TARANAKI DISTRICT HEALTH BOARD

Violence Intervention Programme

Intimate Partner Violence Assessment and Intervention Policy and Procedures

VIP violence intervention programme

Funded by Ministry of Health & TDHB

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INTIMATE PARTNER VIOLENCE MANAGEMENT POLICY

Department:	Clinical Board
Date Issued:	December 2016
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Responsibility:	Violence Intervention Coordinator
Authorised By:	Chief Executive
Version:	1
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Introduction

1. The Taranaki District Health Board (DHB) is committed to the strategic actions and behaviours of We Work Together By:
    - Treating people with trust respect and compassion
    - Communicating openly, honestly and acting with integrity
    - Enabling professional and organisation standards to be met
    - Supporting achievement and acknowledging successes
    - Creating healthy and safe environments
    - Welcoming new ideas

2. This Intimate Partner Violence Management Policy has been developed in accordance with the principles of action including the Treaty of Waitangi principles, recognising Te Whare Tapa Wha and kaupapa principles. This is consistent with cultural training offered and mandated within the Taranaki DHB.

Purpose

3. The purpose of this policy is to provide Taranaki DHB community and hospital-based staff with a framework to identify, assess and family violence; intimate partner violence.
4. It recognises the important role and responsibility staff have in the accurate detection of intimate partner violence.

Scope

5. This policy applies to all Taranaki DHB staff, including volunteers, students, contractors and visiting clinical staff to the Taranaki DHB. In particular, it has significance for those working in clinical settings.

Terms and Definitions

6. **Family Violence:** Violence or abuse of any type, perpetrated by one family member against another family member. It includes child abuse, intimate partner violence and elder abuse.
7. **Physical Abuse:** Includes all acts of violence that may result in pain, injury, impairment or diseases, may include hitting, choking or in any way assaulting another person, and also under/over medication. There is usually visible evidence of physical abuse (bruising, fractures, burns, lacerations etc) though the difference between accidental injury and abuse can be slight and require expert investigation.
8. **Psychological/Emotional Abuse:** Includes any behaviour that causes anguish or fear. Intimidation, harassment, damage to property, threats of physical or sexual abuse, removal of decision-making posers (in relation to adults) and (in relation to child) exposing the child to physical, psychological or sexual abuse of another person.

Concerted attacks on an individual's self-esteem and social competence results in increased social isolation.

9. **Sexual Abuse:** Includes any forced, coerced or exploitive sexual behaviour or threats imposed on an individual, including sexual acts imposed on a person unable to give consent, or sexual activity when an adult with mental incapacity is unable to understand.
10. **Intimate Partner Violence – also called Partner Violence:** Physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners. Intimate partners include current spouses (including de facto spouses), current non-marital partners (including dating partners, heterosexual or same sex), former marital partners and former non-marital partners.
11. **Routine Enquiry:** Routine enquiry, either written or verbal, by the health care providers to individuals about personal history of partner abuse. Unlike indicator based questioning, routine enquiry means routinely questioning all women aged 16 years and over about abuse. The enquiry is usually made within the social history.
12. **Young Person:** 14-17 years old.

Principles

13. The Ministry of Health's Family Violence Assessment and Intervention Guideline guides this policy.
14. Health services should identify, assess, offer referral and advocate for victims of family violence.
15. Health services that care and protect victims of family violence are build on a bicultural partnership in accordance with the Treaty of Waitangi.
16. All people using the services of the Taranaki DHB are assessed and managed in a culturally safe environment. The Maori Health team is available for cultural support. All staff are able to recognise and be sensitive to other cultures.
17. Staff are competent in the identification and management of actual or suspected family violence through the organisation's violence intervention programme infrastructure including policy and procedures, standardised documentation, education programme and access to consultation.
18. Requirement to integrate care through a coordinated approach with community providers.

Organisational Responsibilities

19. The **Taranaki DHB** is responsible for ensuring:
    - An organisation-wide framework for the management of intimate partner violence and associated policies and procedures.
    - Regular training for staff on the policy and related procedures.
    - Regular monitoring of the policy to assess compliance.
    - Adequate support (e.g. access to consultation) and supervision for staff.
    - Activities are properly resourced and evaluated.

20. **Managers** of departments/services will support the implementation of this policy within their department/service as coordinated by the Violence Intervention Programme Coordinator.

21. All **Taranaki DHB staff** have a responsibility to be aware of this policy, follow appropriate procedures and attend appropriate training.
22. All **clinical staff** have a responsibility for the assessment and intervention of family violence. Responsibilities include:
    - Being conversant with the DHB's family violence intervention policy and procedures.
    - Understanding the referral and management of suspected or disclosed intimate partner violence.

- Attending initial training and regular updates appropriate to their area of work.
- Providing or accessing Taranaki DHB specialist health services that may include:
    - Cultural assessments
    - Mental Health assessments
    - Diagnostic medical assessments
    - Social work services, counselling and therapy resources.
- Ensuring clinically and culturally safe practice, for example consulting a senior colleague during the intervention and seeking peer-support/supervision when intimate partner violence is suspected or disclosed.

Violence Intervention Programme Coordinator

Responsibilities include:

- Coordinating the Violence Intervention Programme implementation within services, working with service leaders to ensure system support is readily available.
- Ensuring this policy remains current and aligned with national standards.
- Providing cyclical workforce training in accordance with the Taranaki DHB Violence Intervention training plan.
- Ensuring quality improvement activities in regard to policy compliance are undertaken and reported on at least biannually.

Supporting Information

23. Legislation:
    - Code of Health and Disability Services Consumers' Rights
    - Crimes Act
    - Domestic Violence Act
    - Health Act
    - New Zealand Bill of Rights
    - Privacy Act
    - Summary of Offences Act

24. Taranaki DHB Polices and Procedures:
    - VIP Child Protection Policy
    - VIP Elder Abuse Management Policy

25. Associated Documents
    - Family Violence Assessment and Intervention Guideline, Ministry of Health, 2016

Maori and the Violence Intervention Programme

Maori are significantly over-represented as both victims and perpetrators of whanau violence. This should be seen in the context of colonisation and the loss of traditional structures of family support and discipline. However, violence is not acceptable within Maori culture. This Taranaki DHB Intimate Partner Violence Policy has been developed in accordance with the principles of action including the Treaty of Waitangi principles, recognising The Whare Tapa Wha and tikanga principles. This is consistent with cultural training offered and mandated within the Taranaki DHB.

Family violence intervention for Maori is based on victim safety and protection being the paramount principle. Ensure practice is safe clinically and culturally. Affirm with the person(s) being abused of their right to be safe in their home. Have Maori staff available to offer support to the family whenever possible.

Routinely enquire about intimate partner violence for all Maori women over the age of 16 year; ask men and adolescents when signs and symptoms are present. If abuse is disclosed talk about possible plans of action they would like to take, including appropriate referral options.

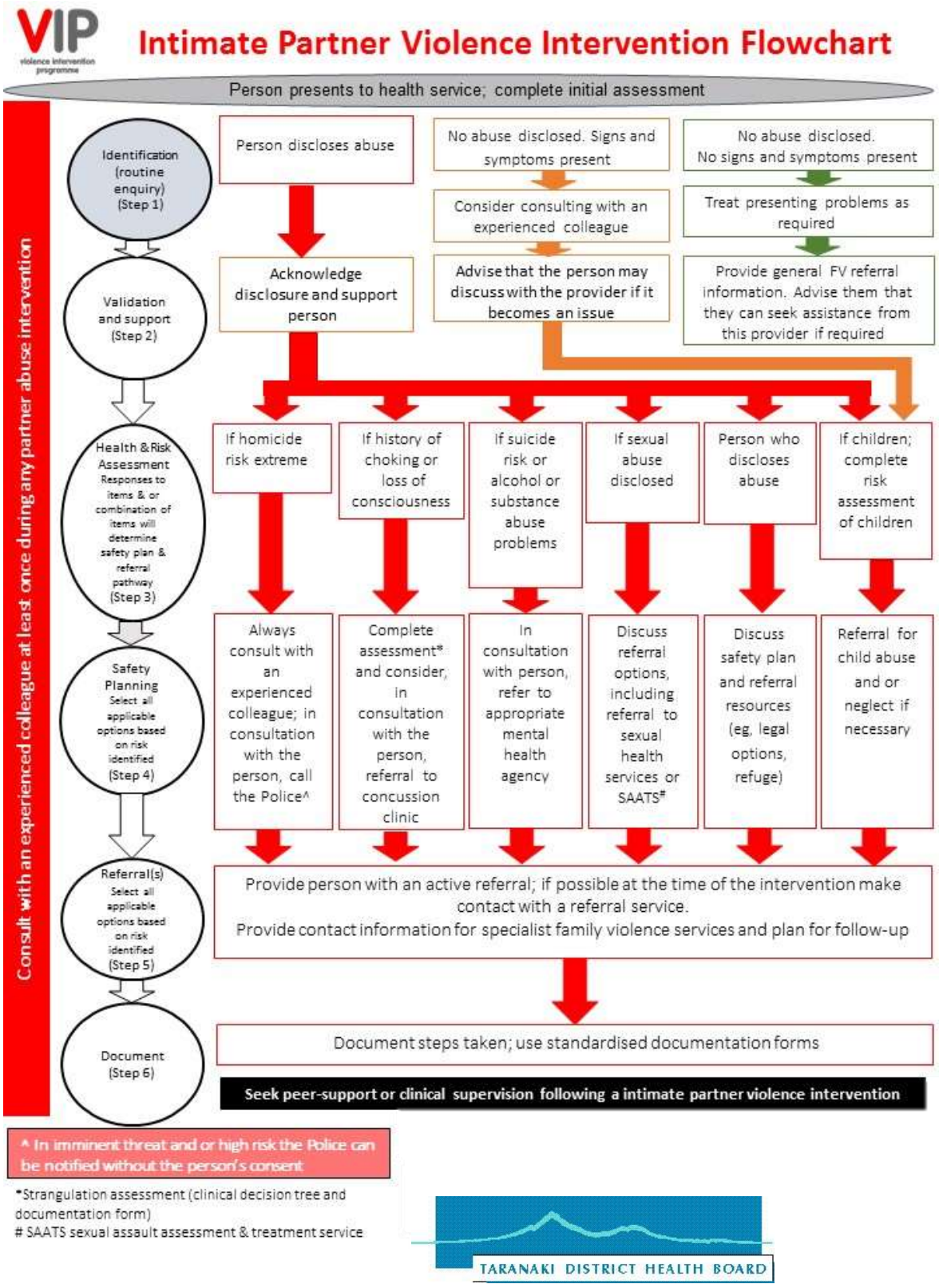
See Appendix 2 - Maori and family violence

Pacific peoples and the Violence Intervention Programme

The complexity of family violence is also evident with Pacific peoples' culture for similar reasons.

See Appendix 3 - Pacific peoples and family violence.

Intimate Partner Violence Intervention Flowchart



Brief Intervention Model: A Six-Step Process

Consultation should occur at <u>least</u> once when intimate partner violence is disclosed or suspected.

The following staff are available:

- Violence Intervention Programme and or Child Protection Coordinator
- Health Social Workers
- VIP Clinical Champions
- An experienced colleague
- Domestic violence advocate

Consultation can occur at any point during the assessment, safety planning and referral process if concerns exist.

Step 1: Identify

Partner abuse occurs in heterosexual and in lesbian, gay, bisexual and transgender relationships. Routine enquiry should only occur when the adult is alone or accompanied by non-verbal age children.

Use a trained professional interpreter if translation is required. Do not use children, or other family members. If the person is deaf and a sign-language interpreter is not available, use written communication.

All females aged 16 years and older should be questioned *routinely.* This includes questioning about physical, sexual and/or psychological abuse. Asking about whether the woman is afraid of her current or previous partner is also important.

Males aged 16 years and older who present with *signs and symptoms* indicative of intimate partner violence should be questioned.

Young people aged 12 to 15 years who present with *signs and symptoms* indicative of abuse should be questioned, preferably in the context of a general psychosocial assessment, such as the HEEADSSS.

Physical and sexual abuse commonly co-exist, therefore assessment for both, needs to occur.

See Appendix 4 - Recommended Intimate Partner Violence Routine Enquiry Guidelines for Different Clinical Settings.

See Appendix 5 - Signs and Symptoms of Intimate Partner Violence.

See Appendix 6 - Guidelines on Identifying Abuse including recommended framing statements and the questions that should be asked routinely.

Step 2: Validation and Support of Persons Experiencing Abuse

Disclosure of intimate partner violence is a difficult step, and many victims feel shame and guilt. Victims of all ages need to be reassured that it is not their fault and that help is available. Hearing these messages from a health care provider is one of the most powerful interventions that health professionals can provide.

Involve Maori staff for support as appropriate, for example the Maori Health Unit.

Involve Pacific staff for support as appropriate, for example the Pacific Health Service.

See Appendix 7 - Guidelines on Validating and Supporting Victims of Intimate Partner Violence.

Step 3: Assess Risk

The purpose of the health and risk assessment is to establish the level of risk for a person leaving the health care facility. This includes immediate risk, the risk of homicide, the risk of suicide and any risk to children.

See Appendix 8 - Guidelines on Health and Risk Assessment.

Health care professionals are responsible for conducting a preliminary health and risk assessment with victims about the abuse in order to identify appropriate safety planning and referral options. A detailed risk assessment may be undertaken by agencies that specialise in responding to intimate partner violence, e.g. a social worker or community agency, such as refuge. A multi-disciplinary team approach is the preferred option for assessment.

When partner abuse is identified and there are children in the person's care, it is imperative that an assessment of risk to children is conducted. In all cases, the emphasis should be on keeping the child safe and enabling the abused person to get real and appropriate assistance. For the assessment and management of children who may be at risk of abuse refer to the VIP Child Protection Policy.

Step 4: Safety Planning

The experience of any violence within relationships is damaging to health and wellbeing, so some level of safety planning is always required. Without intervention, violence within relationships may increase in frequency and severity over time. Safety planning needs to be guided by consideration of a number of factors including degree of risk (high versus moderate), immediacy of the risk (acute, chronic or historic), as well as consideration of protective factors that already exist, or those that can be engaged to support the victim.

Safety planning needs to be done in consultation with the person who has experienced the violence. The health care provider has an important role in assisting victims of IPV to develop a more informed understanding of their degree of risk, to help them work through their options, and to actively connect them with additional resources. The goal is to walk alongside, help and support the person to make their own choices to increase their safety, and, if relevant, the safety of the children.

Information obtained during the health and risk assessment (see step 3) can help the the person and their health care provider to get a better sense of the risks they may be facing, including risks of further violence to themselves or others, and the potential risk of homicide. This can be identified as 'imminent danger', 'high risk' or 'moderate risk'. While, in general, degree of risk can be considered to increase with each question on the health and risk assessment list that the person answers 'yes' to, there are no absolute cut-off points that distinguish between 'moderate' versus 'high' risk. Answers to single a question (such as, 'do you believe your partner is capable of killing you?') may be sufficient for determining that the person is at high risk, and should prompt assertive actions.

Remember, safe practice involves consulting with the person, and senior colleagues, to determine safety options for the future. A multidisciplinary team approach is the preferred option.

See Appendix 9 - Guidelines on Identifying and Responding to Safety Needs.

See Appendix 10 - Safety Plan Resource.

On occasions staff may identify imminent danger or high risk for the individuals including staff secondary to family violence that requires an immediate referral to the Police without consent. See Appendix 11 - Guidelines for Notifying the Police.

Step 5: Referral agencies

Referral agencies are a vital service for the support of victims of intimate partner violence. All identified victims of IPV need to have appropriate referrals made and follow-up planned.

The presence or absence of injuries or other evidence of intimate partner violence are not prerequisites for making a referral, particularly if there is a risk to children. Early referral to support agencies is the preferred intervention.

If the person is in imminent danger, or at high risk, the health care provider needs to make sure the appropriate referral and support agencies are contacted during the consultation.

If the person is at moderate/ongoing risk, or might benefit from early intervention, the health care provider needs to make sure that the person has the information necessary to contact appropriate health, social support or community services.

All victims of IPV should be provided with assistance to contact support services and access legal options for protection.

Appropriate follow-up is also needed; IPV is a health issue that merits appropriate follow-up in its own right. Additionally, the presence/history of IPV may affect the way in which follow-up is delivered when responding to other health issues. If IPV is currently an issue, safety procedures for re-contacting the person need to be considered.

While follow-up will vary depending on the needs of the individual, the resources and training of the health care provider, and the point at which the person has entered the health system (eg, well-health services, primary or secondary care), at least one follow-up appointment (or referral) with a health care provider, social worker, or IPV advocate should be offered after disclosure.

See Appendix 12 - Guidelines on Referral and Follow Up.

TDHB has established interagency processes with a range of organisations and agencies (refer to the directory of family violence community services).

Step 6: Document

Accurate documentation of the health consultation is important for multiple reasons.

Health professionals should record the outcome of the routine enquiry, the findings of the health and risk assessment, the safety planning and referrals made. This documentation process is standard practice in regard to recording the health intervention and it is important part of keeping victims safe because the clinical record may help in future legal action. For example the documentation can be used when securing a Protection Order or prosecuting assault. An objective, systematic history and health and risk assessment is therefore essential. Standard professional requirements also apply (e.g. a legible signature and designation).

See Appendix 13 - Guidelines for Documentation of Family Violence.

To ensure the safety and confidentiality of the information, intimate partner violence disclosures are managed in the following way. The VIP Intimate Partner Violence Documentation Form is stored as accessory file and an electronic record.

This ensures that:

1. The information is kept confidential (minimise the risk that the perpetrator of the abuse can access/see the information),

2. the right information is stored in the right file, and

3. the information is available to clinical staff who provide care in the future.

Safety and Security

At times it may be necessary to suppress patient details and provide secure processes for discharge of persons who are being abused. The guidelines for use when staff assess the safety of a victim of abuse to be high risk are outlined in Appendix 14 – Safety and Security Guidelines.

In these circumstances, staff may choose, in consultation with the victim, to:

- ensure persons making public enquiries about the victim are given no details by suppressing all details on the hospital computer
- use a safe process to discharge the family to an advocacy agency, e.g. women's refuge. This may include informing an inquirer that the patient has left the hospital before this is so and/or denying knowledge of where the patient has gone.

Staff Resources

Training

Family Violence training is mandatory for all staff working with children and women.

The training includes:
- Pre-training information (pre-reading document/online training package)
- A full day (8 hour) training session.

Access to the Violence Intervention Programme training can be obtained through:
- Intranet
- Taranaki DHB Learning and Development Administrator Extn 7649
- Taranaki DHB Co-ordinator of Violence Intervention Programme Extn 8973
- Taranaki DHB Child Protection Co-ordinator Extn 8437

Staff are also required to undertake in-service training as indicated and refresher training biannually.
Advanced training will be offered to designated staff.

Supervision and/or peer support

Clinical supervision and or peer support for staff is recognised as an important requirement to ensure the practice of routinely questioning women for intimate partner violence remains safe for the individual and staff.

Clinical supervision and or peer support is mandatory for staff to whom a disclosure has been made and is available within the service/department.

The Employee Assistance Programme is also available should further counselling be required. Contracted professional staff provide this confidential offsite support and

employees are encouraged to self-refer to this programme. To access the service please call EAP Services Ltd on 0800 7872867 (STRATOS)

Taranaki DHB Employees and Family Violence

The Taranaki DHB Employee Assistance Programme (EAP) is available to support employees experiencing or perpetrating family violence. Contracted professional staff provide confidential offsite services and employees are encouraged to self-refer to this programme. To access the service please call EAP Services Ltd on 0800 7872867.

MoH Family Violence Assessment and Intervention Guidelines (2016)

This resource is available here and on the Ministry of Health website.

Other resources

A number of other resources have been written to support safe practice in family violence. These include a directory of community family violence services, cue cards with sample framing and risk assessment questions, specific intimate partner violence documentation form and a support card for victims.

Reference Documents

Type	Document Title(s)
Organisational Policies	• VIP Child Protection Policy • Taranaki DHB Reportable Events Policy • Taranaki DHB Interpreter Policy • Taranaki DHB Digital Photography Procedure (Patient Clinical Images) • Taranaki DHB Appropriate Access to Health Information Policy
Legislation	• Privacy Act (1993) • Crimes Act (1961) • Crimes Amendment Act (No. 3) 2011 • Domestic Violence Act 1995 • Vulnerable Children's Act 2014
Associated Documents	• Ministry of Health. Family Violence Assessment and Intervention Guidelines; Child Abuse and Intimate Partner Violence. Wellington: Ministry of Health, 2016. • Ministry of Health He Korowai Oranga, the – Māori Health Strategy

For further information contact the Taranaki DHB Violence Intervention Programme Co-ordinator

APPENDIX 1 - Terms and Definitions[a]

The following terms and definitions will be used through-out this document:

Child	Unborn children and children aged 0–14 years old.
Child Protection	Activities carried out to ensure the safety of the child in cases where there is abuse or risk of abuse.
Child Abuse	The harming (whether physically, emotionally, or sexually), ill treatment, abuse, neglect or deprivation of any child/tamaiti, or young person.
Child Physical Abuse	Child physical abuse is any act or acts that may result in inflicted injury to a child or young person.
Child Sexual Abuse	Child sexual abuse is any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not.
Child Emotional/ Psychological Abuse	Child emotional/psychological abuse is any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person.
Neglect	Child neglect is any act or omission that results in impaired physical functioning, injury, and/or development of a child or a young person. This includes physical and medical neglect, neglectful supervision, abandonment and refusal to assume parental responsibility.
Family Violence	Violence or abuse of any type, perpetrated by one family member against another family member. It includes child abuse, intimate partner violence and elder abuse.
Physical Abuse	Includes acts of violence that may result in pain, injury, impairment or diseases, may include hitting, choking or in any way assaulting another person, and also under/over medication. There is usually visible evidence of physical abuse (bruising, fractures, burns, lacerations etc) though the difference between accidental injury and abuse can be slight and require expert investigation.

[a.] Ministry of Health. Family Violence Assessment and Intervention Guidelines; child abuse and intimate partner violence. Wellington: Ministry of Health, 2016.

Psychological/Emotional Abuse	Includes any behaviour that causes anguish or fear. Intimidation, harassment, damage to property, threats of physical or sexual abuse, removal of decision-making powers (in relation to adults) and (in relation to a child) exposing the child to physical, psychological or sexual abuse of another person. Concerted attacks on an individual's self-esteem and social competence results in increased social isolation.
Sexual Abuse	Includes any forced, coerced or exploitive sexual behaviour or threats imposed on an individual, including sexual acts imposed on a person unable to give consent, or sexual activity when an adult with mental incapacity is unable to understand.
Intimate Partner Violence *(also* called partner abuse*)*	Physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners. Intimate partners include current spouses (including de facto spouses), current non-marital partners (including dating partners, heterosexual or same-sex), former marital partners and former non-marital partners.
Routine Enquiry	Routine enquiry, either written or verbal, by health care providers to individuals about personal history of partner abuse. Unlike indicator-based questioning, routine enquiry means routinely questioning all women aged 16 years and over about abuse. The enquiry is usually made within the social history.
Young Person	14-17 years old.

APPENDIX 2 - Maori and Family Violence

This section is drawn from the Family Violence Intervention Guidelines[1] was developed with leadership from the roopu, Te Korowai Atawhai. This appendix offers some background and context for family violence in relation to Maori, and identifies key principles and actions for effective screening and intervention. To strengthen the way health services respond to Māori individuals who are experiencing violence within their whānau, it is recommended that DHBs continue to implement He Korowai Oranga, the – Māori Health Strategy in their planning, governance, ethos, and staff development.

The pathways and principles for action are about ensuring safety and protection, but they are also about supporting families to overcome adversity and draw on their strengths to achieve whānau ora – maximum health and wellbeing.

The experience of family violence for Maori is complex. With the breakdown of traditional whanau structure, loss of beliefs and values, including te reo Maori, patterns of behaviour have emerged. Violence impacts negatively on whanau, hapu and iwi.

The Violence Intervention Programme (VIP) has developed this programme within the founding principles of the Treaty of Waitangi. Consultation with the Maori Health Unit has been a valued component of the programme from planning, through the implementation and evaluation phases.

Health professionals have a role to play in supporting individuals from all cultural backgrounds who are experiencing violence within their families by:

- promoting family environments that are safe and nurturing for children
- identifying abuse early
- offering skilled and compassionate support
- making timely referrals to specialist intervention services.

Solutions to family violence, which are based on traditional Māori values and beliefs (tikanga) and which involve the wider whānau may be more likely to achieve the best outcomes. For this reason it is important for health professionals to be able to identify local Māori health providers and ensure that processes are in place to enable Māori individuals and whānau to access this specialist support, should they wish to.

It is important to acknowledge the diversity of Māori individuals and whanau; take the lead from each individual and/or whānau about what their needs and wishes are.

Safety first

While cultural safety and competence is desirable, the safety of women and children should always come first.

Equity of Health Care for Māori

The *Equity of Health Care for Māori: A framework* is divided into three areas of action:

- leadership: championing the provision of high-quality health care that delivers equitable health outcomes for Māori
- knowledge: developing a knowledge base about ways to effectively deliver and monitor high-quality health care for Māori
- commitment: providing high-quality health care that meets the health care needs and aspirations of Māori.

Health organisations can champion, consider and apply these actions across their practice to facilitate responsive, appropriate and effective care for Māori. This can contribute to improved patient care pathways for Māori patients, and effective identification and response processes to family violence.

Principles for action

The Treaty of Waitangi principles of Partnership, Participation and Protection should underpin efforts to achieve equitable Māori Health outcomes.

Building on the principles of the Treaty of Waitangi, are twelve kaupapa, which health professionals can incorporate into their day-to-day practice to enhance the effectiveness of services for Māori individuals and whānau, and indeed for all people, regardless of cultural or ethnic background.

1. **Wairuatanga –** Wairuatanga refers to spirituality. According to Māori, spiritual connections exist between atua (gods and ancestors), nature and humankind. Every child is born with a wairua (spirit), which is subject to damage as a result of mistreatment.

   Ways to put this into practice:

   - Know that spiritual wellbeing is of key importance within Māori models of health. For example, under the Whare Tapa Wha model, wairua, tinana (physical health), hinengaro (mental health), and whānau are all considered vital for health and wellbeing.
   - Be aware that a person's wairua (soul or spirit) is likely to have been damaged as a result of emotional, physical and/or sexual abuse. Take care to treat victims of violence with compassion, warmth and respect.

2. **Whakapapa** – refers to the genealogical descent of all living things from Ranginui (the Sky Father), Papatuānuku (the Earth Mother), gods, ancestors, and through to the present. Reciting whakapapa enables individuals to identify their genealogical links to one another and to strengthen interpersonal relationships.

   Ways to put this into practice:

   - Note that whakapapa is a fundamental concept of the Māori world-view. Through whakapapa, people can identify and strengthen relationships between themselves and others, develop a healthy sense of belonging, and ground themselves in the world.
   - When building and strengthening relationships with Māori individuals, whānau, hapū, iwi or local Māori services, it is beneficial to share with each other information about your genealogical ties and where you and your ancestors come from.

3. **Atuatanga –** the qualities and wisdom of atua (gods, ancestors, guardians) are considered to endure through people living in the present.

   Ways to put this into practice:

   - Acknowledge the rich whakapapa (genealogical heritage) of each individual.
   - Be aware that Māori support services in the community may be able to help individuals and whānau who are experiencing violence to reconnect with, and pass on to future generations, the mana (prestige and integrity) and wisdom of their ancestors. Rejecting violence is key to this approach.

4. **Ūkaipōtanga –** an Ūkaipō is a place of nurturing and belonging. Ūkaipōtanga is about nurturing and nourishing people and communities.

   Ways to put this into practice

- Encourage parents and whānau to provide a safe and nurturing environment for their children. For example, within maternity services, promote and support parent-infant bonding and talk to parents about how to respond safely to a crying baby.
- Help parents connect with services in their community that can support them in their role as caregivers and protectors.
- Ensure that your health service supports victims of violence within whānau.

5. **Whānaungatanga**- focuses on the importance of relationships. Individuals are seen as part of a wider collective, which has the potential to provide its members with guidance, direction and support.

   Ways to put this into practice

   - Recognise the role of the whānau (family and extended family) in the life of each individual.
   - Engage and build relationships with whānau, identifying key people of influence and those who can provide strength and support to individual members (such as kaumatua and kuia).
   - Note that an individual who is experiencing family violence may wish to call on the support of someone outside their whānau.
   - Help whānau to participate in informed planning and decision making.
   - Work in partnership with whānau, hapū, iwi and Māori community organisations to provide support for individuals experiencing violence.

6. **Rangatiratanga** – is about demonstrating the qualities of a good leader (rangatira); altruism, generosity, diplomacy and the ability to lead by example. It can also refer to the concept of self determination, which respects the right of an individual or group of people to lead themselves. *He Korowai Oranga – Māori Health Strategy* acknowledges whānau, hapū, iwi and Māori aspirations for Rangatiratanga.

   Ways to put this into practice

   - Demonstrate integrity and respect when engaging with whānau.
   - Respect the right of individuals and whānau to determine their own solutions. Support them to make well-informed decisions. Allow them time to ask questions and explore options for action.
   - Ask open-ended questions about what plan of action individuals and/or whānau would like to take, and offer resources, support and guidance.
   - Ask the whānau (rather than assume) what tikanga and kawa (cultural protocols) they wish to follow. Honour their decisions wherever possible.

7. **Manaakitanga –** is about nurturing and looking after people and relationships. Here action is taken to enhance the mana (prestige and integrity) of each individual. Relationships are based on compassion, generosity, reciprocity and respect.

   Ways to put this into practice

   - Build trust with Māori individuals and whānau from the first point of contact.
   - Convey a genuine, open, supportive, caring and respectful attitude.
   - Offer a comfortable and welcoming environment for Māori (including the physical environment and the behaviour and attitudes of health professionals).
   - Aim to pronounce Māori names and words correctly. This will convey a sense of care and respect. If you are not sure how to pronounce someone's name, ask.

8. **Kaitiakitanga –** refers to the guardianship or protection of people, taonga (cultural treasures), and the environment so that they continue to thrive from generation to generation.

   Ways to put this into practice

   - Recognise that safety should always be the number one priority. Ensure processes are in place to keep all vulnerable people, and staff safe.
   - Be aware that the physical, emotional and spiritual safety/wellbeing of mothers is important for the safety of their children.
   - Respect and enable (wherever possible) the expression of Māori and other cultural practices and beliefs.
   - In order to safeguard present and future generations, ensure that there is a sustained commitment within your practice to address violence within whānau.

9. **Oritetanga –** refers to equality.

   Ways to put this into practice

   - Deliver the same high quality service to everyone, no matter what their age, gender, ethnicity or social background.
   - Understand that some whānau may have minimal information about the health sector and your role may be to empower and inform them of their rights and responsibilities.

10. **Kotahitanga –** exists when people work together in unity to support and achieve common goals.

    Ways to put this into practice

    - Take a collaborative approach to keep victims of violence within whānau safe. This should involve information sharing and planning with other professionals, community providers and whānau members.
    - Build a sense of partnership with whānau, hapū and iwi, and Māori organisations in your community.

11. **Pukengatanga** – involves the achievement of progressive milestones and skills, enabling individuals to reach their goals and their potential.

    Ways to put this into practice

    - Work with the individual, whānau, and other professionals (where relevant) to identify achievable plans to ensure short, medium and longer term safety for victims of family violence. After short term safety is established, support them to take the next step.
    - Ensure that individuals/whānau are aware of their options so that they have the opportunity to make informed choices and develop their own plans for the future.

12. **Te Reo** – refers to the Māori language, which is an official language of New Zealand. Its preservation is essential as it is through language that Māori beliefs and traditions are passed from generation to generation. Te Reo carries with it the 'life force' (mauri) of the culture.

    > "Ko Te Reo te mauri o te mana Māori – The language is the life essence of Māori mana." Sir James Henare (1979)

    Ways to put this into practice

    - Aim to pronounce Māori names and words correctly. This will convey a sense of care and respect. If you are not sure how to pronounce someone's name, ask.

- Use Te Reo in signage and posters, and have key documents and resources available in Te Reo.
- Embrace opportunities to learn and use Te Reo and to understand the meanings of key Māori concepts (such as these 12 kaupapa).
- Be aware that Māori words often have multiple layers of meaning and convey perspectives and concepts that cannot always be directly translated into English.

The *Increasing Violence Intervention Programme (VIP) Programmes' Responsiveness to Māori* resource encourages health care providers to seek training to enhance their cultural competence when working with Māori. See www.health.govt.nz/publication/increasing-violence-intervention-programme-vip-programmes-responsiveness-maori

APPENDIX 3 - Pacific Peoples and Family Violence

This section draws on Nga Vaka o Kāiga Tapu (Ministry of Social Development Taskforce for Action on Violence within Families 2012), a conceptual framework, for addressing family violence in seven Pacific communities in New Zealand. Nga Vaka o Kāiga Tapu aims to assist practitioners and service providers, and mainstream organisations working with Pacific families, in:

- their work with victims, perpetrators and their families who have been affected by family violence
- grounding their experiences and knowledge in elements of an ethnic-specific culture in ways that are relevant to the diverse experiences of the families.

What family violence means in a Pacific context

Violence was defined by the working group for Nga Vaka o Kāiga Tapu as violations of *tapu* (forbidden and divine sacredness) of victims, perpetrators and their families. Violence disconnects victims and perpetrators from the continuum of wellbeing, and transgresses the tapu.

Risk factors for family violence amongst Pacific people

The following factors that contribute to family violence in a Pacific context:

- situational factors: including socioeconomic disadvantage, migration culture and identity
- cultural factors: including beliefs that women are subordinate to men; perceptions and beliefs about what constitutes violence; (mis)interpretation of concepts, values and beliefs about tapu relationships between family members including children and the elderly; unresolved historical and intergenerational issues; fusion of cultural and religious beliefs and their (mis)interpretations
- religious factors: including (mis)interpretations of biblical texts; fusion of cultural and religious beliefs and their (mis)interpretations.

Protective factors for Pacific families

- reciprocity
- respect
- genealogy
- observance of tapu relationships
- language and belonging are concepts that are shared across the seven ethnic specific communities as elements that protect and strengthen family and individual wellbeing.

Transformation and restoration

Education is identified as a critical process for transforming violent behaviour and restoring wellbeing to families. It is the responsibility of both practitioners and the communities. The following are four important features that must be practiced together when delivering an education programme aimed at building and restoring relationships within families:

- fluency in the ethnic-specific and English languages
- understanding values
- understanding the principles of respectful relationships and the nature of connections and relationships between family members within the context of ethnic-specific cultures
- the correct understanding and application of strengths-based values and principles.

Principles for action

1 Victim safety and protection must be paramount

The safety of the victim must be paramount. Any practices or interventions that health care providers engage in should not further endanger or disadvantage a Pacific victim of family violence (FV).

Actions and behaviours to ensure victim safety and protection:

- routinely enquire about experience of IPV for women, and about intimate partner violence if there are signs and symptoms for men. Be alert for indication of abuse and neglect among children
- follow the health and risk assessment procedures outlined, and, wherever possible, involve the person in determining the plan of action they would like to take
- your communication style is important. Your language and tone should convey respect and a non-judgemental attitude. Preferably communicate in the language of the victim
- affirm the person's right to a safe, non-violent home
- offer referral to either specialist Pacific or mainstream family violence advocates.

2 The provision of a Pacific-friendly environment

The first point of contact is important in building trust, together with an atmosphere that conveys openness, caring and one that will not judge. Some Pacific peoples will have English as a second language, so communicate simply and clearly; or provide assistance from an appropriately trained (non-family) person who speaks the same language.

Actions and behaviours that contribute to Pacific people feeling comfortable:

- start your consultation with some general conversation; do not be too clinical and business-like
- convey a genuine attitude that is gentle, welcoming, caring, non-judgemental and respectful – first contact is vital
- do not rush – leave time to think about and respond to questions
- ask open-ended questions
- offer resources and support that meets the ethnic-specific needs of the victim.

3 The provision of culturally safe and competent interactions

Health care providers are encouraged to seek training to develop their cultural safety and competence in working with Pacific peoples.

Actions and behaviours that contribute to the development of culturally safe and competent interactions:

- be cognisant of the factors contributing to FV for Pacific peoples
- identify and remove barriers for Pacific victims of FV accessing health care services
- develop knowledge of referral agencies appropriate for Pacific victims of violence.

4 A collaborative community approach to family violence should be taken

The implementation of interventions for Pacific victims of FV should occur in collaboration with other agencies or sectors to ensure that the needs of Pacific victims of violence are adequately addressed.

Actions and behaviours that contribute to a collaborative intersectoral approach:

- recognise that for solutions to be meaningful to Pacific victims of FV, other sectors may need to be involved
- take the time to know your local community and FV referral agencies. If possible, offer referral to Pacific advocates with expertise in FV
- do not assume that the family or church should be involved in supporting the Pacific victim of FV – ask what plan of action they want (it may or may not include the family and the church).

APPENDIX 4 - Recommended Intimate Partner Violence Routine Enquiry for Different Clinical Settings

The Family Violence Assessment and Intervention Guidelines offer a range of recommended routine enquiry guidelines for various services, which are repeated here. Each service and unit may develop a unit-level procedure, specifying where, when, how often and by whom screening will be undertaken. The following are *guidelines only*.

Health care settings

Routine enquiry about intimate partner violence (IPV) is an essential component of clinical care for all females aged 16 years and over. In situations where there is an ongoing relationship between health care provider and patient, enquiry for IPV should occur once annually, unless circumstances suggest more frequent questioning is warranted.

Males and females over 14 years need to be questioned about IPV when presenting with acute injuries, given the common occurrence of early peer dating and sexual relationships, as well as vulnerability to grooming and abuse by adults.

Primary care settings

When should routine enquiry for IPV occur?

- as part of routine health history
- during visits for a new problem
- during any new patient consultation
- any new intimate relationship
- during any preventive care consultation (e.g., cervical screening, mammography)
- as part of Well Child assessments
- at other times that may suggest high risk (e.g., alcohol/drug abuse consultations, sexual health consultations (e.g., for emergency contraception), mental health consultations, presentation for undiagnosed/chronic pain).

What should individuals be questioned about?

- At the first visit, females should be questioned about IPV, physical, sexual, and/or psychological abuse that occurred anytime in their lives.
- Annually, women should be questioned about physical, sexual and/or psychological abuse over the past year.
- Males should be questioned about IPV when they present with signs or symptoms indicative of abuse.

Emergency department/urgent care

When should routine enquiry for IPV occur?

- At every emergency department visit.

What should individuals be questioned about?

- Females should be questioned about physical, sexual and/or psychological abuse over the last year.
- Male and females, aged over 14 should be questioned about IPV when they present with signs or symptoms indicative of abuse.

Maternity and sexual health

When should routine enquiry *for IPV occur?*

- at every prenatal and postpartum visit (maximum three opportunities)
- at any new intimate relationship
- at every routine gynaecological visit
- at family planning visits
- at sexually transmitted disease clinics/visits
- at abortion clinics/visits.

What should women be questioned about?

Routine enquiry should be about current (past year) and lifetime experience of physical, sexual and/or psychological partner abuse.

Paediatric settings

When should routine enquiry for IPV occur?

- as part of Well Child assessments
- when family violence is suspected.

What should individuals be questioned about?

- females should be questioned about physical, sexual and/or psychological abuse over the past year
- males should be questioned about IPV when they present with signs or symptoms indicative of abuse.

Mental health settings

When should routine enquiry for IPV occur?

- as part of every initial assessment
- at every new intimate relationship
- annually, if receiving ongoing or periodic treatment.

What should individuals be questioned about?

- At the first visit, females should be questioned about any IPV, physical, sexual, and psychological abuse that occurred anytime in their lifetime.
- Annually, females should be questioned about physical, sexual and/or psychological abuse over the past year.
- Males should be questioned about IPV when they present with signs or symptoms indicative of abuse.

Inpatient settings

When should screening for abuse occur?

- as part of admission to hospital
- as part of discharge from hospital.

What should patients be questioned about?

- females should be questioned about IPV, physical, sexual and/or psychological abuse over the last year
- males should be questioned about IPV abuse when they present with signs or symptoms indicative of abuse.

APPENDIX 5 - Signs and Symptoms Associated with Intimate Partner Violence (IPV)

The factors below may raise suspicion of IPV, but are not diagnostic.

Physical injuries	**Illnesses**
Injuries to the head, face, neck, chest, breast, abdomen or genitals	Headaches, migraines
Bilateral distribution of injuries, or injuries to multiple sites	Musculoskeletal complaints
Contusions, lacerations, abrasions, ecchymosis, stab wounds, burns, human bites, fractures (particularly of the nose and orbits) and spiral wrist fractures	Gynaecological problems
Complaints of acute or chronic pain, without evidence of tissue injury	Sexually transmitted infections.
Sexual assault (including unwanted sexual contact by a partner)	Chronic pain/undiagnosed causes for pain
Injuries or vaginal bleeding during pregnancy, spontaneous or threatened miscarriage, low birth weight babies	Malaise, fatigue
Multiple injuries, such as bruises, burns, scars, in different stages of healing	Depression
Substantial delay between time of injury and presentation for treatment	Insomnia
Tufts of hair pulled out	Anxiety
Strangulation/choking	Chest pain, palpitations
	Gastrointestinal disorders
Patient's manner	Hyperventilation
Hesitant or evasive when describing injuries	Eating disorders
Distress disproportionate to injuries (e.g., extreme distress over minor injury, or apparent lack of concern about a serious injury)	**Serious psychosocial problems**
Explanation does not account for injury (e.g., 'I walked into a door')	Alcohol abuse or addiction
Different explanation for same injury at different presentations	Severe depression
	Drug abuse or addiction
	Suicidal ideation or attempts
	Continued alcohol, tobacco or substance abuse during pregnancy
	Inappropriate attempts to lose weight, development of eating disorder during pregnancy
	History
	Record or concerns about previous abuse (e.g., injuries inconsistent with explanation)
	Substantial delay between time of injury and presentation for treatment
	Multiple presentations for unrelated injuries

Source: Injury Prevention Research Centre 1996

APPENDIX 6 - Guidelines for Identifying Victims of Abuse (Step 1)

When assessing for intimate partner violence, in most circumstances, it is best to use simple, direct questions, asked in a non-threatening manner.

Asking Adults About Possible Abuse

Framing statements:

'Many of the women I see as patients are dealing with abuse in their homes, and it can have serious effects on their health, so I ask about it routinely.'

'We know that family violence is common and affects women's and children's health, so we are asking routinely about violence in the home.

'I notice…I'm worried…" statements, e.g. "I notice you look sad/have a bruise. I'm worried someone might be hurting you/have caused this.'

Recommended intimate partner violence routine questions:

'Within the past year, did anyone scare you or threaten you, or someone you care about? (If so, who did this to you?)'

'Within the past year, did anyone ever try to control you, or make you feel bad about yourself?'

'Within the past year have you been hit, pushed or shoved, slapped, kicked, choked or otherwise physically hurt? (If so, who did this to you?)'

'Within the past year has anyone forced you to have sex, or do anything sexual, in a way you did not want to? (If so, who did this to you? When did this happen (the last time?)'

***Practice Note*:** While the purpose of these questions is to ascertain experience of 'violence' or 'abuse', people experiencing the violent behaviour seldom apply these terms to what is happening to them.

As a consequence, **it is important that ALL routine enquiries ask about specific behaviours**. Asking a single question, such as 'Are you safe at home?' is not effective, and is unlikely to result in disclosures of violence.

Confidentiality

In many health care settings, confidentiality may have been explained or be understood already, as part of the provider–patient relationship (e.g., in primary care). In other situations, there may be a need to re-state this briefly, 'this is a subject that is confidential (as are all health discussions); however, if there is any situation discussed that suggest someone might be in danger, then we would need to seek other help'.

Making a statement about the limited nature of confidentiality immediately before routine inquiry about IPV is not recommended. Doing so has the potential to raise the anxiety of both individual and health care provider, and is inconsistent with screening practices for other health issues, where confidentiality of the information disclosed is not explicitly stated at the outset.

If information disclosed by the person during routine enquiry, history taking and careful assessment indicates that there is sufficient risk to warrant further action, there is scope to point out the limits of confidentiality of information during the course of the consultation (e.g., 'what you have told me is concerning. I think it is important that we talk to some other people to help make sure you (your child) can stay safe').

APPENDIX 7 - Guidelines for Validating and Supporting Victims of Abuse (Step 2)

Health care provider response to disclosure about experience of violence is important in terms of maintaining rapport with the person, encouraging further disclosure and setting the foundation for further assessment.

How should providers respond?
Listen and express empathy. Be prepared to listen to the experiences of violence and abuse if the person wants to describe these. Do not express shock, horror, or disbelief.

If appropriate, there are five good principles to follow:

- Let them know you believe them.
- Let them know you're glad they told you.
- Let them know you're sorry it happened.
- Let them know it's not their fault.
- Let them know you'll help.

Do not overreact. A first disclosure is a critical moment. The person will monitor every reaction, and may be frightened if the abuser has threatened them not to disclosure the violence, or has told them that no-one will believe them.

Do not panic. Good listening with supportive, minimal encouragers allows the person space to say all they need.

Do not criticise. It may help to tell the person that these sorts of things happen to other people too sometimes. Seek advice and assistance and find support for yourself.

*Acknowledge***:** You are glad the person told you:
'Thank you for telling me.'
'Family violence is never OK.'
'You are not alone – others experience abuse in their homes.'
'You are not to blame for the abuse.'
'You have the right to live free of fear and abuse.'

*Inform***:** let them know that their experiences of violence may be relevant to their health, that help is available, and that you will support them and help them to consider their options.
'Family violence happens in all kinds of relationships.'
'This sort of behaviour (abuse) can affect your health in many ways.'
'Without getting help, this behaviour (violence) can keep happening, and it can get more frequent, and more serious.'
'You are not to blame, but exposure to violence in the family can emotionally and physically hurt your children or others in the family who are dependent on you.'

Don't pressure the person to leave a violent relationship. A person needs to be well resourced and supported before this can be undertaken safely and effectively.

Signs and symptoms indicative of IPV, no disclosure (see Appendix 5)
If partner abuse is suspected, but the individual does not acknowledge that it is a problem:
- respect her/his response
- let the person know that should the situation change you are available to discuss it with them if they would like to
- provide them with the means of contacting appropriate support agencies, and/or give information that can be read at the time of the consultation, pass on to a 'safe' friend, dispose of or take away
- make a note in the medical record to assess for violence again at future presentations

Responding to people who say 'no, that never happened to me'
'I'm glad, that's good to hear. But if you do encounter any problems, please know that I am here to offer help and support if you need it.'

'That's good; you are part of the majority. But it is important to know that if anything changes, this is a good place to come for help. If we are doing our job well we should be asking you about this again in about a year.'

It may also be helpful to provide them with contact details for family violence support agencies. You can introduce this by saying

'It is really common, and therefore you may know someone who may find this information useful. You are very welcome to take this information away to a friend or family member who may find this useful.'

Early intervention (health promotion approach)

There may be circumstances where intimate partner violence is not occurring, but where there still may be opportunities for early intervention. For example, cases where there are high-risk indicators such as alcohol or drug abuse; frequent, low levels of emotional abuse (egg, insults); or other stress points, such as extreme financial stress.

Health care providers can still play an important role in responding to these cases. They can:

- educate about the potential for these risks to escalate into violence and about the importance of good relationships for good health
- offer referrals to community or other agencies that can assist with the problems identified (e.g., relationship services, alcohol and drug services, budgeting services, etc.)
- leave the door open for the person to raise concerns about violence or other issues with them in future if needed.

APPENDIX 8 - Guidelines for Health and Risk Assessment (Step 3)

The health and risk assessment for intimate partner violence (IPV) includes assessment of risk to the person being abused and others in the family. Risk assessment for IPV is not a reliable science. The more information you have the better, but safety lies not so much in the risk assessment tool, but in following a safe process. Even then there is no absolute guarantee of safety.

Thorough risk assessment needs to be conducted prior to the development of appropriate intervention plans. Health care providers should conduct the preliminary risk assessment to identify appropriate referral options. Note that this is different from the role of conducting investigations to determine who is responsible for perpetrating the abuse and/or neglect, which is the role of the Police.

Safe process means never to make decisions about risk in isolation. If you are concerned about the safety of the person, it is important you talk with them about what they have experienced, and work with them and other support services to develop safety plans.

Consult with senior staff within your practice setting, at least once during an IPV intervention. Health care providers do not need to have proof of abuse or neglect, and do not need to seek permission prior to consulting with other colleagues.

Health and Risk Assessment

If a person discloses experience of violence it is important that you conduct a thorough assessment of the violence that has occurred for two reasons: 1) because it will allow you to offer appropriate medical follow-up for the types of violence the person has experienced, and 2) because it will allow you and the person to formulate a better understanding of the risk of future violence they are facing (including risk of re-assault and homicide).

Introducing the Health and Risk Assessment

a) Health and Risk Assessment Questions

1. Is your partner here now?
2. Are you afraid to go/stay home?
3. Has the physical violence increased in frequency or severity over the past year?
4. Has your partner ever choked you (one or more times?)
5. Have you ever been knocked out by your partner?
6. (If applicable) Have you ever been beaten by your partner while pregnant?
7. Has your partner ever used a weapon against you, or threated you with a weapon?
8. Do you believe your partner is capable of killing you?
9. Is your partner constantly jealous of you? If yes, has the jealousy resulted in violence?
10. Have you recently left your partner, or are you considering leaving?
11. Has your partner ever threatened to commit suicide?
12. Have you ever considered hurting yourself/suicide?
13. Is alcohol or substance misuse a problem for you or your partner?
14. Have the children seen or heard the violence?
15. Has anyone physically abused the children?

If you receive a 'yes' answer to the following questions from the health and risk assessment, further investigation is required.

Question	Further assessment may include
3: Has the violence increased in frequency and severity?	Can you tell me more about that?' 'Do you have any injuries that you would like me to look at?'
4: Has your partner ever choked you?	If yes, follow the procedures in the Strangulation Guideline (Appendix 15).
5: Have you ever been knocked out by your partner?	Carry out further assessment for traumatic brain injury.
7: Has your partner ever used a weapon against you, or threatened you with a weapon?	Assess to determine if any injuries were sustained as a result of this assault.

Sexual and reproductive health assessment

The answers you receive to routine enquiry about sexual abuse is the starting point for determining if you need to carry out further assessment of sexual health and reproductive health needs that the person may have. Disclosure of sexual violence is more likely in response to direct questions from the health care provider.

The person's decision regarding police involvement is also relevant to your next steps, and will help determine whether you need to call in an expert medical examiner. If the person does not wish to have an examination for forensic purposes, you can still provide them with relevant sexual and reproductive health care e.g. initial health assessment and treatment and referral to sexual health services).

Mental health assessment

Assessment needs to be undertaken to ascertain if the person is experiencing depression, anxiety, and/or post-traumatic stress disorder. Remember that many mental health problems and substance use issues are consequences (not causes) of experiencing violence. While they are important health issues in their own right, and can exacerbate the difficulties within relationships, any help to address these issues must take place alongside work to improve the person's safety.

Risk of suicide or self-harm

There is a strong association between victimisation from IPV and self-harm or suicide. Health care providers need to consider assessing possible suicide risk by identified victims. Signs associated with high risk of suicide include:

- Suicidal thoughts
- Previous suicide attempts
- Stated intent to die/attempt to kill oneself
- A well-developed concrete suicide plan
- Access to the method to implement their plan
- Planning for suicide (for example, putting affairs in order).

Make direct enquiries to assess if the abused person is thinking about committing suicide, or has attempted suicide in the past.

'You sound really depressed. Are you thinking about hurting yourself?'
'Have you hurt yourself before?'
'What were you thinking about doing to hurt/kill yourself?'
'Do you have access to (a gun, poison, etc.)?'

In extreme cases, referral to the appropriate adult or adolescent mental health service is required. Because of the abuse issues however, joint referral to a specialist family violence agency is also warranted in these cases. The most helpful intervention to reduce suicide risk may be to assist the person to be safe from the abuse.

Physical health assessment

Given the health consequences associated with IPV, additional assessment and appropriate treatment may need to be offered to victims that includes a thorough physical examination to identify all current and past injuries and any appropriate laboratory tests and X-rays.

If intimate partner violence is identified, assess the child/ren's safety

As discussed in the Introduction, IPV and child abuse tend to co-occur within families. As a consequence, if IPV is identified or suspected, it is imperative that some assessment of risk to other members of the family is conducted. In all cases, the emphasis should be on keeping the child safe and enabling the abused partner to get real and appropriate help.

If intimate partner violence exists, and action is needed to protect the children, follow the procedures outlined in the VIP Child Protection Policy.

Remember, if possible, any concerns about the safety of the children should be discussed with the abused person. If you have any doubts about discussing concerns about child abuse and/or neglect with the suspected victim's parents or caregivers, you should *first* consult with senior colleagues within your practice setting.

Do not discuss concerns or child protective actions to be taken with a victim's parents or caregivers under the following conditions:

- If it will place either the child or you, the health care provider, in danger.
- Where the family may close ranks and reduce the possibility of being able to help a child.
- If the family may seek to avoid child protective agency staff.

Be aware that actions taken to protect the child may place the abused partner at risk. Always refer the abused person to specialist family violence support services, and inform CYF about the presence of IPV as well as child abuse.

- Ask the abused partner how they think the abuser will respond.
- Ask if a child protection report has been made in the past, and what the abuser's reaction was.
- If the perpetrator is present in the health care facility, ask the abused partner whom they would like to inform the abuser about the report. For example, would they like the health care provider to do it? Does the abused partner want to be present when the abuser is told? Do they want to do it?

APPENDIX 9 - Guidelines for Safety Planning (Step 4)

Safety planning needs to be guided by consideration of a number of factors including degree of risk (high versus moderate), immediacy of the risk (acute, chronic or historic), as well as consideration of protective factors that already exist, or those that can be engaged to support the victim.

Safety planning needs to be done in consultation with the person who has experienced the violence, because they know the situation they are in better than anyone else, and they are likely to have the clearest awareness of actions that might create further risk for them and their children.

Respectful and considerate engagement with the person related to the development of their safety plans is also important, because IPV is often characterised by high levels of controlling behaviour on the part of the perpetrator, and health care providers need to be aware of, and not replicate this pattern of behaviour.

Health care providers have an important role in assisting victims of IPV to develop a more informed understanding of their degree of risk; the goal is to walk alongside, help and support the person to make their own choices to increase their safety, and, if relevant, the safety of the children.

Simply providing the person with contact details for a support service may be insufficient, and as the health care provider, you may need to make active efforts to ensure that the person has direct contact with a support person, either internally within your organisation (e.g., a health social worker), or with a specialised family violence support agency.

Remember, safe practice involves consulting with the person, and senior colleagues and or community agency advocates, to determine safety options for the future.
A multidisciplinary team approach is the preferred option.

Talk to the person who has disclosed to get a sense of the risks they may be facing, including risks of further violence to themselves or others, and the potential risk of homicide. While, in general, degree of risk can be considered to increase with each question on the health and risk assessment list that the person answers “yes” to, there are no absolute cut-off points that distinguish between ‘moderate’ versus ‘high’ risk. Answers to single questions (e.g., ‘do you believe your partner is capable of killing you?’) may be sufficient for determining that the person is at high risk, and should prompt assertive actions.

Imminent threat/extremely high-risk situations

In situations of imminent threat, or extremely high risk (i.e., the abuser is present, and threatening either the victim or the health care provider), the focus needs to be on securing immediate safety.
Immediate safety risk: things to consider:

- Where is the abuser now?
- Where are the children now?
- Is there a threat to staff safety?
- Is emergency assistance required (for example, Police, onsite security (if available))?

Actions to take:

If the focus is on securing immediate safety for the person, follow the procedures outlined in the DHB’s Emergency Procedures Flipchart. This may include calling the operator on 777 to summon assistance from on-site security or the Police.

Once the immediate situation is contained, it is important to ensure that the abused adult and any children receive the appropriate onward referral and follow-up, as per the high risk situation below.

High Risk

Indicators of high risk

One or more of these indicators may be sufficient to regard the situation as being of high risk.

- Life threatening injuries.
- Children, elders or disabled at risk.
- A threat to kill or a threat with a weapon has been made.
- The person has recently separated from the abusive partner, or is considering separation.
- The person is afraid to go home or stay home.
- Physical violence has increased in frequency or severity.
- The abuser has attempted to strangle the person (loss of consciousness).
- The person has been knocked out.
- The person has been beaten while pregnant (if applicable).
- The perpetrator has access to weapons, particularly firearms, hunting knives, machetes.

Other Factors to Consider

- Has the abuser made threats of homicide or suicide to the person?
- Has the person made threats of suicide?
- Is alcohol or substance abuse involved?
- Does the person believe that their partner is capable of killing them?

Actions to take (high risk)

Ensure immediate safety is secured for the person and their children. Maintaining this may require onsite security and/or Police.

Any decision about reporting a suspected episode of abuse to the Police should be made in consultation with the person.

If there are indicators of high risk, the health care provider needs to make assertive efforts to mitigate these risks. A primary consideration is:

- Does the abused person have a safe place to go when leaving the consultation?
- Does the abused person understand their true level of risk?

If assessment indicates a serious/high risk situation, then you can discuss the need for additional support with the person, e.g. 'Ms X, what you are telling me sounds serious, and perhaps dangerous. I think we may need to involve more specialist support for everyone's safety.' Wherever possible, implement an active referral to a specialist family violence support agency (i.e., make contact with a specialist agency as part of the health visit and have the person speak with someone from the agency directly).

On the rare occasion that a health care provider believes a person's life is in immediate danger, or has good reason to believe that the person is unable to extricate themselves from an ongoing, life-threatening situation, the Police may be notified without the person's permission. The Privacy Act 1993 is not breached if the health care provider has acted in good faith to protect the person from serious harm. Make sure that you inform the person after the Police have been notified. In cases where it is standard procedure to notify the Police, this should be explained to the person (see Appendix 11).

Health care provider options include

- Express your concern for the person's safety (and that of their children, if relevant).
- If possible, initiate a multidisciplinary response
- Depending on the person's health needs, and the resources available, consider arranging inpatient care, which can allow the person both temporary respite and further opportunity to connect with in-house support services (e.g., social workers) or external support agencies (e.g., refuge). If inpatient care cannot be arranged, help the person access emergency shelter/refuge.

- Active referral to a community agency that specialises in responding to family violence is required.
- Encourage the person to seek help from family or friends (or other safe housing).
- If they insist on going home, make sure they have information on safe exit planning if they need to leave a violent situation in a hurry. A detailed safety plan designed as a handout for victims of partner abuse is presented in Appendix 10.
- Make sure the person has information about, and contact details for, other legal and support options that may assist them.

Further information is available regarding interagency information sharing from the Privacy Commission website, follow the following links to the *Sharing personal information of families and vulnerable children: A guide for inter-disciplinary groups* (www.privacy.org.nz/assets/InteractiveEscalationLadder/Escalation-Ladder-FINAL-HiRes.pdf) and the *Escalation ladder* regarding 'Sharing information about vulnerable children' (www.privacy.org.nz/how-to-comply/sharing-information-about-vulnerable-children).

Moderate risk

If you do not think the person is in imminent danger or at high risk, but there is evidence of violence within their relationship (i.e., low-level recent or low-level ongoing violence), it is still important to inform the person about the concerns that this raises, and connect them with options for help and support.

- Let them know that you are concerned about their safety, and that without help violence can increase in frequency and severity.
- Talk to them about what help and support they might get from family and friends.
- Let them know about options for help and support from the community (e.g., refuge, other advocacy groups). Make sure they have contact details for these organisations, and that they have a safe place to keep the information.
- Let the person know about legal options (police safety orders and protection orders), or other supports that might be available if they need help (e.g., Work and Income supports). Make sure they have contact details for these organisations.
- If they have children, let them know about the impact of violence within the family on children, and that children are seldom unaware of what is going on within families. If there are children who are old enough to talk, but the person is adamant that they are not have not been affected by the violence, consider strongly encouraging them to have a private conversation with each child, asking them what they know/how they feel about what is happening.

For all abused individuals

- Educate the person about the likely increase in frequency and severity of abuse, without outside help.
- Support the person, irrespective of their choices. Understand that it is important for each person to make their own choices.
- Let the person know that they can come to you for help with violence, if they need to in the future.
- Help the person work through options for increasing safety. These can include:
  - Actions that s/he can take (e.g., moving house, installing deadbolts and security lights). Note that they are almost certainly already working to keep safe and may have well-developed strategies of their own.
  - Help and support from family members or friends.
  - Help from community agencies (e.g., refuge, or other advocacy groups).
  - Help from police (e.g., police safety orders), courts (e.g., protection orders), and other government agencies (e.g., Work and Income and Housing New Zealand).
  - Help from you, and or from others in the health or social services.

Historic abuse

In some cases, individuals may tell you about violence that they have experienced in the past, but say that it does not pose a current risk for them. This can be important information that is relevant to current health issues they are experiencing, and requires appropriate acknowledgement.

Disclosure of past abuse

- Listen to their story.
- Acknowledge what they have to tell you.
- Validate their experience 'this is not your fault', 'no one deserves to be treated like this.
- It may be relevant to explore if this past violence has current implications in their lives.
  'Do you feel you are still at risk?'
  'Are you still in contact with your (ex-partner)? Do you have children together? Do you share custody?'

Consider if further support may be required.

'How do you think the abuse has affected you emotionally and physically?'
'Would you like to talk to someone else for support about this experience?'

- Discuss referral options (e.g., counselling, information sources).
- Follow up as appropriate.

APPENDIX 10 - Safety Plan – Resource

This safety plan has three parts: safety to avoid serious injury and to escape an episode of violence, preparation for separation, and long-term safety after separation.

1. Avoiding injury, escaping violence

During an episode of violence at home you will want to do everything you can to avoid serious injury. Think ahead and plan.

Leave if you can. Know the easiest escape routes – doors, windows, etc. What's in the way? Are there obstacles to a speedy exit?

Know where you are running to and have a safe place arranged. You may want to organise this with a neighbour in advance of trouble. You may want to leave a spare set of clothes there.

Always keep your purse, cash cards, keys, essential medications and important papers together in a place where you can get them quickly or have someone else fetch them.

If you can't leave the house, try to move to a place of low risk. Try to keep out of the bathroom, kitchen and garage, away from weapons, upstairs or rooms without access to outside.

Talk to your children about getting help. Think of a code word you could say to your children or friends so they can call for help. Depending on age and ability they could:

- run to a neighbour and ask them to call the Police
- call 111. Teach them the words to use to get help ('This is Jimmy, 99 East Street. Mum's getting hurt. She needs help now')
- go to a safe place outside the house to hide. Arrange this in advance.

Try to leave quietly. Don't give your attacker clues about the direction you've taken or where you've gone to. Lock doors behind you if you can – it will slow down any attempt to follow you.

Have refuge or safe house numbers memorised or easy to find.

If you have to leave to save your life – leave fast. Take nothing and go to the nearest safe place and call for help.

2. Preparation for separation – advance arrangements and flight plans

Get support from a refuge or a specialist family violence agency to discuss your options and plans. Make sure you have all the information and support that is available for you.

Arrange transport in advance. Know where you'll go. Make arrangements with the refuge or safe house.

Tell only one or two trusted friends or a refuge worker about your plans. Go through the details together.

Start a savings account. A small amount of money saved weekly can build up and be useful later.

Gather documents. Start collecting the papers and information you need. Make your own list: birth certificates, marriage certificate, copies of protection orders, custody papers, passports, any identification papers, driver's licence, insurance policies, Work and Income documents, IRD number, bank account details and statements, cheque book, cash cards, immigration documentation, adoption papers, medical and legal records, etc.

Ask your family doctor to carefully note any evidence of injuries on your patient records.

What to take

- documents for yourself and children
- keys to house, garage, car, office
- clothing and other personal needs
- a phone or phone card and list of important addresses and phone numbers
- for children, take essential school needs, favourite toy or comforter
- a photograph of your partner so that people protecting you know what s/he looks like.

Playing it safe

- Leave copies of documents, spare clothing and toiletries for yourself and children, some cash, spare keys, medication and other essential items with a trusted friend in case of sudden flight.
- Try not to react to your partner in a way which might make him suspicious about your plans.
- Tell children what they need to know only when they need to know it. Wait until plans are well advanced before talking to them. They don't need the stress of keeping a difficult secret.

3. Living safely after separation

Children

Teach your children what to do if your ex-partner makes contact with them unexpectedly, breaching access arrangements; that is, rules about checking first before opening the door, coming inside or going to neighbours if s/he comes to the house, telling a teacher if they are approached at school.

Teach your children what to do if your ex-partner takes them; for example, calling the Police on 111. Tell other adults who take care of your children (e.g., school teacher, day-care staff, babysitter) which people have permission to pick them up and who is not permitted to do so.

Support

Make contact with a refuge or a specialist family violence agency for support. As well as understanding abuse, these groups usually keep lists of sympathetic lawyers, and can assist in dealing with Work and Income, Housing New Zealand or other government departments you may need to deal with.

Attend a woman's education programme to help strengthen your confidence, independence and freedom, make connections with other women, and deal with your ex-partner. Think about how to deal with potential abuse, feelings of fear and safety issues when you have to communicate with your ex-partner by telephone, or in person.

Tell your employer that you are afraid of your ex-partner. Ask for your phone calls to be screened. Get a protection order from your local District Court. Make four copies – one for your handbag, one kept at home, and one at work. Make sure your local Police Station has a copy. If you move, remember to give a copy to your new local Police Station. Tell your employer that you have a protection order, or that you are afraid of your ex-partner.

If your ex-partner breaches the protection order, phone the Police and report it, contact your lawyer and your advocate. If the Police do not help, contact your advocate or lawyer for assistance to make a complaint. Keep a record of any breaches, noting the time, date and what occurred and what action you took.

Security

Consider installing outside lighting that lights up when a person comes near your house at night. If possible, use different shops and banks to those you used when you lived with your ex-partner.

Ask your phone provider to install 'Caller Display' on your telephone and ask for an unlisted number that blocks your caller display for calls you make from your phone. Warning: make sure that emergency services (Police/fire/ambulance) are allowed access to your telephone number.

Contact Police and request a block on tracing your car registration number.

Contact the Electoral Enrolment Centre on 0800 367656 or contact online and ask for your name and address to be excluded from the published electoral roll. Tell neighbours that your partner does not live with you, and ask them to call the Police if s/he is seen near your house.

From: Auckland Domestic Violence Centre. Safety Plan.

APPENDIX 11 - Guideline for Notification of Police for Family Violence

This guideline sets out the procedure for staff when issues of patient or staff safety are identified secondary to a disclosure of family violence (FV). There are two circumstances in which this guide will apply;

1. There are clear and present safety issues identified for victims of family violence (based on risk assessment)
2. Staff perceive that their own safety may be at risk.

The procedures outlined below will ideally be discussed with and agreed to, by the person who is the victim of abuse. However, in cases of clear and present danger staff do not require the patient/client's consent to refer to the Police. The safety of the person is the paramount consideration. If an individual who is a victim of violence expresses fear of the perpetrator or others, s/he is likely to be correct. It is appropriate in this case for DHB staff to contact the police without consent under Rule 11 of the Privacy Code 1994.

Rule 11 permits disclosure without the person's consent where it is not desirable or practicable to obtain consent and: disclosure is necessary for the maintenance of the law including the prevention and investigation of offences (Rule 11(2)(i); or disclosure is necessary to prevent or lessen a *serious* and *imminent* threat to the life or health of the patient/another individual, or to public safety (Rule 11(2)(d).

Disclosure must only be to the extent necessary for the particular purpose. The purpose of disclosure should be made clear so the person receiving the information (e.g. police) knows the limited purpose to which it can be put.

Principles to consider when taking the step of notifying the police against the person's wishes.

Staff often face real dilemmas when deciding whether to notify police about family violence. There are no firm rules regarding informing police about family violence, however the final decision should consider the following:

1. Safety for the person, public and staff should be the paramount consideration. This also includes risk to children living in the home, recognising the significant co-occurrence of intimate partner violence (IPV) and child physical abuse. The greater the severity and frequency of IPV, the more likely the children are to be victims of physical abuse.
2. If police become involved this may result in further violent acts towards the victim (note victim's fear of retaliation)
3. The individual's relationship with the clinician may be affected if the rights of their rights are felt to be compromised (disclosing the information without consent)
4. Intimate partner violence intervention recognises the following:
    a. The victim is an expert in their own environment and surroundings, s/he may know the reaction a referral to the police would create
    b. The victim is encouraged to take control of the decisions around keeping safe, unless there are immediate issues of safety for either the victim or their children
5. There are no legal requirements to report crimes (e.g. assaults) to the police. However ethically DHB staff have a responsibility to notify police if we suspect any of the following;
    a. Ongoing safety issues, such as further violence to this victim or others if perpetrator remains at large
    b. Injuries that may be life-threatening
6. If there is uncertainty amongst the team about the actions required, team discussion should follow with a consensus being reached on the outcome. Please consult the Clinical Charge Nurse.

ACTIONS

1. Notification to Police due to an individuals safety

In the event staff decide to call the police for reasons of safety for the individual, take the following steps;

1. Advise the person of the need to notify the police and that an ongoing safety plan will be discussed
2. Inform security and Duty Manager (if after-hours) of the concerns regarding safety
3. Ring the Police (111) and advise them of the current situation with information disclosed
4. Refer to the Appropriate Access to Health Information Policy" which is available on intranet under Forms and Templates or attached to this policy
5. On the arrival of the Police to the department, the Police should complete the Consent for the Collection and Release of Information form.
6. Once this form is completed, staff can provide the appropriate and relevant information without concerns regarding breach of privacy. Information shared should be related to the referral to the Police and should include:
    a. The disclosure of abuse, including all relevant history and verbatim statements
    b. The injuries sustained pertinent to their inquires
7. Staff should facilitate the introduction of the Police to the individual and ensure privacy for their ongoing discussions.

2. Notification to Police for staff safety reasons:

1. Advise the individual (abused person) of the need to notify the police and that an ongoing safety plan will be discussed
2. Inform security and Duty Manager (if after-hours) of the concerns regarding safety within department
3. Ring the Police and advise them of the current situation within the department and concerns regarding safety based on assessment and information disclosed as appropriate
4. On the arrival of the Police to the department, provide them with a summary of the issues of safety, as they are known. There is no breach of privacy in the provision of information to the Police if wider safety concerns are identified based on general observations.
5. If the report/information provided to the Police includes information disclosed by a person then complete a Consent for the Collection and Release of Information form.
6. Once this form is completed, staff can provide the appropriate and relevant information without concerns regarding breach of privacy. Information shared should be related to the referral to the Police and can include:
    a. The disclosure of abuse
    a. The injuries sustained as pertinent to their inquires
7. Facilitate the introduction of the Police to the abused person and ensure privacy for their ongoing discussions.

APPENDIX 12 - Guideline for Referral and Follow Up

All identified victims of IPV need to have appropriate referrals made and follow-up planned.

If the person is in imminent danger, or at high risk, the health care provider needs to make sure the appropriate referral and support agencies are contacted during the consultation.

If the person is at moderate risk, or might benefit from early intervention, the health care provider needs to make sure that the person has the information necessary to contact appropriate health, social support or community services.

All victims of IPV need to know that they are not responsible for and do not deserve the violence they have experienced, and need assistance to contact support services and access legal options for protection.

Appropriate follow-up also needs to be undertaken. IPV is a health issue that merits appropriate follow-up in its own right. Additionally, the presence/history of IPV may affect the way in which follow-up is delivered when responding to other health issues. If IPV is currently an issue, safety procedures for re-contacting the person, as well as implications for the person's ability to adhere to treatment regimens for physical and mental health conditions need to be considered.

While follow-up will vary depending on the needs of the individual, the resources and training of the health care provider, and the point at which the person has entered the health system (eg, well-health services, primary or secondary care), at least one follow-up appointment (or referral) with a health care provider, social worker, or IPV advocate should be offered after disclosure.

It may be helpful to ask the person what s/he would like you to do if s/he does not come back for the planned follow-up. For example, does s/he want to establish an alternate follow-up plan, such as having a 'routine reminder' sent to the house with an invitation to make an appointment for 'test results'?

Imminent danger/high risk

a) Referral

- Discuss your concerns with the person, and if at all possible, at the time of consultation, make contact with refuge or other support services, and consider contacting the Police.
- Consider in-patient admission (if a patient). If the person is admitted to hospital, make plans for ensuring safety while on the ward.
- Make sure the person has contact details, and a means of contacting emergency services if required.
- If a person has disclosed recent strangulation (i.e., less than 48 hours ago), they should be provided with the post-strangulation discharge information sheet (see APPENDIX 16).

b) Follow-up

Plan to follow-up with the person at a later date, and/or pass on relevant information for other health care providers to follow-up about their safety later (e.g., if discharged from hospital, ensure their primary care provider knows about and can follow-up on safety issues).

Moderate risk, or persons with ongoing safety concerns

a) Referral

- If possible in your area, make contact *during* the consultation with a refuge or other 24-hour family violence service.
- Suggest the person consider obtaining a protection order through the Family Court. Refuge and other family violence prevention advocates can provide assistance with obtaining such orders.
- Identify an ongoing support system (for example, family, friends who may help).

- Ensure that the person has a list of contact numbers for specialist family violence agencies, and a means of contacting them.
- Provide abused person with information that will help them plan for safely leaving an abusive situation.
- Ensure the person is aware of the legal support available to them, and how to access it.
- If the person feels that it is safe, give them a copy of the safety plan in APPENDIX 11 - . If they don't want to take a copy, talk through the contents of the plan.

b) Follow-up

With any issue that affects health; appropriate follow-up is an important component of overall care. IPV is a health issue that merits appropriate follow-up in its own right. Additionally, the presence / history of IPV may affect the way in which follow-up is delivered when responding to other health issues. If IPV is currently an issue, safety procedures for re-contacting the person, as well as implications for the person's ability to adhere to treatment regimens for physical and mental health conditions need to be considered.

At least one follow-up appointment (or referral) with a health care provider, social worker, or IPV advocate should be offered after disclosure.

Sharing of information between clinicians

Developing and implementing safe and appropriate systems for sharing information about IPV between clinicians (e.g., between hospital-based and primary care and community providers) is important because:

- the information usually has a big impact on health, and healthcare information needs to be shared appropriately
- often the clinician to whom the person has disclosed the sensitive information is not the long-term health care provider, and thus cannot provide ongoing care or support
- failure to share information appropriately has been linked with adverse outcomes (including death).
- individuals need to have a role in determining who information should be shared with. They can best be supported to make these decisions if the health care provider explains to them why the information should be shared and how this might take place.

Examples:

> 'Is it OK if we let your GP, Dr X, know that you have been to see us and what we talked about in relation to your partner's behaviour? That way, your GP will be informed about what is going on for you, and can help you with your health needs better (help you plan for your safety).'
>
> 'It would be helpful for your midwife to know what you have been going through so she can help support you. I can write her a separate note with the referral.'

After disclosure of current or past IPV

At least one follow-up appointment (or referral) with a health care provider, social worker or IPV advocate should be offered after disclosure.

> 'If you like, we can set up a follow-up appointment (or referral) to discuss this further.'
>
> 'Is there a number or address where it is safe to contact you?'
>
> 'Are there days/hours when we can reach you alone?'
>
> 'Is it safe for us to make an appointment reminder call?'

Responding to abused persons at follow-up

At every follow-up visit with people who have previously disclosed being in an abusive relationship:

- Review the medical record and ask about current and past episodes of IPV.
- Communicate concern and assess both safety and coping or survival strategies

  'I see from reviewing your notes that previously you talked to us about what was happening in your relationship at home. How have things been for you since you were here last?'

  'I am concerned about you, and your health and safety.'
- Repeat the routine enquiry questions.
- Repeat the health and risk assessment questions.
- Provide intervention again, based on findings of current health and risk assessment.
- Review the person's options for increasing safety (individual safety planning, talking with friends or family, seeking support from advocacy services and support groups, legal options, transitional/temporary housing, seeking support from Work and Income, etc.).

For current and previous victims of IPV:

- Ensure the person has a connection to a primary care provider.
- Coordinate and monitor an integrated care plan with community-based experts as needed, or other health care specialists, trained social workers or trained mental health care providers.

Co-occurrence of child abuse and IPV

Joint safety planning and referral processes need to be implemented when both IPV and child abuse are identified. It is also important to establish the whereabouts and safety of other child/ren. It may be helpful to contact Child, Youth and Family to ascertain if they have any further information about risk to children in the family. Make use of information obtained during the risk assessment process to identify the most appropriate options to keep the children safe, while enabling the abused parent to get real and appropriate help.

Remember: *when the IPV risk assessment identifies child protection concerns, consultation should occur with a child protection multidisciplinary team.*

Based on the information obtained, health care professionals have three possible referral options (see below, and Flowchart, next page).

Note that:

a) All adults who disclose IPV should be offered referral to specialist family violence support services.
b) Receiving a positive response to IPV routine enquiry does not necessarily require a referral to CYF.

Referral options when intimate partner violence is disclosed and child(ren) are present in the home:

1. <u>Provide the adult with referral information for a specialist family violence support agency</u>
   The intervention selected may be to provide the disclosing adult with information only. The material provided needs to include information about the impact that witnessing IPV can have on children.

   This intervention focuses on empowering the person to contact the services. This can include offering the use of a phone to make contact while the person is in the department/service.

   Follow-up on the outcomes of this intervention can be carried out if and when the person re-presents to the same service, or at another service (eg, when obtaining follow-up health care in the transition from secondary to primary care).

2. <u>Provide the adult with active referral and ensure health care provider follow-up</u>

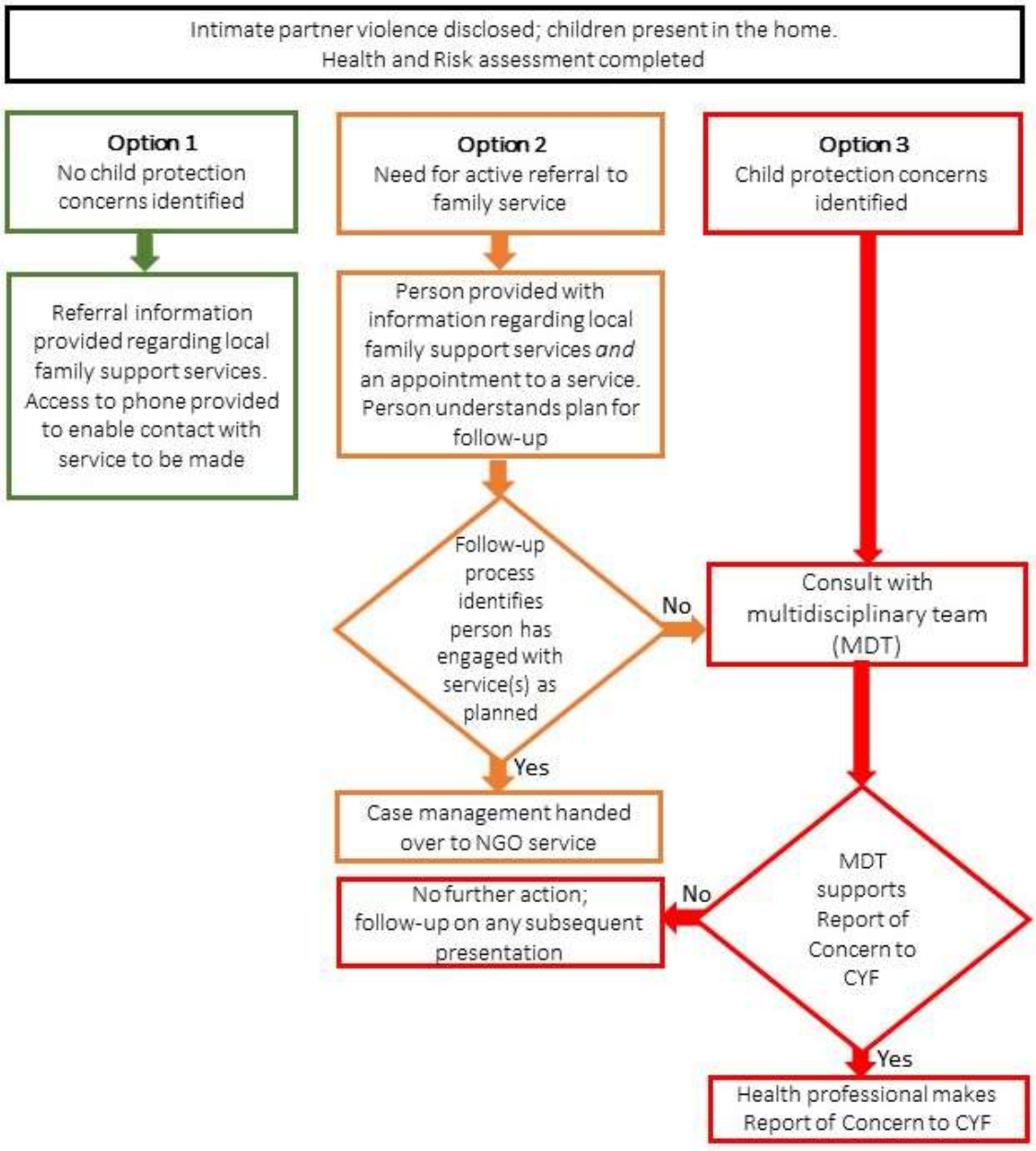
   This intervention requires the health professional to contact an appropriate local family support agency during the episode of care and set a mutually agreed appointment time between the

person and a worker at the family support service. This intervention allows for the adult to take responsibility for engaging with the family support service.

The health professional needs to note the agreed meeting time, and subsequently contact the family support service to confirm that the appointment was attended. In the follow-up process, if it is identified that the person did not engage with services (and no alternative appointment has been made or explanation provided) then the health professional needs to consult with a multidisciplinary child protection team to determine the next course of action. A decision to make a report of concern to CYF may be taken at this time.

3. Statutory intervention
Based on the information disclosed to health care providers and/or members of a child protection multi-disciplinary team, and/or other information they have obtained relevant to the child(ren), the level of risk to children may be such that a report of concern to CYF is indicated. If this is the case, the child protection MDT team will advise on the best process for making this report.

Flowchart: Referral Options When Intimate Partner Violence is Disclosed, and Child(ren) are present in the Home.



APPENDIX 13 - Guidelines for Documentation of Intimate Partner Violence (Step 6)

6.1 Documentation Steps

Record the disclosure on the Intimate Partner Violence Documentation Form. Note the stated or suspected cause of the injuries and when they allegedly occurred. "Assaulted by partner" is not sufficient. A vague history is readily challenged in court and therefore would not help keep a victim safe. Be specific, e.g. "Miss X alleges she was hit with a closed fist/kicked by John Smith".

6.1.1 Record history obtained. Specify aspects you saw and heard, and which were reported or suspected. Use the individual's words as much as possible. Use quotation marks for specific disclosures where appropriate, e.g. "John punched me".
6.1.2 State the identified perpetrator's name and relationship to the person
6.1.3 Mark site(s) of old and new injuries on the body injury map
6.1.4 Describe estimated age of injuries, coloration and measure size
6.1.5 For suspected cases of abuse, record your opinion as to whether the injury is consistent or inconsistent with the person's explanation
6.1.6 Note the action taken by the clinician, referral information offered and follow-up arranged
6.1.7 Include the date, time, a legible signature and designation
6.1.8 Indicate in notes discreetly that IPV has been disclosed. For example, ticking the coded box in the notes
6.1.9 Forward the IPV Identification/Documentation Form to medical records as outlined in Point 5 (Page 6).

6.2 Collection of Physical Evidence

In certain circumstances collection of evidence may be required for legal proceedings
Steps to take in the collection of evidence include:

- Place torn or blood-stained clothing and/or weapons in a sealed envelope or bag (these can be provided by the Police).
- Mark the envelope with the date and time, the person's name, and the name of the person who collected the items. Sign across the seal.
- Keep the envelope in a secure place (e.g., a locked drawer or cupboard) until turned over to the Police. Document in your clinical record the time and date that you handed it over, and to whom the envelope was given.

6.3 Photographs

The use of photographs to document injuries may be appropriate in some circumstances. If photographs with the potential to be used as evidence in legal proceedings are taken then the Digital Photography Procedure (Patient Clinical Images) must be adhered to.

APPENDIX 14 - Safety and Security Guidelines

This guideline sets out the Taranaki District Health Board's (TDHB) procedure's for staff when there is a need to access support to optimise the safety for victims of family violence when the risk to the victim's safety is assessed be a high risk.

Procedures outlined in this policy should be discussed with the patient/client who is the victim of abuse and their consent obtained.

The safety of the person is the paramount consideration. If a victim of abuse expresses fear of the perpetrator or others s/he is likely to be correct. It is defensible in this case for hospital staff to refuse public access to patient details and to facilitate the patient leaving the hospital for a place of safety

1. Procedure to establish name suppression for victims of abuse in the TDHB computer system ensuring persons making public inquires are given no details about the victim.

1.1. The victim of abuse identifies that s/he is concerned that the perpetrator may trace them to the hospital.

1.2. The staff discuss with the victim the potential to place name suppression on the patient's details. The victim consents to this name suppression being actioned.

1.3. The Shift Co-ordinator/Team Leader is informed and s/he directs the Unit Receptionist to place the "No details to be released" flag against the patient details on the patient inquiry screen. Only the Shift Co-ordinator/Team Leader may direct this action.

1.4. The patient's name is replaced with a pseudonym on all patient details boards in the department/ward.

1.5. The following staff are informed of this name suppression being actioned:

1.5.1. Duty Manager
1.5.2. Switchboard staff
1.5.3. Security
1.5.4. All relevant staff within the department. This information transfers if the patient is admitted to a ward

1.6. This directive against the patient details is valid for the duration of the patient's hospital visit or until appropriate personnel remove the directive.

1.7. Complete the name suppression documentation form (available on Intranet under forms and templates or attached to this policy on Intranet).

1.8. The Shift Co-ordinator/Team Leader responsible for the patient's care and/or Duty Manager will remove the name suppression at discharge or when the patient requests this.

2. Procedure for staff to follow when name suppression has been granted.

When any staff member (including switchboard, clinical staff and volunteers) receives an enquiry about a patient for whom a "No details to be released" flag is active s/he will:

2.1 Inform the caller s/he is unable to provide any information

2.2 Ask for the caller's name and write this down (if provided)

2.3 Notify the Shift Co-ordinator/Team Leader responsible for the patient's care

2.4 To notify security (e.g. if the caller is the suspected perpetrator of an assault and police charges are likely).

3. Process used to discharge a victim of abuse in a safe manner from a department or ward setting when there are high-risk safety issues.

3.1. Arrange the discharge plan in consultation with the patient and the discharge agency concerned, e.g. ensure the victim speaks to the agency concerned and that all parties are in agreement with the discharge plan.

3.2. Complete the name suppression process as above if appropriate

3.3. Ensure that the following people are informed of the discharge plan process:

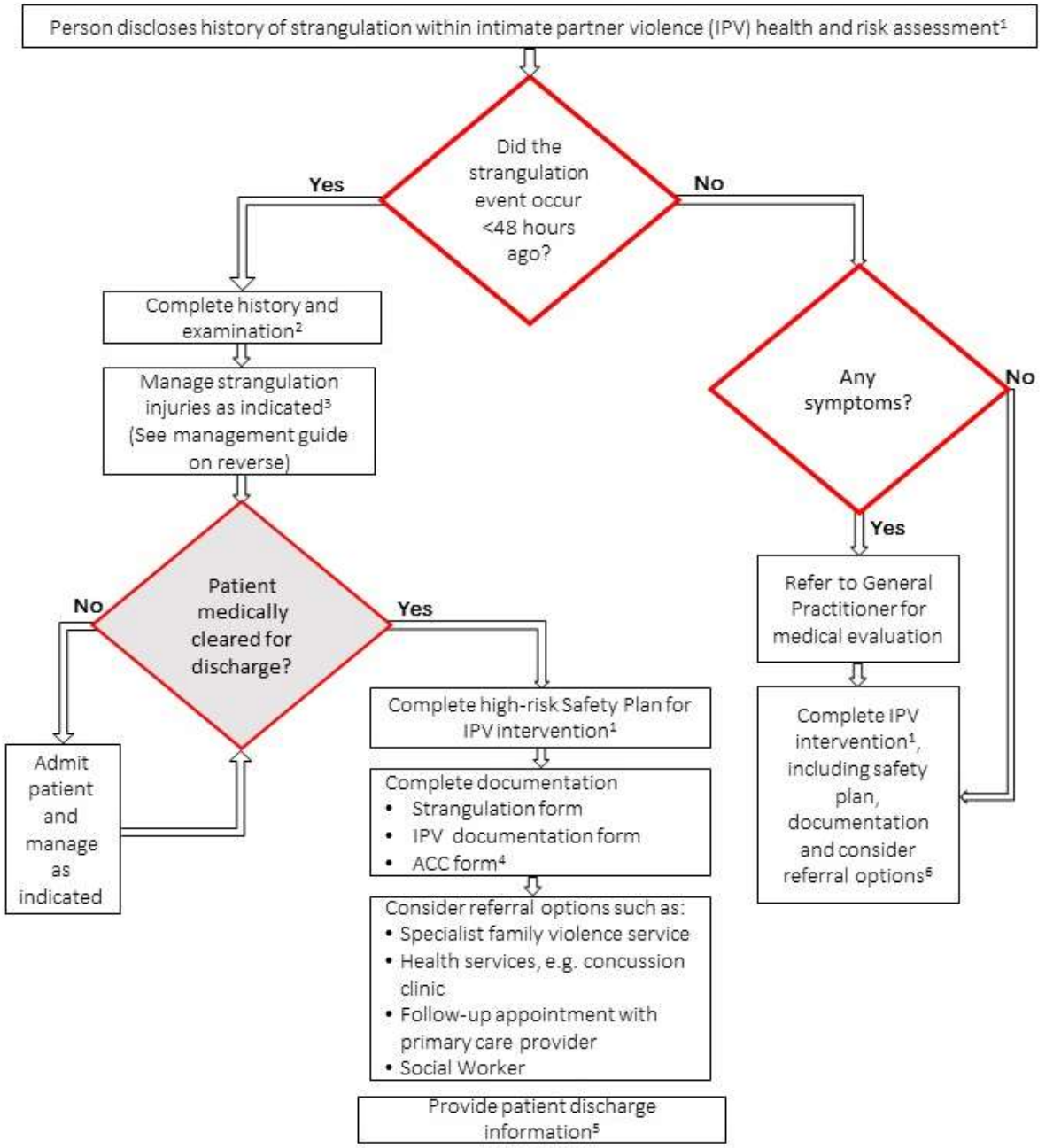
3.3.1. Duty Manager
3.3.2. Security +/- the Police (if risk is considered high by department staff and security)

3.4. The discharge plan may include the leaving the ED / ward or other department by a safe route, in consultation with security staff.

3.5. Document the discharge plan on the Intimate Partner Violence Documentation Form.

3.6. Advise the Duty Manager of the discharge outcome.

APPENDIX 15 - Clinical Guideline: Assessment and Management of Strangulation



Notes

1. Family Violence Assessment and Intervention Guideline (2016) details the intimate partner violence intervention
2. Standardised strangulation documentation form includes items that should be included within assessment and examination
3. Management may be guided by head injury tools such as the Westmead Head injury assessment and management tool
4. Complete ACC form including mechanism of injury/assault and associated health effects. READ code TL32.
5. Discharge information can include strangulation advice sheet, head injury advise sheet, family violence information, ACC form
6. Referral considerations for strangulation event(s) occurring more than 48 hours ago include primary care for neurological assessment, specialist health services, e.g. concussion clinic, specialist family violence services, Whanau ora services.

Acknowledge *Canterbury Health Pathways tool: Physical and sexual assault resource* (Healy, C)

Strangulation (choking) management

Management of strangulation depends upon the mechanism of injury, clinical picture of the patient and time since the strangulation event. The post-strangulation documentation (see Appendix M) form guides clinicians through the processes of care. Be aware that many victims of strangulation have minimal symptoms and signs following the event.

- If patient is alert, orientated, no loss of consciousness, no signs of compromised airways +/- superficial injuries to neck:
  - ensure home support
  - provide post-strangulation information sheet to patients
  - consider referral to primary care for re-evaluation of signs and symptoms that may emerge within 48 hours of the event.

- History of loss of consciousness more than a few hours ago, but is currently clinically stable -
  assess and treat as for any other head injury:
  - ensure home support
  - provide post-strangulation information sheet to patient
  - consider referral to primary care for re-evaluation of signs and symptoms that may emerge within subsequent days.

- Significant neck pain, dysphagia or dysarthria – discuss/manage with emergency department support

- Reduced level of consciousness, confusion or compromised airway – usual emergency care provided and refer to the emergency department for urgent assessment/management

APPENDIX 16 - Strangulation Discharge Information: Discharge Advice to Patients and Their Families and Friends

You or your family member or friend has had a strangulation injury. The doctors and nurses have found no serious injury and think it is safe to go home.

Most people get better after a strangulation injury, but sometimes problems can occur. When people are strangled, the blood vessels, wind pipe and airways can be crushed. Crushing the wind pipe or airways can lead to breathing problems, or brain problems. Our brains need oxygen to work properly, and oxygen is carried to the brain by blood vessels in the neck, so crushing the airways or blood vessels in the neck can lead to a brain injury. This brain injury is a bit like the injury that happens after a concussion, or being knocked out. Serious problems are rare, but can develop after leaving hospital, sometimes days later, so you/ s/he will need to be checked if problems occur.

Serious problems
Return to your doctor or to the hospital or call an ambulance (dial 111) if you or your friends or family notice any of the following:

- sleepy or difficult to wake
- confused (don't know where you are or get things mixed up)
- fits (falling down and shaking)
- bad headache or neck pain not helped by paracetamol (Panadol)
- problems with breathing
- tongue swelling
- vomiting (being sick)
- any weakness or numbness, or problems with balance or walking
- problems with vision, or speaking or understanding speech
- vaginal bleeding (if you are pregnant).

Milder problems

- mild headache
- feeling dizzy, cannot remember things, cannot concentrate for long
- feeling tired, feeling easily annoyed or poor sleep
- bruises (small or pinpoint) on face, neck and body
- small burst blood vessels in the eyes.

These problems usually get better without any treatment, but if you develop new bruises or swelling, or you are worried, see your family doctor (GP) for a check. If the milder problems do not get better after two weeks, see your family doctor.

What you can do to help yourself

Medication and drugs:

- DO take paracetamol (Panadol) for headache. DO take your usual pills.
- DO NOT take sleeping pills unless your doctor says you can.
- DO NOT drink any alcohol until you are better.

Sport: DO start mild exercise when you feel better. DO NOT play any sport where you could injure your head for at least three weeks. DO check with your doctor or coach before playing again.

Work school: DO take a few days off work or school if you have some of the milder problems. DO see your doctor for a check if you need further time off.

Driving: DO NOT drive for at least 24 hours.

Rest: DO have plenty of rest. Eat and drink as usual.

Wellbeing: DO seek counselling if you would like support or if your mood changes.

<u>Your doctor or nurse today will tell you when to see your family doctor (GP) for a check.</u>
<u>Take this sheet and your discharge letter with you to the appointment</u>