
Improving Health Sector Responses to Intimate Partner Violence in the UK: Learning from a Systems Approach in New Zealand



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Finally, I thank my dearest friend and mentor Professor Julie Taylor for your boundless love and support. You were genuinely pleased and proud when I received notification of the Fellowship. Thank you for taking the time to join me when you did. I think it gave you a glimpse into the richness of the entire experience.

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Abbreviations and glossary

CAN	Child Abuse and Neglect
DVA	Domestic Violence and Abuse
DHB	District Health Board
IPV	Intimate Partner Violence
NZ	New Zealand
ONS	Office for National Statistics
UK	United Kingdom
VIP	Violence Intervention Programme
NICE	National Institute for Health and Care Excellence

About the author

I have a clinical background in nursing, midwifery and health visiting, having joined the nursing register in 1983. Since that time, I have practiced in many areas of the UK and entered the higher education sector in my first academic post in 1999. Over the years, my role has become more research focused and I have developed a particular interest in the area of violence against women and girls. Even more specifically, I am concerned with the issue of domestic violence and abuse. Understandably (given my clinical roots) a great deal of my research is concerned with how the health sector responds to, and supports, those who have experienced abuse. Unfortunately, there is plenty of evidence that we do not always do this well. To date, most of my research in the field has taken place in the UK. ‘The Winston Churchill Fellowship’ has provided me with the most invaluable experience to visit another country (New Zealand) to witness first-hand their approach to dealing with the issue. The insights gained are significant. I have been ever-cognisant of how that learning might inform relevant policy, practice and research in the UK. I am excited about the potential impact of the Fellowship and I am pleased to present this report and the recommendations within it, as an important step in the dissemination process. Moreover, I hope it paves the way for discussions with relevant stakeholders, particularly those who can influence and shape policy and practice, about how the recommendations might be implemented.

Executive summary

What I researched: My Fellowship provided me with the opportunity to visit New Zealand to find out about their national Violence Intervention Programme (VIP). The VIP is implemented across District Health Boards to provide training and support for health professionals in responding to intimate partner violence (IPV) as part of a broader, systems approach to addressing the problem.

The questions I wanted to answer: Domestic violence and abuse is a scourge on public health and wellbeing across the globe, responsible for significant morbidity and sometimes mortality. Intimate partner violence is one of the most common forms of domestic violence and abuse. It refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. It is known to disproportionately affect women as regards frequency and severity, with long-term impacts on their health (and that of any children). Health professionals across a range of services are ideally placed to recognise and respond to IPV, particularly those who provide health services for women. However there is evidence that they do not always have confidence in dealing with the issue and they are reluctant to broach the subject with women in their care. The aim of my Fellowship was to find out whether parts of the New Zealand VIP might be relevant to the UK. I was particularly intrigued to find out about one particular resource that is used in the VIP: small cue cards carried or worn by health professionals to help them identify, discuss and respond to IPV.

Major findings: Findings are presented with reference to Bronfenbrenner's Social Ecological Model. The ecological model captures the interplay between different systems, all of which need to be considered in tackling IPV. Findings are presented under headings that reflect the model at microsystem, exosystem and macrosystem levels. For each of these three system levels, I have identified several 'key learning points'.

- **Microsystem level findings:** Dealing with IPV is core business for health professionals, not an optional extra; Success in tackling IPV in the health sector requires a systems approach; IPV training needs to be endorsed by management and it needs to be mandatory; Engaging community experts on IPV training sessions is important; Internal IPV champions can act as change

agents and model best practice in dealing with IPV; IPV cue cards are a route to having difficult conversations about IPV; Assessment needs to incorporate both IPV and CAN.

- Exosystem level findings: Health sector responses are reliant upon cross-agency collaboration and partnerships; Co-location and accessibility of IPV services are a model of best practice; Campaigns and initiatives to address IPV can help raise public awareness; Communities know best what works for them in addressing IPV and so initiatives need to be community driven.
- Macrosystem level findings: The term 'family violence' offers culturally appropriate language in some contexts; The notion of child-centredness takes different forms and is context-dependent; Critical reflection on taken-for-granted social and cultural understandings are necessary in understanding IPV.

Recommendations: My intention is to capitalise on the forthcoming *Domestic Abuse and Violence Bill* and use the political and media attention that it will generate to share the key findings from my Fellowship. Strategically it is important to emphasise the key areas that have potential to make an impact: cue cards as part of a VIP; IPV champions; training; co-location of IPV services and awareness raising campaigns. These five key areas have addressed my Fellowship aim regarding how health sector responses to IPV can be improved in the UK.

Introduction

Domestic violence and abuse (DVA) is a scourge on public health and wellbeing across the globe, responsible for significant morbidity and sometimes mortality (World Health Organization (WHO) 2018a). DVA is described as an incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between people aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality (Home Office 2013). This definition captures the breadth of DVA; it comes in many guises, including honour based violence, early and forced marriage, female genital mutilation and abuse between partners. Women can be violent to men (often in self-defence) and violence occurs in same-sex partnerships. The most common perpetrators of DVA are male intimate partners or ex-partners. Men are far more likely to experience broader societal violence perpetrated by strangers, than by someone close to them (World Health Organization 2012).

Prevalence of DVA is difficult to measure because it is largely a hidden issue. Population estimates in the UK range from 15-71% (The Health Foundation 2011). In 2015/16 nearly 10 per cent of women and 5 per cent of men in England experienced DVA, including 96 fatalities (HM Government 2018). Office for National Statistics (ONS) (2017) statistics indicate that more than 2 million people over 16 years old in England and Wales suffer DVA in some form every year; that is 1 in 4 women and 1 in 6 men. In terms of numbers, the National Institute for Health and Care Excellence (NICE) (2014) has reported that over 1.2 million women and 750,000 men in England and Wales experience DVA. It is important to recognise however, that such figures present only a partial picture that obscures the real extent of the problem.

There is a well-recognised correlation between DVA and poor health, with long-term negative impacts on mental, emotional, physical, social and financial wellbeing (Women's Aid 2018). Additionally, children who live with DVA are affected in multiple ways (Humphreys et al. 2008; Humphreys & Bradbury-Jones 2015; ONS 2017). It is known for example, that they are far more likely than other children to experience post-traumatic stress, depression and behavioural difficulties (Smith et al. 2014). Importantly, they are at elevated risk of being abused themselves (Coordinated Action Against Domestic Abuse 2014). In addition to the significant public health burden arising from DVA, the societal costs are considerable. As regards the financial toll,

estimates suggest that at the very least, DVA costs the public services heavily at circa £4 billion each year, with the NHS bearing almost half of this cost (ONS 2017).

Intimate Partner Violence

Intimate partner violence (IPV) is one of the most common forms of DVA¹. As the name suggests, it refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Table 1 shows the different forms of IPV.

Table 1: Forms of IPV (adapted slightly from WHO 2012)

- Physical violence, such as slapping, hitting, kicking and beating.
- Sexual violence, including forced sexual intercourse and other forms of sexual coercion.
- Emotional (psychological) abuse, such as insults, belittling, humiliation, intimidation, threats of harm, threats to take away children.
- Controlling behaviours, including isolating a person from family and friends; monitoring their movements; and restricting access to financial resources, employment, education or medical care.

Like DVA more generally, IPV rates are difficult to assess. A landmark study undertaken some years ago now, provided evidence for the global nature of the issue. The WHO multi-country study (Garcia-Moreno et al. 2005) collected data on IPV from more than 24,000 women in 10 countries. Among women who had ever been in an intimate partnership:

- 13–61% reported ever having experienced physical violence by a partner;
- 4–49% reported having experienced severe physical violence by a partner;
- 6–59% reported sexual violence by a partner at some point in their lives; and
- 20–75% reported experiencing one emotionally abusive act, or more, from a partner in their lifetime (Garcia-Moreno et al. 2005).

IPV is a serious and preventable public health issue (Spivak et al. 2014; Dutton et al. 2015) and its health impacts have been recognised for some time (Campbell 2002). It

¹ The terminology can be confusing and the terms DVA and IPV are often used interchangeably. The common terms in New Zealand are partner abuse or family violence. For consistency in this report I use the term IPV mainly.

leads to multiple adverse health outcomes such as depression, post-traumatic stress, suicidal behaviour, sexually transmitted infections and unintended pregnancy (Black 2011). IPV happens in many relationship configurations: women can perpetrate abuse against men and IPV occurs in same-sex relationships. However, it is an issue that disproportionately affects heterosexual women. For example, among victims of IPV, women are at least three times more likely than men to experience injury (Spivak et al. 2014). In her analyses of who does what to whom, Hester (2009; 2013) has reported that men's violence against women tends to create a context of fear and control, which is not the case when women are perpetrators and also, in cases where women are perpetrators against men, most have single events recorded compared to the multiple violations associated with male perpetrators. All these issues point to the highly gendered nature of IPV².

Injuries sustained through IPV can be fatal (WHO 2018b) and women suffer violent deaths either directly – through homicide – or indirectly, through suicide, maternal causes and AIDS (Garcia-Moreno & Watts 2011). Reinforcing the gendered nature of the problem, the majority of victims of domestic homicides recorded in the UK between April 2013 and March 2016 were females (70%) (ONS 2017). Post-separation is a dangerous time for women and poses a heightened risk of escalating violence and death (Nikupeteri et al. 2015).

When the impacts of morbidity and mortality are combined, the health burden of IPV is higher than other more commonly accepted public health priorities (Harvey et al. 2007; Garcia-Moreno & Watts 2011). For health services alone, costs reflect victims of IPV as having more operative surgery, more doctors' visits, hospital stays, visits to pharmacies and mental health consultations than non-abused women (Krug et al. 2002). Social problems often affect victim's relationships with family, friends and future intimate partners, as well as their ability to work or attend school (Riger et al. 2003). The broader social costs are profound, but as with many aspects of IPV, they are difficult to quantify (Garcia-Moreno & Watts 2011).

² While accepting that IPV happens in different relationship configurations the focus of my Fellowship is on women who have experienced IPV.

Health Sector Responses to IPV

Health professionals across a range of services are ideally placed to recognise and respond to IPV, particularly those who provide health services for women. This requires professional awareness and confidence in recognising the myriad ways in which IPV presents (as presented in Table 1). As Hooker and Small (2016) point out, identifying and then responding appropriately to disclosure of IPV, provides vital opportunity for sustained safety planning for women. While many health professionals are competent and confident in dealing with the issue of IPV, there is mounting evidence that many are less so (Bradbury-Jones et al. 2014; Davidov & Jack 2014; Sundborg et al. 2015; Taylor et al. 2013; Yeung et al. 2012). The underlying reason seems to be reticence in having what has been termed 'difficult conversations' about IPV (Bradbury-Jones 2015; Bradbury-Jones et al. 2016). The fearful element is based on concerns about causing offence by broaching such an emotive subject. However, most women (whether experiencing IPV or not) are not offended when asked about it and in fact, most want to be asked and for the issue of IPV to be raised proactively and routinely by health professionals (Koziol-McLain et al., 2008; Robinson & Spilsbury, 2008; Taylor et al. 2013).

From a woman's perspective, disclosure is difficult. Fear of social or psychological stigma is a significant feature of under-reporting (Ahmad et al., 2009, Feder et al., 2009, Montalvo-Liendo, 2009; Overstreet & Quinn 2013). According to Robinson and Spilsbury (2008), women report that health professionals do not understand how the emotional aspects of abuse prevent them from disclosing. Other barriers to disclosure are concerns about breach of confidentiality (Feder et al., 2009); anxiety about removal of children (Peckover, 2003, Montalvo-Liendo et al., 2009) and fear of further abuse (Robinson & Spilsbury, 2008). It usually takes many times of being asked about IPV before a woman finds the courage to disclose and it might seem paradoxical that even when asked, many women will deny that they are experiencing IPV. This might be because they choose not to disclose at that time, or because they do not recognise their experiences as abusive (Bradbury-Jones et al. 2014). However, the very act of talking about IPV shows a willingness to address the issue. It is important to recognise that disclosure in itself does not necessarily equate to a woman leaving an abusive relationship. Many women remain, at least for some time – after all, homelessness is not an appealing option. Safety planning then, is not always about immediate exit from

the situation; it comprises many actions that take account of multiple, complex individual and contextual factors.

Overall, empirical evidence indicates that when it comes to talking about IPV, a pervasive and dangerous silence exists whereby health professionals don't ask about a woman's experiences and women don't tell, especially if not asked. This poses risk of further abuse to women and any children in the household, and means that opportunities for safety planning cannot be enacted.

Fellowship aims and objectives

The purpose of my Fellowship was to find out about interventions aimed at improving health sector responses to IPV that seem to work in other countries . Specifically, I was interested in how health professionals can be better supported to have difficult conversations with women about IPV. I knew of the Family Violence Intervention Programme (VIP) in New Zealand that I believed might hold promising insights. I knew in advance that it comprised training and support for health professionals and I was intrigued to find out about one particular resource that is used in the VIP: small cue cards carried or worn by health professionals to help them identify, discuss and respond appropriately to IPV. Because healthcare takes place within a broader societal context, I considered it important to explore other initiatives beyond the direct context of healthcare, that might have some bearing on how the health sector as a whole responds to IPV.

The Fellowship objectives were to:

1. Investigate the parts of the VIP that assist health professionals in having conversations about IPV;
2. Gain qualitative insights into the aspects of the VIP that are critical to its success;
3. Explore how broader, contextual factors might impact on the health sector's response to IPV;
4. Critically evaluate the elements of the New Zealand approach to tackling family violence that might be implemented in the UK.

How I approached the Fellowship

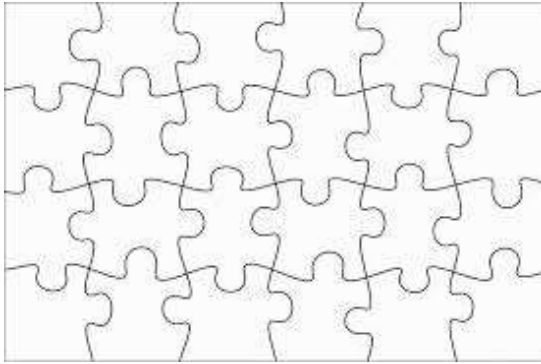
I came here with some knowledge of the programme (and some assumptions about how it is implemented). My purpose is to find out first hand as much about it as possible and bring the learning back to the UK. I am contacting a range of informants across health, social care and voluntary sectors from diverse settings in order to provide the insights I need. (Personal Journal Log October 2017)

The health care structure of New Zealand is such that it is divided into 20 District Health Boards (DHBs). My intention was to travel to as many DHBs areas as possible, to talk with key stakeholders with insights into the use of IPV cue cards. I had planned that these would be primarily from the health sector. I also wanted to meet with a range of experts in the field of IPV more generally, who I considered would help me to understand how IPV is tackled at community and societal levels in New Zealand, for example Refuge and other DVA services. In advance of my visit I made contact with several academics in the higher education sector in New Zealand, most of whom are recognised internationally for their work in the field of IPV (I refer to many of them individually later in the report). While I set up several appointments beforehand, particularly for the first two weeks, I planned to work on a snowballing process regarding contacts. This strategy worked well and during my Fellowship I found that almost without exception, one contact generated another two or three, as people generously directed me towards others in their network.



Figure 1: New Zealand map and details and DHBs

Report overview: Pieces of a puzzle



There are multiple ways that I might have presented this report. I had considered a chronological approach that captured my Fellowship journey from beginning to end. I was concerned that this might be a little descriptive and anyway, my learning was not that linear. I spent far more time than I

had anticipated reflecting on my discussions with the people I met, trying to piece the different aspects of my learning together. I spoke to many different stakeholders, some with opposing viewpoints; IPV is a very emotive subject and people tend to hold strong views, particularly as to its gendered nature³. Making sense of the diverse viewpoints was like a puzzle. In fact, I began to use this analogy a great deal when asked about the purpose of my Fellowship. My response was ‘I’m learning about the New Zealand approach to tackling family violence. It’s like a big puzzle that I am trying to piece together’.

I was keen to capture the piecing together in my report, while still imposing structure. I located an ideal framework to facilitate this in the form of Bronfenbrenner’s (1977) Social Ecological Model (explained in the next section). As regards sequence, after providing some contextual information about the problem of family violence in New Zealand, the findings are presented under headings that reflect the model at microsystem, exosystem and macrosystem levels. For each of these three system levels, I have identified several ‘key learning points’ that subsequently form the recommendations from my Fellowship.

Bronfenbrenner’s ecological model

Developed in the 1970s by the psychologist Urie Bronfenbrenner, the ecological model aimed to show how the inherent qualities of a child and their environment interact. Bronfenbrenner stressed the importance of understanding the individual within the context of multiple environments. The individual is simultaneously enmeshed in different ecosystems, from the immediate, intimate physical and social environment of

³ Out of respect for the many informants that I met as part of the Fellowship, I have avoided attributing specific ideas and viewpoints to individuals unless they gave permission to do so.

home and family system (microsystem), outwards to community systems and wider services (exosystem) and even further outwards to the most expansive, broader political, cultural and societal systems (macrosystem). I chose this particular model because during my Fellowship I was reminded repeatedly by people I met to take an holistic, systems approach to viewing the problem of IPV. The ecological model achieves this by capturing the interplay between different systems, all of which need to be considered in tackling the problem. It would have been too ambitious both in my Fellowship travels and in this report to capture every possible element operating at each system level. What follows then, is the aspects of my learning that seem most relevant and importantly, those that hold promise for improving health sector responses to IPV in the UK.

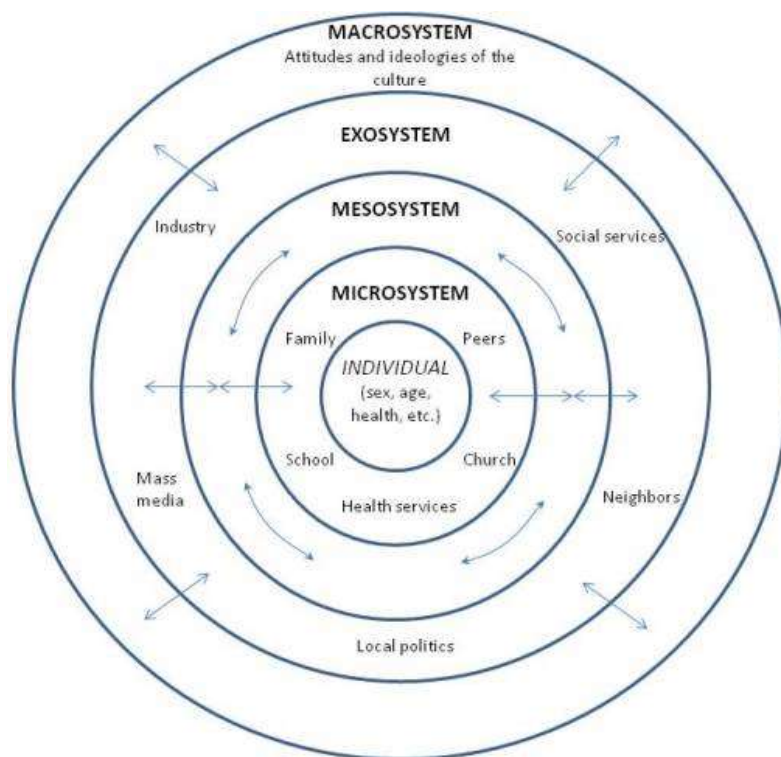


Figure 2: The Social Ecological Model

Findings

New Zealand and family violence

Aotearoa/New Zealand has one of the highest reported rates of family violence in the developed world (New Zealand Government 2017a). The Family Violence Death Review Committee (2016) reported that between 2009 and 2015 there were 194 family deaths: 92 were between intimate partners, 56 were children and 46 were intra-familial (other family members). The extent of abuse perpetrated against women has been recognised for some time. In 2004, Fanslow and Robinson reported that in New Zealand, 1 in 3 women had experienced physical and/or sexual violence perpetrated by a male intimate partner in her lifetime. More recently, of the 92 IPV-related deaths referred to above, 98% were female victims, abused by their male partners (Family Violence Death Review Committee 2016).

There is substantial over-lap between child abuse and IPV (Murphy et al. 2013) and in any 12-month period, 5-10% of New Zealand youth observe violence between one adult and another (Clark et al. 2013). Although I knew about the clear links between child abuse and IPV before embarking on my Fellowship, I was shocked by the extent to which children are represented in the New Zealand statistics. Specifically, the 56 child deaths within a six year period, of which 80% were children under five years of age (Family Violence Death Review Committee 2016). This accounts for more than a quarter of all reported family deaths for that period.

Māori are significantly over-represented as both victims and perpetrators of IPV (Fanslow et al. 2010; Ministry of Health 2016; The Family Violence Death Review Committee 2016). Whānau (extended families) are the principal social unit of Māori society and the causes of violence with whānau are a complex mix of historical and contemporary factors (New Zealand Government 2017a). My first insights into the extent of this complexity were through invaluable discussions with Denise Wilson (Professor Māori Health, AUT University, Auckland). Through her, I was able to appreciate the significant inequity experienced by Māori in almost every health and social domain and within this, the impacts on women and children. I was also to learn about the importance of culturally appropriate and respectful IPV services, that I discuss later in the report. I met Professor Wilson in the first week of my tour. This

timely contact equipped me with a sensitivity to Māori and Whānau issues that I was able to build upon and develop throughout the Fellowship.

Addressing IPV at the microsystem level

One message that is coming over clearly from everyone that I have spoken with so far is that addressing family violence needs to be multi-layered, strategic and adopt a systems approach. For the past few years I have been interested in health professionals' responses to intimate partner violence and I have never looked at this in a vacuum. I know that it takes multiple, complex and long terms interventions to support health professionals in formulating effective responses. So, I am in full support of a systems approach. (Personal Journal Log October 2017)

The microsystem is concerned with the immediate environment with which a person interacts. In the context of my Fellowship, my principal focus was on health sector responses and that is reflected in this section of the report. A motivation for choosing New Zealand as the country for my visit was not only the extent of IPV in New Zealand as already discussed, but also the health sector response to it in the form of the VIP. Dr Janet Fanslow and Dr Robyn Dixon (both from University of Auckland) and Miranda Ritchie (National VIP Manager for DHBs) provided invaluable insights into the development (Fanslow and Dixon) and management (Ritchie) of the VIP. In line with policy on the issue (New Zealand Government 2017b), they all placed emphasis on a systems approach to tackling family violence. I understood this to mean that all six components of the VIP (represented diagrammatically in Figure 3) are complementary and crucial to each other. I was reminded time and again that success in tackling IPV in the health sector requires a systems approach. Resources to support this are in the form of guidelines on how to deal with IPV and child abuse and neglect (CAN):

<https://www.health.govt.nz/publication/family-violence-assessment-and-intervention-guideline-child-abuse-and-intimate-partner-violence>

And how to establish a VIP:

<https://www.health.govt.nz/our-work/preventative-health-wellness/family-violence/establishing-vip-programme>

With reference to these two sources of information, some useful insights can be gleaned that respond directly to the first two objectives of my Fellowship as regards what assists health professionals to have discussions about IPV and what works in the VIP). The geographical, demographical and health system differences between New Zealand and UK are such that replication of a VIP in the way that it has been implemented in New Zealand is unlikely to be feasible. However, there are some aspects of it that have potential for further development in the UK, particularly regarding training, support and resources.

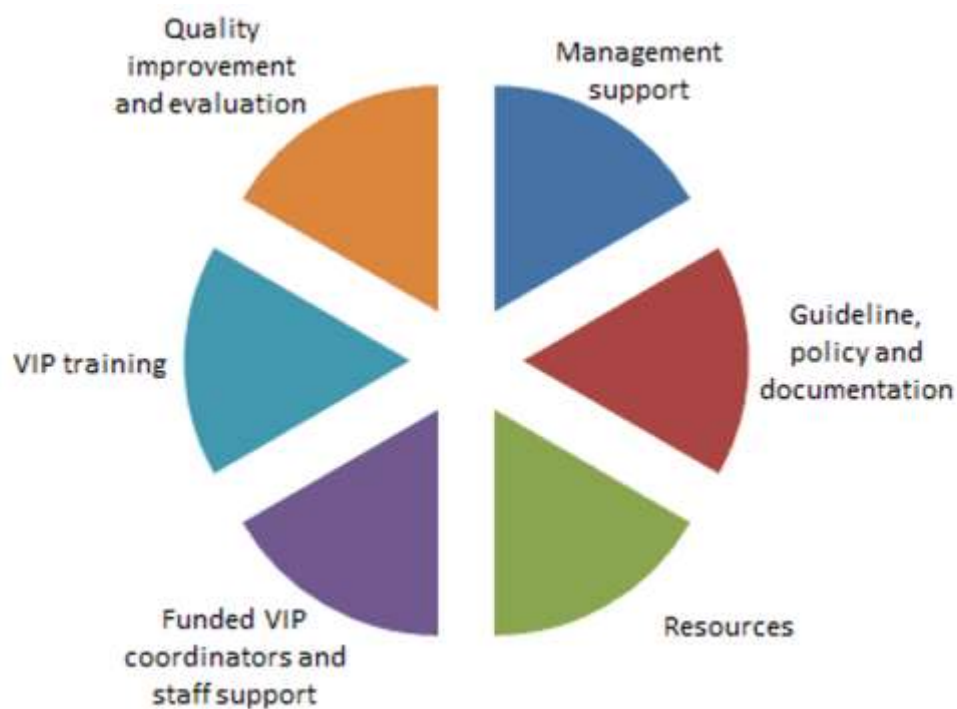


Figure 3: The six segments of the New Zealand national VIP systems approach

A key message within the VIP is that dealing with family violence is core to a health professional's role. They have a responsibility to identify family violence, assess risk and refer victims of abuse, because the prevalence of violence and its health impact make it 'their business'. However, health professionals need training and support to enact this part of their role.

Training ensures that all staff have the necessary knowledge and skills to assist them in dealing with IPV. To be effective though (and for staff to perceive it as important), training has to be endorsed by management, and it also needs to be mandatory.

Engaging community experts on the training sessions is important, and so too is the visibility of ‘internal champions’ who are clinically credible staff that are actively engaged in incorporating VIP activities into their practice. They can act as change agents by supporting colleagues to develop competence in VIP practice and encourage staff to ask patients about IPV. In effect, they have an important role in supporting staff to have difficult conversations.

The resource aspect of the VIP is one that has captured my curiosity, particularly regarding the cue cards (Figure 4). These are available to view online and order through the New Zealand Ministry of Health Website:

<https://www.health.govt.nz/publication/partner-abuse-framing-questions>

<https://www.health.govt.nz/system/files/documents/publications/child-abuse-and-neglect-risk-assessment.pdf>



Figure 4: New Zealand cue cards for partner abuse and child abuse & neglect

The cue cards are a simple, pocket size device that are provided as a resource for healthcare professionals to assist them in asking questions about IPV and CAN and they provide safety planning guidance. Linkage between IPV and CAN within the VIP is important because it encourages health professionals to focus on children and consider their safety. The VIP training incorporates sessions on how to use the cue cards. During my Fellowship I asked as many health professionals as I could about their own use of the cards. Their use is patchy, but of the health professionals who use them, the benefit is reported to be a route in to opening up discussions about IPV.

Sometimes, for example, by starting a conversation: 'I have these questions that I ask everyone about partner abuse...' This normalising of the process of asking everyone is important in reducing the potential stigma associated with IPV.



Addressing IPV at the microsystem level: Key learning points

- Dealing with IPV is core business for health professionals, not an optional extra
- Success in tackling IPV in the health sector requires a systems approach
- IPV training needs to be endorsed by management and it needs to be mandatory
- Engaging community experts on IPV training sessions is important
- Internal IPV champions can act as change agents and model best practice in dealing with IPV
- IPV cue cards are a route to having difficult conversations about IPV
- Assessment needs to incorporate both IPV and CAN

Addressing IPV at the exosystem level

My Fellowship was concerned with health sector responses to IPV, but of course, health care does not take place within a vacuum. Health sector responses to IPV are part of a much broader, interdisciplinary context. Acknowledging the part that the social and voluntary sectors play in addressing IPV, I spent considerable time meeting with people from a range of services to assist in my profile building of what works at the exosystem level. Refuge (Hastings) and SHINE (Auckland) gave their time in informing me of their services and support. I really enjoyed my discussion with the CEO of Refuge, Wellington in exploring critically the term 'family violence' (I say more about this later in the report).

Cross-agency working in addressing family violence is crucial (Ministry of Health 2016). There is often disconnect between what ought to happen in cross-agency working as an ideal, and what happens in reality. I came across an exciting model of co-location of services at AVIVA – The LOFT in Christchurch. Based in a shopping mall, the LOFT provides an accessible space that includes a range of services to assist families experiencing problems, including IPV. Meeting with the CEO, Nicola Woodward, I learned that the initiative was formed out of necessity after the 2011 earthquake in Christchurch, where services lost their buildings and needed to re-locate. Seizing the opportunity to work to a different model, different services came together, not only to share the same space, but to liaise and communicate across teams. 'Leading social services have partnered to co-develop a better way to support our most vulnerable children and their families, simply by working together more closely' (AVIVA 2016). One such service (that I ended up spending several days with) is Plunket; New Zealand's largest provider of support services for the development, health and wellbeing of children under five years of age. Plunket works together with families and communities, to ensure the best start for every child (Plunket 2018). Plunket, I learned, is a well-regarded organisation that is part of the fabric of New Zealand's child health services. Co-locating the service with other family and child orientated services optimises cross-agency communication, maximising opportunities for joined-up working.

In the UK (currently) there are Multi Agency Safeguarding Hubs (MASH) (see <https://www.gov.uk/government/news/working-together-to-safeguard-children->

[multi-agency-safeguarding-hubs](#)) and Multi Agency Risk Assessment Committees (MARACs) (see <http://www.reducingtherisk.org.uk/cms/content/marac>) that are based on the principal of working together to support families and reduce DVA. The difference between these and AVIVA is the focus of the latter on accessibility and provision of services in the place where people spend their time (the mall). There will likely be many such initiatives in communities up and down the UK, but I refer to AVIVA as an example of best practice in joint working and co-location of services to emphasise the importance of operating at this exosystem level.

Part of tackling IPV at an exosystem level is concerned with community levels factors and media. In the context of my Fellowship, one example that caught my attention was in the form of the 'It's not OK' campaign.



'It's not OK' is a community-driven behaviour change campaign to reduce family violence in New Zealand. Link: <http://areyouok.org.nz/>. Its goal is to change attitudes and behaviour that tolerate any kind of family violence. The campaign's vision is a community where each person believes there is something they can do to help and is likely to act when they know violence is happening. It was launched in September 2007 with the simple message 'Family Violence is not OK but It is OK to Ask for Help'. Community ownership of the campaign has been key to its success. Local projects have been supported and funded by the campaign all over New Zealand, illustrating that communities know best what works for them.

I came across the campaign while driving from one DHB to another and its impact is captured in my journal log:

A few days ago, I screeched to a halt in my campervan when I spotted this poster next to the road as I entered one town, Whanganui. I guess this is just one example of the systems approach? (Personal Journal Log November 2017)

In 2014, the Ministry of Social Development commissioned an evaluation of how the campaign has supported change to address and prevent family violence within communities. Link: <http://areyouok.org.nz/resources/research-and-evaluation/>

The evaluation findings include changes identified as a result of the campaign according to the following impacts:

- increased awareness and message infiltration;
- behaviour and attitude change;
- community responsiveness and ownership;
- interagency collaboration;
- statutory intervention (Roguski 2015).



Caption: The billboard that prompted me to stop and look again. Many towns in the UK have signs to inform those who enter it that it is 'twinned' with another in France, or that it carries the accolade of being 'best kept' in a certain year. I preferred this New Zealand example of board space.

What I saw in the 'It's not OK' campaign, is an example of addressing IPV at the exosystem level, with a key determinant of success being community ownership. In other words, the campaign's impact comes from community action and empowerment to tackle the problem and it needs to be driven by the communities themselves.



Addressing IPV at the exosystem level: Key learning points

- Health sector responses are reliant upon cross-agency collaboration and partnerships
- Co-location and accessibility of IPV services are a model of best practice

- Campaigns and initiatives to address IPV can help raise public awareness
- Communities know best what works for them in addressing IPV and so initiatives need to be community driven

Addressing IPV at the macrosystem level

The macrosystem is concerned with cultural and societal contexts and how these interact with the other systems. It isn't difficult to become immersed in cultural issues in New Zealand, particularly regarding the indigenous people and the impacts of colonisation, etcetera. In terms of learning about a systems response to IPV, I was in a unique environment to learn about how Māori health needs are met. Preventing family violence within whānau is complex and among other things, involves reclaiming Māori knowledge, strengthening cultural identity and restoring connections in order to renew cultural traditions (Family Violence Death Review Committee 2016). At the core of health responses is the *He Korowai Oranga*, the Māori health strategy. It includes three elements: Mari ora (healthy individuals); whānau ora (healthy families) and wai ora (healthy environments). It was through learning about the strategy, that I began to sense the significance of whānau as distinct from my own UK-centric understandings of 'family'. Importantly, it was to stimulate my own curiosity about what we mean by family violence.

One question that I began to ask people as my Fellowship progressed was why the term 'family violence' is used, as opposed to say, 'domestic violence or domestic abuse'? Family violence is not a term used frequently in the UK. I learned that use of the term is rooted in cultural values as regards whānau. Focusing on the family unit is one that respects Māori traditions, where problems are dealt with at a family level. I did question (and still do), whether emphasising 'family', risks masking the gendered issue of IPV. As already stated, IPV is disproportionately an issue perpetrated by men against women, including within whānau and I asked several people whether the term 'violence against women' might be a preferred term to highlight this aspect of IPV. I sensed however, that this term is unpalatable and in many contexts, culturally inappropriate.

Another issue that challenged my taken-for-granted assumptions about terminology was in relation to the place of the child within family violence and particularly the issue of child-centredness. Again, there appeared to be cultural issues at the core and I received confusing messages. On one hand, I heard from the Office of the Children's Commissioner that child centredness is important, as reflected in the role and priorities of the commissioner (Children's Commissioner 2016; 2017). Similarly, child-

centeredness is at the core of the VIP, as evidenced for example, through the co-existence of IPV and CAN assessment (Ministry of Health 2016) as indicated in Figure 4. Linking with this, the Family Violence Death Review Committee (2016) emphasised that to be preventative, there is a need to respond to child abuse and neglect and IPV together. It is this type of ‘child-centredness’ that aligns with my own UK-focused understandings of the issue that puts children at the heart of safeguarding decision-making (HM Government 2015; Scottish Government 2015).

However, an important point of learning was, yet again generated from my exposure to the Māori worldview of family. I heard from a number of sources that the simple notion of child-centredness that I had taken to be unproblematic in the UK, can hold different connotations in the context of whānau, where the emphasis is on family, not different members of it, whether or not they are children. What I took from this, was probably a fairly naïve understanding of what the child means culturally within the context of whānau. However, it was a useful one nevertheless, in terms of encouraging me to look far more deeply into the impact of culture on how families themselves, and services more widely, might deal with the issue of IPV.



Addressing IPV at the macrosystem level: Key learning points

- The term ‘family violence’ offers culturally appropriate language in some contexts
- The notion of child-centredness takes different forms and is context – dependent
- Critical reflection on taken-for-granted social and cultural understandings are necessary in understanding IPV

Relevance of findings to the UK

UK health services have a notably poor record when it comes to identification and handling of IPV (The Health Foundation 2011; Bradbury-Jones et al. 2014; Reisenhofer & Seibold 2012; Ormon et al. 2013; Dutton et al. 2015). There is however, a great deal happening in terms of health service responsiveness to the issue. In the health sector, NICE published a guideline on how health and social care services, and the organisations they work with, can respond effectively to domestic violence and abuse (NICE 2014). More recently, the UK Department of Health (2017) has published a resource pack for health professionals in responding to DVA. The resource provides information for health professionals on supporting adults and young people over 16 who are experiencing DVA, and dependent children in their households. The intention is for it to assist healthcare professionals to identify potential victims, initiate sensitive routine enquiry and respond effectively to disclosures of abuse. Health professionals also have numerous assessment tools to support them in this aspect of their role, for example the DASH Risk Identification Checklist:

(<http://www.dashriskchecklist.co.uk/>) and the Barnados Risk Assessment Matrix: (http://www.londonscb.gov.uk/domestic_violence/). There are also evidence based training and referral support programmes, such as the Identification and Referral to Improve Safety (IRIS) programme (<http://www.irisdomesticviolence.org.uk/iris/>). This is a general practice-based DVA training support and referral programme with an enhanced referral pathway to specialist DVA services that has found to be effective in increasing rates of referral for DVA (Feder et al. 2011). In many health settings, there are also Independent Domestic Violence Advisors, who specialise in offering support to high-risk victims of DVA.

My Fellowship findings have provided opportunity to look to another country (with a well-known problem with family violence) to learn what they are doing to address the issue. I focused on health sector responses, but with an eye to broader community and societal contexts. New Zealand is significantly different to the UK in terms of its population, culture and geography. This means that a great deal of what is happening as part of the VIP cannot simply be 'lifted' and applied to the UK. A striking observation was the close networks and ease of communication across DHBs and also across sectors; many people knew each other, which is a significantly different context to the UK. However, there are several aspects of the VIP that hold promise for application in

the UK, either to reinforce best practice in terms of what is already happening, or to suggest new and innovative ways of addressing IPV. Table 2 provides an overview of the findings as relevant to the UK, mapped to the original Fellowship aims 1-3 (aim 4 is concerned with evaluating the elements of the New Zealand approach that might be implemented in the UK reflected in the table of recommendations at the end of the report.

Table 2: Findings mapped to Fellowship aims

Fellowship aims	Relevant findings
Investigate the parts of the VIP that assist health professionals in having conversations about IPV	<ul style="list-style-type: none"> • Availability of resources (cue cards) • Adequate training • Internal IPV champions to act as change agents and model best practice in dealing with IPV
Gain qualitative insights into the aspects of the VIP that are critical to its success	<ul style="list-style-type: none"> • A systems approach • IPV as core business • Assessing for IPV and CAN • Mandatory IPV training endorsed by management • Engaging community experts in IPV training
Explore how broader, contextual factors might impact on the health sector's response to IPV	<ul style="list-style-type: none"> • Multi-agency working and co-location of services • Community action initiatives to raise awareness • Ensuring cultural relevance

Conclusions

The publication of this report comes at an important time as regards UK policy and legislation on DVA. The Home Office and Ministry of Justice are in the process of consulting on the forthcoming *Domestic Abuse and Violence Bill* (HM Government 2018). The consultation closes May 2018. The proposed Bill has five strategic objectives:

- (1) Raise awareness and challenge assumptions;
- (2) Support victims and children;
- (3) Create a criminal justice system that serves victims;
- (4) Reduce offending and reoffending;
- (5) Drive consistency and better performance in the response to DVA.

My Fellowship findings link directly with objectives 1, 2 and 5. In February 2018 I was invited to attend a stakeholder consultation round table in relation the Bill. There appeared to be some interest in my Fellowship findings, particularly the community awareness campaign 'It's not OK'. I suggest therefore, that having considered IPV at the macrosystem level, the benefits of such campaigns has been highlighted. Furthermore, in aligning with the first objective of the forthcoming Bill, I anticipate that similar IPV awareness raising initiatives might be considered for adoption in the UK.

Linkages between the second and last objectives of the Bill and my Fellowship are clear. At the microsystem level I have been inspired by a systems approach to tackling IPV within the health sector, focusing on training, the role of IPV champions and prompts to having discussions about IPV through the use of cue cards. I am particularly excited about the potential for IPV cue cards to support practitioners in having conversations about IPV. Within a systems approach that takes account of the six dimensions of the VIP as discussed in relation to Figure 3, cue cards hold great promise for implementation in the UK.

Recommendations

The key recommendations are proposed in Table 3 and are framed around practice, education, policy and research.

Table 3: Recommendations and actions

Focus	Recommendation	Main actors
Practice	Pilot the use of cue cards as part of VIP and systems approach; Implementation of IPV champions in clinical areas in the NHS; Access to mandatory IPV training for front line health professionals.	NHS managers and commissioners
Explanatory statement	Health professionals in the UK can be better supported to identify and respond to IPV through having the resources, support from champions and access to appropriate training. NHS managers and commissioners need to ensure that this is taken seriously.	
Education	Training on IPV and CAN undertaken jointly; IPV expert engagement with training.	NHS organisations Higher Education Institutes Expert services such as Women's Aid/Refuge
Explanatory statement	Success of the VIP in relation to training is in the focus on both IPV and CAN. Because they often co-exist in families, bringing them together during training helps health professionals understand the links between them. Training needs to be made meaningful though the input of IPV experts (including experts by experience). The NHS is responsible for training its own staff and most training is in-house. Some Higher Education Institutes will also provide training. Engaging with DVA services and agencies can provide the expert input.	
Policy	Develop models of co-location of services; Adopt community awareness campaigns, such as 'It's not OK'	NHS services, Local authorities and voluntary sectors.
Explanatory	It is recommended that health services, local authorities and other	

statement	sectors build on current co-working practices that are happening already in some areas, particularly emphasising the accessibility of such services. This will require new policies on how to work effectively to a co-located model. The 'It's not OK' campaign has been well-evaluated and it could be implemented in the UK. This will require lobbying and persuasion to make policy level changes.	
Research	Impacts and evaluation of all the above will be required; Assessment of cultural appropriateness of any piloting or intervention will be required; Cost benefit analysis of interventions will be required.	Researchers Potential research collaboration between UK and NZ
Explanatory statement	All changes to practice, education and policy need to be subject to robust evaluation. There are opportunities for new research studies, particularly regarding the piloting of new approaches to IPV practice and training in the UK, this includes potential collaboration between the UK and NZ.	

With reference to Table 3 and the recommendations arising from my Fellowship, my next step is to engage with discussions with my colleagues in New Zealand, most notably Janet Fanslow from University of Auckland and Miranda Ritchie (National VIP Manager for DHBs) as regards developing a proposal for the piloting and implementation of the VIP in the UK. This will involve an evaluation of the parts of the VIP that are culturally, pragmatically and politically relevant. Seeking funding from a major funder will be required to support this future venture. In my discussions with Miranda Ritchie during my Fellowship, she advised that piloting and intervention would be best approached through focusing on one clinical area, such as the Emergency Department or Maternity Care, with wider implementation in other areas post-evaluation.

My intention is also to capitalise on the forthcoming *Domestic Abuse and Violence Bill* and use the political and media attention that it will generate to share the key findings from my Fellowship. Strategically it is important to emphasise the key areas that have

potential to make an impact: cue cards as part of a VIP; IPV champions; training; co-location of IPV services and awareness raising campaigns, such as 'It's not OK'. These five areas have answered my Fellowship questions regarding how health sector responses to IPV can be improved in the UK. Next steps are to concentrate on taking forward the recommendations from the Fellowship to ensure that opportunities for implementation and change within the UK are optimised.

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