieving long term sustainable outcomes would require careful planning, widespread community engagement and staged implementation.

Section 10.3 shows the estimated cost of the stage one developments detailed below. This funding would need to be secured before the implementation activities could commence. More detailed funding estimates regarding the full roll-out of the model and the ongoing operational costs would be possible once stage one was completed.

11.4 Principles to guide implementation

The following principles would guide all planning and implementation activities:

- Carefully considered planning prior to implementation.
- Implementation timeframes to be determined by community readiness.
- Open and inclusive communication.
- Collective learning and continual improvements.
- Horizontal and vertical connections from the outset.
- Tangata whenua engaged at all stages.
- Involvement of service users.

11.5 Timeframes

Figure 49 shows indicative timeframes whereby new regions would come on stream every year, with the last regions being fully operational by the end of year nine. It can be seen that the roll would be slower in the early years while the model was tested and fine tuned as learning occurs.

Figure 49: Overall implementation timeline

	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10	Y11	Y12
Stage One												
Develop national backbone infrastructure, frameworks, documentation and processes	█	█										
Establish first region - Wairarapa	█	█										
Develop and trial all regional components	█	█										
Stage Two												
National backbone agency provides leadership and integration, supports regional implementation, continuously improves the model		█	█	█	█	█	█	█	█			
Establish regions 2 & 3		█	█									
Establish regions 4 - 7			█	█								
Establish regions 8- 11				█	█							
Establish regions 12 - 15					█	█						
Establish regions 16 - 20						█	█					
Establish regions 21 - 26							█	█				
Establish regions 27 - 32								█	█			
Stage Three												
National backbone infrastructure in ongoing operational mode									█	█	█	█
All regional hubs in ongoing operational mode									█	█	█	█

11.6 Stage one implementation activities

The following sections outline the broad components of work that would be needed in stage one.

Project Implementation plan- national and regional

As soon as funding was secured to enable stage one developments to commence a detailed project plan would be written for the establishment of both the national backbone agency and the demonstration regional hub in Wairarapa. This would include detailed milestones to be achieved at both national and regional levels, risk and issues registers and processes for mitigating and addressing these matters as they arose during the implementation phase.

National leadership and governance

One of the first steps would be to establish a national backbone agency responsible for creating and managing the national Integrated System and overseeing the establishment of the model in each region. As identified in Chapter 9, we believe this agency needs to be a dedicated 'specific for purpose' entity rather than being added into an existing agency. Strong independent and focused governance with proven skills, expertise and commitment would be required. Specific details that would need to be negotiated and documented in the funding contract would include:

- responsibilities of this agency
- how it would be accountable to its funders including agreed outcome measures
- how government policy and funding agencies would be kept informed and engaged throughout the development of the new model. This may include establishing a cross-ministry advisory group and/or a government representative on the national backbone agency governance group.

To reflect the magnitude of the task, the complexity of the current sector and the challenges discussed in Section 6.3, the agency would need to employ staff with extensive experience in working in the IPV and CAN sector, established relationships with personnel working in the regions, and experience at negotiating and facilitating change with multiple parties from diverse disciplines. During the three implementation stages outlined above the role of the national backbone agency would change as the development moved from implementation to operation. For the first two years, personnel would be a project implementation team responsible for all national developments and for providing support and technical assistance, first to the Wairarapa and then subsequently to other regions.

Regional leadership and governance

Each regional hub would be managed by people with in depth knowledge and proven relationships and networks in the local area. The first step in Wairarapa would be to appoint a project manager to establish governance arrangements and manage all planning and implementation of the Integrated System in the region. The project manager would work closely with the national project implementation team.

A scoping exercise would need to be undertaken to investigate the most appropriate structure, skills and representation required at a governance level to guide the development of the project. Consideration would be given as to how the community would be best represented at a governance level, with particular emphasis placed on the relationship between the national backbone agency's governance group and the Wairarapa governance group. Once established, the governance group

would need to be well supported and provided with robust information regarding the Integrated System model both conceptually and in practice. It would be crucial that governance members were able to disseminate information about the model within their respective communities of interest and assist to socialise the model within the region. Terms of reference for the governance group and a memorandum of understanding (MOU) between the governance group and agencies or individuals who wish to commit to being involved in the Integrated System would be drawn up. This MOU would outline the roles and responsibilities of each part of the Integrated System and the values that underpin the model.

Develop the system specification- national

The first task of the national backbone project team would be to develop the evidence based system specification - a detailed specification of all the component services, processes and related activities that would be required to make up the most effective and efficient Integrated System in each region. To use the metaphor of the London Underground system that we introduced in Chapter 6, the system specification would detail how many stations are needed, the service that each would provide, what capacity (daily throughput) they can expect, what tracks there would be to join them all together and the processes they would all need to follow to ensure provision of high quality services at all parts of 'the system'. The system specification document would be based on findings from various sources as shown in Figure 50. The system specification would be a 'living' document that would evolve over time as the model is implemented and evaluated and as new international evidence and good practice examples comes to hand.

Figure 50: Process for developing the system specification



National strategy and standardised resources - national

A set of documentation detailing the consistent core components would be needed to ensure national consistency of the model. These documents, together with the system specification, would collectively contain the standardised elements that each regional hub would be required to implement and deliver in their area and guidelines pertaining to those areas where regional variations are applicable. This would include, but not be limited to:

- a national strategy including consistent and commonly understood set of principles and practices
- organisational service and practice standards including policies, procedures, referral pathways and required quality assurance processes
- templates to guide regional governance structures and processes
- risk and safety frameworks including standardised risk assessment and safety planning tools and integrated response processes
- service accreditation standards and processes
- written resources to support and guide local groups working together.

The development of this material would be a core component of the work programme for the national backbone agency in the first two years.

Action plan - regional

Once the system specification had been developed and the national backbone agency was up and running, a local action plan would be drawn up to guide the next phase of development. We envisage these would be similar to those developed by regions establishing Social Sector Trials.²⁹⁴

The action plan would drill down from the system specification and detail the steps and stages required to implement the Integrated System model in the first demonstration region (Wairarapa). The action plan would in effect be 'the how' – the map to guide the member agencies and community stakeholders of Wairarapa who would be involved in the evolution of current collaboration towards the Integrated System. It would be a critical development component as it would enable the national project to be tailored to the local context and known regional variables. Member agencies in Wairarapa would be consulted to ensure all components have been considered and that key stakeholders commit to the action plan.

Identify stakeholders - national and regional

Meaningful engagement and discussion about the purpose and objectives of the Integrated System model is critical to the success of the project. Nationally and within each region there are a range of key stakeholders who would need to be identified and engaged. In particular, thought would need to be given to how the project would engage and involve service users²⁹⁵ and Māori as tangata whenua,

²⁹⁴ <http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/social-sector-trials/region-action-plan-documents.html>

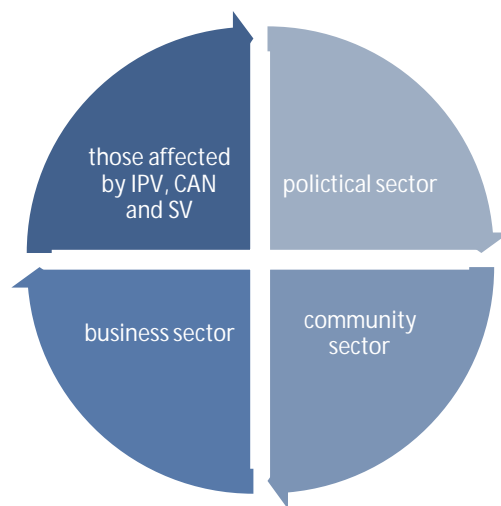
²⁹⁵ The Taskforce report 'Incorporating the Voice of Experience: Family Violence - Service User Involvement Guide' outlines how this is best achieved. Available at <https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/initiatives/action-family-violence/voice-of-experience.pdf>

at all levels in the development, design, implementation and governance. Key stakeholders at a regional level such as Plunket nurses, GPs, faith leaders, teachers and sports coaches would also be central to the success of this new approach. For many of these stakeholders, this would be a new role and time would need to be provisioned to broker these new relationships and clearly communicate information about this new way of working.

Socialise the concept - national and regional

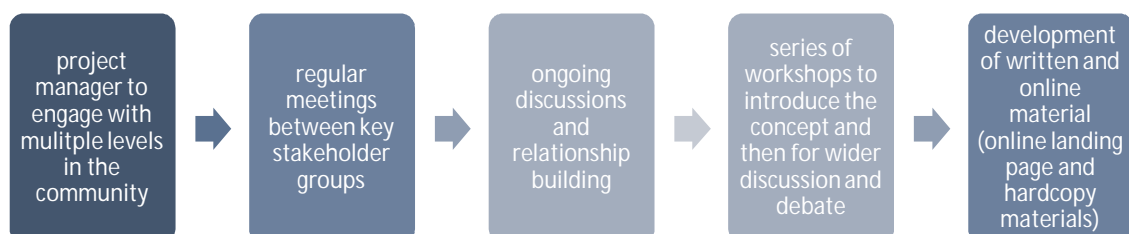
The development of the Integrated System would be an ambitious and complex project. It would require time to socialise the concept in communities in order to create broad engagement of the vision within the community. It would be important that this work be done sensitively and people are given time to fully digest the concept of the Integrated System model. IPV and CAN are issues with far reaching impacts. Therefore, a range of sectors, including those shown in Figure 51, would need to be engaged.

Figure 51: Key sectors to engage



Given the rich diversity of stakeholder groups, there would need to be considerable discussion about the concept and its implementation. A variety of communication channels (formal and informal) would be identified and used for the two-way sharing of information. The process for socialising the Integrated System model is shown in Figure 52.

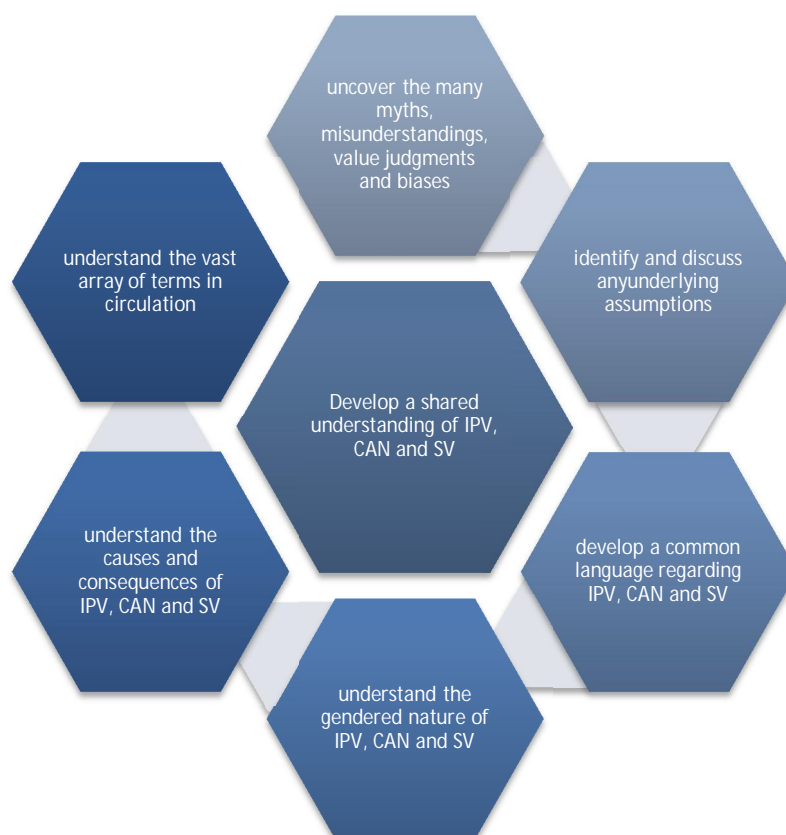
Figure 52: Process for socialising the model



Develop shared understanding - national and regional

Prior to any collaborative work in the area of IPV and CAN, personnel across all parts of the system would need to establish a shared understanding so that all parties were 'looking through the same lens'. As is well-established, the importance of this step is integral to the success of developing the Integrated System approach to address IPV and CAN²⁹⁶ and is a pre-cursor to training of the workforce. The Victorian Family Violence Reforms²⁹⁷ took two years to get everyone looking through the same lens. While two years may appear to be a significant period of time, the evidence is clear that this development stage is a critical and cannot be rushed or forced. Once a shared understanding of IPV and CAN has been achieved there would be a much greater chance of consistency of practice across all practitioners and agencies involved. Figure 53 details the purpose of developing a shared understanding.

Figure 53: Process for developing a shared understanding



Training and workforce development framework - national

The IPV and CAN sector includes multiple disciplines and a diverse range of professional groups working in mainstream and specialist IPV and CAN agencies. Consistent and multi-disciplinary training and workforce development would be essential to creating an effective Integrated System response. In particular, this would involve developing a shared understanding, ensuring safety for

²⁹⁶ For example this was one of the key success factors in the award winning Victorian Family Violence Reforms

²⁹⁷ <http://www.dpc.vic.gov.au/index.php/featured/innovation/case-study-victorian-family-violence-reforms/22-html/99-family-violence-reforms-html>

victims/survivors and accountability for abusers, enhancing collaborative efforts and ensuring best practice and strengths-based continuous improvement. It would be important to ensure that workforce capacity and competency was available to deliver the Integrated System as it evolved over time.

The Taskforce's 2011/12 Programme of Action²⁹⁸ included an initiative to '*work with government and non-government providers who currently have their own training programmes, to assess the merits in developing one multi-disciplinary national training framework*'. The national backbone agency would be ideally placed to develop such a framework and to co-ordinate training and workforce development activities for all personnel working at any level of the Integrated System. Training programmes could be developed by a team within, or contracted to, the national backbone agency, and provided through approved consortia of training providers. This would need to be discussed with the Taskforce and its member agencies as part of negotiating the contract for the stage one developments and once agreement was reached a detailed sub project plan would need to be developed for this workstream.

Prepare individual agencies - regional

Collaborative projects stand the best chance of success when agencies are supported to work in new ways. To prepare for working as part of the Integrated System the national implementation team would work with the Wairarapa project manager to develop guidelines to assess the capacity and capability of each agency and determine how 'integration ready' they are. For the Integrated System to be successful, gaps in capacity and capability would need to be identified and addressed in advance of implementing the new model. There are several ways that agencies could be assisted to develop their capability and capacity. These would need to be explored in more detail when the action plan was developed, but in some instances separate funding would be required to enable agencies to make the necessary changes.

Population needs assessment - regional

IPV and CAN 'needs assessment' is often referred to in an individual sense. In this context we use the term to refer to an assessment of the needs of the population of the region. The purpose of this is to identify particular requirements that would need to be built into the Integrated System at a regional level. The population needs assessment in each region would be undertaken alongside the service mapping. Matters considered in a population needs assessment include, geography of the region, age of population, socio demographic mix, ethnic mix, age of the population, past and current rates of IPV and CAN. This material could be gathered from local or national data sets (ie census results), from service users and frontline workers. Given the considerable links between IPV, CAN and multiple other social issues; agencies providing related social services would also need to be consulted to identify the wider needs to be considered in the design and delivery of the Integrated System at a regional level.

²⁹⁸ <https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/initiatives/action-family-violence/taskforce-poa-2011-2012.doc>

Service mapping - regional

One of the first steps in establishing the Integrated System model in each region would be undertaking a scan of that region to get a thorough understanding of the current 'system'.²⁹⁹ This would need to be done in collaboration with the relevant government funding agencies and include collecting and documenting information about:

- the scope, nature and consistency of all current services
- the flows and referral pathways within and between agencies and services
- current service volumes at the respective entry points into 'the system'
- funding sources and contracted volumes.

Once this was complete, a system mapping exercise would be done to compare the 'what is' (system scan) against the 'what needs to be' (system specification). This would identify any service gaps, overlaps or duplications, fragmentation and inconsistencies as well as any required services or processes that are missing altogether in that region. The national and local governance boards would then need to negotiate with the relevant government funding agencies to implement the required changes.

Quality and evidence management - national and regional

The Integrated System would involve multiple agencies, professions, communities and individuals all working collaboratively together towards a common agenda, towards achieving collective impact. To ensure the new model was both accountable and measurable, data would need to be collected and results measured consistently across all parts of the system to ensure efforts remained aligned and participants held each other accountable.

A comprehensive range of what can be broadly called quality management activities would need to occur nationally and within each region to:

- ensure all parts of the Integrated System were operating to best practice levels and achieving optimal immediate and, intermediate outcomes
- feed information into the continuous improvement process so learning can occur and ongoing improvements made over time.

The frameworks, methodology and documentation pertaining to each of following key components would need to be developed as part of stage one and tested in Wairarapa as the demonstration region.

²⁹⁹ The methodology used will draw on international examples such as Map of Gaps 2: the postcode lottery of Violence Against Women support services in Britain. End Violence Against Women and Equality and Human Rights Commission (2009)

Performance and outcome monitoring

This would include:

- agreeing immediate, intermediate and long term objectives and outcome measures
- establishing a set of national indicators underpinned with a data dictionary, standardised data sets etc.
- annual quantitative monitoring against these indicators
- setting system and service performance measures; ie response times (these would be documented in the organisational service and practice standards).

System evaluation

Quantitative data alone is not satisfactory for measuring change with wicked or complex problems. A range of evaluation types and data gathering techniques³⁰⁰ would be needed including:

- Baseline evaluation in each region from which subsequent improvements can be measured - this would include gathering information from service users (victims/survivors and abusers), frontline workers and others within each region to identify what is and isn't working in the current system in that region. A baseline evaluation would be conducted in Wairarapa within the first year of development.
- Formative evaluation whereby independent evaluators 'walk alongside' those undertaking the planning and development in a 'learn as we go' approach. This would be particularly relevant in the first two or three regions to ensure lessons learned during implementation in these regions could be used to make implementation more effective in subsequent regions. There would also need to be a commitment to maintaining transparency in the implementation of the model. Therefore, it would be essential that the developments are evaluated and clearly documented to show that implementation objectives were being met and if not then why not.
- Outcome/impact evaluations would be conducted periodically (probably every three years) in each region to measure improvements against the regional baseline.

System quality assurance

Another quality platform would be to ensure all services and processes within the Integrated System were able to meet the organisational practice standards and other nationally consistent requirements. It is envisaged that this would be achieved by:

- system and service accreditation prior to each regional hub going live
- system and service audits undertaken periodically to review practice against specified requirements or to respond to specific issues if they arise.

Building evidence and knowledge

Evidence is continually emerging within New Zealand and internationally about IPV and CAN and the numerous related social issues. It would be essential to establish mechanisms to continually collect, review, assess and integrate (where relevant) this new information in ongoing ways to identify

³⁰⁰ Including but not limited to one on one interviews, focus groups, online surveys and submissions

emerging evidence. Without this, the system specification, the national strategy and standardised resources, the shared understanding, training curriculum and local practice would quickly fall out-of-date and the Integrated System would no longer be operating at an optimal level.

Complaints processes

In order to hear about areas where the system was failing it would be important to establish mechanisms regionally and nationally for services users, family/whānau, friends and frontline workers to 'complain' or notify where there are problems. Wherever possible complaints these would be considered at a regional level but where that was not possible or appropriate they would be investigated and responded to nationally. System failures identified via complaints locally would be reported nationally so national staff could ensure similar problems were not occurring in other regions.

Death reviews

All IPV and CAN deaths are preventable. They are not the result of a one-off isolated episode. Typically, there is a long history of abuse, and most cases would be known to one or more services within the Integrated System. The FVDRC regional death reviews and nationally aggregated findings would also be important sources of information about where the system was failing to keep victims/survivors safe and to hold abusers to account.

Continuous improvement

A formalised continuous improvement process would be established within the national backbone agency and at each regional hub to provide the framework for maximising opportunities for changeability, while minimising risks. This would not need to constrain service provision or innovations anywhere within the system. What is critical is that there are mechanisms to make changes as the learning occurs.

Material sourced for continual improvement would be drawn together from multiple sources (as shown in Figure 54) to:

- generate and share knowledge around the system to ensure the system was continually learning
- disseminate knowledge and offer opportunities for further shared understanding, training curriculum and programmes and professional development
- identify innovative and promising practice for the system as a whole to learn from
- identify where incremental change was required either in all regions, individual regions, one specific service or profession including:
 - changes within the system ie updating the system specification, local or national documentation
 - changes that would need to be negotiated with central government agencies, national NGO bodies or national professional bodies.

Figure 54: Continuous improvement process



Information management - national

The Glenn Inquiry People's Report³⁰¹ noted: '*Information systems were reported to be out-of-date and not used effectively*' and '*Information systems and databases appear to be unique to each organisation, and therefore, do not lend themselves to cross-agency sharing of information*'.

We could not expect the system to be integrated if data pertaining to all parts of the system was not integrated. To ensure there could be cross-agency sharing of information throughout the Integrated System and to provide a continual flow of standardised data for performance and outcome monitoring, a nationally standardised information management system would be needed. Key requirements would include:

- Compliance with the Privacy Act.
- National indicators underpinned by data sets, data dictionary and processes for data matching and data cleaning. The national system would interface with the system operating in each of the regional hubs.
- At a regional level the information management system would need to:

³⁰¹ https://glenninquiry.org.nz/uploads/files/The_Peoples_Report_-_full_document.pdf

- interface with, and draw data from all parts of the regional system
- be used as a case management system for FVIARS or any other regional multi-agency case management process
- ensure the history of an individual case could be shared with another regional hub if the victims/survivors or abusers move.
- Clear protocols and processes would be developed to ensure that individual agency data is kept confidential to that agency except where it is needed to inform multi-agency case management and the national indicators.
- Strict protocols and processes would need to be put in place at all levels of the information management system to ensure the confidentiality and safety of individuals experiencing IPV and CAN.
- No data that identifies an individual would be held at a national level.

A specialist workstream would need to be established early in stage one to fully scope this work.

Community engagement - regional

As explained earlier in this document the community need to be engaged and feel they have a critical part to play in addressing these problems. For the Integrated System to be effective, the community must feel they have a say in the developments that occur in their area and that the system was accommodating and reflecting their views.

A community development and engagement approach would be established in Wairarapa to:

- engage the community in a thorough and systematic way
- consider the best ways to socialize the integrated system
- identify what different individuals and groups need to know, at which point and how that information is best conveyed
- identify any particular matters that need to be more tailored for that region³⁰²
- ensure that all services and support systems for those experiencing IPV or CAN in Wairarapa are connected into the system
- ensure services and processes within the Integrated System are responsive to the needs of the Wairarapa community
- identify and mobilise community strengths and skills.

Community development and engagement would be done by identifying a variety of communication channels (formal and informal) and exploring how these could be used for two-way sharing of information, starting with a series of workshops to bring stakeholders together. In the early stages of development these meetings would be largely about introducing the concept but would extend to cover wider issues as they arise. Initial half-day workshops would be held in the Wairarapa region at

³⁰² This would include such matters as how the regional integrated system can be most effective in large geographic regions where victims may live a considerable distance from services

the beginning of the project to:

- outline the concept of the integrated system
- provide an overview of why a 'whole of community approach' is the preferred approach
- discuss who the key stakeholders are who need to be involved
- highlight potential opportunities
- allow for the development of new relationships with key individuals and groups
- discuss possible ways of working collectively on this project.

11.7 Stages two and three implementation activities

Once planning and implementation of the national backbone agency and the demonstration region in Wairarapa were underway and initial evidence was available about the applicability and acceptability of the Integrated System model, funding would be sought to extend the system to another two regions.

Discussions would be held with other regions interested in establishing the model and an assessment of their readiness undertaken, in a similar way as was done in Wairarapa (outlined earlier in this chapter). The national implementation activities outlined above would be further developed and fine tuned as the project moved to stage two. All regional implementation activities conducted in Wairarapa would be repeated in subsequent regions. A project plan detailing this would be written once stage one development was underway.

Summary

Throughout this final chapter we have discussed how the Integrated System model would be developed and implemented. The overall timeframe for implementation in 32 regional hubs around the country would be up to ten years.

There would need to be a commitment to ensuring robust project management, carefully staged implementation and sustainable funding. Development should not begin without these. One of the first steps would be to establish a national backbone agency responsible for creating and managing the national Integrated System and a regional hub in Wairarapa to oversee the establishment of the model in that region.

There would be a lot of work ahead to establish the most effective and efficient Integrated System possible. This document has shown that it is time to take a new approach. The cost of not doing so is too great in every sense.

Appendix 1: About the Authors



Ruth Herbert

Ruth is well known for her work in trying to improve New Zealand's system response to violence against women and children. She has given many presentations and media interviews and researched and written extensively about intimate partner violence, child abuse and neglect and sexual violence. Ruth has a Master of Public Policy (dist.) and was awarded the 2008 Holmes Prize for her evaluation of New Zealand's family violence strategies.

For the past 20 years Ruth has run her own consultancy specialising in strategy, implementation and evaluation. During this time she has managed a range of major projects including national and regional service development, change management, programme design, system and structural audits, reviews and evaluations. In recent years she has been a member of the independent Ministerial Review Panel assessing the implementation and impact of Accident Compensation Corporations' new sensitive claims clinical pathway, the Director of Family Violence at the Ministry of Social Development and the Executive Director of the Glenn Inquiry.

In August 2013 Ruth and Jessica Trask set up 'The Impact Collective', a specialist consultancy committed to working collaboratively to find lasting solutions for complex social problems.



Deborah Mackenzie

Deborah is passionate about improving the experience of women survivors of IPV in New Zealand. She has extensive front line experience working in the intimate partner violence sector including roles at the Auckland Family Court and the District Court as a victim adviser, a women's advocate for an NGO and the family violence interagency network coordinator in Auckland for six years.

Her more recent roles have involved more behind the scenes work including policy analyst at a sexual abuse agency, project manager in the Family Violence Unit (Ministry of Social Development) and independent research/writer.

Deborah has a strong interest in improving the justice sector response to intimate partner violence with a particular focus on specialist domestic violence courts. Deborah has written papers on Specialist Domestic Violence Courts and female offenders in Auckland (2006, 2007 & 2009). She has extensive experience in presentation and trainings on dynamics of intimate partner violence and creating coordinated response systems. Deborah has a MA in Education.

Appendix 2: Glossary of Terms

Abuser	The person who is perpetrating any form of abuse against adults and/or children.
Child Abuse and Neglect (CAN)	CAN (sometimes called child maltreatment), includes all forms of physical and emotional ill-treatment, sexual abuse, neglect and exploitation that results in actual or potential harm to the child's health, development or dignity. Within this broad definition, five subtypes can be distinguished – physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse and exploitation. Children's exposure to IPV is defined in Section 3 of the Domestic Violence Act 1995 as psychological abuse of the child; as such it is included in our definition of CAN.
Family Violence	An umbrella term used in New Zealand and defined by the Taskforce as covering the following five forms of violence in families/whānau: <ul style="list-style-type: none"> • violence among adult partners (IPV) • abuse/neglect of children by an adult (CAN) • abuse/neglect of older people aged approximately 65 years and over by a person with whom they have a relationship of trust (elder abuse) • violence perpetrated by a child against their parent • violence among siblings.³⁰³
Intrafamilial Violence (IFV)	All forms of abuse between family members other than intimate partners or parents of their children. It includes abuse/neglect of older people aged approximately 65 years and over by a person with whom they have a relationship of trust, violence perpetrated by a child against their parent, violence perpetrated by a parent on their adult child and violence among siblings.
Intimate Partner Violence (IPV)	Any behaviour within an intimate relationship (including current and/or past live-in relationships or dating relationships) that causes physical, psychological or sexual harm to those in the relationship. Such behaviour includes: <ul style="list-style-type: none"> • acts of physical aggression – such as slapping, hitting, kicking and beating • psychological abuse – such as intimidation, constant belittling and humiliating • forced intercourse and other forms of sexual coercion • various controlling behaviours – such as isolating a person from their family and friends, monitoring their movements and restricting their access to information and assistance.
Offender	The person who has been charged or convicted of an offence.
Perpetrator	The person who is abusing adults and/or children.
Service User	Those people who have experienced violence within families, either directly or indirectly. This includes those people who are survivors (adults and children), perpetrators and family members living with or supporting perpetrators and victims. It also includes those who may not have accessed a service (but could have potentially benefited from doing so).
Sexual Violence (SV)	All forms of sexual abuse, assault and violence.
Social issues	Issues pertaining to all parts of the social sector as described below.
Social sector	All government and non-government agencies represented on, or funded by members of the government's Social Sector Forum, ie social, justice, health and education and their contracted service providers ³⁰⁴ and other government, non-government, voluntary or community agencies that provide social services, for example Accident Compensation Corporation (ACC).
Victim/Survivor	A person who has experienced abuse of any form of IPV or CAN. In this document we acknowledge that many perpetrators have themselves been victims/survivors earlier in their lives but when we refer to victims/survivors in this report we are referring to those currently being abused or who have recently left an abusive relationship.

³⁰³ <http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/action-family-violence/family-violence-indicators.html>

³⁰⁴ See <http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/corporate/statement-of-intent/2012/cross-agency-leadership.html>

Appendix 3: Domestic Violence Act 1995 - interpretation

3. Meaning of domestic violence

(1) In this Act, *domestic violence*, in relation to any person, means violence against that person by any other person with whom that person is, or has been, in a domestic relationship.

(2) In this section, *violence* means—

- (a) physical abuse:
- (b) sexual abuse:
- (c) psychological abuse, including, but not limited to,—
 - (i) intimidation:
 - (ii) harassment:
 - (iii) damage to property:
 - (iv) threats of physical abuse, sexual abuse, or psychological abuse:
 - (iva) financial or economic abuse (for example, denying or limiting access to financial resources, or preventing or restricting employment opportunities or access to education):
 - (v) in relation to a child, abuse of the kind set out in subsection (3).

(3) Without limiting subsection (2)(c), a person psychologically abuses a child if that person—

- (a) causes or allows the child to see or hear the physical, sexual, or psychological abuse of a person with whom the child has a domestic relationship; or
- (b) puts the child, or allows the child to be put, at real risk of seeing or hearing that abuse occurring;—

but the person who suffers that abuse is not regarded, for the purposes of this subsection, as having caused or allowed the child to see or hear the abuse, or, as the case may be, as having put the child, or allowed the child to be put, at risk of seeing or hearing the abuse.

(4) Without limiting subsection (2),—

- (a) a single act may amount to abuse for the purposes of that subsection:
- (b) a number of acts that form part of a pattern of behaviour may amount to abuse for that purpose, even though some or all of those acts, when viewed in isolation, may appear to be minor or trivial.

(5) Behaviour may be psychological abuse for the purposes of subsection (2)(c) which does not involve actual or threatened physical or sexual abuse.

4. Meaning of domestic relationship

(1) For the purposes of this Act, a person is in a *domestic relationship* with another person if the person—

- (a) is a spouse or partner of the other person; or
- (b) is a family member of the other person; or
- (c) ordinarily shares a household with the other person; or
- (d) has a close personal relationship with the other person.

(2) For the purposes of subsection (1)(c), a person is not regarded as sharing a household with another person by reason only of the fact that—

- (a) the person has—
 - (i) a landlord-tenant relationship; or
 - (ii) an employer-employee relationship; or
 - (iii) an employee-employee relationship—

with that other person; and

- (b) they occupy a common dwellinghouse (whether or not other people also occupy that dwellinghouse).

(3) For the purposes of subsection (1)(d), a person is not regarded as having a close personal relationship with another person by reason only of the fact that the person has—

- (a) an employer-employee relationship; or
- (b) an employee-employee relationship—

with that other person.

(4) Without limiting the matters to which a court may have regard in determining, for the purposes of subsection (1)(d), whether a person has a close personal relationship with another person, the court must have regard to—

- (a) the nature and intensity of the relationship, and in particular—
 - (i) the amount of time the persons spend together:
 - (ii) the place or places where that time is ordinarily spent:
 - (iii) the manner in which that time is ordinarily spent:—

but it is not necessary for there to be a sexual relationship between the persons:

- (b) the duration of the relationship.

5. *Object*

(1) The object of this Act is to reduce and prevent violence in domestic relationships by—

- (a) recognising that domestic violence, in all its forms, is unacceptable behaviour; and
- (b) ensuring that, where domestic violence occurs, there is effective legal protection for its victims.

(2) This Act aims to achieve its object by—

- (a) empowering the court to make certain orders to protect victims of domestic violence:
- (b) ensuring that access to the court is as speedy, inexpensive, and simple as is consistent with justice:
- (c) providing, for persons who are victims of domestic violence, appropriate programmes:
- (d) requiring respondents and associated respondents to attend programmes that have the primary objective of stopping or preventing domestic violence:
- (e) providing more effective sanctions and enforcement in the event that a protection order is breached.

(3) Any court which, or any person who, exercises any power conferred by or under this Act must be guided in the exercise of that power by the object specified in subsection (1).

Appendix 4: Local interagency / co-ordination mechanisms

Title	Details
38 x Family Violence Networks	<p>These networks, in towns and cities around NZ, are funded via MSD. Formerly known as the Te Rito Networks, they are made up of a range of government and community agencies that work in the family violence sector to provide a forum where a range of government and community organisations meet to direct a local joined-up response to family/whānau violence.</p> <p>There is a wide variety of models. Some are only involved in coordination, others focused primarily on primary prevention while others are comprehensive multi-agency networks encompassing many of the other inter-agency activities in that particular region/local area.</p>
62 x Family Violence Inter-agency response Systems	<p>The Family Violence Interagency Response System (FVIARS) is a collaborative inter-agency initiative led by the Police in partnership with Child, Youth and Family and the National Collective of Independent Women's Refuges to more effectively manage cases of domestic violence reported to the Police. Most FVIARS groups also include a wide range of other government and NGO agencies from the local area.</p> <p>FVIARS groups meet regularly to discuss family violence intervention around specific cases of family violence. A key objective of FVIARS is to enable collaborative, coordinated interagency responses to family violence.</p> <p>There is no standardised model, operating standards, or monitoring for the FVIARS process. There is a National Working Group with representatives from the Police, CYFs and NCiWR but no overarching governance or leadership infrastructure.</p>
6 x Family Safety Teams	<p>A joint initiative between Police, Ministry of Justice, and Ministry of Social Development (Child Youth and Family) in collaboration with the community sector - Auckland, Hamilton, Hutt Valley, Wairarapa, Christchurch, Counties-Manukau with a Police national coordinator and a national steering group.</p>
10 x Children's teams	<p>Currently two teams with eight more to be established by the end of 2014. The new teams will be made up of local education, health, and social sector professionals to respond to the needs of vulnerable children.</p> <p>The teams will ensure:</p> <ul style="list-style-type: none"> • vulnerable children's needs are assessed • all parties required to address those needs are brought to the table • a single multi-agency plan for each vulnerable child is developed, implemented, and a lead professional is allocated to see the plan through • local services are delivered according to the plan • outcomes are achieved for each child.
16 x Family Violence Funding Coordination networks	<p>The FVFC networks:</p> <ul style="list-style-type: none"> • share their expertise across government agencies (including information on the effectiveness of family violence prevention policies) • provide regional input into planning for the funding of family violence prevention services • identify providers of family violence prevention services likely to benefit from an Integrated Contract • provide advice on good practice service delivery in the family violence prevention area. <p>Agencies involved are the Department of Internal Affairs, Ministry of Justice, Ministry of Social Development's Child, Youth and Family, and Family and Community Services, Department of Corrections, ACC and District Health Boards.</p>

27 x DHB Violence Intervention Programme (VIP) Coordinators	Family violence intervention coordinator positions in all district health boards ³⁰⁵ as part of the Violence Intervention Programme. VIP focuses on a partnership approach with community agencies. ³⁰⁶
52 Police Family Violence Coordinators	This is made up of 10 District Family Violence Coordinators, and 42 Area Family Violence Coordinators. Some District Coordinators have a dual role of Victims/Family Violence Coordinators. In some of the smaller areas the Area Coordinator hold other roles in addition to Family Violence Coordinator portfolios. ³⁰⁷
15 Work and Income family violence coordinators	There are 15 family violence response co-ordinators across 11 regions to provide support to case managers and liaise with local support services.
60 Strengthening Families coordinators	A voluntary process for families with children to access the support of a range of government and non-government agencies who work together to support the family. Each local area has a coordinator and a local management group.
16 x social sector trials local advisory groups	Education, Justice, Health, MSD and Police working together to test a new model where contracted NGO or individual leads work using cross agency resources at a local level. Being trialled in 16 communities with completion of trial due June 2015. Local advisory groups, most are focused on youth outcomes.
34 x Whānau Ora collectives	Whānau Ora collectives are located throughout the country and provide an interagency approach to responding to whānau health and social needs. The providers offer wrap-around services tailored to whānau rather than individual needs. The collective provides a 'navigator' to work with whānau to identify their needs, develop a plan to address those needs and broker their access to a range of health and social services.
21 x safer city coordinators	A WHO international accreditation system whereby a city receives 'safer city' status by meeting many different safety criteria and initiatives to increase action on injury prevention and safety promotion. The coordinators role includes relationship building, promotion of safer city messages, presentations, data collection, prepare submissions etc. Roles and governance may vary from district to district. ³⁰⁸
Mayoral taskforces	There is a Rotorua Mayoral Inter-agency Taskforce on Family Violence. Auckland Council has a family violence project leader.

³⁰⁵ <http://www.health.govt.nz/our-work/preventative-health-wellness/family-violence>

³⁰⁶ <http://www.health.govt.nz/our-work/preventative-health-wellness/family-violence/establishing-vip-programme/part-two-what-can-health-services-do-respond-victims-family-violence#collaborating-comm-agencies>

³⁰⁷ Information from the NZ Police 9 June 2014. From an Official Information Request made by Impact Collective.

³⁰⁸ <http://www.safecommunities.org.nz/>

Appendix 5: Timeline of reports 1987-2014

1987	<p><i>Review of the Children and Young Persons Bill</i> (Department of Social Welfare 1987)</p> <p><i>Report of the Ministerial Committee of Inquiry into Violence</i> (Roper Report)</p> <p>FVPCC Statement on Family Violence issued; Tūkino Tangata (Māori caucus) established</p>
1988	<p><i>Attitudes to Family Violence: A Study Across Cultures</i> published (Synergy Applied Research & FVPCC 1988)</p>
1992	<p>Victims' Task Force published an abridged version of a report on protection orders, <i>Protection from Family Violence</i></p> <p>Child abuse guidelines for health services published by the Department of Health</p>
1993	<p><i>The Measurement of Family Violence: A Critical Review of the Literature</i> (Lapsley, Social Policy Agency 1993)</p>
1994	<p><i>New Zealand Economic Cost of Family Violence</i> published (Snively 1994)</p> <p><i>Report of inquiry into Family Court proceedings involving Christine Madeline Bristol and Alan Robert Bristol</i> (Davison, Department of Justice 1994)</p>
1996	<p><i>New Zealand Government Statement of Policy on Family Violence</i> released (Department of Prime Minister and Cabinet 1996)</p> <p><i>Good Practice Guidelines for Coordination of Family Violence Services</i> published (Department of Social Welfare, Family Violence Unit 1996)</p> <p><i>The Economic Cost of NCIWR Refuge Services</i> published (Snively 1996)</p> <p><i>Hitting Home</i> survey (Leibrich, Paulin and Ransom 1995)</p> <p><i>Breaking the Cycle: Interagency Protocols for Child Abuse Management</i> published (CYPs 1996)</p>
1997	<p><i>1996 Women's Safety Survey</i> published (Morris)</p> <p><i>Patterns and Reflections</i>, Kinley, Liz; Doolan, Mike. for Children, Young Persons & Their Families Service</p>
1998	<p><i>An Agenda for Family Violence Research</i> (Department of Social Welfare, Family Violence Unit 1998)</p> <p><i>Family Violence: Guidelines for Health Sector Providers to Develop Practice Protocols</i> published (Ministry of Health 1998)</p> <p><i>First Responses to Crime: Annual Review 1998</i> report published (Ministry of Justice 1998)</p>
1999	<p><i>Second Responses to Crime: Annual Review</i>, Ministry of Justice</p> <p><i>The domestic violence legislation and child access in New Zealand</i> report</p> <p><i>The Domestic Violence Legislation and Child Access in New Zealand</i>, Alison Chetwin, Trish Knaggs, Patricia Te Wairere Ahiahi Young for Ministry of Justice</p> <p><i>Women and Access to Justice</i>, Law Commission, Wellington</p> <p><i>Justice - The Experiences of Māori Women, Te Tikanga o te Ture Te Mātauranga o ngā Wāhine</i> Māori, Law Commission, Wellington</p>
2000	<p><i>James Whakaruru investigation report</i> published (Office of the Commissioner for Children 2000)</p> <p><i>Care and protection is about adult behaviour : the ministerial review of the Department of Child, Youth and Family Services</i> : Michael J.A. Brown, a report to the Minister of Social Services and Employment, Hon. Steve Maharey</p> <p><i>Domestic Violence Act Process Evaluation</i> (Barwick, Gray and Macky, Ministry of Justice 2000)</p> <p><i>Family Violence: The Health Care Response; Bibliography</i> published (Elvidge 2000)</p> <p><i>If I really loved him enough, he would be okay: Women's accounts of male partner violence</i>, Towns and Adams 2000</p>
2001	<p><i>Review of Family Violence Prevention in New Zealand: Plan of Action</i> released (Maharey2001)</p> <p>Family Violence Strategic Agenda for Māori report (Te Puni Kōkiri)</p>
2002	<p><i>Free from abuse</i> published (Hand et al)</p> <p><i>Family Violence Intervention Guidelines</i> published (Fanslow)</p> <p><i>Te Rito: New Zealand Family Violence Prevention Strategy</i> released (Ministry of Social Development)</p> <p>Whānau Violence: A Māori Conceptual Framework report published (Kruger)</p>
2003	<p><i>Care and Protection Blueprint</i> published (Ministry of Social Development 2003)</p> <p><i>Aplin investigation report</i> published (Office of the Commissioner for Children 2003)</p> <p><i>Silencing Talk of Men's Violence Towards Women</i> (Towns, Adams and Gavey 2003)</p>
2004	<p><i>Transforming Whānau Violence</i> published (Kruger 2004)</p> <p><i>The Implementation of the Domestic Violence Act 1995</i>, by Sheryl Hann for the National Collective of Independent Women's Refuges</p> <p><i>Transforming whānau violence : a conceptual framework : an updated version of the report from the former Second Māori Taskforce on Whānau Violence</i>. Kruger, Tamati ; Pitman, Mereana ; Grennell, Di ; McDonald, Tahuaroa ; Mariu, Dennis ; Pomare, Alva</p> <p><i>Safer Communities - action Plan to reduce community violence and sexual violence</i>. Ministry of Justice</p>

2005	<p><i>Opportunities for All New Zealanders</i> identifies family violence as area for priority action by the government over the next 3-5 years</p> <p><i>Domestic Violence and Harassment Legal Education Kit</i> published (Legal Services Agency 2005)</p> <p><i>Beyond Zero Tolerance: Key issues and future directions for family violence work in New Zealand.</i> research report 3/05, Janet Fanslow for the Families Commission</p>
2006	<p><i>The First Report</i> of the Taskforce for Action on Violence within Families</p> <p>CEDAW Report: (6th) <i>The Status of Women in New Zealand</i> (2006)</p> <p>New Zealand Standard NZS 8006:2006 <i>Screening, risk assessment and intervention for family violence including child abuse and neglect</i></p> <p><i>Creating a culture of non-violence.</i> The report from the New Zealand Parliamentarians' Group on Population and development</p>
2007	<p><i>The scale and nature of family violence in New Zealand. A review and evaluation of knowledge.</i> Ministry of Social Development (Lievore and Mayhew)</p> <p><i>Living at the Cutting Edge: Women's Experiences of Protection Orders</i> University of Waikato (Robertson, Busch, D'Souza, Lam Sheung, Anand, Balzer, Simpson and Paina)</p> <p><i>Domestic Violence: A Review of the Domestic Violence Act 1995 and Related Legislation,</i> Ministry of Justice</p> <p><i>Monitoring Report For the Auckland Family Violence Court The First Three Months 27 March 2007 – 30 June 2007,</i> Deborah Mackenzie & Holly Carrington</p> <p><i>Key stakeholders consultation reports - Strong and safe communities - effective interventions for adult victims of sexual violence,</i> Ministry of Women's Affairs</p> <p><i>An evaluation of the Waitakere Family Violence Court protocols</i> by Morgan, Mandy ; Coombes, Leigh ; McGray, Sarah . Palmerston North Massey University; WAVES</p> <p><i>Counting on protection : a statistical description of the Waitakere Family Violence Court,</i> Coombes, Leigh ; Morgan, Mandy; McGray, Sarah . Palmerston North Massey University; Viviana (Waitakere) ; Man Alive (Waitakere)</p> <p><i>Accounting for safety : a sample of women victims' experiences of safety through the Waitakere Family Violence Court,</i> Morgan, Mandy ; Coombes, Leigh ; Te Hiwi, Erika ; McGray, Sarah . Palmerston North, N.Z. Massey University</p> <p><i>Report of the Commission of Inquiry into Police Conduct = Te Komihana Tiroitiro Whanonga Pirihimana Violence and NZ Young People,</i> University of Auckland</p>
2008	<p><i>The Ongoing Programme of Action</i> for the Taskforce for Action on Violence within Families released in February 2008</p> <p><i>Family violence Intervention Guidelines for Elder abuse and neglect</i> (Ministry of Health)</p> <p><i>The Waitakere and Manukau Family Violence Courts: An evaluation summary,</i> Trish Knaggs Felicity Leahy Nataliya Soboleva Su-Wuen Ong</p> <p><i>Preventing Physical and Psychological Maltreatment of Children in Families - Review of Research for Campaign for Action on Family Violence.</i></p> <p><i>Family Safety Teams Pilot Evaluation: Stage One Baseline Study and Formative Evaluation.</i> A report prepared for the Ministry of Justice</p> <p><i>Programme of Action for Pacific Peoples 2008 and Beyond,</i> Pacific Advisory Group of the Taskforce</p>
2009	<p><i>Te Toiora Mata Tauherenga:</i> report of the Taskforce for Action on Sexual Violence : incorporating the views of Te Ohaakii a Hine-National Network Ending Sexual Violence Together</p> <p><i>Enhancing safety : survivor's experiences of Viviana's advocacy at the Waitakere Family Violence Court</i> by Coombes, Leigh ; Blake, Denise ; McGray, Sarah ; Morgan, Mandy . Palmerston North Massey University</p> <p><i>Arrested female offenders in Auckland City : April-September 2008</i> by Mackenzie, Deborah. Auckland, [N.Z.] shine* (Safer Homes In New Zealand Everyday)</p> <p><i>Family Violence Death Review Committee : first annual report</i> to the Minister of Health October 2008 to September 2009</p> <p><i>E Tu Whānau Ora Programme of Action for addressing family violence 2008-2013</i></p> <p><i>Report of the Expert's Forum on Child Abuse to Minister Bennett</i></p> <p><i>Death and Serious Injury from assault of children under 5 in A/NZ - literature review</i> Mavis J Duncanson, Don A R Smith, Emma Davies for Office of the Children's Commissioner</p> <p><i>Responding to sexual violence: attrition in the New Zealand justice system,</i> Ministry of Women's Affairs</p> <p><i>Responding to sexual violence: a review of literature on good practice,</i> Ministry of Women's Affairs</p> <p><i>Responding to sexual violence: pathways to recovery,</i> Ministry of Women's Affairs</p> <p><i>Restoring soul: effective interventions for adult victim/survivors of sexual violence,</i> Ministry of Women's Affairs</p> <p><i>Responding to sexual violence: environmental scan of New Zealand agencies,</i> Ministry of Women's Affairs</p> <p><i>Violence Against Women in Aotearoa New Zealand: The case for an integrated plan of action.</i> Ruth Herbert, Alice Hill, Sandra Dickson. Available from http://www.womens-health.org.nz/uploads/Roundtablepaper%20-%20an%20Integrated%20approach.pdf.</p>

2010	<p><i>Inquiry into Police conduct, practices, policies and procedures relating to the investigation of child abuse : part 1</i>, Independent Police Conduct Authority</p> <p><i>Taskforce Programme of Action, 1 April 2010–31 March 2011</i></p> <p><i>Clinical review of the ACC Sensitive Claims Clinical Pathway</i>, Sensitive Claims Pathway Review Panel</p> <p><i>Government Response to the Report of the Taskforce for Action on Sexual Violence</i></p> <p><i>Learning from Tragedy: Homicide within Families in New Zealand 2002-2006</i>, Jennifer Martin and Rhonda Pritchard</p> <p><i>It's Not OK New Zealand's Efforts to Eliminate Violence Against Women</i>, Fenrich, J. & Contesse, J. Leitner Centre for International Law and Justice</p> <p><i>Protecting victims : rebuilding lives : sending the right message : a discussion paper written by survivors of domestic violence. It's STILL Not OK!</i> Survivors of Domestic Violence Group.</p> <p><i>Evaluation of the Family Violence Interagency Response System (FVIARS) Summary Report</i>. MSD</p> <p><i>National Stocktake of Kaupapa and Tikanga Māori services in Crisis, Intervention, long term recovery and care for sexual violence</i> October 2008 - April 2009 Hamilton- Katene, S. for Te Puni Kokiri</p> <p><i>Speak up, seek help, safe home. A review of literature on culturally appropriate interventions for intimate partner violence in ethnic communities</i>. Ministry of Women's Affairs</p> <p><i>The nature and economic costs from child abuse and neglect in New Zealand</i> by Infometrics Ltd. for Every Child Counts</p> <p><i>Sexual coercion, resilience and young Māori: A scoping review</i>, Ministry of Women's Affairs</p>
2011	<p><i>Inquiry into Police Conduct, Practices, Policies and Procedures Relating to the Investigation of Child Abuse: Part II</i>, Independent Police Conduct Authority</p> <p><i>Inquiry into the Serious Abuse of a Nine Year Old Girl and Other Matters Relating to the Welfare, Safety and Protection of Children in New Zealand</i>, Mel Smith for the Hon Paula Bennett, Minister of Social Development</p> <p><i>Taskforce Programme of Action, 1 July 2011 – 30 June 2012</i></p> <p><i>Briefing paper : the community sexual violence sector in the Auckland Region</i>.</p> <p><i>Family Violence Death Review Committee : second report: October 2009 to November 2011</i>. Inaugural report to the Health Quality & Safety Commission</p> <p><i>Successful Models of Prevention and Intervention with Migrant and Refugee Families</i>, Boutros Nam, Joan Waldvogel, Geoff Stone, Marlene Levine</p> <p><i>From 'Real Rape ' to Real Justice: Prosecuting Rape in New Zealand</i></p>
2012	<p><i>Falevitu: A Literature Review on culture and family violence in seven Pacific communities in New Zealand</i>, MSD</p> <p><i>Incorporating the Voice of Experience: Family Violence - Service User Involvement Guide</i>. Taskforce for Action on Violence Within Families</p> <p><i>Taskforce for Action on Violence within Families – Programme of Action 2012/2013</i></p> <p><i>Lightning does strike twice: preventing sexual revictimisation</i>, Ministry of Women's Affairs</p>
2013	<p><i>Family Violence Death Review Committee : third annual report: December 2011 to December 2012</i></p> <p><i>Policy and practice implications : child maltreatment, intimate partner violence and parenting</i> by Murphy, Clare; Paton, Nicola; Gulliver, Pauline; Fanslow, Janet L.</p> <p><i>Reporting sexual violence in Aotearoa New Zealand</i> by Nicola Wood & Sandra Dickson for the Tauwiwi Caucus of TOAH-NNEST</p> <p><i>Inquiry into improving child health outcomes and preventing child abuse, with a focus on preconception until three years of age : Volume 1</i> by Hutchison, Paul. Parliamentary Health Select Committee</p> <p><i>Review of Child, Youth and Family complaints system : report to the Minister of Social Development</i>, by Broad, Howard</p> <p><i>Current thinking on primary prevention of violence against women</i>, Ministry of Women's Affairs</p>
2014	<p><i>Family Violence Indicators: Can national administrative data sets be used to measure trends in family violence in New Zealand?</i> Social Policy Evaluation and Research Unit, Families Commission</p> <p><i>Government response to report of the Health Committee on Inquiry into improving child health outcomes and preventing child abuse, with a focus on preconception until three years of age</i></p> <p><i>E Tu Whānau Programme of Action for Addressing Family Violence 2013 – 2018</i> The Māori Reference Group for the Taskforce for Action on Violence within Families.</p>

Source: Updated from an initial list developed Fanslow (2005), *Beyond Zero Tolerance: Key issues and future directions for family violence work in New Zealand*.

Appendix 6: Recent recommendations from selected international treaty monitoring bodies

CEDAW	UNCROC	Human Rights Council
<ul style="list-style-type: none"> • Take the necessary measures to encourage the reporting of domestic and sexual violence cases, including by ensuring that education professionals, health-care providers and social workers are fully familiar with relevant legal provisions and are sensitized to all forms of violence against women and are capable of complying with their obligation to report cases • Strengthen training for the police, public prosecutors, the judiciary and other relevant government bodies on domestic and sexual violence • Provide adequate assistance and protection to women victims of violence, including Māori and migrant women, by ensuring that they receive the necessary legal and psychosocial services • Improve the level of representation on the Task Force for Action on Violence within Families and ensure appropriate resourcing with a view to enhancing the perception of its status within the State party • Ensure systematic collection and publication of data, disaggregated by sex, ethnicity, type of violence, and by the relationship of the perpetrator to the victim; to collect data on the number of women killed by partners or ex-partners; and to monitor the effectiveness of legislation, policy and practice relating to all forms of violence against women and girls 	<ul style="list-style-type: none"> • Establish mechanisms for monitoring the number of cases and the extent of violence, sexual abuse, neglect, maltreatment or exploitation, including within the family, in schools and in institutional or other care • Ensure that professionals working with children (including teachers, social workers, medical professionals, members of the police and the judiciary) receive training on their obligation to report and take appropriate action in suspected cases of domestic violence affecting children • Strengthen support for victims of violence, abuse, neglect and maltreatment in order to ensure that they are not victimized once again during legal proceedings • Provide access to adequate services for recovery, counselling and other forms of reintegration in all parts of the country 	<p>The committee made 25 recommendations pertaining to violence against women and children. Our government has accepted and committed to take action on 24 of these and rejected one.³⁰⁹ These are précised below:</p> <p>Accepted:</p> <ul style="list-style-type: none"> • Develop a comprehensive strategy and action plan to target gender-based violence against women, with clear goals and timelines for their implementation • Develop government-sponsored initiatives which focus solely on ending domestic violence and sexual and gender-based violence • Provide victims with prompt and full support and improve programmes that address violence against women and children • Set up a system collecting and analysing data on violence against women and improve the monitoring and evaluation of domestic violence prevention programmes and agencies • Take the necessary measures to collect data about and prevent and sanction forced and early marriage and female genital mutilation • Enhance legislation and policies ensure that the implementation of legislation and policy concerning all forms of violence • Strengthen awareness-raising campaigns both in the media and in educational establishments • Strengthen training and capacity building and programmes on human rights for civil servants of the State that address this issue <p>Rejected:</p> <p>Our government has rejected the recommendation to take into account the relationship between child abuse and contributing factors such as domestic violence and poverty³¹⁰</p>

³⁰⁹ The government's response to the recommendations can be found at <http://www.hrc.co.nz/international-human-rights-new/upr-1314-nzs-second-universal-periodic-review/> (pg 5-6)

³¹⁰ The reason given by our government for rejecting this recommendation is 'The Children's Action Plan aims to protect vulnerable children from maltreatment. New Zealand has other programmes to address intimate partner violence and child poverty'.

Appendix 7: Strategic fit with Better Public Services

Result 1: Reducing long-term welfare dependence

A collaborative project of Taylor Institute and the University of Michigan Research Development Center on Poverty, Risk and Mental Health (1997)³¹¹ reports on four studies that provide useful information on the relationship between violence against women and children and welfare dependency. The studies found that the majority of women on welfare are current or past victims/survivors of IPV. Other studies³¹² found that:

- Young people who are removed from the care of their parents because of abuse or neglect may also face homelessness and unemployment soon after leaving out-of-home care.
- The main reason for women with children to seek supported accommodation was domestic or family violence.

Any reduction in the incidence and the severity of violence against women and children in the community can therefore be expected to reduce welfare dependency.

Result 2: Increase participation in early childhood education

The cumulative effects of trauma experienced by victims/survivors of violence lead to multiple other social problems e.g. moving home multiple times, welfare dependency, poverty and mental health issues for women. These circumstances make it much less likely that children who are directly abused or exposed to IPV will be in some form of early childhood education. Any reduction in the incidence and the severity of violence against women and children in the community can therefore be expected to increase the safety and stability of the lives of vulnerable children and increase the likelihood they will be engaged in early childhood education.

Result 4: Reduce the number of assaults on children

The physical abuse of children is one form of CAN which is a key type of violence against women and children.

The Family Violence Death Review Committee³¹³ reports that:

'Family violence as an adverse childhood experience with lifelong consequences is closely linked to intergenerational family violence. IPV and CAN damages not only the children involved, but also their mothers and caregivers. Also, exposure to violence during childhood heightens the risk of intergenerational violence, with girls more likely to become victims and boys more likely to become perpetrators as adults.'

All strategies and initiatives to address violence against women and children are directly aimed at reducing the number of assaults on children. The development of an integrated system for violence against women and children will be directly aligned with the work of the Children's Action Plan (see below).

Result 5: Increase the proportion of 18-year-olds with NCEA Level 2 or equivalent qualification and

Result 6: Increase the proportion of 25 to 34-year-olds with advanced trade qualifications, diplomas and degrees (at Level 4 or above)

The international evidence shows strong links between violence against women and children, truancy, failure at school, young people not in education, employment or training (NEET). Research conducted by the New Zealand Council for Educational Research³¹⁴ on children in alternative education found the majority of young people interviewed had experienced family violence in some form. Australian Institute of Family Studies resource sheet on the effects of child abuse and neglect for children and adolescents³¹⁵ reports:

- Strong associations between child abuse/neglect and learning difficulties/poor academic achievement.
- Abuse and neglect in the early years of life can seriously affect the developmental capacities of infants, especially in the critical areas of speech and language.
- Abused and neglected children perform less well on standardised tests and achieve poorer school marks, even when socio-economic status and other background factors are taken into account.
- Maltreated children have lower educational achievement than other groups of children.

Any reduction in the incidence and the severity of violence against women and children in the community can therefore be expected to reduce the incidence of truancy, failure at school and the number of children and young people not in education, employment or training.

³¹¹ <http://humanservices.ucdavis.edu/resource/uploadfiles/x%20Trapped%20by%20Poverty,%>

³¹² <http://www.aifs.gov.au/nch/pubs/sheets/rs17/rs17.html> and <http://www.aifs.gov.au/nch/pubs/sheets/rs20/rs20.pdf>

³¹³ <http://www.hqsc.govt.nz/our-programmes/mrc/fvdr/publications-and-resources/publication/992/>

³¹⁴ <http://www.nzcer.org.nz/system/files/background-students-adult-education-2008.pdf>

³¹⁵ <http://www.aifs.gov.au/nch/pubs/sheets/rs17/rs17.html>

Result 7: Reduce total crime rate

There are numerous international studies³¹⁶ showing a conclusive link between violence against women and children and youth offending. In his foreword to 'Young People and Violence'³¹⁷ which is part of the Youth '07 series Principal Youth Court Judge Andrew Becroft explained:

'In the Youth Court, we believe that all roads lead back to the family environment, especially the critical early years. It ought to be a cause for real concern that nearly 17% of students report witnessing family violence in the home, and over 12% of young people report being kicked, hit or punched in their home. Violence begets violence. As Youth Court Judges we see the consequences of family violence every day.'

Result 8: Reduce re-offending

Violence against women and children contributes directly to approximately half of all violent crime in New Zealand³¹⁸ and is a major driver of all types of crime at all ages.³¹⁹ The Ministerial Committee of Inquiry into Violence (1987) (Roper Report)³²⁰ noted that 'family violence is the cradle for the perpetuation of violence in the community' - children who grow up experiencing violence in their families/whānau are more likely to develop severe cognitive and behavioural problems; become violent as adolescents; and in due course continue the cycle of violence with their own partner and children. Assuming Roper is correct in his calculations reducing the incidence and severity of violence against women and children can therefore be expected to have a positive impact on 80% of all forms of crime and reoffending in New Zealand.

³¹⁶ See <http://www.aifs.gov.au/nch/pubs/sheets/rs17/rs17.html> and <http://www.aifs.gov.au/institute/pubs/fm2011/fm89/fm89d.pdf>

³¹⁷ http://www.fmhs.auckland.ac.nz/faculty/ahrg/_docs/2007-violence-report-2010a.pdf

³¹⁸ http://www.areyouok.org.nz/files/news/Updated_Stats_Final.pdf

³¹⁹ The 'Drivers of Crime' meeting convened by Ministers Power and Sharples in April 2009 concluded that family violence is one of the leading drivers of crime

³²⁰ Roper, C. (1987). Report of Ministerial Committee of Inquiry into Violence. Presented to the Minister of Justice March 1987. Wellington, N.Z. Ministry of Justice

Appendix 8: Selected studies of the cost of violence ³²¹

Cost of child abuse - selected studies

Study	Study location and population	Cost categories included (indirect costs in italics)	Total annual costs (2001 US\$)
Peer reviewed articles and government studies			
Courtney (1999)	US. Maltreated children and their families	Direct medical (including counselling)	\$14.0 billion
Evasovich et al. (1998)	US, Ohio (4 counties). Children referred to burn unit for suspected child abuse (n = 104)	Direct medical, legal fees (court costs, fines)	\$0.3 million; \$13 781 per child
Forjuoh (2000)	US, Pennsylvania, 1995. Hospital discharge data (n = 348 children)	Direct medical	\$6.3 million; \$18 103 per child
Irazuzta et al. (1997)	US, West Virginia, 1991-1994. Paediatric ICU admissions (n = 13)	Direct medical	\$0.6 million; \$42 518 per child
New & Berliner (2000)	US, Washington state, 1994. Mental health treatment costs compensated by Crime Victims Compensation program (n = 608 children)	Direct medical	\$1.2 million; \$2 921 per child
Summers & Molyneux (1992)	UK, 1990. Children hospitalized (n = 181)	Direct medical - examinations only	\$128,758 per child
US Department of Health and Human Services (2001)	US, Colorado, 1995	Direct medical, legal services, incarceration, <i>workers' productivity, lost earnings and opportunity cost of lost time</i>	\$468 million
Walker et al. (1999)	US, Washington state. Randomly selected sample of women (n = 1 225) enrolled in an HMO, 42.8% maltreated as children	Direct medical	\$9.1 million; \$17 356 per child
Studies conducted by advocacy groups			
Caldwell (1992)	US, Michigan. Cases recorded by Department of Social Services	Direct medical, incarceration, policing (Protective Services), lost earnings and opportunity cost, <i>lost investments in human capital, psychological costs, other non-monetary costs</i>	\$1.0 billion
Fromm (2001)	US. Aggregated studies	Legal services, direct medical, policing, incarceration, <i>workers' productivity, psychological costs, other non-monetary costs</i>	\$94 billion

³²¹ Extracted from World Health Organisation (2004) The Economic dimensions of interpersonal violence. Geneva (pg 16-22) . Available at <http://whqlibdoc.who.int/publications/2004/9241591609.pdf>

Cost of intimate partner violence - selected studies

Study	Study location and population	Cost categories included (indirect costs in italics)	Total annual costs (2001 US\$)
Peer reviewed articles and government studies			
Australian Institute of Criminology (2001)	Australia. Cost of refuge accommodation for victims of intimate partner violence	Costs of legal services, costs of incarceration, victim compensation costs, <i>lost earnings and opportunity cost of lost time</i>	\$14.2 million
Health Canada (2002)	Canada. All types of violence against women	Direct medical	\$1.1 billion
Mansingh & Ramphal (1993)	Jamaica, Kingston Public Hospital, 1991. Costs for treating victims of intimate partner violence	Direct medical	\$454 000
Morrison & Biehl (1999)	1997 stratified random samples: 310 women in Santiago, Chile; 378 women in Managua, Nicaragua	Lost earnings and opportunity cost of time	Extrapolated lost earnings: \$1.73 billion in Chile; \$32.7 million in Nicaragua
New & Berliner (2000)	US, Washington state, 1994: 318 women victims compensated by the Crime Victims Compensation programme	Direct medical (mental health treatment costs)	\$3 087 per patient (median 15 sessions)
Snively (1994)	New Zealand	Direct medical, welfare, legal, policing	\$717 000 for New Zealand
Stanko et al. (1998)	UK, borough of Hackney, 1996	Public services only: policing, legal, medical costs, other monetary costs (housing, refuge, social services)	\$13.3 million
Wisner et al. (1999)	US, Minnesota, 1992-1994. 126 victims of intimate partner violence in a large health plan	Direct medical	\$4 341 per patient
Studies conducted by advocacy groups			
Day (1995)	Canada. Data drawn from surveys	Direct medical (including dental costs), <i>lost earnings and opportunity cost of time, other monetary costs, psychological costs</i>	\$1.2 billion
Korf et al. (1997)	Netherlands, 1997. Female victims of domestic violence	Direct medical, costs of legal services, costs of incarceration, other monetary costs, costs of policing, <i>lost earnings and opportunity costs of time</i>	\$142.2 million
Womankind Worldwide (2002)	US. Lost work and legal expenses for private companies	Direct medical, cost of legal services, costs of policing, <i>employment and workers' productivity, psychological costs, lost earnings and opportunity cost of time</i>	\$3.5 billion
Women's Advocates Inc. (2002)	US overall	Legal services, direct medical, policing, incarceration, other monetary costs (shelters), <i>lost earnings and opportunity cost of time, employment and workers' productivity</i>	\$12.6 billion

Cost of sexual violence - selected studies

Study	Study location and population	Cost categories included (indirect costs in italics)	Total annual costs (2001 US\$)
Peer reviewed articles and government studies			
Cohen (1988)	US. Pain and suffering awards from more than 100 000 jury decisions	Direct medical, <i>lost earnings and opportunity costs of time, psychological costs, other non-monetary costs</i>	Cost of rape: \$14.9 billion
Miller, Cohen & Rossman (1993)	US National Crime Victimization Survey: all victims of non-fatal physical and psychological injury, 1987-1990	Direct medical, life insurance, victim compensation costs (jury awards), <i>employment and workers' productivity, psychological costs, lost earnings and opportunity costs of time</i>	Cost per rape: \$85 000
US Department of Justice (1994)	US National Crime Victimization Survey	Direct medical, <i>lost earnings and opportunity cost of time</i>	Cost of rape: \$33 million
Studies conducted by advocacy groups			
Children's Safety Network Economics and Insurance Resource Center (1997)	US National Crime Victimization Survey and Survey of State Prison Inmates	Legal services, direct medical, <i>lost earnings, quality of life, and opportunity cost of time</i>	\$159 million
Illinois Coalition Against Sexual Assault (2002)	US	Direct medical, <i>employment and workers' productivity, psychological costs, other non-monetary costs</i>	Cost per rape: \$110 000

Appendix 9: Indicative regional hubs based on population size

Group A - under 100,000 population	
Horowhenua	29,865
Buller, Grey, Westland	31,326
Hauraki, Thames, Coromandel	43,131
Gisborne	44,460
Malborough, Kaikoura	46,170
Kapiti Coast	46,200
Porirua	48,546
Whakatane, Kawerau, Opotiki	49,191
Far North	55,845
Wairarapa	56,250
Rotorua	65,898
Whanganui, Ruapehu and Rangitikei	70,917
Queenstown Lakes, Clutha, Central Otago, Waitaki	76,662
Ashburton, Timaru, MacKenzie, Waimate	81,252
Selwyn, Waimakariri, Hurunui	86,976
Nelson, Tasman	87,516
Invercargill, Southland, Gore	90,870
Whangarei, Kaipara	92,598
Group B - 100,000- 250,000 population	
Palmerston North, Manawatu	103,794
New Plymouth, Stratford, South Taranaki	104,274
Waipa, Otorohanga, South Waikato, Waitomo and Taupo Waitakere	116,079
Dunedin City	118,683
Lower Hutt, Upper Hutt	136,119
Tauranga, Western Bay of Plenty	145,710
Napier, Hastings, Central Hawkes Bay, Wairoa	147,636
Wellington City	179,463
Waitakere	186,447
Hamilton, Waikato, Matamata-Piako	203,685
Group C - above 250,000 population	
North Shore, Rodney	295,167
Christchurch, Chatham Islands	349,047
Auckland Central	404,658
Counties/Manukau	433,086
TOTAL POPULATION (2006 census)	
	4,242,048

Appendix 10: Member agencies of the VFNW

1. Autism NZ Wairarapa
2. Child Youth and Family Services
3. CareNZ
4. Department of Corrections
5. Family Works Wairarapa
6. Lifeline
7. Like Minds, Like Mine
8. LYF4U
9. Masterton Christian Childcare Centre
10. Masterton Neighbourhood Support
11. Masterton Safe & Healthy Community Council
12. Ngati Kahungunu ki Wairarapa
13. Open Home Foundation
14. Pathways Wairarapa
15. Plunket
16. Rangitane o Wairarapa
17. Relationships Aotearoa
18. Safer Wairarapa
19. SPCA Wairarapa
20. Stopping Violence Services Wairarapa
21. Southern Wairarapa Safer Community Council
22. Strengthening Families
23. Supergrans
24. Supporting Families Wairarapa
25. Te Hauora Runanga o Wairarapa
26. Victim Support
27. Wairarapa Community Centre
28. Wairarapa Community Counselling Centre
29. Wairarapa Courts
30. Wairarapa District Health Board*
31. Wairarapa Plunket
32. Wairarapa Police
33. Wairarapa Rape Crisis
34. Wairarapa Women's Centre
35. Wairarapa Women's Refuge
36. Whaiora
37. Work and Income
38. Whānau Ora Wairarapa Collective
39. Wairarapa Organisation for Older Persons
40. Wairarapa REAP