The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

17 September 2018 Our ref: MT18-491

National Office
Ministry of Justice
SX10088
WELLINGTON

By email: FVinformationsharing@justice.govt.nz

Dear Sir/Madam

Draft family violence information sharing guidance

Thank you for giving the Royal New Zealand College of General Practitioners the opportunity to comment on the draft family violence information sharing guidance. This is a well thought out document and an important reference point for GPs. However, we do have some suggestions to improve the language and structure of the document.

Introduction to general practice and the College

General practice is the medical specialty that treats patients: with the widest variety of conditions; with the greatest range of severity (from minor to terminal); from the earliest presentation to the end; and with the most inseparable intertwining of the biomedical and the psychosocial. General practitioners (GPs) treat patients of all ages, from neonates to elderly, across the course of their lives.

GPs comprise almost 40 percent of New Zealand's specialist workforce and their professional body, The Royal New Zealand College of General Practitioners (the College), is the largest medical college in the country. The College provides training and ongoing professional development for GPs and rural hospital generalists, and sets standards for general practice. The College has a commitment to embed the three principles (participation, partnership and protection) of Te Tiriti o Waitangi (Treaty of Waitangi) across its work, and to achieving health equity in New Zealand.

Health equity is the absence of avoidable or remediable differences in health outcomes and access to health services among groups of people, whether those groups are defined socially, economically, demographically, or geographically (WHO). To achieve health equity, we advocate for:

- A greater focus on the social determinants of health (including labour, welfare, education, housing, and the environment).
- Funding and support to sustain the development of a GP workforce of sufficient capacity to meet population need for access to quality primary medical care, particularly in rural and high need areas.
- Sustained focus on measures to reduce smoking and to increase healthy food options for low-income families.
- Improved integration of primary, community, and secondary care health and social services which ensures the provision of high quality services.
- Universally accessible free primary health care for children and low-income families, because health inequities begin early and compound over the life course.
- A review of the funding model for primary care to ensure that resourcing is allocated equitably across diverse populations with differing needs

Submission

Definition of family violence Sector

The term 'family violence sector' may not immediately resonate with GPs. As such we recommend including the list of "Terms used in this document'' (currently on page 12) after the table of contents.

More information on how guidance complements existing guides

In the section on page 15 titled "What is a risk or needs assessment?'' it would be helpful to explain how these guidelines complement existing guidelines that already exist in the sector. One member suggested the below wording:

> ''The Risk Assessment and Management Framework has been developed specifically for agencies across the family violence sector. It creates a consistent way of talking about risk and you should use it as your main reference point. Formal sector guidelines already developed for example Family Violence Assessment and Intervention Guideline – Child abuse and intimate partner violence, Ministry of Health 2016 and Recognising and Responding to Partner Abuse – a resource of General Practice 2003, are consistent with this framework.''

Removal of "apparent causes of family violence."

On page 23 the College recommends rewording the following:

> "causes of family violence, or factors that may contribute to the violence or its severity (such as mental health conditions, alcohol or drug addiction, current financial pressures, family history of violence, or housing or education difficulties)."

We suggest that this passage should read:

> "factors that may contribute to family violence or its severity (such as mental health conditions, alcohol or drug addiction, current financial pressures, family history of violence, or housing or education difficulties)."

Our rationale is that it seems unlikely that a violent incident can ever be attributed to a single 'cause'.

Further information on knowing what information GPs are allowed to share

Although the guidance refers to 'medical privilege', page 34, it would be helpful to clarify what information GPs are allowed to share. For example, in most cases it would not be appropriate for a GP to share medical information not related to family violence with a non-medical agency, however, there will be cases where relevant medical information might help that agency to decide whether acute intervention is needed.

Suggestion of calling recipient when sharing information

The College suggests adding in a point to the section "Particular steps to ensure safety of information," on page 36. We would suggest that it is good practice to call the intended recipient before electronically transferring information, and requesting acknowledgement the information has been received and a read receipt. This alerts the recipient that they can expect an email and will help them prioritise it.

Highlighting key points in the document

The College recommends bolding or placing a text box around the following key points:

On page 20 ‘’Why is there a duty to consider sharing? The words “safety generally takes priority” should be in bold. As a member pointed out, GPs are aware of this point, however, concerns about confidentiality may mean they are reluctant to share information. Placing this phrase in bold would help emphasise the key point, that safety (not confidentiality), comes first.

On page 32 ”Protection from liability for sharing”, the phrase ‘’Provided that you do not breach the professional codes of ethics that relate to health professionals, teachers, and social workers” should be in a separate text box or in bold. Again, this point will make GPs feel more comfortable with sharing information where necessary.

On page 41 “What to do when you get an access request” paragraph three. We suggest that the following section should be placed in a separate text box to highlight it:

> Before giving the requester the information:
>
> - make sure that you’re giving it to the right person (it’s not unheard of for people to pretend to be someone else in order to get access to information, for example an associate of a perpetrator might pretend to be the victim)
> - check it’s going to reach that person safely and isn’t likely to be intercepted (for instance, arrange a safe place for collection).

This advice is important to ensure the safety of victims, and failing to meet these expectations is common in many sectors.

Feedback on A3 Poster

The College suggests adding a point to the proposed A3 poster which states that a person in the family violence sector should consider the safety of the person of whom the information is about before sharing it.

Feedback on one-page overview

The College suggests starting the proposed one-page overview with “Who the new provisions apply to,” and then “Why change?” This will ensure the relevant people will read the changes and make it clear who the changes apply to.

We hope you find our submission helpful. Should you require any further information or clarification please contact the College’s policy team at policy@rnzcgp.org.nz.

Yours sincerely

Michael Thorn
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