

# **Family Violence Assessment and Intervention Guideline**

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Child abuse and intimate  
partner violence

The cover illustration is by Isabella Tupp, aged 7 years.

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# Foreword

The Ministry of Health is pleased to publish this refreshed version of the *Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence*. It contains updated research and practice information to inform health care response to this important issue, and will enhance and support the work of one of the Ministry's flagship programmes, the Violence Intervention Programme.

The Ministry has developed this revised guideline as part of its ongoing programme of work related to family violence. The Ministry is committed to undertaking a population health approach to the problem of family violence. This includes the development of training for health professionals, public education, information systems and public policy that support reduction of family violence. The Ministry's family violence programme started in 2001, when it established the Family Violence Intervention Pilot Programme (FVIPP) to work with selected district health boards (DHBs) to develop responses to victims of family violence. A key platform of the FVIPP was the development of the 2002 Ministry of Health *Family Violence Intervention Guidelines: Child and Partner Abuse*, which was implemented in four pilot DHBs.

In 2007, this programme of work was extended nationally into the Violence Intervention Programme (VIP). The VIP supports the national VIP manager for DHBs and funds family violence intervention coordinators in all DHBs, VIP training contracts to support different health care professional groups (eg, DHBs, primary care, Plunket and Family Planning), national guidelines, resources and a programme of monitoring and evaluation. The VIP recognises intimate partner violence and child abuse as important health issues, because they are significant precursors of a range of poor health outcomes and long-term conditions. The programme seeks to ensure that victims of violence using health services receive support, and that staff are competent to assess and intervene appropriately with people who may be victims of child or partner abuse.

We have learned much about the crucial role that health care providers have in responding to victims of violence since the programme started. The clinical knowledge, health system support and referral source links we have built mean that it is no longer acceptable for us *not* to respond to an issue that is of fundamental importance to the health of New Zealanders. We know we can make a difference, and need to work proactively so that delivery of this programme continues to be robust and well supported.

The Ministry of Health continues to welcome partnerships with other government departments, DHBs, health professionals and professional organisations, non-governmental organisations and communities to reduce violence in New Zealand families.

**Dr Pat Tuohy**  
**Chief Advisor, Child and Youth Health**  
**Ministry of Health**

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The Clinical Guideline: Assessment and Management of Strangulation was developed with an advisory group including Professors Jacquelyn Campbell, Denise Wilson, Jane Koziol-McLain, Nancy Glass, Doctors Kim Yates, Clare Healy and Ms Miranda Ritchie.

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- Dr Faye Clark, primary care trainer in recognition and response to partner abuse for Doctors for Sexual Abuse Care and subject matter expert for the Ministry of Health.

In addition the following individuals reviewed and provided feedback to the original document and / or the 2012 review:

- Delwyn Clement, Vulnerable Infants Programme, Child, Youth and Family
- Alison Eddy, violence prevention training programme for midwives manager, New Zealand College of Midwives
- Claire Gear, Interdisciplinary Trauma Research Unit, AUT University
- Professor Jane Koziol-McLain, Interdisciplinary Trauma Research Unit, AUT University
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# Endorsements

The following organisations have endorsed *Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence*:

- Aotearoa New Zealand Association of Social Workers
- Australasian College for Emergency Medicine (New Zealand Faculty)
- Child, Youth & Family
- College of Emergency Nurses New Zealand
- College of Nurses, Aotearoa (New Zealand), Inc.
- Doctors for Sexual Abuse Care
- Family Planning Association New Zealand
- National Collective of Independent Women's Refuges
- New Zealand College of Midwives
- New Zealand Nurses Organisation
- Nursing Education in the Tertiary Sector
- Pan Pacific Nurses Association, New Zealand
- Paediatric Society of New Zealand
- Office of the Children's Commissioner.

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# Introduction

This Guideline, the *Family Violence Assessment and Intervention Guideline: Child Abuse & Intimate Partner Violence* (2016) replaces the Ministry of Health's 2002 Family Violence Intervention Guidelines: Child and Partner Abuse. The revision has been informed by contemporary international and national research and health guidelines for responding to victims of violence, extensive consultation with the health sector in New Zealand, and practice-based evidence.

The main differences between this document and the 2002 Guidelines include:

- We reframed the document to clarify that the health sector's role in responding to family violence is part of a larger societal repertoire of responses designed to support healthy and nurturing relationships.
- We expanded the introduction to include sections discussing ethics and principles guiding the document, as well as updated information on the prevalence and health consequences of violence across the lifespan.
- We have retained the six-step process for identifying and responding to victims of violence, and woven in an emphasis on safe process and the importance of consultation with senior colleagues when responding to family violence. We have made the following changes to the six steps:
  - The changes made in the child abuse section more strongly reflect the clinical pathway for responding to child abuse that is currently used, and an emphasis on careful assessment and history taking, in the absence of routine enquiry about child abuse.
  - We have changed terms from 'routine screening' to 'routine enquiry' for intimate partner violence. This reflects the international trend to think of this step as part of broader assessment practices, and less as a diagnostic tool.
  - We have improved recommendations on assessments for physical, mental, and sexual and reproductive health, as well as the risk assessment tools.
  - We have expanded and clarified safety planning options, including possibilities for early intervention and high risk situations.
  - We have placed increased emphasis on the importance of planning care transitions (eg, between secondary and primary care settings), and putting clinical follow-up procedures in place.

## **The wider social movement toward prevention of family violence in New Zealand/Aotearoa**

The Ministry of Health's VIP is part of larger social effort to prevent family violence in New Zealand. These efforts have been fuelled by a number of factors, including high-profile instances of children killed by family members, government commissions of inquiry and strong public feeling that we must take action to prevent these tragedies (for a summary see Fanslow 2005; Kelly 2011).

Preventing and reducing family violence is a priority for the Government. Three of the 'Better Public Services' result areas relate to this issue: result area four (Reduce assaults on children), result area seven (Reduce the rates of total crime, violent crime and youth crime) and result area eight (Reduce re-offending). More information on Better Public Services is available at [www.ssc.govt.nz/bps-results-for-nzers](http://www.ssc.govt.nz/bps-results-for-nzers)

Efforts to prevent family violence include: high-level cross-department government support in the form of the Ministerial Group on Family Violence and Sexual Violence (Ministry of Social Development 2015); the Taskforce for Action on Violence within Families (Ministry of Social Development, 2007); and the Taskforce for the Prevention of Sexual and Community Violence (2007–2009) (Ministry of Justice 2009). Cross-ministry collaboration is integral to the programmes of action that include initiatives for the justice sector to increase the safety of victims of domestic violence and better address rates of domestic violence; and a comprehensive, long-term and whole-of-government approach to further reduce family violence and achieve intergenerational change.

The Ministry of Social Development hosts the Campaign for Action on Violence within Families (comprising a national media campaign and community based-action projects ([www.areyouok.org.nz](http://www.areyouok.org.nz)) and the Work and Income Family Violence Intervention project (Work and Income 2011).

The Government's increased emphasis on protecting children is evident through the repeal of Section 59 of the Crimes Act, as well as multiple activities through Child, Youth and Family.

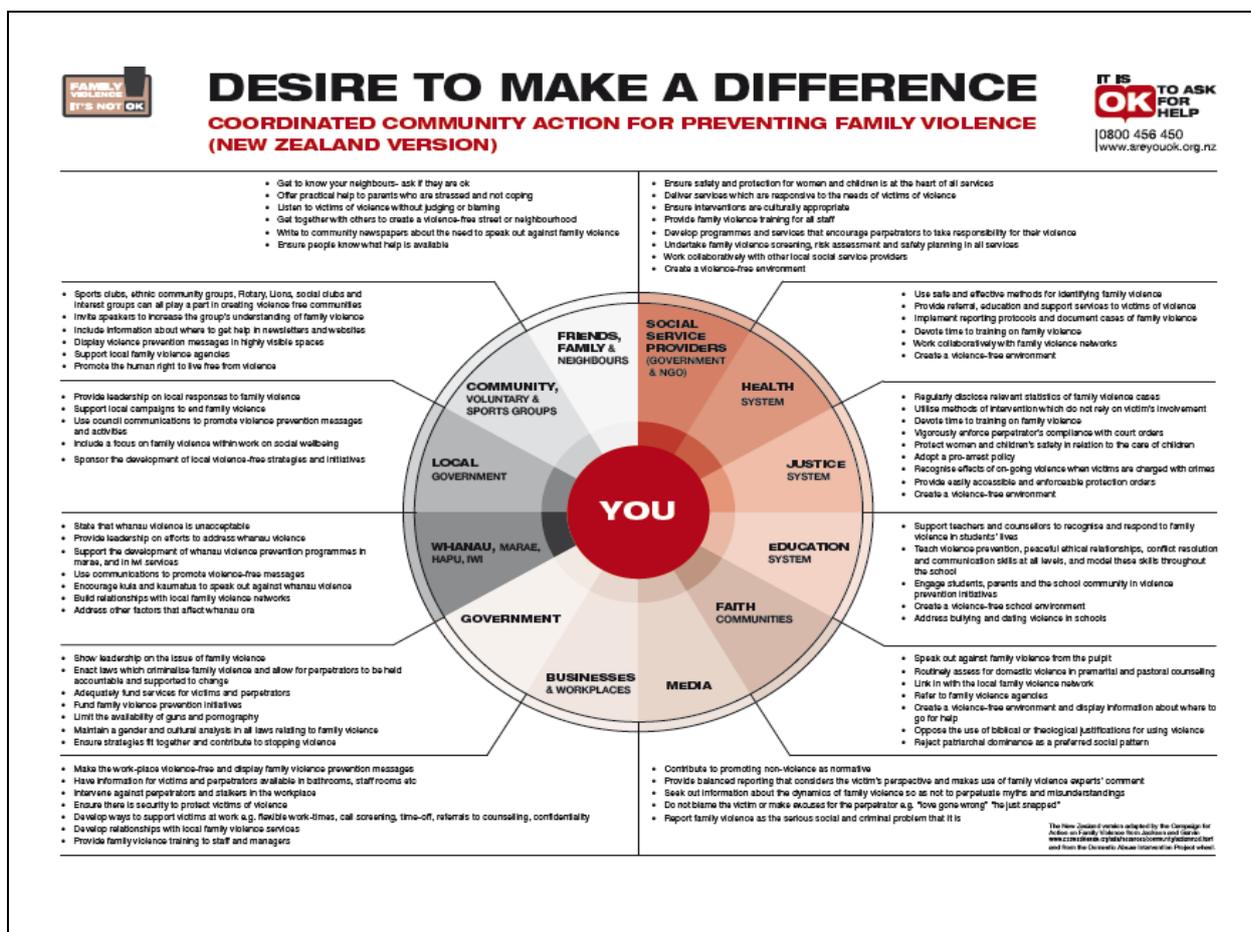
The justice sector has recently taken a strong role in responding to family violence; the Ministry of Justice has established specialist family violence courts, and the New Zealand Police have been granted additional powers in regard to family violence, such as the ability to issue police safety orders.

Cross-agency working is also developing, with key projects such as the Family Violence Interagency Response System (Carswell et al 2010) and the Family Safety Teams (Dixon et al 2006)). The Vulnerable Children's Act 2014 requires that the chief executives of departments of state responsible for child protection, education, health, policing and corrections must work together to develop a 'vulnerable children's plan'. As a result, multiple agencies and local networks are implementing the 'Children's Action Plan', which can bring together information to formulate and deliver the most appropriate wrap-around services for families (<http://childrensactionplan.govt.nz>).

Collectively, these efforts demonstrate a country-wide commitment to responding to family violence.

An important aspect of the national effort has been the recognition that different sectors of society are uniquely placed to respond to family violence. The coordinated community action wheel (Figure 1), illustrates this perspective. In the next section, the rationale and role for the health sector in responding to family violence is described.

**Figure 1: Coordinated community response model**



**The importance of a systems approach**

National and international best practice recommendations and research shows that health care providers need to be supported by ‘whole-of-system’ approaches to improve their responses to victims of violence (Campbell et al 2001; Wills et al 2008). System change approaches are cost-effective methods to increase identification of IPV, and support health care providers by improving their sense of self-efficacy and decreasing their fear of giving offense and of safety concerns (Ritchie et al 2009; Thompson et al 2000). Without organisational changes, there is evidence that health care providers underestimate the prevalence of violence in their practices (Miller et al 2005), or may use ineffective cues (eg, presenting injuries) as the sole basis for identifying victims of abuse (Fanslow et al 1998; Kelly et al 2006). Organisational changes are also necessary if improvements in staff responses to victims of violence are to be maintained (Fanslow et al 1999).

New Zealand is taking a leading role in terms of recognising and implementing a national system change approach for supporting health care providers’ response to victims of IPV and child abuse. The Ministry of Health’s VIP is implemented in DHBs nationally, and there are growing efforts to engage the primary care sector in active responses to family violence. This is consistent with the goal of creating a whole health systems approach to reducing family violence, working across both secondary and primary care.

Evaluation plays an important part in informing programme development and supporting implementation. VIP has been well evaluated, with eight evaluations conducted to date (baseline, 2006, 2007, 2008, 2009, 2011, 2012 and 2013). The evaluations have monitored the implementation of the VIP by looking at important domains of organisational practice (see Table 1, below) using an audit tool at 27 hospitals (20 DHBs). The results of the evaluation demonstrate evidence of programme development over time. Evaluation tools have also been developed for monitoring implementation of the VIP in primary care settings. Findings are available at [www.aut.ac.nz/vipevaluation](http://www.aut.ac.nz/vipevaluation)

**Table 1: Audit tool domains**

<b>Partner abuse and child abuse and neglect programme evaluation audit tools</b>	
Policies and procedures	<ul style="list-style-type: none"> <li>• Policies and procedures outline assessment and treatment of victims; mandate identification and training; and direct sustainability</li> </ul>
Safety and security	<ul style="list-style-type: none"> <li>• Children and young people are assessed for safety, safety risks are identified and security plans implemented [CAN tool only]</li> </ul>
Physical environment	<ul style="list-style-type: none"> <li>• Posters and brochures let patients and visitors know it is okay to talk about and seek help for family violence</li> </ul>
Institutional culture	<ul style="list-style-type: none"> <li>• Family violence is recognised as an important issue for the health organisation</li> </ul>
Training of providers	<ul style="list-style-type: none"> <li>• Staff receive core and refresher training to identify and respond to family violence based on a training plan</li> </ul>
Screening and safety assessment	<ul style="list-style-type: none"> <li>• Standardised screening and safety assessments are performed [PA tool only]</li> </ul>
Documentation	<ul style="list-style-type: none"> <li>• Standardised family violence documentation forms are available</li> </ul>
Intervention services	<ul style="list-style-type: none"> <li>• Checklists guide intervention and access to advocacy services</li> </ul>
Evaluation activities	<ul style="list-style-type: none"> <li>• Activities to monitor programme efficiency and whether goals are achieved</li> </ul>
Collaboration	<ul style="list-style-type: none"> <li>• Internal and independent collaborators are involved across programme processes</li> </ul>

Source: Koziol-McLain and McLean 2014

## **Violence as a health issue**

### **Prevalence and health consequences of violence over the life course**

There is extensive information on the prevalence of violent victimisation in New Zealand in the general population, and among those presenting to health care settings. Reviews summarising this information include: the Family Violence Statistics Report (Families Commission 2009); Lievore and Mayhew (2006); Fanslow (2005), and reports on fatalities resulting from family violence (Family Violence Death Review Committee 2014; Kelly 2011; Martin and Pritchard 2010). The Youth'12 study provides national estimates of the violence experienced by and witnessed by young people.

This section briefly outlines the population prevalence of some types of violence across the lifespan.

## **Violence against children**

- Physical violence
  - Approximately 4 percent (1 in 25) of the general population have experienced harsh or severe physical punishment from one or both parents (Fergusson and Lynskey 1997).
  - Approximately 1 in 5 children have experienced regular physical punishment by their parents (Fergusson and Lynskey 1997).
  - Among contemporary young parents (under the age of 25) in the Christchurch Health and Development Study, 77 percent reported that they had physically punished a child, and 12 percent had severely punished a child in the previous 12 months (Woodward et al 2007).
- Sexual violence
  - Approximately 1 in 4 girls have experienced some form of unwanted sexual touching by the time they are 15 years old (Fanslow et al 2007).
  - Approximately 1 in 16 boys have experienced this form of abuse (Fergusson et al 2000).
- Psychological/emotional abuse and neglect
  - New Zealand has not conducted studies to estimate the population prevalence of psychological/emotional abuse of children, or of child neglect. Some information is presented in the study by Martin, Fielding and Taylor (2010).

## **Violence against adolescents/young people (Clark et al 2013)**

- Physical violence in the previous 12 months
  - 34.1 percent of males and 24.0 percent of females had been deliberately hit or physically harmed.
  - 19.6 percent of males and 9.6 percent of females had been in a serious physical fight.
  - 4.9 percent of males and 2.0 percent of females had carried a weapon.
- Sexual violence ever (lifetime exposure)
  - 9.0 percent of males and 19.5 percent of females had had unwanted sexual contact.
- Witnessing violence in the home in the previous 12 months (most figures show a downward trend)
  - 50 percent had witnessed an adult yelling or swearing at another child.
  - 48.3 percent had witnessed adults yelling or swearing at each other.
  - 13.9 percent had witnessed an adult hitting or physically hurting another child.
  - 7.4 percent had witnessed adults hitting or physically hurting each other (in 2001, this was 5.6%).
  - 14.1 percent had themselves been hit or physically hurt by an adult.

There are no New Zealand community studies of the incidence of physical violence against preverbal children. However, international literature suggests that between 2 and 6 percent of adults in community surveys admit having shaken, smothered or slapped a preverbal child in their household (Reijneveld et al 2004; Theodore et al 2005; Windham et al 2004).

The highest risk of death or serious disability from physical abuse in childhood occurs in the first 12 months of life, often when a baby is shaken or struck in response to their crying (Barr et al 2006).

## **Population-based studies**

- Intimate partner violence
  - Women
    - Overall findings show that 1 in 3 New Zealand women have experienced physical and/or sexual violence by a male intimate partner in their lifetime (Fanslow and Robinson 2004).
    - Approximately 1 in 20 women had experienced physical and/or sexual IPV in the previous 12 months.
    - The prevalence of psychological/emotional violence is higher, and overlaps considerably with the experience of physical and sexual violence (Fanslow and Robinson 2011).
  - Men
    - Data from the New Zealand Crime Victimization Survey indicates that 18 percent of men have experienced IPV in their lifetime, and 6 percent have experienced physical IPV within the previous 12 months (Families Commission 2009).
    - Available data shows violence by women against their male partners tends to be less prevalent and less severe (Lievore and Mayhew 2006).

Studies have identified groups at higher risk of victimisation from IPV, including:

- females (Lievore and Mayhew, 2006; Tjaden and Thoennes 1998)
- Māori (Fanslow et al 2010)
- people with disabilities (Smith 2008)
- gay, lesbian, bisexual and transgender (Balsamet al 2005; Rothman et al 2011).

Health care providers should be aware that knowledge of these high risk groups does not add diagnostic utility when they are providing care to individual clients. Overall prevalence rates of violence are sufficiently high in all groups to justify consideration of violence as a contributor to health problems (VicHealth 2004).

## **Co-occurrence of child abuse and IPV within the same families**

Available evidence indicates that there is substantial overlap between the occurrence of child abuse and IPV in families (Murphy et al 2013), with between 30 and 60 percent of families who report one type of abuse also experiencing the other type of abuse (Edleson 1999). Reviews suggest that lower rates of co-occurrence tend to be found in community samples, while higher rates are often found in samples drawn from families where domestic violence has been identified, or that are involved with child protective services (Mbilinyi et al 2007). In the United Kingdom, 53–69 percent of statutory child protection cases are known to also involve domestic violence (Radford and Hester 2006). Similarly, the likelihood of co-occurrence of child abuse increases as partner violence intensifies. A man who has committed 50 or more acts of violence against his female partner is almost certain to also have been physically abusive to their children. For females who have hit their partners, the association with perpetration of child abuse is less pronounced with 30 percent of chronic female partner abusers likely to have physically abused their children (Ross 1996).

'Co-occurrence' can refer to multiple situations. In a study of 111 battered mothers from four United States metropolitan areas 25 percent of their children were intentionally hurt while trying to stop their mother from being abused; 50 percent of the mothers were hurt by the abuser while trying to stop their children from being abused. In addition to these direct effects, other adverse consequences are possible, as 88 percent of mothers also reported being unable to care for their children in the way they wanted, due to the abuse they were enduring (Mbilinyi et al 2007).

Recognition of the frequent co-occurrence of child abuse and IPV within families means that the issues cannot be addressed in isolation. Increasingly, there are moves to develop interventions that jointly address both issues. In reality, this often means developing interventions that seek to ensure the safety of the children by empowering and supporting the mother to a position of increased safety, and inviting the abuser to take responsibility for the violence he has committed. Initial evaluations of this integrated approach show that it can result in increased safety for both the woman and her child(ren), and reduce the rate of foster care placements for children, allowing them to safely stay with their mothers (Burke 1999). However, it is important to recognise that in high-risk situations, safety planning may need 'to shift from the creation of a list of actions that victims take to empower themselves and keep themselves safe, to generating collective actions that agencies can take to contain, challenge and change the abuser's behaviour' (Family Violence Death Review Committee 2014).

### **Child exposed to violence**

In any 12-month period, 5–10 percent of New Zealand youth observe violence by one adult towards another adult (Clark et al 2013). This causes distress, and can be considered an adverse event in its own right (Carroll-Lind et al 2011). Long-term consequences associated with witnessing violence can include depression, trauma-related symptoms, low self-esteem and substance abuse (McCloskey et al 1995), although Edleson (2004) and others note that there can be individual differences in how children are affected (Edleson 2004), dependent on the extent to which the child was exposed to the abuse, whether the child was directly or indirectly involved in the violence, and the frequency and duration of exposure (Jouriles et al 1987). Protective factors such as positive relationships with the mother or other significant adult can also mitigate problems and support positive outcomes (Sousa et al 2011).

### **Multiple victimisation experiences for individuals across the lifespan**

There are associations between childhood and adult victimisation. Adult females who reported experience of childhood sexual abuse were twice as likely to also have experienced IPV, and three times more likely to have experienced physical or sexual violence by non-partners (Fanslow et al 2007). This increased risk may be created through the multiple behavioural, social and cognitive vulnerabilities that are set in place by victimisation, or may be the result of increased risk associated with generally deprived circumstances. As the result of these associations, health-based queries about violence within relationships may elicit disclosures about violence by strangers or acquaintances. Although not the focus of this Guideline, these too are traumatic events that can have long-term effects on health, and require sensitive and appropriate handling.

## **Violence by non-partners**

Violence is not always perpetrated by family members.

- Physical violence
  - Women: 1 in 7 had experienced physical violence by a non-partner when they were 15 years or older ( Fanslow and Robinson 2004).
  - Men: 5 percent had experienced physical violence by a non-partner in the previous year (Families Commission 2009).
- Sexual violence
  - Women: 1 in 10 experienced sexual victimisation when they were 15 years or older (Fanslow and Robinson 2004).
  - Men: 2 percent had experienced sexual victimisation in the previous year (Families Commission 2009).

## **Developing whole-of-family services/wrap around/integrated and coordinated responses**

The recognition that there can be multiple victims of abuse within the same family, as well as the recognition and of the adverse effects of children witnessing episodes of IPV has led to increased efforts to establish coordinated service delivery for families and whānau experiencing such abuse. In part, these efforts have been driven by the awareness that some of the most in-need families may already be known to one or more services, and that only by sharing information between services can a realistic assessment of risk be established (Carswell et al 2010). There is also the hope that by pooling their separate areas of expertise, agencies can provide the most appropriate services to meet families' needs.

Some of the chief collaborators in these ventures include health, child protective services, police and, in some instances, non-governmental organisations that support adult victims of violence. While there can be value in this shared expertise and collaborative working, there are also risks. These include the risk that the mother will be blamed for 'allowing' children to 'witness' or 'be exposed' to IPV. This can create situations in which there is threatened or actual risk that the children might be removed from non-abusive parents, a threat that the woman may also have heard from an abusive partner. These fears, threatened or actual, can inhibit women from disclosing their experience or their children's experience of violence to outside parties (Potito et al 2009). For these reasons, referral pathways and partnership care models need to be strategically planned and carefully implemented. Health care policies, procedures and referral pathways should be worked out in advance, while maintaining a commitment to working flexibly, in order to respond to the needs of particular persons.

## **Health effects of violence**

Knowledge of the acute and long-term health consequences of violence and trauma continues to increase. A comprehensive summary of the health effects of violence is beyond the scope of this document. However, key findings are summarised in the *World Report on Violence and Health* (Krug et al 2002). The United States Academy of Violence and Abuse 'consequences of lifetime exposure to violence and abuse (COLEVA)' project is developing a website that documents health consequences of violent victimisation across 20 health categories (see [www.coleva.net](http://www.coleva.net)). In addition, the ACE study is a key source of data on the long-term health effects of violence against children (see [www.cdc.gov/violenceprevention/acestudy](http://www.cdc.gov/violenceprevention/acestudy) and Edwards et al 2005). Findings are unequivocal and indicate that the health effects of violent victimisation are far

reaching, including not only injuries but also effecting sexual and reproductive health, mental health and increasing the risk of chronic disease.

Further, there are higher prevalence rates of violent victimisation among those attending health care services compared with individuals in the general population (Koziol-McLain et al 2004; Koziol-McLean et al 2007). Despite this, victims of violence tend to be under-recognised within health care settings (Miller et al 2005). Part of this under-recognition is because of health care provider reluctance to identify violence among their own patients, but also because there are misconceptions that the main health effects of violence are in the form of injuries. An increasing body of evidence makes it clear that violent victimisation can result in chronic as well as acute health problems, and can affect all bodily systems.

Some of these health effects are summarised in the following tables.

**Table 2: Consequences of child abuse**

<b>Consequences of child abuse</b>	
Physical	Abdominal/thoracic injuries Bruises and welts Burns and scalds Disability Fractures Head injuries Lacerations and abrasions Ocular damage Other neurodevelopmental problems*
Sexual and reproductive	Reproductive health problems Sexual dysfunction Sexually transmitted diseases, including HIV/AIDS Unwanted pregnancy
Psychological and behavioural	Alcohol and drug abuse Cognitive impairment Delinquent, violent and other risk-taking behaviour Depression and anxiety Developmental delays Eating and sleep disorders Feelings of shame and guilt Hyperactivity Poor relationships Poor school performance Poor self-esteem Post-traumatic stress disorder Psychosomatic disorders Suicidal behaviour and self-harm
Other longer-term health consequences	Cancer Chronic lung disease Fibromyalgia Irritable bowel syndrome Ischaemic heart disease Liver disease
Other consequences	Reduced educational attainment and annual earnings**

Sources: Krug et al 2002; \*Perry 2002; \*\*Hyman 2000

**Table 3: Health consequences of IPV**

Health consequences of intimate partner violence	
Physical	Abdominal/thoracic injuries Bruises and welts Chronic pain syndromes Chronic disease Disability Fibromyalgia Fractures Gastrointestinal disorders Head injuries Irritable bowel syndrome Lacerations and abrasions Ocular damage Reduced physical functioning
Sexual and reproductive	Gynaecological disorders Infertility Pelvic inflammatory disease Pregnancy complications/miscarriage Sexual dysfunction Sexually transmitted diseases, including HIV/AIDS Unsafe abortion Unwanted pregnancy
Psychological and behavioural	Alcohol and drug abuse Depression and anxiety Eating and sleep disorders Feelings of shame and guilt Phobias and panic disorder Physical inactivity Poor self-esteem Post-traumatic stress disorder Psychosomatic disorders Smoking Suicidal behaviour and self-harm
Other consequences	Reduced ability to obtain and retain paid employment**

Source: Krug et al 2002;\*\*Riger et al 2004; Browne et al 1999

## Pathways for health consequences

While any experience of violence can lead to immediate physical and mental health consequences, family violence can also have long-term health consequences. Violence occurring in families can, and often does, occur repeatedly over time, and is likely to involve multiple types of violence (ie, with combinations of physical, sexual and psychological violence co-occurring). These experiences are detrimental to health at all stages of the life course.

Research investigating the health effects of violence has identified a variety of mechanisms by which exposures to adverse situations increase short- and long-term health risks. Mercy and Saul note that 'chronic exposure to stress can accumulate and lead to potentially irreversible changes in the interrelated brain circuits and hormonal systems that regulate stress' (eg, sympathetic-adrenomedullary system hypothalamic-pituitary-adrenocortical system) (Center on the Developing Child at Harvard University 2007; Mercy and Saul 2009; Shonkoff and Phillips 2000; Repetti et al 2002). These exposures also increase the risk of engaging in health risk behaviours such as smoking, substance abuse, overeating and unsafe sexual behaviours, which in turn are associated with a variety of long-term adverse health outcomes. Exposure to these adversities might also contribute to poor health by compromising the development of skills that influence income and socioeconomic status (Repetti et al 2002).

Kendall-Tackett (2013) describes behavioural, social, cognitive and emotional pathways that may explain some of the mechanisms by which adverse health problems are more likely for abuse victims. She reports that (Kendall-Tackett 2013):

**Behavioural pathways** are the most direct, and are clearly linked to the fact that adult survivors of child maltreatment are more likely to engage in harmful activities than non-victims. Some of these behaviours include substance abuse, disordered eating behaviours, high-risk sexual behaviour (eg, higher incidence of unprotected sex or multiple sexual partners), suicide attempts and ideation, smoking and sleep difficulties.

**Social pathways** to ill-health include a variety of relationship difficulties, such as social isolation and poor social connections, re-victimisation and homelessness. Some of these disruptions to social connections may result from the fact that abuse victims are more likely to adopt dysfunctional interpersonal styles (eg, avoidant or intrusive).

**Cognitive pathways** to ill-health include adoption of 'internal working models' that represent the world as a dangerous place, and leave the survivors with high levels of anxiety, paranoia, hostility and lack of trust. Survivors of child abuse also have poor self-rated health, which is in itself a predictor of illness and mortality.

**Emotional pathways** to ill-health also occur through some of the two most commonly reported symptoms of past abuse: depression and post-traumatic stress disorder. Not only is depression more common among abuse survivors, but depression itself can have severe and dramatic effects on health, including immuno-suppression, failure to engage in health-promoting activity, negative impacts on sleep and increased risk of coronary heart disease.

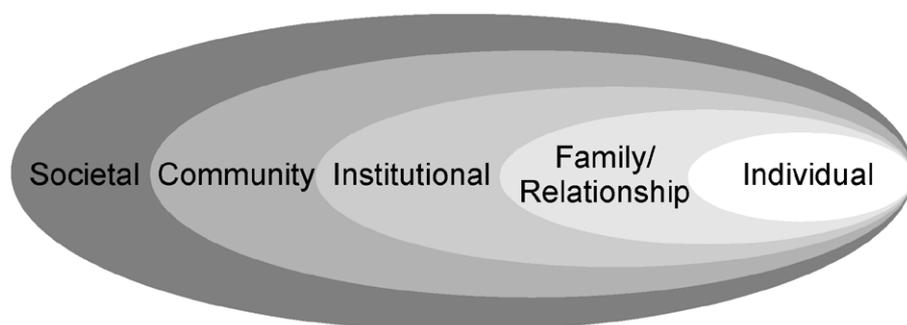
These pathways can function individually or in combination. Understanding these pathways, however, increases the likelihood that clinicians can work to improve health outcomes for survivors. Identifying those individuals who have experienced abuse can provide important contextual information, so that clinicians can assess the most appropriate treatment and referral options. As Kendall-Tackett (2002) points out:

Admonitions to abstain from smoking or substance abuse are unlikely to be successful until the traumatic events driving these behaviours has been addressed and resolved. Admonitions to exercise are unlikely to be effective if the patient believes that nothing he/she does will make a difference. And telling someone to 'lose weight' may be setting an individual up for further failure if she/he has limited ability to make and keep friends, and eats when lonely or stressed (Kendall-Tackett 2002).

# A population health/ecological model of family violence

Family violence is a population health issue that occurs globally, and is not limited to any one gender, religious, cultural or income group. A wide range of studies agree that the causes of violence are multi-factorial, and that the co-occurrence of factors may increase the likelihood that a person will abuse a family member. New Zealand and international research and scholarship indicates that we need to consider risk and protective factors, and intervene at multiple levels (individual to societal) and in multiple sectors (eg, health, justice and education) in order to be effective in reducing family violence. For a more detailed discussion of these issues (see Fanslow 2005 and Krug et al 2002). By combining individual-level risk factors with findings of cross-cultural studies a population health or ecological model has been developed that contributes to understanding why some societies and some individuals are more violent than others.

**Figure 2: Ecological model**



## Dynamics of child abuse

The causes of child abuse are complex and multi-faceted and there is a vast and conflicting literature on 'risk factors' and risk prediction.

Causes of neglect are also acknowledged to be complex and multi-faceted. Neglect can be described on a continuum of episodic, reactive or chronic:

- 'Episodic neglect' is typically a one-off, occasional or infrequent incident.
- 'Reactive neglect' generally occurs in response to a new stressor.
- 'Chronic neglect' refers to persistent low-level care, or repeated failure to meet a child's needs, or to protect the child from harm.

It may include structural factors; poverty, homelessness and unemployment and other factors such as family and domestic violence, age and maturity of parent, mental health status, impaired intellectual functioning, alcohol and drug abuse, gambling, poor parenting patterns and lack of social support (Department for Child Protection 2008).

## Dynamics of violence between partners

All relationships are dynamic and influenced by multiple factors, including the individual characteristics of the partners, their histories (individual and shared), their current circumstances, their relationships with others, and the community and society they live in. Violent relationships are also influenced by factors across these ecological levels, and over time (For further discussion of the influence of ecological levels on violence issues see Fanslow 2005, Heise 1998 and Krug et al 2002). The dynamics of violence in relationships may be influenced by factors associated with the perpetrator (see, for example Holtzworth-Munroe and Stuart 1994). The victim's response to the violence is also complex, and can include cognitive and emotional factors, as well as being influenced by practical issues (eg, finance housing) (Roehl et al 2005).

It has also been suggested that the dynamics of the relationship may also affect the pattern and likelihood of re-occurrence of the violence (Johnson 2008). Other researchers have described changing cycles of perpetrator behaviour over time (Walker 1979) and processes or stages that victims may go through when seeking to extricate themselves from violent relationships (Landenberger 1989).

Further understanding of these levels of complexity can assist health care providers to understand why presenting dichotomous options to victims (eg, leave/don't leave the relationship) is an oversimplified solution to a complex issue (Hamby and Gray-Little 2007). The alternative response, and the one recommended in this Guideline, is for health care providers to undertake to actively identify the person's experiences of violence, and work with them to assess their risk and inform about options for further support. In this way, health care providers can respect the person's autonomy, while fulfilling their duty of care.

## The role of the health care sector in responding to violence: purpose, rationale and ethical basis for this guideline

It is widely recognised in Aotearoa/New Zealand that health is a holistic concept. The Māori model of health, Te Whare Tapa Whā, compares health to 'the four walls of a house, all four being necessary to ensure strength and symmetry, each wall representing a different dimension of health – taha wairua, taha tinana, taha hinengaro and taha whānau' (Durie 1994). These dimensions are interdependent, and assessing the person across all taha can facilitate the development of a comprehensive treatment plan. Holistic understandings of health are shared internationally.

	Taha wairua	Taha hinengaro	Taha tinana	Taha whānau
Focus	Spiritual	Mental	Physical	Extended family
Key aspects	The capacity for faith and wider communion	The capacity to communicate, think and feel	The capacity for physical growth and development	The capacity to belong, care and share
Themes	Health is related to unseen and unspoken energies	Mind and body are inseparable	Good physical health is necessary for optimal development	Individuals are part of a wider social system

Each of these capacities is diminished by the experience of abuse and violence. Early identification and intervention is important to minimise damage to all aspects of health as a result of abuse. More importantly, working to foster safe, stable and nurturing relationships between adults and children, and healthy and respectful relationships between intimate partners are fundamental aspects of supporting health. Whānau Ora is one model of many approaches to health from a Te Ao Māori perspective, and can be used as a tool to support the health system, and health professionals to address the impacts of family violence in a holistic, interdependent way. It seeks to empower whānau as a whole, rather than focusing separately on individual whānau members and their problems (Whānau Ora TaskForce [www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/whanau-ora/](http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/initiatives/whanau-ora/)).

## **Health care providers and healthy relationships**

The Te Whare Tapa Whā model makes it clear that interpersonal relationships, and the quality of these relationships, are fundamental to achieving health. The United States Centers for Disease Control and Prevention has identified the importance of fostering safe, stable and nurturing relationships throughout the life course as a key health priority (Centers for Disease Control and Prevention 2011). The extensive evidence base documenting the adverse health effects of violent and abusive relationships illustrates how poor relationships can be detrimental to health.

As with other issues (eg, eating patterns, physical activity) that have profound impacts on health, health care providers have a responsibility to consider the role that relationships play in the health of their patients. Victims of abuse seek care from health care providers far more frequently, and for a wide range of health problems, compared with individuals who have not experienced abuse. As a result, health care providers are ideally positioned to foster understanding about the connection between health and relationships, as they come into contact with the majority of the population seeking routine health care, for themselves or their children. In addition, health care providers have ethical responsibilities to assist in early intervention and provide acute intervention for violent and abusive relationships. As with other health care issues, health care providers have a continuum of options for their responses to relationship issues. For example:

1. If health care providers observe safe, stable and nurturing relationships between adults and children, and healthy/respectful relationships between adults, they can reinforce these through positive responses.
2. If health care providers identify risk factors or problematic relationships, they can emphasise the importance of positive relationships on health, provide information and/or refer people to additional sources of help (early intervention).
3. Health care providers can provide acute or crisis intervention for those at high risk.
4. Health care providers can ensure that there is appropriate follow-up care for those with identified problems, either within health care services, or through transfer of information/referral to those involved with the person's ongoing health care.

# Ethical principles that underpin health care practice

The fundamental ethical principles which underpin all health care practice are relevant when guiding responses to violence and abuse.

**Beneficence:** To do good. Defined as going beyond simply addressing the physical injury or disease of patients, and considering the psychological, social, spiritual dimensions of health. Knowing the prevalence of family violence, and its impact on health, but not responding to this knowledge by considering or enquiring about it in health consultations would violate the principle of beneficence (Council on Ethical and Judicial Affairs and American Medical Association 1992).

**Non-maleficance:** To do no harm. Failing to recognise family violence when it exists may lead to inappropriate or harmful treatment (eg, pain medications or tranquilisers that may be contraindicated because they can lead to increased risk of suicide or drug or alcohol abuse, or may hamper alertness, which can result in increased vulnerability to assault). Failing to respond to family violence may also contribute to victim's sense of entrapment and powerlessness (Council on Ethical and Judicial Affairs and American Medical Association 1992).

**Justice:** Fostering conditions that are necessary for individuals to develop self-respect, and creating institutions that enable the development and exercise of individuals' capacities. This principle emphasises the importance of health care provider enquiry about, and effective response to family violence, as an important facet of supporting an abused individual's authority and ability to effect change. In this analysis, doing nothing can reinforce a patient's feelings of humiliation and can compound damage to their sense of self-worth, while supporting the abuser's privilege and dominance (Jecker 1993).

**Autonomy:** Supporting the autonomy and dignity of patients is fundamental to ethical medical practice. Tauber (2005) notes that this ethic of care is best achieved 'when facts and values are integrated and humane values are deliberately included in the program of care' (Tauber 2005). The principles of beneficence and health care provider responsibility are central to creating conditions for ethical practice.

## Important considerations when developing responses to children

**Rights of children:** The United Nations Convention on the Rights of the Child, to which New Zealand is a signatory, outlines the fundamental rights to which all children are entitled, including the right to be supported and nurtured and the right to live free from violence and abuse (see [www.unicef.org/crc](http://www.unicef.org/crc)).

**The paramountcy principle:** This states that the welfare of children is at all times paramount, and overrides all other considerations. 'The welfare and interests of the child or young person shall be the first and paramount consideration' (Section 6 of the Children, Young Persons, and their Families Act 1989). Decisions need to be made with the child's best interests in mind, including consideration of the child's physical and emotional needs.

# Evidence of effectiveness

This Guideline makes use of the most robust evidence available at the time of writing, and includes use of clinical expertise where research data is not available.

There have been increasing efforts to assess the effectiveness of health care provider interventions with family violence. Most of these studies have been in the area of responding to intimate partner violence. Establishing a definitive pathway of evidence remains challenging, as what constitutes appropriate outcomes are still under debate (eg, more proactive responses to victims by health care providers? Increased safety of victims?). Further, any pathways for improvement are likely to involve multiple steps and actions, some of which will be under the control of health care providers and health care systems, and some of which will be reliant on other individuals (eg, the perpetrator of violence) and other systems (eg, justice or social welfare). For these reasons, as well as the methodological and ethical challenges associated with evaluating effectiveness of interventions for victims of violence (see O'Campo et al 2011; Spangaro et al 2009), definitive answers on the effectiveness of health care interventions may not be established for some time.

However, some findings have been well established. Systematic reviews and individual studies have documented that there are a number of short, reliable and easily administered tools that can improve the detection of intimate partner violence (see, eg, Ernst et al 2004; Federet al 2009; Sohal et al 2007; Wathen and MacMillan 2003). Women find being questioned about their experience of IPV in health care settings to be both acceptable and appropriate (Feder et al 2009; Koziol-McLain et al 2008; MacMillan et al 2009). These reviews also note that while health care providers report barriers to screening for IPV, there is increasing evidence that these barriers can be overcome with appropriate institutional support and training. However, Feder et al (2009) also noted that there was a discrepancy between health care providers' and women's views of the purpose of screening for IPV, with health care providers regarded 'screening' as a procedure for obtaining disclosure, which can be followed with appropriate care, while women see questioning about IPV as a means of raising awareness about abuse (Feder et al 2009). The United States Institute of Medicine has recommended 'screening and counselling for interpersonal and domestic violence. Screening and counselling involve elicitation of information from women and adolescents about current and past violence and abuse in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems' (Institute of Medicine 2011).

The World Health Organization (WHO) (2013) recommended that routine enquiry about IPV should not be implemented, however, they noted that the strength of this recommendation was 'conditional'. Key concerns raised were that, in many settings, there are insufficient resources available to respond to women who identify that they have experienced IPV, and the women find repeated enquiry difficult if no action is taken (WHO 2013). However, given the efforts that have been made in New Zealand to establish appropriate referral options, and the health and ethical imperatives to respond to victims of IPV, routine enquiry about IPV among women is recommended in the current Guideline.

Promising strategies are being assessed. Taft et al (2009) are trialling the implementation of a model combining social support, advocacy and non-professional mentoring to see if this can reduce levels of violence and associated mental health damage as well as improving women's health, safety and connection with her children (Taft et al 2009). McFarlane et al (2006) have reported that routine abuse assessment and referral have the potential to improve the behavioural functioning of children exposed to domestic violence (McFarlane et al 2006). Some carefully structured and supervised home-visiting programmes have been shown to have an effect in reducing child maltreatment (eg, Fergusson et al 2005; Goodman 2006), as have some parenting programmes (eg, Prinz et al 2009).

Dubowitz et al (2009) reported on the evaluation of a paediatric primary care model to help prevent child maltreatment. Model care, consisted of (1) resident physicians who received special training; (2) administration of the Parent Screening Questionnaire and (3) the availability of a social worker (Dubowitz et al 2009). Risk factors for child maltreatment were identified and addressed by the resident physician and/or social worker and compared to standard care, involving routine paediatric primary care. Model care resulted in significantly lower rates of child maltreatment on all outcome measures: fewer child protective services reports, fewer instances of possible medical neglect being documented as treatment non-adherence, fewer children with delayed immunisations, and less harsh punishment reported by parents. Dias et al have reported on the effectiveness of strategies to help caregivers cope with a crying baby and reduce the risk of 'shaken baby syndrome' (Altman et al 2011; Barr et al 2009; Dias et al 2005). Such promising interventions have the potential to be more widely implemented in future.

## Conclusion

The prevalence and health impacts of family violence are considerable. New Zealand is committed to ensuring that health care providers are well supported to work with other government departments and community agencies in creating a healthier, happier future for families in Aotearoa.

# Prerequisites for assessing and intervening with family violence

Prior to instituting family violence assessment and intervention in health care settings, a whole of system approach is required that includes:

- **governance and leadership** (eg, a steering group) including high-level management support and dedicated funding
- **programme coordination and development/support of programme champions:** positions should be dedicated specifically for family violence work, and sustainably funded
- **collaboration** with the community and referral agencies and other health care settings (supporting information sharing and safe care transitions, supported by memoranda of understanding)
- **policy and procedures** regarding assessment and treatment of (suspected) victims of violence, aligned to best practice guidelines
- **organisational policies and procedures** supporting consultation with senior colleagues and/or other agencies (eg, Child, Youth and Family (CYF)) throughout the process, including debriefing, as well as specifying procedures for what to do if confronted by someone who is violent/aggressive

- **clarity of roles and responsibilities within immediate clinical teams and wider health network**, for example, are all staff to be trained in assessment and intervention procedures and responses? Are some staff primarily responsible for the initial intervention and other staff to take lead responsibility for working with the client to develop an intervention plan? How will relevant communication be shared between team members so the client does not have to repeat their story multiple times? When, how, and with whom should staff consult?
- **availability of resources**, for example, cue cards, risk assessment guides, model safety plans, documentation forms and referral brochures, and other forms as required
- **referral pathways**: how will referrals to internal or external sources of help and support occur? What happens when patient's present outside of normal working hours or on weekends?
- **education** including a formal training plan for family violence education for clinical and non-clinical staff aligned to the organisational policies for family violence. The training plan should include the provision of ongoing training (eg, core, in-service and refresher training) and; training should only delivered after the systems supports have been established, eg, 'train last'
- **evaluation and monitoring** including quality improvement tools should be aligned to the organisational policies, to support planning and to identify and inform programme refinements
- **cultural responsiveness and Whānau Ora** supporting culturally responsive family violence intervention practices and whānau wellbeing (Gear et al 2011)
- **provisions for the safety of practitioners and allied staff**: considerations include ability to respond to staff's personal experiences of family violence, as well as options for maintaining safety with perpetrators of violence.

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# Māori

## Introduction

This section of the guideline sets out principles for action to effectively support Māori adults and children experiencing violence within their whānau (immediate and extended families).

There are many things health professionals can do in their day-to-day practice to ensure that they are providing the best possible service to Māori.

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 (Ministry of Health 2014b).

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.

## He Korowai Oranga

He Korowai Oranga: Māori Health Strategy sets the overarching framework to guide the Government and the health and disability sector to achieve the best health outcomes for Māori (Ministry of Health 2014b).

The overall aim of *He Korowai Oranga* is pae ora – healthy futures for Māori. Pae ora provides a platform for Māori to live with good health and wellbeing in an environment that supports a good quality of life and includes three interrelated elements:

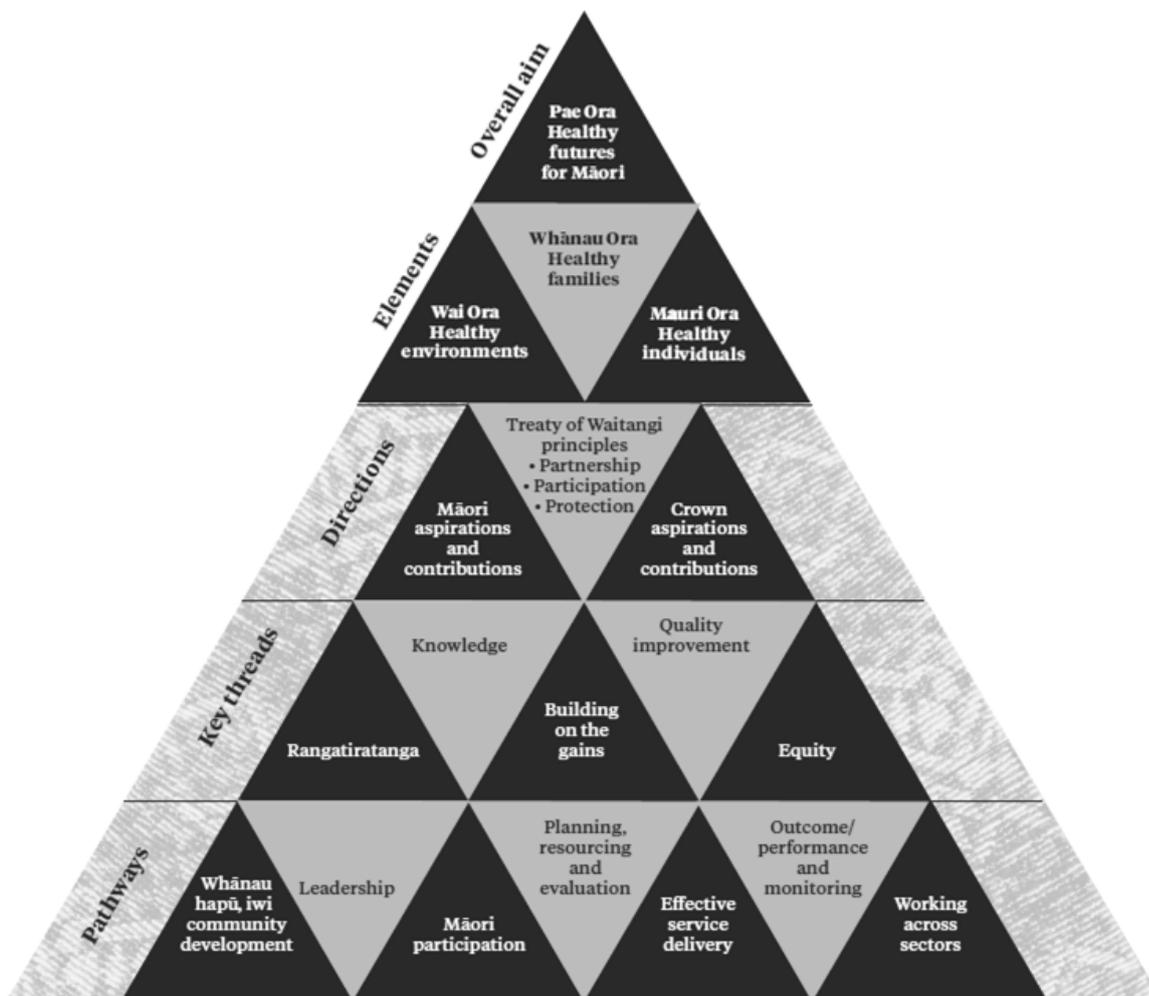
- mauri ora – healthy individuals
- whānau ora – healthy families
- wai ora – healthy environments.

Implementing *He Korowai Oranga* is the collective responsibility of the whole health and disability sector, notwithstanding the implications for and application to other sectors.

*He Korowai Oranga* includes four integrated pathways for action:

- Te Ara Tuatahi – Pathway 1: Development of whānau, hapū, iwi and Māori communities
- Te Ara Tuarua – Pathway 2: Māori participation in the health and disability sector
- Te Ara Tuatoru – Pathway 3: Effective health and disability services
- Te Ara Tuawhā – Pathway 4: Working across sectors.

**Figure 3: The conceptual framework of He Korowai Oranga**



## Whānau Ora

The concept of whānau ora is about supporting Māori families to achieve their maximum health and wellbeing (Ministry of Health 2014c).

*Whānau ora* is driven by a focus on whānau being self-managing, living healthy lifestyles and confidently participating in te ao Māori and in society (Ministry of Health 2014c).

When operating at its best, a whānau supports and nurtures its members. Elders are honoured, women are held as sacred and children are treasured. Whānau members take responsibility for their collective health and wellbeing, and work together to meet their aspirations. The whānau is a source of identity and strength, and tikanga (customs and values) and this is passed from generation to generation (Durie 2001).

Whānau (extended families) are the basic social unit and foundation of Māori society and may include kuia and koroua (elders), matua and whaea (parents, aunts and uncles), rangatahi and tamariki (young people and children). While traditionally, whānau comprised relatives connected by whakapapa (genealogy), modern-day whānau may also include members who do not share common descent (Durie 2001). Each whānau and each individual will define for themselves who their whānau is (Ministry of Health 2002).

The Whānau Ora Tool (Ministry of Health 2008) is a practical guide that can support health services to engage with and support Māori in a culturally competent way, and design programmes that are effective for Māori.

## **Keeping whānau safe and encouraging them to thrive**

As in all cultures, many Māori families are thriving, while others are considerably less resilient. Where violence exists within whānau, action needs to be taken to protect those who are at risk of harm.

Health professionals, whānau, hapū, iwi and local community organisations all have a role to play in ensuring the safety and protection of victims of violence, and in helping to build whānau strength and resilience.

## **What do we know about violence within whānau?**

Violence within whānau was not the norm and was not tolerated in traditional Māori society (Pihama et al 2003).

Tamariki were treated as future leaders, and symbolised a link with tupuna (ancestors). They were cared for by the wider whānau, and men played a significant role in raising the next generation (Taonui 2011). This is evident in early observations of Maori.

The father, or uncle, often carried or nursed his infant on his back for hours at a time ...  
(William Colenso 1868 (Pihama et al 2003))

The whānau dealt with incidences of violence against women and children swiftly, to restore whānau relationships. Violence and abuse were also considered to negatively impact the mana (integrity/prestige) and wellbeing of individuals and the whānau as a whole (Pihama et al 2003):

Our histories speak of people acting with mana in their response to violence and abuse – of whānau and hapū moving in to support their women. Our histories speak of the great lengths to which violators would go to restore their mana – mana diminished through their actions ... (Jenkins et al 2002)

In Aotearoa/New Zealand today, violence within families is an issue experienced across all ethnicities (The Ministry of Social Development Te Manatu – Whakahiato Ora 2002) Māori, however, are now significantly overrepresented both as victims and perpetrators of family violence (Lievore and Mayhew 2006), and violence within whānau has been described as 'entrenched and intergenerational' (Te Puni Kōkiri 2008).

Several factors have contributed to the occurrence of violence with whānau, such as disproportionate exposure to socioeconomic pressures and family problems in childhood (Marie et al 2008). Historical impacts of the changes to New Zealand society since the 19th century have had a significant impact on whānau relationships (Pihama et al 2003). Loss of land and urbanisation distanced many Māori whānau from the support of their extended whānau, hapū and iwi, and Māori knowledge and values became fragmented.

This meant that traditional sanctions against violence in whānau were lost, and what happened in the home became increasingly thought of as 'private business'.

Ngā hiahia kia titiro ki te timata, ā, ka kite ai tātou te mutunga: You must understand the beginning if you wish to see the end (Jackson 1988)

# Responding effectively to violence within whānau

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 (Te Puni Kōkiri 2010). 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 whānau (Durie 2001). The key is to 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

*Equity of Health Care for Māori: A framework* (Ministry of Health 2014a) is a guiding document for health practitioners, health organisations and the health system to achieve equitable health care for Māori.

The 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. The Government is committed to these principles.

Partnership – working together with iwi, hapū, whānau and Māori communities to develop strategies and services to improve Māori health and wellbeing.

Participation – involving Māori at all levels of decision-making, planning, development and service delivery.

Protection – working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

Building on the principles of the Treaty of Waitangi, are 12 kaupapa (Te Wānanga-o-Raukawa nd), 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), Papatūānuku (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 in to 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. They should also be aware of their own culture, values and beliefs, and how they may affect the care they provide. This resource and the associated user guide, which demonstrate how these kaupapa can be incorporated within a health setting encourages professional development. They are available online, see: [www.health.govt.nz/publication/increasing-violence-intervention-programme-vip-programmes-responsiveness-maori](http://www.health.govt.nz/publication/increasing-violence-intervention-programme-vip-programmes-responsiveness-maori)

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# Pacific peoples

## Introduction

This section draws on Nga Vaka o Kāiāga 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. It is informed by, and aligned with, seven ethnic-specific conceptual reports on addressing family violence (Ministry of Social Development Taskforce for Action on Violence within Families 2012a; 2012b; 2012c; 2012e; 2012f; 2012g; 2012h), and a literature review.

Nga Vaka o Kāiāga 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.

For the purpose of this document, this section summarises context around family violence for Pacific peoples as described in greater detail in the Nga Vaka o Kāiāga Tapu, to enable those who work in the health sector to have an understanding of the complex issues that underpin family violence for Pacific people. In addition, this section outlines principles for action to ensure services provided by health care practitioners and providers are culturally appropriate and safe.

## What family violence means in a Pacific context

### Violence and violations

Violence was defined by the working group for Nga Vaka o Kāiāga Tapu as violations of *tapu* (forbidden and divine sacredness) of victims, perpetrators and their families. Violence ‘threatens family stability, and shatters and tears down all that holds the family together’ (Ministry of Social Development Taskforce for Action on Violence within Families 2012h) with devastating impact on the wellbeing of victim(s), perpetrator(s) and their families, ‘leading to volatile families’ (Ministry of Social Development Taskforce for Action on Violence within Families 2012f; 2012h).

Violence disconnects victims and perpetrators from the continuum of wellbeing, and transgresses the *tapu* (Ministry of Social Development Taskforce for Action on Violence within Families 2012g). It is an ‘aberration of wellbeing’ (Ministry of Social Development Taskforce for Action on Violence within Families 2012c) and a disruption of the balance and harmony of relationships of wellbeing (Ministry of Social Development Taskforce for Action on Violence within Families 2012e; 2012f). ‘The offence of violence is that it violates the boundary of relationships through disrespect, of which an outcome is physical and emotional harm’ (Ministry of Social Development Taskforce for Action on Violence within Families 2012b).

## **Risk factors for family violence amongst Pacific people**

Nga Vaka o Kāiāga Tapu (Ministry of Social Development Taskforce for Action on Violence within Families 2012a) outlined 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. Education should be the responsibility of both practitioners and the communities. One element of the educative process is to find appropriate alternatives to violence.

Nga Vaka o Kāiāga Tapu emphasises four areas as important features in an education programme aimed at building and restoring relationships within families. They must all be practised together as interdependent entities, otherwise 'on their own they are simply cultural concepts isolated in space' (Ministry of Social Development Taskforce for Action on Violence within Families 2012g):

- 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

Health care providers should ensure that the service they provide is safe and respectful of Pacific victims of family violence. The delivery of a culturally safe and competent service that responds to Pacific victims of family violence should be underpinned by the following principles.

## 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.

Actions and behaviours to ensure victim safety and protection and that do not further endanger or disadvantage a Pacific person:

- 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 family violence for Pacific peoples
- identify and remove barriers for Pacific victims of family violence 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 family violence 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 to family violence:

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

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# Section 1: Child abuse and neglect

This guideline provides a recommended strategy for identifying, assessing, responding to, and referring children who may be victims of violence and/or neglect. Appropriate documentation is also discussed.

## Introduction

Routine enquiry about child abuse and neglect is not recommended (Bailhache et al 2013). Health care providers do, however, need to be alert for signs and symptoms that require further assessment, or that might be indicative of violence and abuse. Health care providers should also review the child's medical records, as previous presentations or admissions may indicate risk.

Child abuse and neglect is often described in categories such as 'physical abuse', 'sexual abuse', 'emotional abuse' (such as exposure to IPV between adults in the home) and 'neglect'. This introduction provides lists of some 'indicators' associated with these categories. However, these categories seldom occur in isolation from each other, and the 'indicators' may not be obvious.

The main focus of this section is therefore on what follows the Introduction: strategies for a thorough and careful approach to clinical assessment of all children and young people presenting for health care (see section 1.1), and for an appropriate response to those situations where the health care provider becomes concerned that a child is either 'at risk' or actually coming to harm (see sections 1.2–1.6).

## Signs and symptoms of abuse and neglect

It is important to realise that very few signs and symptoms are specific for abuse. Conversely, children may experience abuse and neglect but show no obvious signs or symptoms at all. If you are concerned about a child, consult with practitioners experienced in child protection (for example, a paediatrician) or with Child Youth and Family (CYF). The Paediatric Society of New Zealand Special Interest Group in Child Protection consists of a network of child health professionals around the country with special interest and expertise in child protection, and they can be accessed through your local paediatrician.

If there is clear clinical evidence of child abuse or neglect, sufficient in your opinion to justify referral to CYF in its own right, then do not interview the child. Record any information that the child volunteers, but if you interrogate the child you may create more problems than you solve.

Some factors related to the child and child's family that may increase the risk of child abuse and neglect are discussed in the Introduction to this Guideline, and in section 1.1.6. However, 'risk factors' alone have relatively poor predictive value for individual families in child protection. Children may be experiencing abuse or neglect where no known 'risk factors' are present, and may not be experiencing abuse or neglect in families with multiple 'risk factors'.

Useful information on the signs and symptoms of child abuse and neglect can be accessed online from the United Kingdom NICE guideline “*When to Suspect Child Maltreatment*” ([www.nice.org.uk/guidance/cg89/evidence](http://www.nice.org.uk/guidance/cg89/evidence)).

## Physical abuse: injuries that don't make sense

If you're worried about physical abuse, always remember that if in doubt, it is always safer to consult. Seek a second opinion from a more experienced colleague or local paediatrician. Some signs may include the following (Maguire 2010).

- **Unexplained head injuries** – even an apparently trivial bruise to the head of a baby or young infant with no evident signs of concussion may be reason for concern (Ingham et al 2011; Jenny et al 1999).
- **Unexplained bruises, welts, cuts and abrasions** – particularly in unusual places (face, ears, neck, back, abdomen, buttocks, inner arms or thighs, back of the leg), clustered, patterned or in unusually large numbers (Labbe and Caouette 2001; Maguire and Mann 2013; Pierce et al 2010).
- **Any unexplained bruise or injury in a baby who is not yet independently mobile** – especially if they are not yet pulling to stand, crawling or walking (Pierce et al 2009). Fractures in babies are often not clinically obvious, and may present as reluctance to use one limb or to crawl, or with non-specific irritability.
- **Unexplained fractures** – many children get accidental fractures, but always consider whether the history is consistent with the fracture type. This depends entirely on the quality of the history you take (Flaherty et al 2014; Maguire et al 2013; Pierce 2006).
- **Unexplained burns** anywhere on the body. Burns may be difficult to interpret, and if you are concerned they should be referred early to a doctor with expertise in burns or child protection (Kemp, Jones et al 2014; Kemp, Maguire et al 2014).
- **The child or their parent** can't recall how the injuries occurred, or their explanations change or don't make sense. While there may be innocent explanations for this, 'no history of trauma' is a common feature of child abuse (Hettler and Greenes 2003).

## Sexual abuse

For further information on sexual abuse, see Section B01 in the manual published by Doctors For Sexual Abuse Care (DSAC) ([www.dsac.org.nz/dsac-manual.php](http://www.dsac.org.nz/dsac-manual.php)).

In sexual abuse particularly, physical signs or symptoms are usually absent (Kelly et al 2006) and behavioural changes may not be evident (Drach et al 2001). If a child or young person tells you they have been abused (ie, 'makes a disclosure'), this should always be taken seriously and referred to Child Youth and Family.

Anogenital symptoms in children (like redness or swelling, bruising or bleeding from the genital or anal area) do not necessarily indicate sexual abuse, but they do need to be evaluated by a doctor with the appropriate expertise. Most urinary tract infections in childhood are not related to sexual abuse. However, if you or the family have concerns about sexual abuse for these or other reasons, the child should be referred as soon as possible to a doctor trained in the area of child sexual abuse.

There is a network of doctors trained by Doctors For Sexual Abuse Care (DSAC) throughout New Zealand, and you can contact them through your local Police, local DHB or the DSAC office ([www.dsac.org.nz](http://www.dsac.org.nz)).

Always consult with such a doctor before you decide whether or not to examine the child. It is pointless for the child to be examined twice, and in some situations it may be inappropriate for you to examine the child yourself.

Behaviour changes after sexual abuse may not be evident and if they do occur they may be highly variable (Kellogg 2010). Concern may exist if there is:

- **age-inappropriate sexual play or interest** and other unusual behaviour, like sexually explicit drawings, descriptions and talk about sex. However, this does not necessarily indicate sexual abuse, and should be discussed with clinicians experienced in child behaviour or child sexual abuse
- **fear of a certain person or place.** Children might try to express their fear without saying exactly what they are frightened of, so listen carefully, and take what they say seriously. However, never jump to conclusions
- other behavioural change suggesting emotional disturbance (see below).

## Emotional abuse

Most forms of abuse, exposure to violence or neglect are accompanied by emotional effects, which may or may not cause behavioural changes. The changes in behaviour noted below are not however specific for the emotional consequences of abuse or neglect.

- **sleep problems** like bed-wetting or soiling – with no medical cause, nightmares and poor sleeping patterns
- **frequent physical complaints** – real or imagined, such as headaches, nausea and vomiting, and abdominal pains
- **signs of anxiety**
- **other altered behaviour.** Children who are abused may withdraw, present as sad and alone, or consider hurting themselves or ending their lives. Some children may develop conduct disorder, such as oppositional or aggressive behaviour, acting out or deteriorating school performance.

## Neglect

Neglect is one of the most common forms of child maltreatment, with serious long-term consequences for children (Stoltenborgh et al 2013), but can be very difficult to define. It is useful to consider (DePanfilis 2006):

- do the conditions or circumstances indicate that a child's basic needs are unmet?
- what harm or risk of harm may have resulted?

These questions cannot be answered without sufficient information. This includes the pattern of caregiving over time, how the child's basic needs are met (or not met) and whether there have already been specific examples when an omission of care has led to harm or the risk of harm (DePanfilis 2006). See Appendix A.

Neglect can consist of (Fong and Christian 2012):

- **physical neglect** – not providing the necessities of life, like a warm place enough food and clothing. In babies or young children, this may present as poor growth ('failure to thrive')
- **neglectful supervision** – leaving children home alone, or without someone safe looking after them during the day or night

- **emotional neglect** – not giving children the comfort, attention and love they need through play, talk and everyday affection
- **medical neglect** – the failure to take care of their health needs (Jenny et al 2007)
- **educational neglect** – allowing chronic truancy, failure to enrol children in school or inattention to special education needs.

## 1.1 Identification of signs and symptoms

There is no ‘one-size-fits-all’ approach to the identification of children or young people at risk. If engaged with a family through the provision of health care to the mother, the health-care provider’s first point of concern may be the parent–child interactions that they observe. If engaged through the provision of health care to a child with an injury, their first point of concern may be how that injury was sustained.

The health care provider should begin with their first point of concern. However, they should also be aware that, if they are concerned about a child or young person, all the aspects described below may need to be assessed. The younger and more vulnerable the child (such as a pre-verbal infant), the more important this becomes. For example, a baby caught in the cross-fire of an incident of IPV may need formal physical examination and other investigations for injury, even if they appear physically unharmed.

### 1.1.1 Observing child–caregiver interactions

There are opportunities for health care providers to observe caregiver–child interactions at any clinical encounter, whether it is a visit to an emergency department (ED), a Well Child check-up, or an immunisation visit. These observations are not ‘diagnostic’, but can provide additional information that may be helpful in determining future courses of action (eg, by providing clues about who the child is comfortable with and seeks support from, or adults whose behaviour towards the child raises some concerns).

All observations which raise concern should be documented objectively, prospectively and in detail in the clinical records, even if the health care provider is uncertain of their significance at the time. The presence of a documented pattern of concerning behaviours over time may at some stage become very important in enabling the health provider to take effective action on behalf of a child at risk.

Possible cues/signs and symptoms in parent – child interaction:

- lack of emotional warmth, as opposed to strong attachment/bonding
- dismissive/unresponsive behaviours as opposed to sympathetic/comforting responses
- interaction between the child and parent or caregiver seems angry, threatening, aggressive or coercive
- indications that may raise concern are: a parent/caregiver calling the child names, using harsh verbal discipline, telling the child that they will harm something important to the child, threatening to seriously hurt or abandon the child, mocking the child or putting the child down in front of others.

## **1.1.2 Taking a history from parents and caregivers**

Your ability to interpret signs and symptoms in a child is, above all, reliant on the quality of the history taken from the family and (in some circumstances) the child about those signs and symptoms.

If a child presents with an injury, it is important to understand how that injury occurred. Essential components of the history include the following:

- Who is giving you the history (what is their name and relationship to the child)?
- Who saw it happen (the history should be obtained from an eye-witness, if possible)?
- When exactly did these events occur (time and date)?
- How exactly did they occur? For example, if it was a fall, where was the child at the beginning of the fall, and were they stationary or already moving? How precisely did they fall (head first, feet first, arms out)? What was the height of the fall (estimated on the eyewitness' own body)? What was the surface on which they fell? What was their position after the fall? Were there any complicating factors, like use of a baby walker, or a fall in the arms of an adult? (Duhaime et al 1992; Pierce 2006)
- When exactly did symptoms begin in relation to the accident? How were they noticed, and who noticed them?

In a young child, it is important to know the developmental capacities of the child. (Can they crawl, pull to stand, climb, run or manage stairs?) It is also important, especially with babies, to know their usual pattern of feeding, sleeping and behaviour, and when that pattern changed.

## **1.1.3 Asking children about possible abuse and/or neglect: an area of specialist practice**

As noted in the introduction to this section, if there is clear evidence of child abuse or neglect, sufficient in your opinion to justify referral to CYF in its own right, then do not interview the child. Record any information that the child volunteers. If you interrogate the child you may create more problems than you solve.

If a child has an injury, it is perfectly all right to ask open, non-leading questions eg, 'how did this happen?' They may or may not tell you the truth, depending on a variety of factors which will probably be unknown to you, but may include who is present in the room. However, no harm is done by asking the kind of question you would ask of any child you see for treatment of an injury.

If you have concerns about possible abuse or neglect, but there are other possible explanations for the things causing you concern, then you may want to give the child an opportunity to talk about what might be happening. However, always ask yourself whether or not this is an appropriate thing for you to do. If you have never had this kind of conversation, it may be better for someone else to speak with the child, or to do it with an experienced colleague. Seek advice first; for example, from a local paediatrician, a social worker with experience in child protection or CYF.

Relevant considerations include how well you know the child, what kind of rapport you have with them, what their developmental stage and language ability is, and whether you can raise the topic safely. A child is unlikely to disclose abuse or neglect if they have any concerns for their own safety afterwards.

Privacy is just as important as with adults. Giving an adolescent a chance to talk to you alone should be part of your routine practice. With younger children, you should consider carefully whether or not it is appropriate. A hasty conversation in a gap created by another staff member taking the caregiver away is unlikely to create the time and space necessary for disclosure by an anxious child. If something is going on at home, the caregiver involved may be suspicious, and interrogate the child afterwards.

When talking to the child, be aware of the need to approach and talk with children at an age-appropriate level. Children may not know what to say and use different words to express what is going on. Remember that if abuse is going on, a powerful adult may have given strong messages to the child not to tell, threatening them that they, or people or things they love will be hurt if they tell the secret. You need to create an atmosphere where the child feels safe to talk to you.

### **What should be asked?**

If you are going to have this kind of conversation, you need to frame it in a way that makes sense in terms of the signs and symptoms for which the child has come to see you, or in terms of your usual practice. For example: 'Sometimes when I see children with pain in their tummy like this, it's because they're worried or anxious about something. Is there anything that's making you worried or unhappy?' Or, 'One of the things I always do with children who come to see me, when they're old enough like you, is to check how things are at home.'

There is no specific evidence to guide questioning children about these issues in a health context. However, it is reasonable to ask open and non-threatening questions, such as:

- How are things at home?
- What happens when people disagree with each other in your house?
- What happens when things go wrong at your house?
- What happens when your parents/caregivers are angry with you?
- Who makes the rules? What happens if you break the rules?

### **Asking children about sexual abuse**

There are no evidence-based 'screening' questions for children about sexual abuse. If a presenting symptom has raised this concern for you, then open-ended questions (which do not suggest the answer) are always best (Jenny et al 2013).

If for some reason you believe it is appropriate to raise the topic of sexual abuse specifically with an older child or an adolescent, it is often best to frame a question like 'Sometimes, when I have seen someone your age with [symptom x], they have told me that someone has touched them in a way they didn't like. Has anything like that ever happened to you?' If someone has taught the child about 'good touching' and 'bad touching', you can ask about that, and use that terminology as the first line of enquiry.

You can be more specific about what you mean if the interaction with the child makes it clear that you need to be, but the right language to use is so dependent on the particular child that it is difficult to define it in advance. As already stated, if you have clear reason to suspect sexual abuse anyway, and the child is old enough to be interviewed, the matter is best referred directly to CYF.

### **1.1.4 Asking young people about possible abuse**

Discussions with young people also need to take place in private, and confidentiality of information needs to be discussed.

The different profile of abuse that young people may experience (eg, violence by peers/bullying, violence by family/whānau, dating violence) requires a developmentally appropriate assessment to be undertaken if signs and symptoms of abuse are detected. Assessment of the causes of violence in this age group is best accomplished as part of a thorough psychosocial assessment for adolescents such as the HEEADSSS assessment (Goldenring and Rosen 2004), which outlines a review of home environment, education and employment, peer activities, drugs, sexuality and suicide or depression (see Appendix B). You might also want to consider asking about cyber-abuse, text bullying and other antisocial behaviour.

When seeing a young person who is sexually active, it is important to consider the possibility of non-consenting sexual activity. This should be a part of routine HEEADSSS assessment in adolescents.

### **1.1.5 Past history**

Health care providers should review the child or young person's medical record, as previous presentations or admissions, particularly multiple presentations for illnesses and injuries, may indicate risk. Remember that the normal milestones of physical and mental development may be delayed or disrupted by abuse or neglect, and abuse or neglect may exacerbate the effects of chronic disease, behavioural problems or mental illness.

Health care providers who work in District Health Boards with a Child Protection Alert system, should ensure that they look out for the presence of a Child Protection Alert. If an Alert exists, they should follow their DHB Policies and Procedures to access the health information behind the Alert, and take it into consideration when assessing the child. It is important to be aware that the presence of an Alert does not necessarily mean that the child is still at risk, nor does the absence of an Alert mean that the child is safe. Further information about the National Child Protection Alert System can be obtained from the DHB's violence intervention programme or child protection coordinator.

### **1.1.6 Social history**

There are a variety of factors that may have an effect on the risk of child abuse and neglect. Intimate partner violence is obviously an important consideration. Other recognised risk factors (in no particular order of importance, and by no means exclusive) include: multiple changes of address; alcohol/drug abuse in the household, a family which actively avoids contact with health care providers or family support agencies, a caregiver with a past history of harming and/or neglecting children; severe social stress; social isolation and lack of support; untreated mental illness. While these factors are all relevant to the health and welfare of the child, and ideally should be part of a thorough evaluation in any child or young person where you are concerned, they do not necessarily predict abuse or neglect in any individual case. Some of these factors may only be able to be properly assessed as part of a multi-disciplinary and multi-agency process when you have already decided that you need to refer the family into such a process.

### **1.1.7 Physical examination**

If you are unsure what further medical assessment is appropriate in the particular circumstances of this child, seek advice from a colleague or local paediatrician experienced in child protection.

A thorough physical examination is indicated in all cases of identified or suspected child abuse and/or neglect, to identify all current and past injuries. The thoroughness of your examination will depend on circumstances. If you are referring this child on to a local hospital or experienced colleague for more detailed assessment, then your examination may be limited to an initial assessment. If no other doctor is going to examine this child for abuse or neglect, then you will need to act on the presumption that you may end up being asked to give evidence. In that case, your assessment should be very thorough.

Further investigations may be necessary, but this will depend on the exact circumstances, including the age and developmental capacities of the child, and the type of abuse or neglect that is suspected. For example, a suspected head injury from child abuse in a child under one (even if they have no symptoms of concussion) will almost always require a CT scan of the head, and a skeletal survey will be required in most children under two years with suspected physical abuse and in some older children (Kemp 2011; Maguire et al 2013). Full blood count and coagulation studies may be required in the presence of bruising (Anderst et al 2013).

Cases of sexual abuse, or suspected sexual abuse, should always be discussed with a doctor specifically trained in this field. Always consult with such a doctor, before you decide whether or not to examine the child. It is pointless for the child to be examined twice, and in some situations it may be inappropriate for you to examine the child yourself.

There is a network of doctors trained by Doctors For Sexual Abuse Care (DSAC) throughout New Zealand, and you can contact them through your local Police, local DHB or the DSAC office ([www.dsac.org.nz](http://www.dsac.org.nz)).

### **1.1.8 Using a checklist or flow chart in children under two years old**

There has been considerable research into the use of checklists or flow charts for assessing the possibility of abuse in children presenting to emergency departments (Louwers et al 2014; Newton et al 2010; Sittig et al 2014; Woodman et al 2010). The short summary of this literature is that such tools probably increase the quality of assessment and documentation, particularly in preverbal children, but have limitations in both sensitivity and specificity. The Ministry of Health's 2016 *Family Violence Assessment and Intervention Guideline; child abuse and intimate partner violence* (the *Guideline*) supports the use of this approach, provided that it is understood simply as a tool to support a better quality structured clinical assessment. It does not reduce the need for good clinical judgement, good supervision by senior staff and a careful multi-disciplinary approach if (for any reason) a clinician has concerns.

The Children’s Emergency Department at Starship Children’s Hospital has developed a tool suitable for use in New Zealand Emergency Departments, which has been trialled and audited in various formats since 2004. This began as a flow chart, but now consists of a sticker containing seven questions which is placed routinely in the ED assessment record for all children under two years old. This approach keeps the focus on the youngest children (those at greatest risk of serious physical abuse). It also acknowledges that preverbal children may present for care for one reason (such as a chest infection), but may be found on examination to have unexplained injuries (such as bruises). The experience at Starship has been that if the checklist is not used universally in the group most at risk, it is extremely difficult to achieve consistent practice (Shepherd 2013).

The *Guideline* recommends the use of this simple checklist (called the ‘Child Protection Checklist’) consistently throughout New Zealand Emergency Departments. It is provided below. These questions will of course also be relevant for older children presenting for healthcare where any of the listed concerns exist.

These are questions which health providers should ask of themselves before a child leaves the Emergency Department. The checklist is placed at this point in this section, because it is only possible to answer the questions it contains, if you have conducted a thorough assessment following the principles outlined above.

The checklist is only a guide to assist safe process, not a diagnostic algorithm. Never jump to conclusions.

**CHILD PROTECTION CHECKLIST** to be completed for ALL children under the age of 2 presenting to ED

COMPLETE a)–d) FOR ALL PATIENTS UNDER 2 YEARS OF AGE

- a) Is there any concern about the child and/or family’s BEHAVIOUR?  Yes  No
- b) Is there a past history of PREVIOUS INJURIES or does a CHILD PROTECTION ALERT exist?  Yes  No
- c) On examination, does the child have any UNEXPLAINED INJURIES?  Yes  No
- d) Any other concern?  Yes  No

ALSO COMPLETE e)–g) FOR ALL PATIENTS UNDER 2 YEARS PRESENTING WITH AN INJURY

- e) Has there been a DELAY between the injury and seeking medical advice, for which there is no satisfactory explanation?  Yes  No
- f) Is the HISTORY INCONSISTENT with the injury and/or with the child’s developmental level?  Yes  No
- g) Is the child UNDER 12 MONTHS of age?  Yes  No

ANY SUSPICION OF NON-ACCIDENTAL INJURY (NAI)?

- Uncertain or possible (“Yes”) to any answer above  
→ **Discuss with ED Senior Doctor** and ensure **routine enquiry for intimate partner violence** is completed
- No suspicion of NAI

Name:..... Signature:..... Date:.....

### **1.1.9 Collection of physical evidence**

In some circumstances, collection of physical evidence may assist a criminal investigation ('forensic evidence'). Analysis of such evidence is only performed by the Environmental Science and Research Institute (ESR), and must go through the Police. If you consider that forensic evidence is required, you should be discussing the matter with the Police.

To avoid loss of relevant information, it is best if forensic examinations are conducted by specially trained health care providers. Doctors trained by DSAC are specially trained to undertake examinations for sexual abuse, but would be unable to provide this level of service for all cases of physical abuse. The first point of contact would usually be DSAC-trained doctors through your local Police, local DHB or the DSAC office ([www.dsac.org.nz](http://www.dsac.org.nz)).

Even if a specialist doctor is not able to see the child, you should seek their advice before you collect any forensic evidence. In such cases, with the patient's permission, collection of physical evidence associated with the assault can be undertaken.

Steps for collection and safe storage of evidence include the following:

- 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 patient's name, and the name of the person who collected the items. Sign across the seal.
- Keep the envelope in a secure place (eg, 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.
- Canterbury HealthPathways maintains a standalone website that can assist health care providers in the identification and description of assault injuries (<http://assault.healthpathways.org.nz>). The website is not available to the general public, but health care providers can request a username and password to access the site by emailing [healthpathways@cdhb.health.nz](mailto:healthpathways@cdhb.health.nz)

## **1.2 Validation and support**

If you have developed concerns about the safety of a child or young person, then you will need to act on those concerns. Sooner or later (depending on the urgency of the situation) someone is going to have to have a frank conversation with the caregivers and (if old enough to understand) with the child.

While your actions are intended to support and validate the child or young person, they may not (depending on the circumstances) be seen as supporting or validating their caregiver(s).

However, you should not assume that raising care and protection concerns with a family will necessarily result in a hostile reception. Some caregivers may appreciate your honesty and be willing to accept help, and it may not be apparent until you raise your concerns, which adults in the family are protective.

*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.
- If the family may seek to avoid child protective agency staff.
- Where the family may close ranks and reduce the possibility of being able to help a child. If safe to do so, you should still be transparent about the actions you as a health care provider need to take, and the reasons for them, but do not divulge details of actions planned by the statutory authorities.

### **1.2.1 Talking with the parents/caregivers of the child**

If you have decided to refer a child to CYF, in most cases it is best practice to tell the child's caregivers, if safe to do so. If you are unsure how to go about this, you should *first* consult with a colleague with experience in child protection or with CYF (see Section 1.4.4).

The basic principles are:

- create time and space for a private conversation
- be professional (be calm, start with the facts before you, explain the reasons for your concern and the reasons for the actions you need to take)
- don't accuse anyone. For example, if a child has an injury, you have reached the appropriate point in the consultation and have explained the features of the injury that are unusual, you might use phrasing such as 'I am concerned that someone may have injured your child'
- use interpreters (not family members) if there are language barriers
- use other cultural support if available and appropriate
- be transparent about what happens next.

If you don't know that abuse and neglect has occurred, but your concern is risk and how to reduce it, then it may be possible, in some circumstances, to address this with the parents or caregivers yourself.

The context and tone of the interaction should be; asking about things at home because they are important for the child's health, and offering help and support if things are difficult or stressful.

If circumstances permit discussing concerns with a victim's parents or caregivers, follow these principles:

- broach the topic sensitively
- help the parents/caregiver feel supported, able to share any concerns they have with you
- help them understand that you want to help keep the child safe, and support them in their care of the child.

#### **Framing statement:**

'Looking after kids can be a big job, and most people find it difficult or stressful at times. How is it for you?'

Use open-ended, non-judgemental questions about parenting and discipline, for example:

'Do you ever fear for your children's safety?'

'Who looks after your children when you are not home?'

If you suspect a caregiver may be at risk of harming a child:

‘Do you ever worry about your children’s safety when they are with you?’

‘What do you do when your child misbehaves?’

‘Have you ever hurt your child?’

‘Do you know what practical help is available to assist you?’

If you’re still uncertain but suspect child abuse or neglect, discuss the situation and your concerns with CYF to determine if a formal report of concern should be made.

## **1.2.2 Health care provider response to child’s disclosure of abuse**

If a child or young person discloses any form of abuse, the following approach may be helpful.

Listen. Do not put words in a child’s mouth. Allow them to tell only as much as they want. It is not your role to judge whether a child is telling the truth. Although false allegations can occur, they are uncommon, and it is far safer to act on the assumption that the child is telling the truth.

A child old enough to disclose is probably old enough to be evidentially interviewed at a later date. It is therefore important not to interrogate the child, which may only cause distress and may confuse any subsequent evidential process. Keep questions to a minimum, keep them open-ended, and document the conversation carefully in the clinical notes immediately afterwards.

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 child will monitor every reaction, and may well be very frightened if the abuser has threatened them or said no one will believe them.

Do not panic. If the child judges you unable to handle the situation, he or she may stop talking. Good listening with supportive, minimal encouragers allows the child space to say all they need.

Do not criticise. Don’t say ‘You should have told me sooner’ or ‘Why did you let him?’. It may help to say that these sorts of things happen to other children too sometimes.

Ensure the child’s immediate safety. Try not to alert the alleged abuser. Seek advice and assistance, and find support for yourself.

### **1.2.3 Health care provider response to parent/caregiver's disclosure of abuse**

Listen to what the parent or caregiver is saying. Thank them for telling you. Let them know that you will act to keep the child safe, and them safe, if they need it.

## **1.3 Health and risk assessment**

### **1.3.1 Risk to the child or young person**

Risk assessment around child abuse and neglect is not a reliable science. The more information you have about the child and family the better, but safety lies not so much in a particular 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 are responsible for conducting a preliminary risk assessment with victims of abuse and/or neglect, in order 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 CYF or the Police.

Immediate protection of a child is required if the child has suffered harm which in your view is a result of child abuse, and the environment to which the child is returning is unsafe. Obviously, the more serious the harm and the more vulnerable the child (for example, a baby or a preverbal child), the more critical the risk becomes.

Safe process means never to make decisions about risk in isolation. If you are concerned about the possibility of child abuse and neglect, it is important you do not jump to conclusions. Consult with senior staff within your practice setting, a paediatrician, with a health social worker or youth health service, or with the duty social worker at CYF as you work to determine what level of risk the child might be facing. Be aware that other organisations (such as CYF) may hold information which is crucial to determining the safety of the child.

Health care providers do not need to have proof of abuse or neglect, and do not need to seek permission from a child's family, prior to talking with colleagues or a CYF social worker about a child. Early communication with CYF can help identify if there have been other concerns raised about the safety of the child. It can be considered an additional component of reviewing the child's history. This early communication does not need to result in a report of concern to CYF, which is a decision that ideally should only be made after a thorough assessment.

### **1.3.2 Mental health assessment**

Children's experience of abuse or neglect is strongly associated with a number of poor mental health and behavioural outcomes, including depression, anxiety, conduct disorders and other indicators of psychopathology. One simple and widely used screening test for such indicators in children and young people is the Strengths and Difficulties Questionnaire or SDQ (see <http://www.sdqinfo.com>). This is not a diagnostic tool but may be helpful in identifying concerns that need further mental health assessment.

Other factors that are frequently associated with the risk of suicide or self-harm may themselves be symptoms of abuse. These include depression, extreme anxiety, agitation or enraged behaviour, excessive drug and/or alcohol abuse. These factors are associated with suicidality, defined as thoughts and/or actions that if fully carried out may lead to serious self-injury or death (Tishler et al 2007), even in children younger than 12 years.

Health care providers treating children who are known or suspected victims of abuse or neglect need to be alert to possible suicide risk, and assess for it accordingly. Similarly health care providers who are treating children or young people for self-harm/suicide should assess children to determine if they are experiencing abuse and/or neglect.

Signs associated with risk of suicide include (Rives 1999):

- 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 (eg, putting affairs in order).

See Appendix C for a chart of factors to consider when assessing a child's risk of suicidal behaviour, and suggestions for referral and follow-up. If you are concerned that the child may be at risk of suicidal behaviour, it is appropriate to ask questions such as:

'Do you ever think about hurting yourself?'

'Do you ever feel sad enough that it makes you want to go away and not come back?'

'Do you ever feel like crying a lot?'

Do NOT ask questions using the words 'suicide' or 'killing oneself'. These can suggest behaviours that the child may not have thought of.

The results of the suicidality assessment will help you determine what intervention and follow-up plans will be required. Appendix C shows recommended pathways for referral for children depending on the level of assessed risk.

This can include referral to the appropriate child or adolescent mental health service, but if abuse or neglect issues are also present, referral to CYF is also warranted, particularly if the child or young person cannot be cared for safely within their home. Remember that the most helpful intervention to reduce suicide risk may be to assist the person to obtain safety from the abuse.

### **1.3.3 Risk to other children or young people**

If child abuse is identified or suspected, it is important to consider possible risk to other members of the family because of the high co-occurrence of multiple types of violence within families. This includes establishing the whereabouts and safety of other children in the home. Child, Youth and Family should be able to determine if previous concerns have been raised about the safety of other children in the family.

### **1.3.4 Co-occurrence of child abuse and intimate partner violence**

If child abuse is identified, assess the non-abusive parent's safety. Follow the procedure outlined in Section 2 of this document.

Victims of IPV are frequently threatened by the perpetrator that if they disclose the violence, s/he will tell CYF that the non-abusive partner is a bad parent/abusive to the children, and that CYF will take the children away. Careful assessment needs to be undertaken to ensure that children's disclosure of violence, or the non-abusive partner's disclosure of violence, leads to further safety for them both, rather than additional trauma through separation or other consequences. It is recognised that there are occasions when the only way to ensure the safety of a child in a situation of family violence may be to separate the child from the non-abusive parent, even if only temporarily. In these circumstances, best efforts should be made to mitigate the trauma of the separation to both.

### **1.3.5 Other risk factors**

If the social history has identified other risk factors (see 1.1.6), then they should be addressed through the appropriate pathways in your area – for example, serious untreated mental illness through local mental health crisis teams, alcohol and drug addiction via referral to community alcohol and drug services.

## **1.4 Intervention/safety planning**

If child abuse and/or neglect is identified or suspected, then a plan is required for ensuring the safety of the child, or for providing help and support to the family. Information from the health and risk assessment process described in the previous section will help to ensure that acute needs are identified and can be included in the safety plan.

If there are concerns about immediate safety (including your own), contact the Police (or in-house security if available) and contact CYF.

Working as part of a multi-disciplinary team can help ensure that the safety needs of children, and the safety needs for the non-abusing parent / caregiver are met. Consult with an experienced colleague, a social worker in your agency, a specialist child protection team, paediatrician, a family violence prevention advocate or contact the duty social worker at CYF or youth health service. If the health care setting where you work has access to social worker services on site, or specialist child protection teams or services, or has negotiated arrangements with local family violence prevention advocates, enlist this support whenever possible.

For those health care providers who do not have immediate access to these services however, this section outlines some of the primary risks associated with abuse that need to be considered, and suggests appropriate referral options. All healthcare providers can undertake basic intervention and safety planning activities if they have received training, and have access to support, as designated by the policies and procedures of their health care organisation.

Note that the purpose of risk assessment and subsequent referral is to ascertain the likely level of immediate risk for a patient leaving the health care setting. Actual injuries or other evidence of abuse are not required for referral to CYF, particularly if there is risk to children.

When undertaking safety planning, assessing for positive/protective factors is an important part of identifying resources that may help improve the situation. These can include the family's efforts to actively pursue the safety and wellbeing of the child/young person, their willingness and capacity to respond, or their willingness to engage with, or develop a relationship with a service provider. The identification of support needs within the family (eg, health, education or disability) can be a strength if meeting these needs assists in establishing connections with other services.

The tasks at this stage are to:

- identify the support and safety procedures that are required eg, what are the child's needs for; safety, physical and emotional needs, health and rehabilitation, access to caregivers?
- specify what are the support or safety procedures that need to be put in place
- allocate responsibilities for action (eg, who are the key individuals and agencies that need to be engaged?).

In non-critical situations, multiple referral and follow-up pathways are possible. For healthcare providers, the key issue is whether the child is 'at risk' (but there are pathways of referral open to them which are likely to reduce that risk, see 1.4.2), or whether the child is actually already coming to harm (see 1.4.1).

A child who, in the opinion of the healthcare provider, is already coming to harm, should be notified to CYF as a 'report of concern'. The template for referring is available via this [link](http://www.starship.org.nz/childprotectnetwork) [www.starship.org.nz/childprotectnetwork](http://www.starship.org.nz/childprotectnetwork). If the child also needs acute referral to hospital, do not delay that referral in order to notify CYF. If necessary, you can notify CYF while the child is on the way to the hospital. Speak to the hospital in person and inform them of your concerns, and consider whether the child should be transported to hospital by ambulance.

### **1.4.1 Child being harmed**

CYF will form their own opinion as to the risk faced by the child. They will deal with reports of concern according to their own triage of the risk to the child. Further information is available on the Child Youth and Family practice centre, follow the link:

[www.practicecentre.cyf.govt.nz/knowledge-base-practice-frameworks/care-and-protection/phases-and-triggers/engagement-and-assessment.html](http://www.practicecentre.cyf.govt.nz/knowledge-base-practice-frameworks/care-and-protection/phases-and-triggers/engagement-and-assessment.html)

- If this is a case of alleged physical or sexual abuse, serious wilful neglect or serious family violence (where the child is a witness or the violence could have caused death or serious injury), CYF will conduct a critical or urgent investigation in collaboration with the Police.
- If the case is not as serious, but CYF believes that the care, safety or wellbeing of the child or young person may be at risk, they will conduct a child protection investigation in consultation with the Police.
- If CYF form the view that safety, care or behavioural issues exist, but engagement by an agency with the family is likely to achieve positive outcomes, they may pass the family on to a community agency for a 'partnered response' with that agency to ensure that connections and supports are achieved. The Children's Action Plan is establishing 'children's teams' across New Zealand to work with the families of vulnerable children and young people. If there is a Children's Team in your area CYF may pass the family on to the Children's Team. See: <http://childrensactionplan.govt.nz/childrens-teams>

Children admitted to hospital will be managed according to a standard inter-agency process. This is governed by a memorandum of understanding between DHBs, CYF and the Police and the associated schedules. The documents are available on the Child Youth and Family website, see [www.cyf.govt.nz/working-with-others/working-with-health.html](http://www.cyf.govt.nz/working-with-others/working-with-health.html)

### **1.4.2 Child at risk**

Identify the safety, care or behavioural issues that exist. Consider if the risk is likely to be mitigated by the family engaging further with your service, or another health or social agency. Will the family accept this referral? What positive or protective factors exist that could be enhanced?

If you are unsure, discuss the situation and your concerns with CYF to determine if a formal report of concern should be made.

In such a discussion, CYF will consider whether the whānau is actively pursuing the safety and wellbeing of the child or young person, and has the willingness and capacity to respond. If the answer is yes, a formal report of concern may not be regarded as necessary, and CYF is likely to respond by encouraging your service to affirm and support those positive behaviours.

If safety, care or behavioural issues exist, but you consider that engagement by an agency with the family is likely to achieve positive outcomes and the family is willing to accept referral, CYF is also likely to suggest that a formal report of concern may not be necessary. In this situation, your service may be able to address the risk by ensuring that connections to appropriate agencies are made, reinforcing the importance of these to the family, affirming the family for taking positive steps to look after their child, and providing follow-up.

If there is a children's team in your area, this may provide another avenue for effective action. See: <http://childrensactionplan.govt.nz/childrens-teams>

### **1.4.3 Co-occurrence of child abuse and intimate partner violence**

Remember, JOINT safety planning and referral processes need to be implemented when both intimate partner violence and child abuse are identified.

#### **Where intimate partner violence exists, and action is needed to protect the children**

- Any concerns about the safety of the children should be discussed with the abused partner, unless you believe that doing so will endanger the child, another person or yourself. If you or your colleagues decide to notify CYF, the abused partner should be informed, unless the same concerns apply.
- Be aware that actions taken to protect the child may place the non-abusive parent at risk. Always refer this parent to specialist family violence support services, and inform CYF about the presence of partner abuse as well as child abuse.
- Ask the abused partner how they think the abuser will respond (risk that the perpetrator will retaliate for disclosure of the family secret).
- Ask if a child protection report or report of concern 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?
- Make sure the abused partner has information on how to contact support agencies (eg, Police, refuge, CYF) if problems arise.

#### **1.4.4 Talking to parents and caregivers about referral to the statutory authorities**

If it is safe to do so, discuss referral to CYF with the child's parents or caregivers:

- Broach the topic sensitively and reasonably, in the light of the concerns you have.
- Help the parents/caregiver feel supported, able to share any concerns they have with you.
- Help them understand that you want to help keep the child safe, and support them in their care of the child.
- Keep the parents informed at all stages of the process.
- Where options exist, support the parents/caregivers to make their own decisions.
- Involve extended family/whānau and other people who are important to them.
- Be sensitive to, and discuss the patient or caregiver's fears about CYF.
- However, be clear that your role is to keep the child safe. Do *not* seek permission to consult with CYF. You may do this at any time.

## **1.5 Referral and follow-up**

Follow-up and referral plans need to be developed for all children and their families, based on the information obtained during the health and risk assessment and safety planning, and the collaborative planning undertaken by the health care provider and those they consulted with. Working with the specified policy and procedures of your organisation, the tasks at this stage are:

- Make referrals as appropriate, and ensure that relevant information is appropriately and accurately transferred to receiving individuals/agencies.
- Ensure there is a plan for review and follow-up, eg, what is the timeframe for the referral and follow-up plan? Who, when, and how, will the plan be reviewed?
- A phone referral to CYF should be made whenever possible. A copy of the written referral (eg, report of concern) must be sent to CYF and a copy placed in the clinical record of the child/young person (or mother when the concerns reported relate to the antenatal period). If the report is made by a DHB, a copy must also be sent to the VIP/child protection coordinator in accordance with the DHB's policy for the Child Protection Alert System.

### **1.5.1 Child coming to harm**

Once immediate safety for the child has been secured, think about what other follow-up might be necessary. For example, if the child and family have been seen in an acute health care setting, it is important that information about a report to CYF is transferred back to the child's usual primary care provider. Working within the policy and procedures of their health care organisation, health care providers need to decide how this information be transferred (eg, written discharge summary, telephone call, other procedure).

It is important that healthcare providers still continue to provide follow-up to children and families who have been notified to CYF. You cannot assume that CYF or some other provider will take responsibility for the follow-up of the health care needs of the child and family.

### **1.5.2 Child at risk**

If you have concerns about risk, but there has been no disclosure, and no definitive signs or symptoms, discuss the situation with experienced colleagues and/or CYF, as described above.

This may be a situation where early intervention initiated by a healthcare provider may prevent abuse or neglect in a family at risk. Therefore, whether or not a formal report of concern to CYF is made:

- leave the door open for further contact with the child and the child's caregivers
- look for further indicators at the next consultation, or consider if you should raise your concerns with others within the health system (eg, with the patient's primary care provider, Plunket), so that additional follow-up and support can be offered, if required
- consider if there are other health, social, or community agencies where you can refer the family, to reduce stressors, and/or promote health. These may include Children's Teams established under the Children's Action Plan, non-health agencies, such as educational or social support agencies (for the child or the parent/caregiver), or agencies that provide support that may alleviate other risks (eg, budgeting advice, community alcohol and drug services, community mental health services).

### **1.5.3 Co-occurrence of child abuse and intimate partner violence**

Remember, JOINT safety planning and referral processes need to be implemented when both intimate partner violence and child abuse are identified. This can also be helpful where the caregiver is working to keep the child safe, but is her/himself experiencing violence within the home. Make sure that the abused partner has contact details for local support agencies. In some circumstances, it may be possible to arrange for the adult/caregiver to have confidential on-the-spot phone contact from the practice/healthcare facility at the time of consultation. This can be a very empowering action for the person, and can break the ice for any future urgent contact she needs to initiate.

## **1.6 Documentation**

Thorough documentation of all steps of the health consultation is necessary. Always include the date and time that you saw the child or young person, and when you wrote your notes (if different from the time you saw the patient). Always include a legible signature and practice designation.

Clearly and thoroughly document the behaviours, signs and symptoms you observed.

### **1.6.1 History**

Document carefully and in detail the history you took, and who you took it from.

If you spoke to the child, write down what you asked, and the child's answers to your questions. If you spoke to the parent/caregiver, record what you asked, and how the caregiver responded. Use direct quotes.

### **1.6.2 Examination**

Note the time and date of examination.

Use simple body diagrams to improve accurate documentation. Suitable diagrams can be downloaded from a variety of sources. They should be printed and completed, then either scanned into the electronic patient records or kept as a hard copy in the patient notes, for example, the diagrams used by the Starship Hospital's Child Protection Team, which can be downloaded from the Starship website as the 'Te Puaruruhau record Booklet' (see medical assessment on [www.starship.org.nz/for-health-professionals/starship-clinical-guidelines/a/abuse-and-neglect](http://www.starship.org.nz/for-health-professionals/starship-clinical-guidelines/a/abuse-and-neglect)).

Document the following features for each injury: site, shape, size (use a tape measure), characteristics (eg, colour, depth, edges, surroundings, margins, swelling, tenderness).

The ageing of injuries is a difficult and potentially contentious issue. Many factors influence healing such as site of injury, force applied, age and health of patient and infection.

Only make a diagnostic conclusion on the basis of your examination findings if you consider yourself expert enough to do so. If in doubt, consult or refer.

Canterbury HealthPathways maintains a standalone website that can assist health care providers in the identification and description of assault injuries (see <http://assault.healthpathways.org.nz>). The website is not available to the general public, but health care providers can request a username and password to access the site by emailing [healthpathways@cdhb.health.nz](mailto:healthpathways@cdhb.health.nz)

### **1.6.3 Photographs**

Many health care organisations now regard photography as a routine supplement to the medical records, and do not require written patient permission prior to photographing injuries. Consult the policies and procedures for your organisation. Note that thorough documentation and body maps are always required, and cannot be replaced by photographs.

If photographs are taken, this should be stated in the written notes, including the name of the photographer and time taken. The photographs should be clearly identified with the patient's National Health Index number, date and time they were taken, and filed in the clinical record with a clear annotation as to what part of the body they represent. Ideally, a scale measure should be incorporated in a photograph of an injury.

### **1.6.4 Document the results of your health and risk assessment**

Be sure to include suspected or confirmed risk to other family members (eg, other children in the family, parents or caregivers who may be at risk).

### **1.6.5 Document the consultative process you undertook**

Who did you speak with? At what points?

### **1.6.6 Document the support agencies, referrals and follow-up plan agreed to**

Note the action taken by clinician, referral information offered, follow-up care arranged (eg, report of concern to CYF, discharge summary to GP, or referral information provided to family for other health and social service agencies).

Note who will take responsibility for follow-up, and when this will occur.

### **1.6.7 Confidentiality of abuse documentation on the medical record**

Care must be taken to ensure the confidentiality of any information about abuse recorded in any records potentially available to family /whānau members. If the perpetrator finds out that the victim has disclosed the violence, the victim may be at increased risk of retribution for having revealed the 'family secret'.

Children's health records are private to them. Parents can ask to access their children's notes until they are 16 years old, but they are not automatically entitled to them. Withholding grounds may apply, and one of these is when the healthcare provider believes that it is not in the child's best interests to give the parents access. Therefore, your service must have a process where the primary clinician reviews a child's file whenever a parent requests access to it. The health care provider must decide whether the parent can have access, and, if so, whether there is any information that might pose a risk to the child's safety which should be removed first. If information is withheld, you are obliged to inform the parent that some information has been withheld, and why. (See the Health Information Privacy Code: [www.privacy.org.nz/the-privacy-act-and-codes/codes-of-practice/health-information-privacy-code](http://www.privacy.org.nz/the-privacy-act-and-codes/codes-of-practice/health-information-privacy-code).)

The health notes for each individual should be stored in a separate file.

### **Conclusion**

After the health child protection intervention has been completed, and you have implemented plans for the health care of the person, it is appropriate to seek supervision and/or peer support for yourself. This can include a conversation with a senior colleague, a family violence intervention champion, or other colleague. In some cases, it may include a formal debrief or case review. These steps are an important part of self-care for you as a health care provider, and provide important opportunities to reflect on practice.

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# Section 2: Intimate partner violence

This section provides information on the routine enquiry, support and validation, health and risk assessment, intervention and safety planning, referral and follow-up and documentation of health care provider responses to victims of intimate partner violence (IPV).

## 2.1 Routine enquiry

This section provides recommendations on *where* questions should be asked, *who* should receive enquiries about violence, *when* in the health consultation the questions should occur, *how* questions should be introduced, *what* questions should be asked and *how* providers should respond.

This step serves multiple purposes. It can facilitate disclosure of IPV by current and past victims, inform health care providers about crucial factors that may be impacting on the health of their patients, signal the importance of the issue to those who have not been victimised and can educate all patients that health care providers are important sources of help on this issue.

Considerable research has been undertaken exploring this step of health care provider response/intervention to IPV. This research has consistently found that:

- health care provider enquiry about IPV is acceptable to women
- multiple, direct questions about IPV elicit higher levels of disclosure than single, general questions about home life
- the health care provider's way of introducing the questions can facilitate disclosure
- health care provider's initial supportive, non-judgemental and informative response to initial disclosure is an important source of help and validation.

See Appendix D for recommended IPV routine enquiry guidelines for different health care settings.

### Where should routine enquiry about IPV take place?

The interview should take place in private.

- No friends or relatives of the patients should be present during the violence questioning and preferably no children over two years of age. If violence is disclosed, risk assessment should also take place in private, unless the person requests the presence of a friend or family member for support.
- 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.

## Who should receive enquiries about violence?

### Women

- *Routine enquiry about intimate partner violence should be conducted with all females aged 16 years and older.* At a minimum, health care providers should assess new female patients for current (past-year prevalence) physical violence, sexual violence and psychological abuse. Asking whether the woman is afraid of a current or former partner is also important.
- In many practice settings it may also be appropriate to assess for IPV that occurred any time in a patient's life.
- **Asking older women.** Older women can also be hurt by their intimate partners, so there is no reason to exclude them from routine enquiry about IPV. However, older women can also be vulnerable to violence from others (non-partners, eg, adult children, caregivers). Routine enquiry can lead to disclosures about violence by non-partners, and practitioners need to be resourced and supported to respond to these disclosures appropriately (see Glasgow and Fanslow 2007).

### Adolescents/young people about possible IPV (aged 12–15 years)

- The different profile of abuse that young people may experience (for example, violence by peers/bullying, violence by family/whānau, dating violence) requires a developmentally appropriate assessment to be undertaken if signs and symptoms of abuse are detected. Assessment of violence in this age group might best be accomplished as part of a thorough psychosocial assessment for adolescents, such as the HEEADSSS assessment, which includes a review of home environment, education and employment, eating, peer activities, drugs, sexuality, suicide/depression and safety (Goldenring and Rosen 2004, Appendix B).

### Men

- Men aged 16 years and older who present with signs and symptoms indicative of IPV should be questioned (see Appendix E).
- Routine enquiry is not recommended because of the differences in prevalence and severity of violence against men. However, if signs and symptoms of IPV are present, males should also be questioned about the occurrence of IPV, or other experiences of violence. Remember not to make assumptions about the gender of the man's partner, and that you will need to have appropriate referral pathways identified to support men.

## When in the health consultation should the questions take place?

Ideally, questioning about IPV should take place after some rapport has been established with the person, but while there is still time remaining in the health consultation to respond to any issues identified.

## How should questions be introduced?

When enquiring about IPV, it is best to use simple, direct questions, asked in a non-judgemental manner. Setting up the enquiry appropriately is important. Options for introducing the topic include: enquiring about IPV as part of a wider psycho-social assessment, or using framing statements that explain the relevance of the query to the health consultation can facilitate disclosure.

Examples of framing statements:

‘Because we know partner violence affects a lot of women’s health we are asking all our female patients about it.’

‘Because violence affects people’s health, I routinely ask all my patients about any violence they may have experienced.’

‘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.’

If you feel it provides a better introduction to the issue, you can begin by asking open-ended questions to start the conversation:

‘Is everything ok at home?’ or ‘Does anyone in your home make you feel bad?’

*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 (Feder et al 2009).

Examples of direct questions are below.

## **What routine enquiry questions should be asked? Answer: Direct questions about specific behaviours**

Direct questions need to be asked about all major types of violence: physical violence, sexual violence, psychological/emotional abuse, and controlling behaviours. Asking specifically about each type is necessary in order to get a clear understanding of, and to enable you to respond appropriately to the scope of the violence the person may be experiencing. Questions about feelings of safety are also relevant for identifying situations of stalking, or other experiences that are creating unease.

Note that while the labels ‘physical violence’, ‘sexual violence’ and ‘psychological/emotional abuse’ are useful as conceptual frames for what might be going on, they are terms that should not be used when first discussing the topic with an individual. Instead, health care providers should ask about the person’s experience of specific behaviours (examples below). Depending on the practice setting you are working in, questions about past (historical) IPV by a current or previous (ex-) intimate partner may also be relevant for understanding and treating current health problems (eg, in primary care, in mental health and addiction settings, or in sexual and reproductive health care settings).

‘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?)’

Note: Consistent with good clinical practice and communication skills, health care providers may need to ask these questions in slightly different ways, using different words (the person's words if possible), and monitor that they have been understood by the patient. For example, be prepared to pick up clues from the patient, and seek clarification or expansion as appropriate, such as 'What do you mean by "grumpy"?'.

## Confidentiality

In many health care settings, confidentiality may have been explained or be understood already, as part of the provider–patient relationship (eg, 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 patient 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 patient 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 (eg, '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').

## 2.2 Validation and support

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 disclose the violence, or has told them that no-one will believe them.

*Do not panic.* If the person judges you unable to handle the situation, he or she may stop talking. Good listening with supportive, minimal encouragers allows the person space to say all they need.

*Do not criticise.* Don't say 'You should have told me sooner' or 'Why did you let your partner do that?'. 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.

Note that supportive responses to the person are important throughout the consultation, not just at the point of initial disclosure.

*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 did nothing to deserve or provoke this. Being hurt by someone in this way is never OK.'

'What (your partner) is doing is a crime. It is not just a family or private matter.'

'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 (see section on safety and intervention planning (section 2.4)).

## **Signs and symptoms indicative of IPV, no disclosure (see Appendix E)**

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 IPV is not occurring (ie, there are no reports or evidence of physical and/or sexual violence in the relationship, and no evidence that high levels of psychological/emotional violence are occurring (eg, the patient does not describe humiliating or controlling behaviour by their partner)), 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 (eg, 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 (eg, 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.

## **2.3 Health and risk assessment**

This section describes procedures for further assessment of physical, reproductive and mental health consequences that may have resulted from the experience of IPV. Assessment of risk to others in the family is also discussed. It also includes questions that may help you and the person, to gain a sense of risk of future violence that may be directed at them, including risk of homicide. However, as with child abuse and neglect, risk assessment for IPV is not a reliable science. The more information you have the better, but safety lies not so much in a particular 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 are responsible for conducting a preliminary risk assessment with victims of abuse and/or neglect, in order 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, a family violence champion, or talk with a health social worker, or victim advocate, 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.

### **2.3.1 Health and Risk Assessment**

If a person discloses experience of violence in response to routine enquiry, it is important that you conduct a thorough assessment of the violence that has occurred. This is important 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). Responding to risk of future violence is discussed further in section 2.4 Safety planning.

#### **a) Introducing the Health and Risk Assessment**

The way you introduce the topic of health and risk assessment will be important in engaging the person in the process. Suggested statement:

‘I am sorry that this has happened to you. No one deserves to be hurt in that way. There are options – people and places – that can help to make you safer. We can help you sort these out, but first, we need a little more information about what has been going on for you. We ask all people who have been hurt by their partners to do this. It will help us to provide you with the best care we can.’

#### **b) 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 threatened 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?

### **2.3.2 Physical health assessment**

Given the health consequences associated with IPV, additional assessment and appropriate treatment may need to be offered to victims.

This should include:

- a thorough physical examination to identify all current and past injuries
- appropriate laboratory tests and X-rays.

This is important, because victims of abuse may forget or downplay the extent of violence they have experienced, or they may have been prevented from receiving appropriate medical care by their partner. Documentation of current and previous injuries in the medical record can also assist the person later if they wish to access legal help, such as protection orders (see section 2.5).

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

**Question 3: Has the violence increased in frequency and severity?**

Further assessment may include: ‘Can you tell me more about that?’ ‘Do you have any injuries that you would like me to look at?’

**Question 4: Has your partner ever choked you?**

If yes, follow the procedures in the Strangulation Guideline (Appendix F).

**Question 5: Have you ever been knocked out by your partner?**

Carry out further assessment for traumatic brain injury.

**Question 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.

### **2.3.3 Sexual and reproductive health assessment: The role of Sexual Assault Assessment & Treatment Services (SAATS)**

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 patient may have, or if referral to a specialist sexual assault assessment and treatment service (SAATS) would be beneficial. Disclosure of sexual violence is more likely in response to direct questions from the health care provider.

The practice setting you work in may have its own protocols for responding to sexual violence. Follow these protocols where applicable, but also consider if referral to Sexual Assault and Treatment Services would be beneficial. SAATS provide free expert medical care after recent or historic sexual assault. Expert medical examination is useful in two situations:

- Acutely:
  - To collect forensic medical evidence after a recent event. Recent is usually less than 72 hours where contact has not involved penile–vaginal penetration but up to seven days if penile–vaginal contact has occurred
  - To initiate any necessary treatment and to identify any injury.
- Non-acutely:
  - To provide reassurance
  - To detect sexually transmitted infections/pregnancy
  - To identify and address other issues/problems eg, depression, self-harming, family violence, etc.

The timeframe of the sexual assault and the patient's decision regarding police involvement is relevant to your next steps, and will help determine whether you need to refer the patient to the local SAATS acutely for an examination for forensic purposes. If the patient does not wish to have an examination for forensic purposes, you can provide them with relevant sexual and reproductive health care. If a more comprehensive medical assessment would be beneficial, the patient can be referred to the SAAT service subsequently, if they wish.

If you are going to manage the patient in the acute situation, your basic requirements are to:

1. Attend to any injury
2. Provide emergency contraception
3. Provide antibiotic prophylaxis
4. Provide information about crisis support and ACC support counselling ([findsupport.co.nz](http://findsupport.co.nz))
5. Arrange follow-up with a GP, counselling agency or other local referral agency, as appropriate.

Assessing and responding to these medical and psychological health risks is important as there is a high likelihood of prevalent infection amongst victims of sexual assault and it is well known that follow up rates are low (Seña et al 2015). It is also important because men who use violence against their female partners are more likely to have concurrent sexual partners, and are more likely to refuse to use condoms (Fanslow et al 2008).

### **2.3.4 Mental health assessment**

Assessment needs to be undertaken to ascertain if the person is experiencing depression, anxiety, and/or post-traumatic stress disorder. Depression, extreme anxiety, agitation or enraged behaviour or excessive drug and/or alcohol use or abuse may also be the result of experiences of violence. If a person presents with these signs and symptoms, make direct enquiries about their experiences of violence. This will provide opportunities to determine if improved safety might alleviate mental health problems.

Answers to the following questions from the health and risk assessment will give you a starting point to determine if additional follow-up is needed in this area.

Have you ever considered hurting yourself/suicide? and

Is alcohol or substance misuse a problem for you or your partner?

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.

Note: Use caution when prescribing tranquillisers or anti-depressants to victims of IPV. While there is a need to properly identify and treat mental disorders (including depression), some studies have indicated that these drugs are over-prescribed to women in abusive relationships, and that these drugs may place the woman at increased risk of more serious abuse. Proper treatment for any identified mental disorder for victims of IPV should include addressing the abuse as a central part of treatment. Any treatment should also convey to the person that abuse may be a causative factor in their mental health problems.

### **Risk of suicide or self-harm**

There is a strong association between victimisation from IPV and self-harm or suicide (Fanslow and Robinson 2004). Psychological/emotional abuse in the context of intimate relationships can contribute to the victim's feelings of worthless, and perceived lack of options can leave a person who has experienced violence thinking that suicide is their only escape. Health care providers need to consider assessing possible suicide risk by identified victims. Signs associated with high risk of suicide include (Rives 1999):

- 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.

Guidelines are available for the assessment and management of people at risk of suicide (see Appendix G).

[www.health.govt.nz/publication/assessment-and-management-people-risk-suicide](http://www.health.govt.nz/publication/assessment-and-management-people-risk-suicide)

### **2.3.5 If intimate partner violence is identified, assess the children'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/ren safe and enabling the abused partner to get real and appropriate help.

#### **Ask**

Has anyone physically hurt the child/ren?

#### **Questions and issues to consider when assessing risks the abusive partner may pose to children**

- Does the abuser have access to the child/ren?
- Has the abuser ever hurt or threatened to hurt or kill the child/ren?
- Has the abuser ever removed or threatened to remove the child/ren from the abused partner's care?
- Have the child/ren ever witnessed the partner abuse (physical or verbal) occurring?
- Has the abuser ever hit the child/ren with belts, straps or other objects that have left marks, bruises, welts or other injuries?
- Has the abuser ever touched or spoken to the child/ren in a sexual way?
- Have the child/ren tried to intervene to protect the abused partner from the abuser?
- Were the child/ren injured as a result?

#### **Questions that may assist assessment of risks that the abused partner may pose to the child/ren**

'When women are experiencing the sort of abuse you have described to me, it can affect their ability to parent in the way they would if they were free from abuse. Is this true for you? In what ways has your parenting been affected?'

'Are you ever afraid that you might hurt your child/ren?'

'Have you ever hurt your child/ren?'

'Do you know what practical help there is to assist you?'

Note that asking these questions of the abused partner will provide you with some information about the child's safety, but will not necessarily provide a complete picture. Information from other sources (eg, grandparents, other family members or CYF) may be needed. In all cases, document what you have been told and consult with experienced colleagues if you have concerns about risk to children.

If intimate partner violence exists, and action is needed to protect the children, follow the procedures outlined in Section 1.

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, and with the duty social worker at CYF. If available, consult with the social work department or specialist child protection team for your service.

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?
- Make sure the abused partner has information on how to contact support agencies (for example, the Police, refuge, CYF) if problems arise.
- Ensure follow-up is planned and agreed on.
- Reinforce the importance of keeping children safe, and not minimising the negative impact of witnessing violence. It may also be useful to consider to what extent violence is impacting on the abused person's ability to parent his/her children.

## 2.4 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. This is important 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.

However, health care providers also have 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 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. Note however that this does not mean placing the responsibility for ‘solving’ the violence solely on the person who has experienced it.

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 (eg, a health social worker), or with a specialised family violence support agency.

Information obtained during the health and risk assessment (see section 2.5) can help you and the person 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. However, as with child abuse and neglect, risk assessment for IPV is not a precise science. 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. If the person discloses experience of violence of the types described in the routine enquiry and health and risk assessment questions, then they are likely to already be at high risk of experiencing future violence. Answers to single questions (eg, ‘do you believe your partner is capable of killing you?’) may also be sufficient for determining that the person is at high risk, and should prompt assertive actions by the health care system, and other agencies to help and support the person experiencing violence.

Safety planning should not be the sole responsibility of the person who has experienced the abuse. While there may be things that the person can do to increase their safety (and they are likely already actively engaged in safety strategies of their own), they may be disclosing the violence to you as part of their efforts to get help and be safe, and may be looking to you to provide help and assistance to address their partner’s behaviour.

Remember, safe practice involves consulting with the person, and senior colleagues, to determine safety options for the future.

### **2.4.1 Imminent threat/extremely high-risk situations**

In situations of imminent threat, or extremely high risk (ie, 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 policy of the organisation where you work. This may include calling on-site security, if available, or the Police (phone 111).

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.

### **2.4.2 High risk**

Don't make these decisions on your own. Consult with a senior colleague, a health social worker, and/or a community agency family violence specialist.

#### **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 patient (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 or Police.

Any decision about reporting a suspected incident 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 patient, eg, '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 (ie, 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 individual 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 (refer to the Crimes Act 1961, Appendix H, Appendix I).

Health care provider options include the following:

- Express your concern for the person's safety (and that of their children, if relevant).
- If possible within your organisation, initiate a multidisciplinary response (eg, with social work, or other in-house resources).
- Depending on the person's health needs, and the resources of the health care organisation, consider arranging inpatient care, which can allow the person both temporary respite and further opportunity to connect with in-house support services (eg, social workers) or external support agencies (eg, refuge).
- Active referral to a community agency that specialises in responding to family violence is required.
- If inpatient care cannot be arranged, help the person access emergency shelter/refuge.
- 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 intimate partner violence is presented in Appendix J.
- 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](http://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](http://www.privacy.org.nz/how-to-comply/sharing-information-about-vulnerable-children)).

### **2.4.3 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 (ie, low-level recent or low-level ongoing violence), it is still important to inform the patient 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 (eg, refuge, other advocacy groups). Make sure they have contact details for these organisations, and that they have a safe place to keep the information. Discovery of the information by a violent partner has the potential to escalate violence.
- Let the person know about legal options (police safety orders and protection orders), or other supports that might be available if they need help (eg, 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 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 patients**

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. While the person may not choose to take any action at this time, be aware that your support can make it easier for the person to seek further assistance when they are ready.

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 (eg, 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 (eg, refuge, or other advocacy groups). These agencies can offer telephone and other support and advice, as well as safe housing, or help and advice about making their own home more secure
- help from the Police (eg, police safety orders), courts (eg, protection orders), and other government agencies (eg, Work and Income (emergency benefits), and Housing New Zealand)
- help from you, and or from others in the health or social services.

### **2.4.4 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 (eg, counselling, information sources).

Follow up as appropriate.

## **2.5 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 patient 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’?

## 2.5.1 Imminent threat/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 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 (ie, less than 48 hours ago), they need to be given the post-strangulation discharge information (see Appendix K).

### 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 (eg, if discharged from hospital, ensure their primary care provider knows about and can follow-up on safety issues).

## 2.5.2 Moderate risk, or patients 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 J. If they don't want to take a copy, talk through the contents of the plan.

### Follow-up

#### After disclosure of current or past IPV

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 (eg, 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) (Office of the Commissioner for Children 2000 and 2003).

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?’

## **2.5.3 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 patient 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.

## **2.5.4 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 partner abuse intervention 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:

- all adults who disclose IPV should be offered referral to specialist family violence support services
- 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 Provide the adult with referral information for a specialist family violence support agency**

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. Provide the adult with active referral and ensure health care provider follow-up**

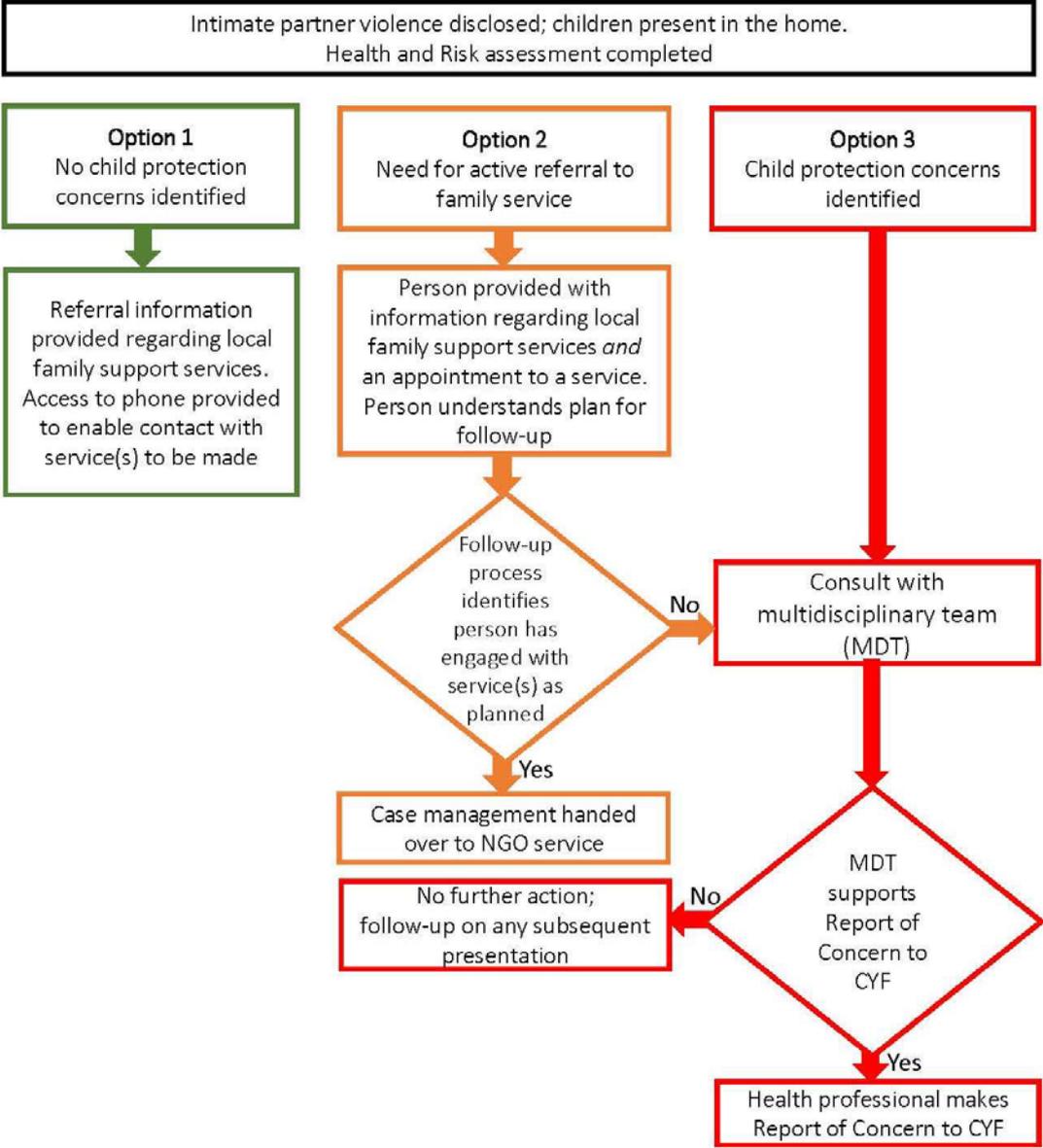
This intervention requires the health professional to contact an appropriate local family support agency during the episode of care and set a mutually agreed appointment time between the individual and a worker at the family support service. This intervention allows for the adult to take responsibility 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.

**Figure 4: Referral options when intimate partner violence is disclosed, and child(ren) are present in the home**



## 2.6 Documentation

Thorough and accurate documentation of the health consultation is important for multiple reasons. Completing the relevant documentation can assist your practice, by providing an aide memoire and can help you and the person to identify and work through the relevant steps and options.

Appropriate documentation can be instrumental in ensuring that appropriate support is offered to the person when they next return to the health care setting. Careful documentation of the abuse can assist abused adults to obtain protection orders immediately or in the future. Let the person know about the documentation, so that they can make use of this resource if they need it later.

Make sure you record information pertaining to the person's health, and the safety assessment. Include your assessment of potential for serious harm, suicide and the health impact of IPV.

### Confidentiality of abuse documentation on the medical record

Care must be taken to ensure the confidentiality of any information about abuse recorded on the medical record, particularly if the notes for other members of the family are stored in the same file.

If the perpetrator finds out that the victim has disclosed the violence, the victim may be at increased risk from retributive violence for having revealed the 'family secret'. It is best for notes for each individual to be maintained in a separate file. Documentation recommendations from the United States of America Family Violence Prevention Fund (2004) are outlined below (Family Violence Prevention Fund 2004).

#### 2.6.1 Document relevant history

- Record the chief complaint or history of present illness or injury.
- Record details of the abuse and its relationship to the presenting problem.
- Document any concurrent medical problems that may be related to the abuse.
- For current IPV victims, document a summary of past and current abuse, including:
  - social history, including person's relationship to the perpetrator, and the perpetrator's name
  - person's statement about what happened, not what led up to the abuse incident (eg, 'my partner Joe Brown kicked me in the stomach' rather than 'arguing over money')
  - include the date, time and location of incidents where possible
  - write down the person's actual appearance and observed demeanour (eg, 'tearful, shirt ripped' not your opinion, eg, 'distraught')
  - write down any objects or weapons used in an assault (eg, knife, vacuum cleaner hose, closed or open fist)
  - include person's description of any threats made, or other type of psychological/emotional abuse
  - the names or descriptions of any witnesses to the abuse.

## **2.6.2 Document results of examinations undertaken**

- Include findings related to physical, neurological, gynaecological, or mental status examinations, indicated.
- If any injuries are noted (past or present), describe the injury: its type, colour, texture, size and location. Do not attempt to date the age of the bruises.
- Use a body map and/or photographs to supplement the written description.

## **2.6.3 Document results of assessment, intervention and referral**

- Record information pertaining to the person's health and safety assessment, including your assessment of potential for serious harm, suicide and health impact of IPV.
- Document post-strangulation assessment and intervention provided (Appendix K).
- Document referrals made, options discussed, and follow-up arrangements arranged.
- Include the date and time of your contact with the victim, when you wrote your notes (if different from the time of contact).
- In the event that the person declines to have the information recorded:
  - in situations where statutory referrals have been made, you should still record information from the health and risk assessment, the rationale for making a statutory referral and the referrals made
  - if the level of risk is moderate, and the person has declined to have the health and risk documented, then record that they have declined the documentation, and do record any referrals provided.
- Include a name, a legible signature and practitioner designation, if notes are handwritten.

## **2.6.4 If person does not disclose IPV victimisation**

For suspected cases of abuse, document that assessment was conducted and that the person did not disclose abuse.

If you still suspect abuse, document the reasons for your concerns, (eg, 'physical findings are not congruent with history or description' 'patient presents with indications of abuse').

## **2.6.5 Document laboratory and other diagnostic procedures**

Record the results of any laboratory tests, X-rays or other diagnostic procedures, and their relationship to the current or past abuse.

## **2.6.6 Collection of physical evidence**

In some circumstances, collection of physical evidence may be required to assist in any legal proceedings that the person or others choose to initiate. It is important for all health care providers to have a general level of training and expertise around this issue. In some instances specially trained health care providers can be called upon. Doctors for Sexual Abuse Care are specially trained to undertake examinations for sexually abused patients who require examination for forensic evidence. In cases where this help is not available, with the patient's permission, collection of physical evidence associated with the assault can be undertaken.

Steps for collection and safe storage 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 patient's name, and the name of the person who collected the items. Sign across the seal
- keep the envelope in a secure place (eg, 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.

### **2.6.7 Photographs**

Many health care organisations now regard photographs as a routine supplement for the medical records, and do not require written patient permission prior to photographing injuries. Consult the policies and procedures for your organisation. Note that thorough written documentation and body maps are always required, and cannot be replaced by photographs.

Persons with injuries can also be offered medical photography from a forensically trained photographer. This service may be provided by the Police.

Sexual assault photographs should only be taken by a DSAC trained/accredited doctor.

### **Conclusion**

After the IPV health intervention has been completed and you have implemented plans for the health care of the person, it is appropriate to seek supervision and/or peer support for yourself. This can include a conversation with a senior colleague, a family violence intervention champion, or other colleague. In some cases, it may include a formal debrief or case review. These steps are an important part of self-care for you as a health care provider, and provide important opportunities to reflect on practice.

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# Glossary

**Child** unborn children and children aged 0–14 years old.

**Child abuse** means the harming (whether physically, emotionally, or sexually), ill treatment, abuse, neglect or deprivation of any child or young person.

**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. It may include, but is not restricted to: rejection, isolation or oppression; deprivation of affection or cognitive stimulation; inappropriate and continued criticism; threats; humiliation; accusations; inappropriate expectations of, or towards, the child or young person; exposure to family violence; corruption of the child or young person through exposure to family violence; corruption to the child or young person through exposure to, or involvement in, illegal or anti-social activities; the negative impact of the mental or emotional condition of the parent or caregiver; the negative impact of substance abuse by anyone living in the same residence as the child or young person.

**Child neglect** is any act or omission that results in impaired physical functioning, injury and/or development of a child or a young person. It may include, but is not restricted to:

- *physical neglect* – failure to provide the necessities to sustain the life or health of the child or young person
- *neglectful supervision* – failure to provide developmentally appropriate and/or legally required supervision of the child or young person, leading to an increased risk of harm
- *medical neglect* – failure to seek, obtain or follow through with medical care for the child or young person, resulting in their impaired functioning and/or development
- *abandonment* – leaving a child or young person in any situation without arranging necessary care for them and with no intention of returning
- *refusal to assume parental responsibility* – unwillingness or inability to provide appropriate care or control for a child or young person.

**Child physical abuse** is any act or acts that may result in inflicted injury to a child or young person. It may include, but is not restricted to bruises and welts; cuts and abrasions; fractures or sprains; abdominal injuries; head injuries; injuries to internal organs; strangulation or suffocation; poisoning; burns or scalds.

**Child sexual abuse** is any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not. It may include, but is not restricted to: non-contact abuse; exhibitionism; voyeurism; suggestive behaviours or comments; exposure to pornographic material; contact abuse; touching breasts; genital/anal fondling; masturbation; oral sex; object or finger penetration of the anus or vagina; penile penetration of the anus or vagina; encouraging the child or young person to perform such acts on the perpetrator; involvement of the child or young person in activities for the purposes of pornography or prostitution.

**Family violence** is violence or abuse of any type, perpetrated by one family member against another family member. It includes child abuse, partner abuse and elder abuse.

- *Physical abuse* includes acts of violence that may result in pain, injury, impairment or disease. This may include hitting, choking/strangulation 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 differences between accidental injury and abuse can be slight and require expert investigation.

- *Psychological and emotional abuse* includes any behaviour that causes anguish or fear. Intimidation, harassment, damage to property or animals (pets), threats of physical or sexual abuse, the removal of decision-making powers (in relation to adults), and (in relation to a child) exposing the child to the 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 forcing an individual to witness sexual acts in person or on media. It includes sexual acts imposed on a person unable to give consent, or sexual activity with an adult with mental incapacity who is unable to understand issues of consent.

**Intimate partner violence** (IPV; also called partner abuse) is 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** is an enquiry, either written or verbal, by health care providers to an individual about their personal history of partner abuse, child abuse or neglect. Unlike indicator-based questioning, routine enquiry means routinely questioning all individuals, or specified categories of individuals, about abuse.

**Young person:** 14–17 years old.

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# Appendix A:

## Assessing for child neglect

The guide for prevention, assessment and intervention of child neglect (DePanfilis 2006) identifies two primary questions that should be asked in order to identify whether child neglect has occurred:

- Do the conditions or circumstances indicate that a child's basic needs are unmet?
- What harm or threat of harm may have resulted?

To answer these questions, sufficient information is required to assess the degree to which neglect can or may result in significant harm or risk of significant harm. The decision often requires considering patterns of caregiving over time. The analysis should focus on examining how the child's basic needs are met and on identifying situations that may indicate specific omissions in care that have resulted in harm or the risk of harm to the child (DePanfilis 2006). While information on all these domains will not be accessible to all health care providers, the list provides some indications of issues that may require consideration.

Further questions which may indicate that a child's physical or medical needs and supervision may be unmet include the following:

- Have the parents or caregivers failed to provide the child with needed care for a physical injury, acute illness, physical disability or chronic condition?
- Have the parents or caregivers failed to provide the child with regular and ample meals that meet basic nutritional requirements, or have the parents or caregivers failed to provide the necessary rehabilitative diet to a child with particular health problems?
- Have the parents or caregivers failed to attend to the cleanliness of the child's hair, skin, teeth and clothes? Note: It can be difficult to determine the difference between marginal hygiene and neglect. Health care providers should consider the chronicity, extent and nature of the condition, as well as the impact on the child.
- Does the child have inappropriate clothing for the weather? Health care providers should consider the nature and extent of the conditions and the potential consequences to the child. They also must take into account diverse cultural values regarding clothing.
- Does the home have obviously hazardous physical conditions (eg, exposed wiring or easily accessible toxic substances) or unsanitary conditions (eg, faeces- or trash-covered flooring or furniture)?
- Does the child experience unstable living conditions (eg, frequent changes of residence or evictions due to the caretaker's mental illness, substance abuse or extreme poverty)?
- Do the parents or caregivers fail to arrange for a safe substitute caregiver for the child?
- Have the parents or caregivers abandoned the child without arranging for reasonable care and supervision?

The effects of neglect are as bad as, if not worse than, physical and sexual abuse. They include serious long-term disorders of attachment and behaviour, delays in cognitive and emotional development, mental health disorders, substance abuse, risk-taking sexual behaviour, violence and educational and employment failure (Stoltenborgh et al 2013).

# Appendix B: HEEADSSS

**Table 4: The HEEADSSS psychosocial interview for adolescents**

<b>Key:</b>	
Green = essential questions	
Blue = as time permits	
Red = optional or when situation requires	
<b>Home</b>	<b>Drugs</b>
Who lives with you? Where do you live? Do you have your own room?	Do any of your friends use tobacco? Alcohol? Other drugs?
What are relationships like at home?	Does anyone in your family use tobacco? Alcohol? Other drugs?
To whom are you closest at home?	Do you use tobacco? Alcohol? Other drugs?
To whom can you talk at home?	Is there any history of alcohol or drug problems in your family? Does anyone at home use tobacco?
Is there anyone new at home? Has someone left recently?	Do you ever drink or use drugs when you're alone?
Have you moved recently?	(Assess frequency, intensity, patterns of use or abuse, and how youth obtains or pays for drugs, alcohol, or tobacco)
Have you ever had to live away from home? (Why?)	(Ask the CRAFFT questions)
Have you ever run away? (Why?)	
Is there any physical violence at home?	
<b>Education and employment</b>	<b>Sexuality</b>
What are your favourite subjects at school? Your least favourite subjects?	Have you ever been in a romantic relationship?
How are your grades? Any recent changes? Any dramatic changes in the past?	Tell me about the people that you've dated. OR Tell me about your sex life.
Have you changed schools in the past few years?	Have any of your relationships ever been sexual relationships?
What are your future education/employment plans/goals?	Are your sexual activities enjoyable?
Are you working? Where? How much?	What does the term 'safe sex' mean to you?
Tell me about your friends at school.	Are you interested in boys? Girls? Both?
Is your school a safe place? (Why?)	Have you ever been forced or pressured into doing something sexual that you didn't want to do?
Have you ever had to repeat a class? Have you ever had to repeat a grade?	Have you ever been touched sexually in a way that you didn't want?
Have you ever been suspended? Expelled? Have you ever considered dropping out?	Have you ever been raped, on a date or any other time?
How well do you get along with the people at school? Work?	How many sexual partners have you had altogether?
Have your responsibilities at work increased?	Have you ever been pregnant or worried that you may be pregnant? (females)
Do you feel connected to your school? Do you feel as if you belong?	Have you ever gotten someone pregnant or worried that that might have happened? (males)
Are there adults at school you feel you could talk to about something important? (Who?)	What are you using for birth control? Are you satisfied with your method?
	Do you use condoms every time you have intercourse?
	Does anything ever get in the way of always using a condom?
	Have you ever had a sexually transmitted disease (STD) or worried that you had an STD?

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**Key:**

Green = essential questions

Blue = as time permits

Red = optional or when situation requires

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**Eating**

What do you like and not like about your body?

Have there been any recent changes in your weight?

Have you dieted in the last year? How? How often?

Have you done anything else to try to manage your weight?

How much exercise do you get in an average day? Week?

What do you think would be a healthy diet? How does that compare to your current eating patterns?

Do you worry about your weight? How often?

Do you eat in front of the TV? Computer?

Does it ever seem as though your eating is out of control?

Have you ever made yourself throw up on purpose to control your weight?

Have you ever taken diet pills?

What would it be like if you gained (lost) 10 pounds?

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**Activities**

What do you and your friends do for fun? (with whom, where, and when?)

What do you and your family do for fun? (with whom, where, and when?)

Do you participate in any sports or other activities?

Do you regularly attend a church group, club, or other organized activity?

Do you have any hobbies?

Do you read for fun? (What?)

How much TV do you watch in a week? How about video games?

What music do you like to listen to?

---

**Suicide and depression**

Do you feel sad or down more than usual? Do you find yourself crying more than usual?

Are you 'bored' all the time?

Are you having trouble getting to sleep?

Have you thought a lot about hurting yourself or someone else?

Does it seem that you've lost interest in things that you used to really enjoy?

Do you find yourself spending less and less time with friends?

Would you rather just be by yourself most of the time?

Have you ever tried to kill yourself?

Have you ever had to hurt yourself (by cutting yourself, for example) to calm down or feel better?

Have you started using alcohol or drugs to help you relax, calm down or feel better?

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**Safety**

Have you ever been seriously injured? (How?) How about anyone else you know?

Do you always wear a seatbelt in the car?

Have you ever ridden with a driver who was drunk or high? When? How often?

Do you use safety equipment for sports and or other physical activities (for example, helmets for biking or skateboarding)?

Is there any violence in your home? Does the violence ever get physical?

Is there a lot of violence at your school? In your neighbourhood? Among your friends?

Have you ever been physically or sexually abused? Have you ever been raped, on a date or at any other time? (If not asked previously)

Have you ever been in a car or motorcycle accident? (What happened?)

Have you ever been picked on or bullied? Is that still a problem?

Have you gotten into physical fights in school or your neighbourhood? Are you still getting into fights?

Have you ever felt that you had to carry a knife, gun, or other weapon to protect yourself? Do you still feel that way?

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Source: Goldenring and Rosen 2004

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# Appendix C: Assessment and referral for children under 12 at risk of suicide

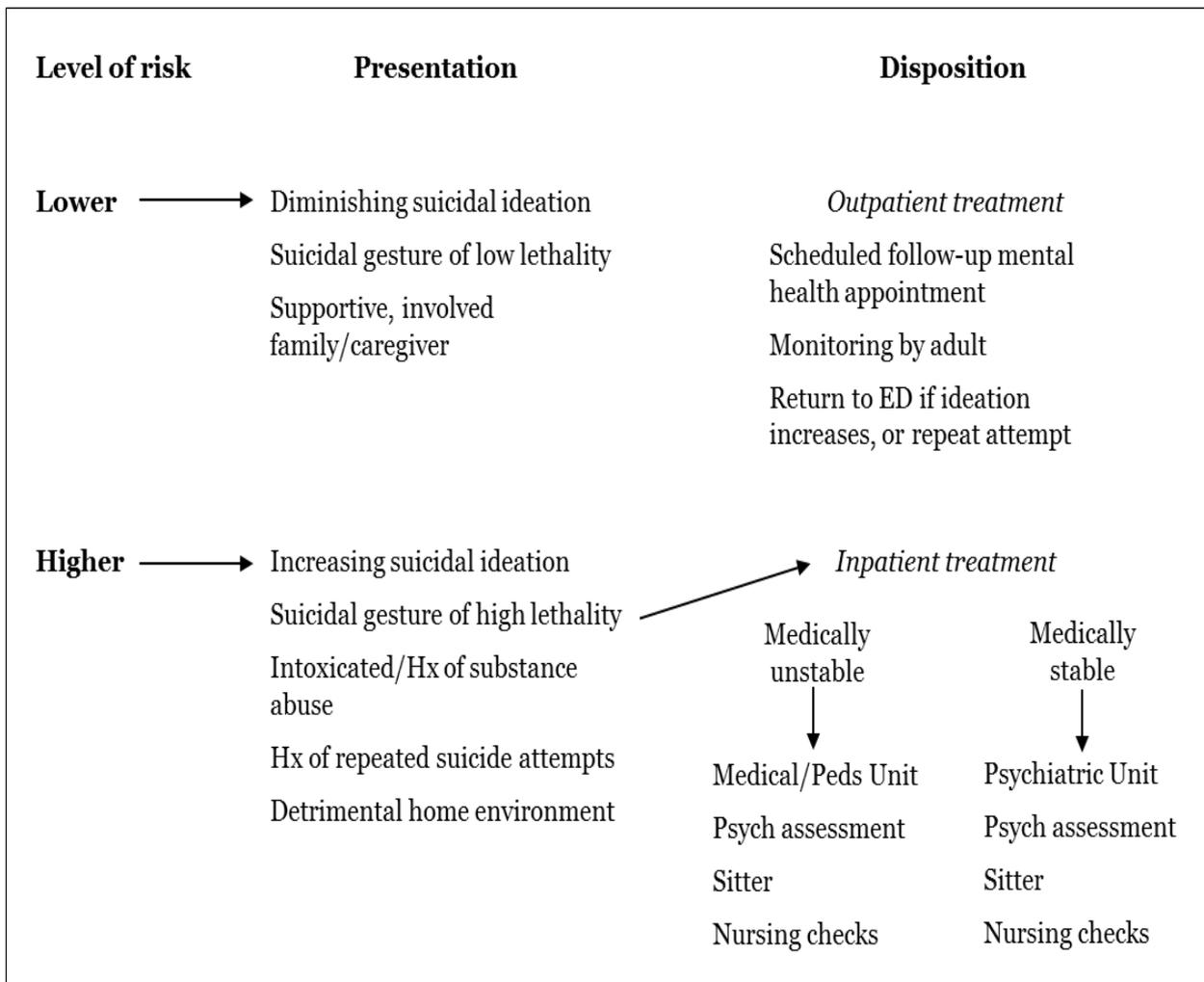
**Figure 5: Factors to consider when assessing the child's level of risk of suicidal behaviour**

Seriousness of injury	Current presentation
<p><b>Suicidality history</b></p> <p>History (Hx) of prior suicide attempts<sup>1</sup></p> <p>Child's Hx of prior suicide attempts<sup>2</sup></p> <p>Hx of suicidal ideation<sup>1</sup></p> <p>Child's Hx of suicidal ideation<sup>2</sup></p>	<p>Intend to die<sup>1</sup></p> <p>Child's intent to die<sup>2</sup></p> <p>Suicide plan, method, access to method<sup>1</sup></p> <p>Current psychiatric symptoms (depression, psychosis, etc.)<sup>1,2</sup></p> <p>Child's reasons for living<sup>1</sup></p> <p>Current substance intoxication</p> <p>Cognitive level of child</p>
<p><b>Medical history<sup>2</sup></b></p> <p>Hx of psychiatric diagnoses</p> <p>Hx of mental health treatment and/or psychotropic drug use</p> <p>Hx of substance use or abuse</p> <p>Number of previous ED visits for suspicious accidents</p> <p>Chronic illness-frequency requiring compliance</p>	<p><b>Environmental factors<sup>1,2</sup></b></p> <p><b>Family</b></p> <p>Unsecured potential suicide methods (guns, medications, etc)</p> <p>Recent suicide, death, or loss in family</p> <p>Suicidal ideation or suicidal attempts in family</p> <p>Presence of child abuse or neglect</p> <p>Supportiveness of parents or caregivers</p> <p style="padding-left: 20px;">Family turmoil</p> <p style="padding-left: 40px;">Marital problems</p> <p style="padding-left: 40px;">Domestic violence</p> <p style="padding-left: 60px;">Financial crisis</p> <p style="padding-left: 60px;">Incarceration</p> <p style="padding-left: 40px;">Alcohol and substance use</p> <p><b>Child</b></p> <p>Social isolation (ask about the effects)</p> <p>Bullying or being bullied (ask about the effects)</p> <p>Changes in school performance</p>

Notes: 1 denotes questions addressed to the child, and 2 denotes questions addressed to the child's caregiver. The interviewer should also investigate with the child the impact of issues raised by the caregiver (eg, how does being bullied make you feel?)

Source: Tischler et al 2007

**Figure 6: ED disposition of suicidal children**



\* All children should be carefully monitored (with repeated checks) by health care staff in all inpatient settings to avoid suicide in these environments.

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# Appendix D: Recommended intimate partner violence routine enquiry guidelines for different settings

## 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 (eg, cervical screening, mammography).
- As part of Well Child assessments.
- At other times that may suggest high risk (eg, alcohol/drug abuse consultations, sexual health consultations (eg, 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 partner abuse 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 individuals 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?**

- 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.

## **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, women should be questioned about any IPV, physical, sexual, and psychological abuse that occurred any time in their lifetime.
- 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.

**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 E: Signs and symptoms associated with intimate partner violence

## Signs and symptoms associated with intimate partner violence (IPV)

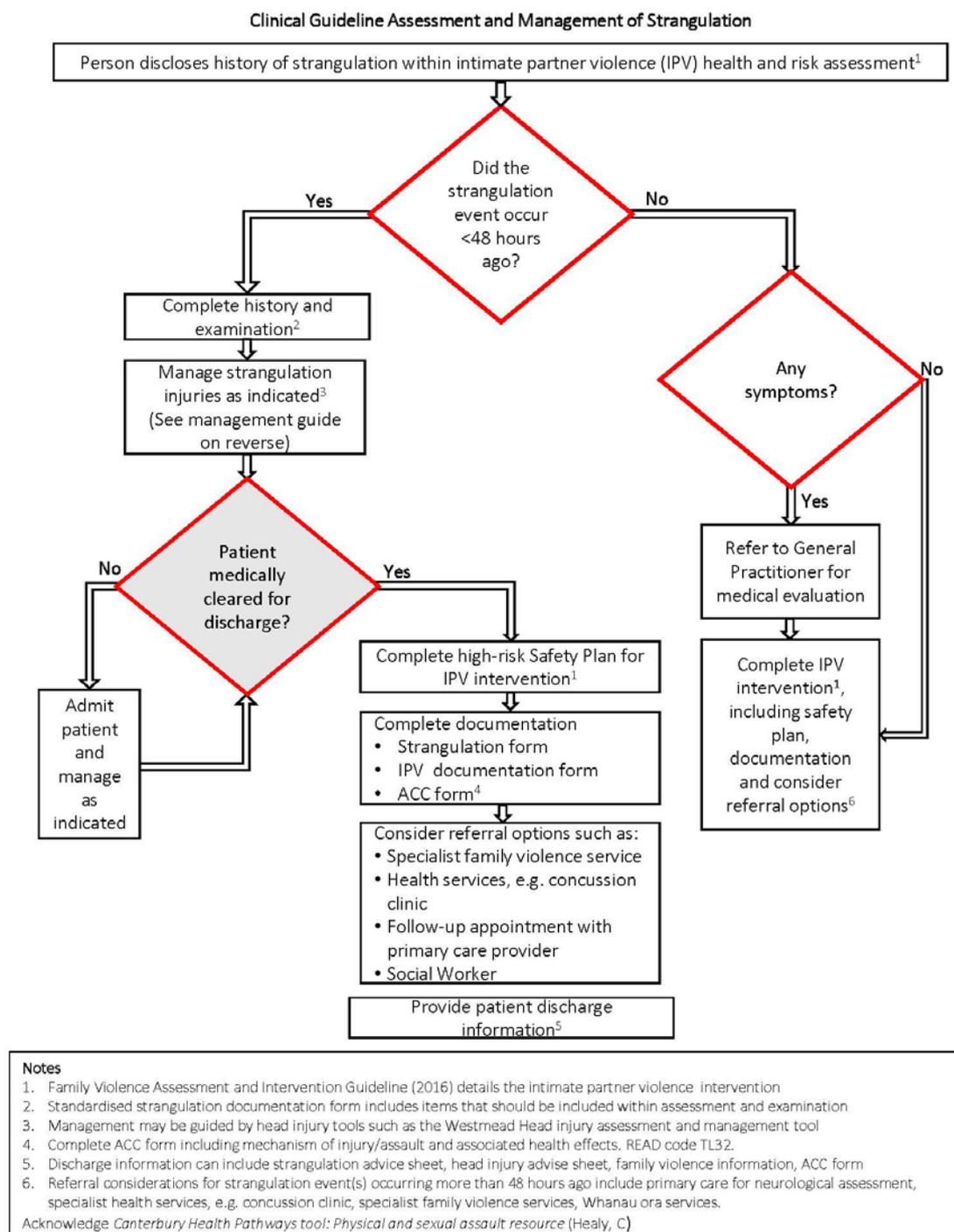
The factors below may raise suspicion of IPV, but are not diagnostic.

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

Source: Injury Prevention Research Centre 1996

# Appendix F: Clinical guideline: assessment and management of strangulation

Figure 7: Clinical guideline: assessment and management of strangulation



## **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 L) 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

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# Appendix G: The assessment and management of people at risk of suicide

See [www.health.govt.nz/system/files/documents/publications/suicide\\_guideline.pdf](http://www.health.govt.nz/system/files/documents/publications/suicide_guideline.pdf)

Anyone who talks about suicide should be taken seriously. People who die by suicide have often previously expressed suicidal thoughts or displayed warning signs.

- Clinicians should involve whānau/family/support people of the suicidal person wherever possible when working with that person (see Notes below).
- Any person at risk should be re-assessed regularly, particularly if their circumstances have changed. A suicidal person's mental state and suicide risk can fluctuate considerably over time.
- Health care providers should contact a suitably trained mental health clinician whenever anyone seeks assistance following an act of deliberate self-harm, irrespective of intent, or who is expressing suicidal ideation.
- Case notes should be augmented with structured assessments. Clinicians often overlook key information when recording their suicide assessments in case notes. Adding structured assessments provides a systematic approach to avoiding such oversights.
- A person's clinical case notes should include the following information if they have been assessed for suicide risk:
  - relevant suicide risk assessments
  - whānau/family members' concerns
  - previous psychiatric history (see Notes below)
  - previous treatment received
  - risk/benefit assessments of key clinical decisions.
- People should be followed up closely over the week following discharge or disclosure, after an inpatient admission or primary care consultation, especially if they fail to attend their follow-up appointment. The week following disclosure is a very high-risk time for people who have been suicidal.
- Training in suicide assessments improves practitioner performance, appropriate referrals and overall care.
- All clinicians who work with people who self-harm or are suicidal should be in regular clinical supervision to mitigate the negative impact that this work can have, both on them and on the quality of their work with suicidal people.
- Culturally appropriate services should be offered to the suicidal person whenever available.

Notes: Involving whānau/family/support in situations of family violence may not always be appropriate. Remember to check with the patient privately to ensure that s/he nominates the safe support people to be involved. Remember also that responses to victimisation can present as psychiatric/psychological disturbance. You need to consider the possibility that the symptoms may be indicative of victimisation, rather than a mental health problem.

## **Management of depression/anxiety, other mental health issues for victims of violence**

Trauma and victimisation can create many symptoms that masquerade as mental illness. Research with women who present with these symptoms who are currently in abusive relationships indicates that the following are some of the helping options women most need (Hager 2011).

Women need:

- sleep
- to be asked, specifically and comprehensively, about domestic violence
- to be heard and believed. Never minimise or disregard what a woman is saying
- information and language to describe their experiences and make informed choices
- to be safe – to be offered and encouraged to use appropriate support services
- time to think and reflect
- not to be pathologised it may be a reasonable response to a dangerous and traumatic situation
- help women develop a safety plan
- help women access appropriate support and information groups
- never send women home to an abusive partner – unless she insists.

Remember medication can make her less able to protect herself and the children.

Do not judge her parenting by the abuse she has put up with – it may have kept the children as safe as possible.

Provide information – like the power and control wheel and the cycle of violence – to help her understand her situation.

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# Appendix H: Legal options

Health care providers can support a patient's efforts to get legal protection by responding promptly and positively (within hours, where possible) to requests for letters/medical documentation confirming patient's history, presentation, and the results of consultations related to IPV. These requests may come directly from the patient, from the patient's lawyer, or from an advocate for the patient.

## Protection orders

Any person who has been injured or threatened can obtain a protection order through the Family Court. The abused person can make an application with the assistance of legal aid or through a lawyer. Under the terms of the Domestic Violence Act 1995, temporary protection orders, valid for a period of three months, can be served without prior notice to the alleged abuser. Children of the abused partner are automatically covered by the order. The order grants the person protection from being physically, sexually or psychologically abused, or from the threat of such actions against her.

It is important for the abused person to be aware that obtaining a protection order may trigger additional attacks. For this reason, it is important that the person understands what protection the order is intended to provide, and that they contact the Police every time their partner threatens or assaults them. Refuge advocates, the abused person's lawyer and or the Police should all be able to explain to the person how to access and use the orders in the safest and most effective way.

## Police safety orders

Police safety orders (PSOs) can also provide protection (see [www.police.govt.nz/safety/home.domesticviolence.html#police-safety-order](http://www.police.govt.nz/safety/home.domesticviolence.html#police-safety-order)).

A PSO is issued in circumstances where the Police have reasonable grounds to believe that family violence has or may occur. An order lasts for up to five days, but usually one or two days. The purpose of the PSO is to protect people at risk from violence, harassment or intimidation. The order stays in force until the expiry time/date listed on the order. The Police do not need the consent of the person at risk to issue the order.

### What is the effect of a PSO?

When a PSO is made, the person bound by the order must leave the address while the PSO is in force, even if they own the address and/or normally live there. The bound person must not assault, threaten, intimidate or harass the protected person (the person at risk) or encourage anyone else to do the same. They must not follow, stop or contact in any way the person at risk in any place, either at home, at work or anywhere else the person at risk visits often. The bound person must surrender all firearms and their firearms licence to the Police for the period of the PSO. The PSO also protects any children living with the person at risk, and any conditions of parenting orders or agreements permitting access or care by the bound person are suspended. The Police may detain the bound person for up to two hours to issue and serve the PSO. There is no right of appeal.

## **What happens if a PSO is breached?**

If the bound person does anything that is not permitted by the PSO, the Police can take the person in custody and bring them before the court. The court may issue a warrant to arrest the bound person if it is required to bring them before the court. The court may:

- release the bound person without any further order
- direct the Police to issue another PSO
- issue a temporary protection order (if the person at risk does not object).

The Court does not need an application from anyone to issue a temporary protection order.

No criminal convictions result from the issue of a PSO.

Other offences, such as assaults or property damage, will be investigated and charges laid where sufficient evidence exists.

## **Assault charges**

Assault charges can also be laid against the abuser. These charges are heard in the criminal court. Adequate documentation of the abused person's past and present injuries can assist both these processes.

If the person wishes, they can lay charges against their partner through the criminal court. In addition, it is Police policy to press charges against the abuser when they have evidence that an assault has occurred. However, these cases can take several months to come to trial, and the person may be at increased risk of assault during this waiting period.

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# Appendix I: Excerpts from relevant legislation

## **Bail Amendment Act 2000**

### **Police Bail (section 22)**

If a person charged with domestic violence offences is granted police bail, the police are able to impose any conditions they consider 'reasonably necessary to protect' the alleged victim and anyone living with the victim.

## **Sentencing Act 2002**

### **Protection orders (section 123B)**

Courts can issue protection orders where:

1. it is satisfied that the order is 'necessary for the protection of the victim'
2. the victim does not object to the order being issued; and
3. the offender has been convicted of a domestic violence offence or domestic violence proceedings have been filed by the victim of the offence against the offender, and those proceedings have not yet been determined.

## **Children, Young Persons, and Their Families Act 1989**

### **Paramountcy principle (section 6)**

... [the] welfare and interests of the child or young person shall be the first and paramount consideration.

### **Reporting (section 15)**

Any person who believes that any child or young person has been, or is likely to be, harmed (whether physically, emotionally or sexually) ill-treated, abused, neglected, or deprived may report the matter to a social worker or a constable.

### **Protection when disclosing (section 16)**

No civil, criminal, or disciplinary proceedings shall lie against any person in respect of the disclosure or supply or the manner of the disclosure or supply, by that person pursuant to section 15 of information concerning a child or young person (whether or not that information also concerns any other person), unless the information was disclosed or supplied in bad faith.

Note: Section 16 provides statutory protection for health care providers who suspect child abuse and/or neglect to report.

## **Responsibility for investigation (section 17)**

Where any social worker or constable receives a report pursuant to section 15 [of this Act] relating to a child or young person, that social worker or constable shall, as soon as practicable after receiving the report, undertake or arrange for the undertaking of such investigation as may be necessary or desirable into the matters contained in the report and shall, as soon as practicable after the investigation has commenced, consult with a care and protection resource panel in relation to the investigation.

## **Crimes Act 1961**

Failure to provide the necessities of life, abandonment, cruelty and abduction in relation to children are offences under the Crimes Act.

## **Domestic Violence Act 1995**

Section 3 of this Act defines domestic violence as:

- (1) ... violence against a person by any other person with whom that person is, or has been, in a domestic relationship.
- (2) **violence** means –
  - (a) physical abuse:
  - (b) sexual abuse:
  - (c) psychological abuse, including but not limited to –
    - (i) intimidation:
    - (ii) harassment:
    - (iii) damage to property:
    - (iv) threats of physical abuse, sexual abuse, or psychological abuse:
    - (iva) financial or economic abuse (for example, denying or limiting access to financial resources, or preventing or restricting employment opportunities or access to education):
    - (v) in relation to a child, abuse of the kind set out in subsection (3).
- (3) Without limiting subsection (2)(c), a person psychologically abuses a child if that person –
  - (a) causes or allows the child to see or hear the physical, sexual, or psychological abuses of a person with whom the child has a domestic relationship; or
  - (b) puts the child, or allows the child to be put, at real risk of seeing or hearing that abuse occurring –

but the person who suffers that abuse is not regarded, for the purposes of this subsection, as having caused or allowed the child to see or hear the abuse, or, as the case may be, as having put the child, or allowed the child to be put, at risk of seeing or hearing the abuse.
- (4) Without limiting subsection (2) –
  - (a) a single act may amount to abuse for the purposes of that subsection:
  - (b) a number of acts that form part of a pattern of behaviour may amount to abuse for that purpose, even though some or all of those acts, when viewed in isolation, may appear to be minor or trivial.

- (5) Behaviour may be psychological abuse for the purposes of subsection (2)(c) which does not involve actual or threatened physical or sexual abuse.

## **Domestic Violence Act 1995**

Part 6A of this Act provides for the issuing of police safety orders.

## **Health Act 1956**

Section 22C provides guidance on when health information can be released. The Act provides that:

- (1) Any person (being an agency that provides services or arranges the provision of services) may disclose health information –
  - (a) if that information –
    - (i) is required by any person specified in subsection (2); and
    - (ii) is required (or, in the case of the purpose set out in paragraph (j) of that subsection, is essential) for the purpose set out in that subsection in relation to the person so specified; or
  - (b) If that disclosure is permitted –
    - (i) by or under a code of practice issued under section 46 of the Privacy Act 1993 ...
- (2) The persons and purposes referred to in subsection (1)(a) are as follows: ...
  - (c) a Social Worker or a Care and Protection Co-ordinator within the meaning of the Children, Young Persons, and Their Families Act 1989, for the purposes of exercising or performing any of that person's powers, duties, or functions under that Act ...
  - (j) any employee of a district health board, for the purposes of exercising or performing any of that board's powers, duties, or functions under the New Zealand Public Health and Disability Act 2000.

Section 22F covers communication of information for diagnostic and other purposes, as follows.

- (1) Every person who holds health information of any kind shall, at the request of the individual about whom the information is held, or a representative of that individual, or any other person that is providing, or is to provide, services to that individual, disclose that information to that individual or, as the case requires, to that representative or to that other person.
- (2) A person that holds health information may refuse to disclose that information under this section if –
  - (a) that person has a lawful excuse for not disclosing that information; or
  - (b) where the information is requested by someone other than the individual about whom it is held (not being a representative of that individual), the holder of the information has reasonable grounds for believing that that individual does not wish the information to be disclosed; or
  - (c) refusal is authorised by a code of practice issued under section 46 of the Privacy Act 1993.

- (3) For the purposes of subsection (2)(a), neither –
- (a) the fact that any payment due to the holder of any information or to any other person has not been made; nor
  - (b) the need to avoid prejudice to the commercial position of the holder of any information or of any other person; nor
  - (c) the fact that disclosure is not permitted under any of the information privacy principles set out in section 6 of the Privacy Act 1993 –
- shall constitute a lawful excuse for not disclosing information under this section.
- (4) Where any person refuses to disclose health information in response to a request made under this section, the person whose request is refused may make a complaint to the Privacy Commissioner under Part 8 of the Privacy Act 1993, and that Part of that Act, so far as applicable and with all necessary modifications, shall apply in relation to that complaint as if the refusal to which the complaint relates were a refusal to make information available in response to an information privacy request within the meaning of that Act.

## **Health Information Privacy Code 1994**

Rule 11(2)(d) of the Health Information Privacy Code replicates Principle 11(f) of the Privacy Act 1993 concerning limits on the disclosure of personal information.

Rule 11 does not oblige an agency to disclose information. Instead it allows disclosure if an exception to the rule applies. However, an agency may decide not to disclose even though an exception to the rule applies. The decision to disclose, when permitted by the rule, remains within the agency's discretion.

Rule 11 provides:

- (1) A health agency that holds health information must not disclose the information unless the agency believes, on reasonable grounds, that ...
  - (b) the disclosure is authorised by –
    - (i) the individual concerned; or
    - (ii) the individual's representative where the individual is dead or is unable to give his or her authority under this rule ...
- (2) Compliance with subrule (1)(b) is not necessary if the health agency believes on reasonable grounds that it is either not desirable or not practicable to obtain authorisation from the individual concerned and that –
  - (a) the disclosure of the information is directly related to one of the purposes in connection with which the information was obtained; or
  - (b) the information is disclosed by a health practitioner to a person nominated by the individual concerned or to the principal caregiver or a near relative of the individual concerned in accordance with recognised professional practice and the disclosure is not contrary to the express wish of the individual or his or her representative ...
  - (d) the disclosure of the information is necessary to prevent or lessen a serious threat to –
    - (i) public health or public safety; or
    - (ii) the life or health of the individual concerned or another individual ...

- (i) non-compliance is necessary –
  - (i) to avoid prejudice to the maintenance of the law by any public sector agency, including the prevention, detection, investigation, prosecution, and punishment of offences; or
  - (ii) for the conduct of proceedings before any court or tribunal (being proceedings that have been commenced or are reasonably in contemplation) ...
- (3) Disclosure under subrule (2) is permitted only to the extent necessary for the particular purpose. ...
- (5) This rule applies to health information about living or deceased persons obtained before or after the commencement of this code.
- (6) Despite subrule (5), a health agency is exempted from compliance with this rule in respect of health information about an identifiable deceased person who has been dead for not less than 20 years.

Note: Except as provided in subrule 11(4), nothing in this rule derogates from any provision in an enactment which authorises or requires information to be made available, prohibits or restricts the availability of health information or regulates the manner in which health information may be obtained or made available (Privacy Act, Section 7). Note also that rule 11, unlike the other rules, applies not only to information about living individuals, but also about deceased persons (Privacy Act, Section 46(6)).

Should health care providers breach the Health Information Privacy Code, a complaint can be laid with the Privacy Commissioner for resolution.

While this resource has been developed with all care and after consultation with many organisations, it is not intended to be legal advice.

## **Health and Disability Services (Safety) Act 2001**

This Act's purpose as stated is to:

- (a) promote the safe provision of health and disability services to the public; and
- (b) enable the establishment of consistent and reasonable standards for providing health and disability services to the public safely; and
- (c) encourage providers of health and disability services to take responsibility for providing those services to the public safely; and
- (d) encourage providers of health and disability services to the public to improve continuously the quality of those services.

## **Health and Disability Sector Standards**

NZS 8134.1:2008 Health and Disability Services (Core) Standards contain required outcomes, standards and criteria across the whole of the health and disability sector, including home-based health care service providers. The standards include issues of quality and safe practice. They replace previous sector standards NZS 8134:2001 and NZS 8143:2008 (the National Mental Health Standard).

NZS 8134.2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards are intended to reduce the use of restraint in all its forms and to encourage the use of least restrictive practices. They replace NZS 8141:2001 (the Restraint Minimisation and Safe Practice Standard).

## **Vulnerable Children Act 2014**

The Vulnerable Children Act (VCA) forms a significant part of comprehensive measures to protect and improve the wellbeing of vulnerable children and strengthen New Zealand's child protection system.

The reforms within the VCA were proposed in the White Paper for Vulnerable Children, and confirmed in the Children's Action Plan, which was released in October 2012 after significant public consultation.

The Action Plan and the VCA are based on the premise that cross-sector collaboration and responsibility is essential to protecting vulnerable children. Chief executives from five government agencies are jointly accountable for implementing the Children's Action Plan.

Relevant provisions within the VCA include: requirements for government agencies and their funded providers to have child protections policies, and standard safety checking for paid staff in the government-funded children's workforce.

Part 2, covering child protection policies, states:

The purpose of this Part is to require child protection policies (that must contain provisions on the identification and reporting of child abuse and neglect) to be –

- (a) adopted and reported on by prescribed State services and DHBs boards; and
- (b) adopted by school boards; and
- (c) adopted by certain people with whom those services or boards enter into contracts or funding arrangements.

It is appreciated that DHBs already have child protection policies in place, as part of the VIP and their wider commitment to identifying and responding to child abuse and neglect.

Part 3, covers children's worker safety checking, and provides:

The purpose of this Part is to reduce the risk of harm to children by requiring people employed or engaged in work that involves regular or overnight contact with children to be safety checked.

The VCA contributes to the Government's Better Public Services result to reduce the number of physical assaults on children.

Legislative changes are being phased in over several years, together with other Children's Action Plan initiatives, including the roll-out of further children's teams and common competencies for all children's workers.

The requirements of the VCA should complement and strengthen the implementation of the VIP within the public health setting.

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# Appendix J: Safety plan (personal resource)

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

## 1. Avoiding injury, escaping violence

During an incident 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 (eg, 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.

Ask your neighbours to contact the Police if they hear signs of an assault occurring.

From: Auckland Domestic Violence Centre. Safety Plan.

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# **Appendix K: 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.

Your doctor or nurse today will tell you when to see your family doctor (GP) for a check.

Take this sheet and your discharge letter with you to the appointment.

# Appendix L: Acute post-strangulation documentation form

Patient name/label:

DOB: NHI:  
Contact details:

## Subjective/history

### Description of event

Date(s) and time(s) of event(s)  
.....

Who strangled you (and relationship)?  
.....

Did the person approach you from:  Front  Behind

Where on your body were you held? .....

How did the person strangle you?

- One arm:  Left  Right  Unknown
- One hand:  Left  Right  Unknown      Fist:  Open  Closed  Unknown
- Two hands
- Ligature/rope/wire: .....
- Other (please describe): .....

Consciousness (please ✓)	No	Yes	Estimated length of LOC (insert minutes/hours)
Did you faint or lose consciousness (LOC)?			

Incontinence (please ✓)	No	Yes	Urination	Defecation
Did you wet or soil yourself?				

Do you have other injuries? .....

Did you try to protect yourself?  Yes  No    How? .....

Symptoms (please ✓)	No	Yes, at presentation	Yes, at time of event to present
Headache or head pain			
Neck pain			
Difficulty breathing			
Tongue swelling			
Fits or seizures			
Confusion			
Drowsiness			
Dizziness or light-headedness			
Difficulty speaking or understanding speech			
Numbness, paralysis or weakness (usually on one side of the body)			
Loss of balance or coordination			
Difficulty walking			
Drooping eyelid			
Vision problems			
Vomiting			

Difficulty swallowing, painful throat			
Voice changes eg, raspy or hoarse: if yes, please describe			
<b>Pregnancy (please ✓)</b>	<b>No</b>	<b>Yes</b>	
Are you pregnant?			If pregnant, vaginal bleeding?
<b>Medications and drugs (please ✓)</b>	<b>No</b>	<b>Yes</b>	<b>What and when</b>
Have you taken any aspirin or warfarin or blood thinners?			
Have you taken any other medications?			
Have you taken and alcohol or other drugs?			

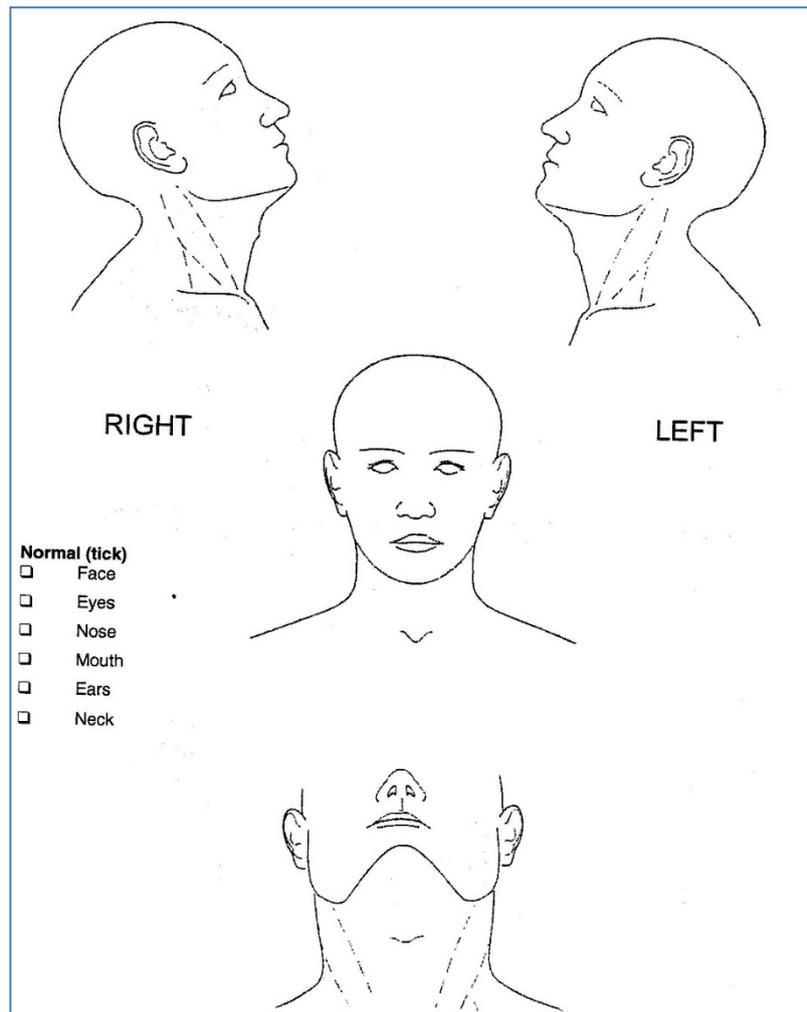
## Objective/examination

A study of 300 strangulation cases suggested that only 50 percent have physical findings on initial evaluation (Strack et al 2001).

Good lighting is necessary for a thorough examination of the head, neck and inside the mouth.

Look for strangulation injuries behind the ears, back of neck, chest and shoulder areas, eyelids (above and under), jaw and upper chin. Tick all that apply. Use body maps to record injuries.

- No injury noted/visible
- Scratch marks
- Bruising
- Red eyes
- Red spots/petechial haemorrhages
- Neck swelling



]

<b>Assessment</b> (please ✓)	<b>No</b>	<b>Yes</b>	<b>Detail</b>
Airway or breathing problems?			
Suspected brain injury?			
Other visible injuries?			
Other problems (describe)			
No obvious serious problems			

]

<b>Plan</b> (please ✓)	<b>No</b>	<b>Yes</b>	<b>Detail</b>
Discharge home?			
Refer for further assessment?			
Police contacted? (with patient consent)			
Other referrals?			

Date of assessment:..... Time of assessment.....

Assessor's name:..... Designation:..... Signature:.....

---

# Appendix M: Child abuse assessment and intervention guideline: summary

## 1 Identification of sign and symptoms of abuse

If there is clear evidence of child abuse or neglect, sufficient in your opinion to justify referral to CYF in its own right, then do not interview the child. Record any information that the child volunteers.

If there are signs and symptoms of child abuse and neglect, take a thorough history. If you have concerns about possible abuse or neglect, seek advice first; for example, from a local paediatrician, a social worker with experience in child protection or Child Youth and Family (CYF).

A child assessment tool can support a better quality structured clinical assessment for children up to the age of two years when used in conjunction with good clinical judgement, access to supervision from senior staff and a careful multi-disciplinary approach if (for any reason) a clinician has concerns.

## 2 Validation and support

If you have identified that abuse or neglect has occurred:

- tell the child that no one deserves to be hurt or neglected, and that it was not their fault
- tell them that you will seek help for them and their family/caregivers
- tell the child that they can come back and talk to you, the health care provider, at any time, if they need to
- ensure the child's immediate safety. Try not to alert the alleged abuser. Seek advice and assistance, and find support for yourself.

If you have developed concerns about the safety of a child or young person, then you will need to act on those concerns. Sooner or later (depending on the urgency of the situation) someone is going to have to have a frank conversation with the caregivers and (if old enough to understand) with the child.

*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
- if the family may seek to avoid child protective agency staff
- where the family may close ranks and reduce the possibility of being able to help a child. If safe to do so, you should still be transparent about the actions you as a health care provider need to take, and the reasons for them, but do not divulge details of actions planned by the statutory authorities.

### **3 Health and risk assessment**

Immediate protection of a child is required if:

- the child has suffered harm which in your view is a result of child abuse
- there is immediate danger of death or harm
- the environment to which the child is returning is unsafe.

Safe process means never making decisions about risk in isolation.

Consult with senior staff within your practice setting, a paediatrician, with a health social worker or youth health service, or with the duty social worker at CYF.

Be aware that other organisations (such as CYF) may hold information that is crucial to determining the safety of the child.

Refer to Child, Youth & Family if:

- the child has injuries which seem suspicious, or are clearly the result of abuse
- interaction between the child and parent or caregiver seems angry, threatening or aggressive
- the child states that they are fearful of parent/s or caregivers, or have been hurt by parents or caregivers.

Consider risk of self-harm or suicide.

Assess for co-occurrence of intimate partner violence.

### **4 Intervention/safety planning**

If there are concerns about immediate safety (including your own), contact the Police (or in-house security if available), and contact CYF.

- Identify the support and safety procedures that are required eg, what are the child's needs for safety, physical and emotional needs, health and rehabilitation, access to caregivers?
- Specify. What are the support or safety procedures that need to be put in place?
- Allocate responsibilities for action eg, who are the key individuals and agencies that need to be engaged?

For health care providers, the key issue is whether the child is 'at risk' (but there are pathways of referral open to them which are likely to reduce that risk: see 1.4.2), or whether the child is actually already coming to harm (see 1.4.1). In non-critical situations, multiple referral and follow-up pathways are possible.

If safety, care or behavioural issues exist, but you consider that engagement by an agency with the family is likely to achieve positive outcomes and the family is willing to accept referral, CYF is also likely to suggest that a formal report of concern may not be necessary. In this situation, your service may be able to address the risk by ensuring that connections to appropriate agencies are made, reinforcing the importance of these to the family, affirming the family for taking positive steps to look after their child, and providing follow-up.

If there is a children's team in your area, this may provide another avenue for effective action.

If you are unsure, discuss the situation and your concerns with CYF to determine if a formal report of concern should be made.

*JOINT* safety planning and referral processes need to be implemented when both intimate partner violence and child abuse are identified.

## **5 Referral and follow-up**

- Make referrals as appropriate, and ensure that relevant information is appropriately and accurately transferred to receiving individuals/agencies.
- Ensure there is a plan for review and follow-up, eg, what is the timeframe for the referral and follow-up plan? Who, when, and how, will the plan be reviewed?
- A phone referral to Child Youth and Family should be made whenever possible.

A copy of the written referral eg, report of concern must be sent to Child Youth and Family and a copy placed in the clinical record of the child/young person (or mother when the concerns reported relate to the antenatal period). If the report is made by a DHB, a copy must also be sent to the VIP/child protection coordinator in accordance with the DHB policy for the Child Protection Alert System.

If the child and family have been seen in an acute health care setting, it is important that information about a report to CYF is transferred back to the child's usual primary care provider.

It is important that healthcare providers still continue to provide follow-up to children and families who have been notified to CYF. You cannot assume that CYF or some other provider will take responsibility for the follow-up of the health care needs of the child and family.

## **6 Documentation**

Thorough documentation of all steps of the health consultation is necessary. This includes recording the history, examination findings, results of your risk assessment, consultative process and the support agencies, referrals and follow-up plan agreed.

Always include the date and time that you saw the child or young person, and when you wrote your notes (if different from the time you saw the patient). Always include a legible name, signature and practice designation.

**Remember to seek support from colleagues and/or debrief after the child abuse and or neglect intervention is concluded.**

---

# Appendix N: Intimate partner violence guideline: summary

## 1 Routine enquiry

Routine enquiry about intimate partner violence should be conducted with all females aged 16 years and older.

‘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?)’

Adolescents/young people about possible IPV (aged 12–15 years). Assessment of violence in this age group is best accomplished as part of a thorough psychosocial assessment, such as the HEEADSSS assessment.

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

## 2 Validation and support

- Listen to the person’s story.
- Acknowledge what they tell you.
- Validate their experience.

## 3 Health and risk assessment

### 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 threatened 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?

A thorough physical examination, where appropriate including laboratory tests and X-rays, is indicated in all cases of IPV, to identify all current and past injuries. Carry out other assessments as required for physical health, sexual and reproductive and mental health needs (including suicide risk). Assess risk to children, or others in the family, as required.

Consult with a colleague or a specialist family violence agency to determine the appropriate response.

## **4 Safety planning**

In situations of imminent threat, or extremely high risk (ie, the abuser is present, and threatening either the victim or the health care provider), the focus needs to be on securing immediate safety. Contact the Police, and or on-site security, if available. If a health care provider believes a person's life is in immediate danger, or that person is unable to extricate themselves from an ongoing, life-threatening situation, the Police and/or CYF may be notified without the person's permission.

### **High risk**

Ensure immediate safety is secured for the person and their children. Maintaining this may require onsite security and or the Police. If possible within your organisation, initiate a multidisciplinary response (eg, with social work, or other in-house resources).

Any decision about reporting a suspected incident 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. An active referral to a community agency that specialises in responding to family violence is required.

Make sure the person has information about, and contact details for, other legal and support options that may assist them.

### **Moderate risk**

If you do not think the person is in imminent risk or high risk, but there is evidence of violence within their relationship (eg, low-level recent or low-level ongoing violence), 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 and or from the community.

## **5 Referral and follow-up**

Referral to a specialist family violence agency, Police, lawyer, or (for under-17-year-olds) child protection services, such as Child, Youth and Family, if required.

For all victims: letting them know that they are not responsible for and do not deserve the violence they have experienced, and assisting them to contact support services and access legal options for protection, may be the most powerful interventions you can offer.

Appropriate follow-up at subsequent health care presentations also needs to be undertaken.

## **6 Documentation**

Thorough documentation of all steps of the health consultation is necessary. This includes recording the history, examination findings, results of the health and risk assessment, consultative process and the support agencies, referrals and follow-up plan agreed.

Always include the date and time that you saw the person, and the date and time you wrote your notes (if different from the time you saw the patient). Always include a legible name, signature and practice designation.

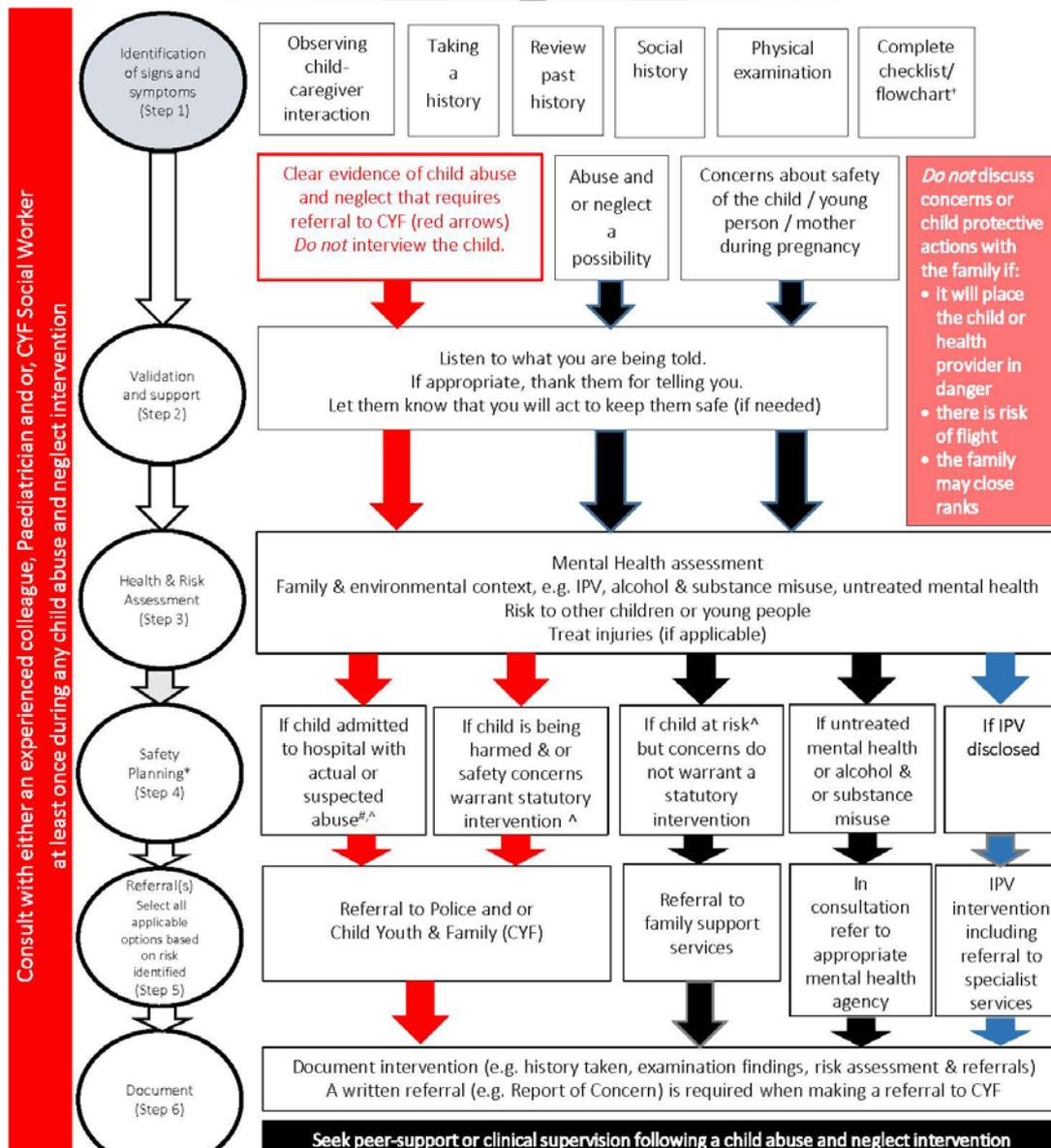
**Remember to seek support from colleagues and/or debrief after the health care visit is concluded.**

# Appendix O: Child abuse and neglect intervention flow chart



## Child Abuse and Neglect Intervention Flowchart

Patient presents to health professional complete initial clinical assessment



\*Red pathway for statutory intervention  
 #Black pathway for non-statutory intervention  
 ^Blue pathway specialist service, e.g. FV, MHAS  
 \* Tool for use in Emergency Departments for child up to 2 years age  
 # Standard interagency protocol, Memorandum of understanding between DHB, CYF and Police and associated schedule 1  
 ^consult with experienced colleague and/or Multidisciplinary team prior to a referral

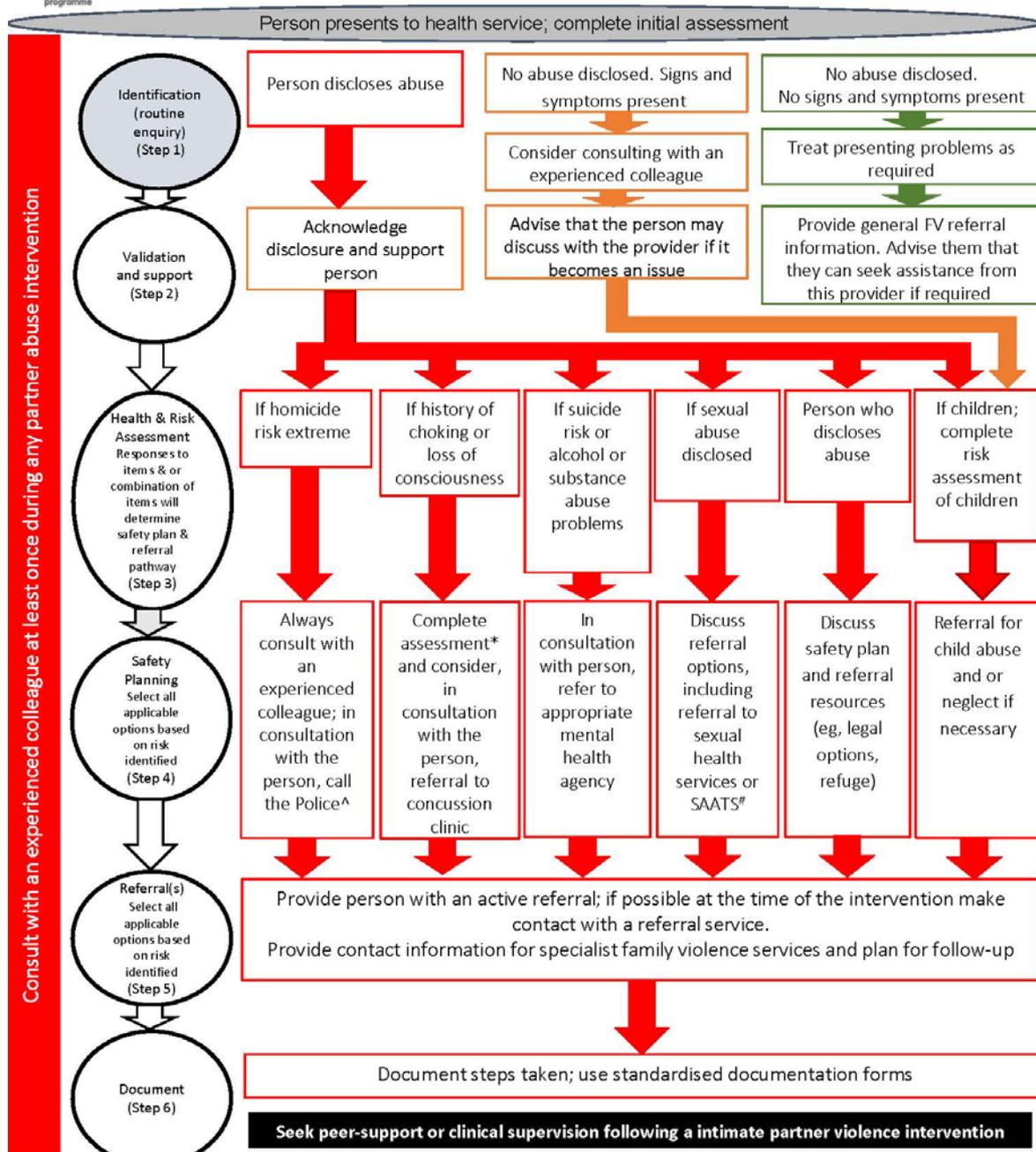
Insert local information /DHB logo here

\* Tool for use in Emergency Departments for child up to the age of two years.  
 # Standard interagency protocol, memorandum of understanding between DHB, CYF and Police and associated schedule 1.  
 ^ Consult with experienced colleague and/or multidisciplinary team prior to a referral.

# Appendix P: Intimate partner violence intervention flow chart



## Intimate Partner Violence Intervention Flowchart



Consult with an experienced colleague at least once during any partner abuse intervention

<sup>^</sup> In imminent threat and or high risk the Police can be notified without the person's consent

\*Strangulation assessment (clinical decision tree and documentation form)  
# SAATS sexual assault assessment & treatment service

Insert local information /DHB logo here