Canterbury District Health Board
Te Poari Hauora ō Waitaha

West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

CORPORATE OFFICE

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12 July 2018

[redacted]

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[redacted]

RE Official information request CDHB 9850 and WCDHB 9131

We refer to your email dated 30 April 2018 requesting the following information from Canterbury DHB and West Coast DHB under the Official Information Act regarding your research into the incidence of gender dysphoria diagnosis, prescription of puberty blockers and administration of opposite-sex hormones to under 18 year olds in New Zealand.

As discussed with you by telephone, to answer all of your questions at the level of detail you require would, in our opinion, constitute significant research and collation which under section 18(f) of the Official Information Act we are entitled to refuse. We are therefore providing a partial response to your request on the basis of using information that is held and that is readily available to us.

In addition to the specific responses to your questions below I have attached the current health pathway that will give you some insight into the current clinical guidelines for caring for people with gender dysphoria (see attached as **appendix one**).

The Canterbury DHB has a dedicated child and youth health workstream that is currently reviewing the guidelines for gender diverse people (including people with gender dysphoria) with a view to providing a more comprehensive and coherent response. These are currently scheduled for publication by the end of this year.

1. ***Approximately how many under 18 year olds are in your DHB?***

According to the most recent records (Stats NZ 2013 census), there were 122,784 people aged 0 – 19 in the *Canterbury District* at that time. Please see table 1 below for a breakdown of these figures:

Table one: Canterbury DHB Population of 0 – 19 years old as at 2013 census.

Age	Male	Female	Total
0 - 4	15,342	14,808	30,150
5 - 9	15,249	14,676	29,925
10 - 14	15,345	14,847	30,189
15 - 19	17,103	15,417	32,520

According to the most recent records (Stats NZ 2013 Census), there were 7,974 people aged 0-19 in the *West Coast District* at that time. Please see **Table two** (below) for a breakdown of these figures:

Table two: West Coast DHB: Population of 0-19 years old as at 2013 Census

Age	Male	Female	Total
0–4 Years	1,059	1,077	2,136
5–9 Years	1,044	933	1,974
10–14 Years	1,053	984	2,037
15–19 Years	945	879	1,827

Please note that a detailed breakdown of all DHB population numbers is published by Census New Zealand is published on line and can be found at:
http://archive.stats.govt.nz/Census/2013-census/data-tables/dhb-tables.aspx

2. ***Approximately what percentage of under 18 year olds in your DHB have a diagnosis of a mental illness? What is the breakdown of that by biological sex [M, F, I]? [Feel free to express this as a ratio or percentage]***

There are varying degrees of severity of mental illness. Children and young people with mild to moderate mental disorders are usually treated in the primary care setting by their general practitioner. Children and young people with moderate to severe mental disorders are usually (but not always) treated by Canterbury DHB or West Coast DHB specialist Child, Adolescent and Family Service (CAFS).

Within Canterbury there were 1185 young people (aged under 18 years) referred to specialist metal health services with an open case (650 or 55% males and 535 or 45% females as at 25 June 2018).

Within the West Coast there were 219 young people (aged under 18 years) with an open Specialist Mental Health Service referral (133 or 61% males and 86 or 39% females as at 25 June 2018).

3. ***How many under 18 year olds have a diagnoses of gender dysphoria?***

Less than five people currently in the care of Canterbury DHB and West Cast DHB specialist mental health service have a primary diagnosis of gender dysphoria.

4. ***Does your DHB know the comorbidity rate of gender dysphoria with other mental illnesses/conditions? If so, what is it?***

To identify the comorbidity rate of gender dysphoria of under 18-year-olds with other mental illnesses/conditions would require investigating each individual patient's patient file. We are therefore declining to provide this information under section 18(f) of the Official Information Act i.e. to provide this information would require substantial research and collation.

5. ***What services are available to under 18's with gender dysphoria who do NOT wish to medically transition? (e.g. counselling, psychology, psychiatry, group therapy, day programmes, inpatient admissions to adolescent facilities.)***

A limited range of counselling, psychology and psychiatric support may be available on a case by case basis through Canterbury DHB secondary services. In addition the Canterbury DHB funds access to free primary healthcare for 'at-risk' youth via a Youth One Stop Shop. This agency also provides a limited range of health and social support to gender diverse young people.

6. ***What services are available to under 18's with gender dysphoria who do wish to medically transition? (e.g. counselling, psychology, psychiatry, group therapy, day programmes, appointments with GP's or endocrinologists to access cross-sex hormones and/or puberty blockers.) (e.g. counselling, psychology, psychiatry, group therapy, day programmes, appointments with GP's or endocrinologists to access cross-sex hormones and/or puberty blockers.)***

The Canterbury and West Coast Clinical Pathways guidance for clinicians (extract attached as **Appendix 1**) we believe will provide the information you require. **Please note:** Clinical pathways are practice guidance written by clinicians for clinicians and this information is not available to the general public.

However the Canterbury DHB and West Coast DHB also provide a complementary website that is available to the public:

https://www.healthinfo.org.nz/
https://www.healthinfo.org.nz/WestCoast/

7. ***What practitioners can prescribe goserelin or leuprorelin to under 18's in your DHB, for the purposes of 'blocking puberty'?***

Any registered medical practitioner can prescribe these medications. Young people under the age of 18 years and a resident in Canterbury or West Coast may have these medications started by specialist services via appropriate GP referral. We are also aware that some general practitioners with a special interest may prescribe appropriate medication, oversight and review.

https://www.pharmac.govt.nz/medicines/my-medicine-has-changed/goserelin-and-leuprorelin/leuprorelin-and-goserelin/

8. ***What specific services manage the care of 'transgender' children in your DHB?***

The care of 'transgender' children is not currently provided by a single dedicated service in either DHB. For example, transgender / gender diverse children may access a range services including General Practice, General Practitioners with Special Interest, Child Adolescent and Family Services, Child Health (Paediatric Services), and/or Child Endocrinology depending on the specific health support or treatment they require.

(Please note: Children and young people living on the West Coast identified as requiring specialist care would be referred to Canterbury DHB specialist services under the 'trans-alpine/ service delivery agreement between the two district health boards.)

9. ***Who is responsible for ensuring this/these services abide by medical ethics?***

All clinical staff employed by the Canterbury DHB and West Coast DHB subject to the Health Practitioners Competence Assurance Act 2003 are required to conform to the relevant a Code of Ethics for their clinical registration or practising certificate.

In response to **questions 10 to 21** below this information is not held, the Canterbury DHB or West Coast DHB are consequently not responding to these questions under section [18(g) of the Official Information Act.

10. ***How many youth under 18 in your DHB have a diagnoses of gender dysphoria and have been prescribed puberty blockers within the past 12 months?***
11. ***How many of these youth were female?***
12. ***How many of these youth were male?***
13. ***Do you have data on these patterns for the past 5 years? If so could you please provide that as requested above [number of females and number of males prescribed puberty blockers by year]?***
14. ***How many under 18 year olds were referred by their primary health provider to endocrinology with a diagnoses of gender dysphoria the past 12 months?***
    a) How many of these youth were female [transitioning away from female]?
    b) How many of these youth were male [transitioning away from male]?
15. ***Do you have data on these patterns for the past 5 years? If so could you please provide that as requested above [number of females and number of males referred to endocrinology with a diagnoses of gender dysphoria each year]?***
16. ***How many youth under 18 in your DHB had a diagnoses of gender dysphoria and were prescribed either testosterone, or oestrogen and progesterone, between 1 January 2017 and 31 December 2017?***
    a. ***How many of these youth were female [transitioning away from female]?***
    b. ***How many of these youth were male [transitioning away from male]?***

18 ***How many youth under 18 in your DHB had a diagnoses of gender dysphoria and were prescribed either testosterone, or oestrogen and progesterone, between 1 January 2016 and 31 December 2016?***
    a. ***How many of these youth were female [transitioning away from female]?***
    b. ***How many of these youth were male [transitioning away from male]?***

19 ***How many youth under 18 in your DHB had a diagnoses of gender dysphoria and were prescribed either testosterone, or oestrogen and progesterone, between 1 January 2015 and 31 December 2015?***
    a. ***How many of these youth were female [transitioning away from female]?***
    b. ***How many of these youth were male [transitioning away from male]?***

20 ***How many youth under 18 in your DHB had a diagnoses of gender dysphoria and were prescribed either testosterone, or oestrogen and progesterone, between 1 January 2014 and 31 December 2014?***
    a. ***How many of these youth were female [transitioning away from female]?***
    b. ***How many of these youth were male [transitioning away from male]?***

21 ***How many youth under 18 in your DHB had a diagnoses of gender dysphoria and were prescribed either testosterone, or oestrogen and progesterone, between 1 January 2013 and 31 December 2013?***
    a. ***How many of these youth were female [transitioning away from female]?***
    b. ***How many of these youth were male [transitioning away from male]?***

22 ***Does your DHB acknowledge that the literature suggests medical transition of youth is likely to disproportionately impact children who would otherwise grow up to be gay and lesbian?***

Neither the Canterbury DHB nor the West Coast DHB holds a formal opinion regarding the literature you refer to.

23 What precautions are taken to ensure medical transition is not motivated by homophobia of the patient or the patient's guardian(s)?

Both Canterbury DHB and West Coast DHB have a strong focus on providing a person centred approach and recognise that sexual minority youth (which can include lesbian, gay, bisexual, transsexual, intersex (LGBTI) or other gender nonconforming young people are more likely to experience mental illness, alcohol and other drug abuse, as a consequence of negative peer and societal attitudes. Our approach is that the wellbing of individual is paramount and the young person themselves is assessed on their own and given the opportunity to express their own views and preferences. Ideally this is as well as providing ongoing support with the family and/or caregivers of the young person.

24 Does your DHB assess attitudes about invert theory before beginning hormone blockers?

Neither the Canterbury DHB nor West Coast DHB specifically use the term "invert theory" in their patient pathway. They do however, ensure that a comprehensive assessment process occurs over a period of time to enable thorough engagement and understanding of the young person's needs.

25 Would clear homophobia of a parent/guardian or patient themselves be a reason to not prescribe puberty blockers or cross-sex hormones?

Homophobia would not be a reason to decline the prescription of puberty blockers or cross-sex hormones.

26 Can you refer me to any experts in your area who may be willing to discuss their perspective on this?

Through our inter-District relationships we are conscious that Auckland District Health Board probably has the most advanced service model and practice guidelines on the topic of gender diversity amongst children and young people at this time.

27 What policies about homophobia pertain to your DHB? Do you recognise there is a pattern of male violence against females in New Zealand?

The Canterbury DHB and the West Coast DHB recognises that family violence and Intimate Partner Violence (IPV) are important health issues that can lead to immediate physical and mental health consequences and are significant precursors to a range of poor health outcomes and long-term conditions. As such has an active approach to identifying intimate partner violence through their Violence Intervention Programme. Please refer to Policies attached as **Appendix 2.**

28. Approximately how many females have presented to emergency room(s) within your DHB as a result of domestic violence by males between 1 January 2017 and the 31 December 2017?

This information is not held in our data warehouse. To obtain the information at this level of specificity would entail a manual review of Emergency Department patient notes. Consequently we are declining to answer this question (for both DHBs) under section 18(f) of the Official Information Act i.e. it would require significant research and collation.

29. ***It would be useful to clarify the definitions of a few basic terms as they are used within your DHB. This is important as I am doing comparative research. It is preferable that you do not use circular logic: Could you please define the terms - 'woman', - 'man', - 'female', - 'male', - 'sex' [as in 'biological sex'], - 'gender', - 'transgender', - 'sexual orientation' and - 'gender identity'?***

As discussed above, the Canterbury DHB is currently working on a revised health pathway and 'position statement' on the treatment and healthcare support for gender diverse children and you people. This will be congruent with the existing practice guidelines about gender identity as found on the Ministry of Health, Humana Rights Commission and Health & Disability Commission's websites (below):

https://www.health.govt.nz/your-health/healthy-living/transgender-new-zealanders
https://www.hrc.co.nz/your-rights/social-equality/our-work/trans-people-facts-information/
http://www.hdc.org.nz/your-rights/about-the-code/the-code-summary/

Please also find attached as **Appendix 3**, definitions (from the Northern Regional Advisory Group for Transgender Advisory Services) recommended by adoption by all DHBs.

Although I have not been able to provide information in response to all of the elements of your request, I hope the information provided is sufficient to meet your needs. You are welcome to come back to us if you would like to follow up on the information we have provided.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB and West Coast DHB websites ten working days after your receipt of this response.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

Gender Dysphoria

This pathway is about the suitability for hormone therapies which is managed either by the Endocrinology Department in adults, or by the paediatric endocrinologist in children.

About gender dysphoria

- Gender dysphoria is when a person, who identifies as a gender that is different from their biological sex, experiences discomfort or distress about this discrepancy.
- Gender nonconformity (or gender incongruence) refers to a person who identifies with a gender that is different to their biological sex.
- Treatment for gender dysphoria may involve psychological assessment and support, hormonal or surgical treatment. Treatment is individualised.
- Other names include: gender variance, gender incongruence, gender identity disorder, and transgenderism.
- "Trans" is often used as an umbrella term but some people may prefer to be referred to as transsexuals, transgender people, trans people, trans woman (male becoming a female) or a trans man (female becoming a male).
- Some transsexual people do not gender identify as either male or female, but feel they are both, or somewhere in between, and are considered "gender variant".
- Check with your patient about their preferred term.

Assessment:

1. Assess history of gender non-conformity and gender dysphoria.
   - Obtain a history of symptoms, age of onset, whether trial of desired gender role has occurred and for how long and supports available.
   - Ask about depression, anxiety, PTSD, suicidality, self-harm, and drug or alcohol dependence.
   - Check sexual history.
2. Discuss what treatments your patient is wishing to pursue:
   - Psychological treatment alone may be all that is needed.
   - Hormone manipulation. Assess whether the patient meets the Canterbury DHB *criteria* for endocrine manipulation through hormone treatments, which are all arranged through secondary care.

Criteria

- For adults, endocrine manipulation through hormone replacement is not undertaken lightly and usually only performed in adults who fulfil the following 3 criteria:
- Aged > 18 years.
- Has clear knowledge of the risks and benefits of endocrine therapy (undertaken in secondary care).
- Has either a documented real life experience of consistently filling the desired gender role for at least 3 months before the administration of hormones, or has a minimum of 3 months of regular psychotherapy with the conclusion that the gender reassignment and endocrine manipulation is appropriate.

Note: If aged 15 to 18 years, endocrine therapy may be considered on a case-by-case basis after psychological assessment.

Gender Reassignment surgery is not currently funded by the Canterbury DHB, but there are a small number of gender reassignment surgeries (GRS) funded overseas through the Ministry of Health High Cost Treatment Pool.

3. Consider sexual health check and blood tests for hepatitis B, hepatitis C, HIV either through general practice or a non-acute sexual health assessment.

4. Look at any lifestyle changes which will reduce any risks associated with hormone treatments e.g., smoking cessation, and assessment of cardiovascular risks such as lipids, blood pressure, and diabetes.

Management:

1. Provide patient information and support.
2. If psychological treatment only is required, arrange an appointment with a psychologist with appropriate experience in gender dysphoria.
3. Address any comorbidities such as mental health, sexual health, and drug or alcohol dependency. For more specific general practitioner care and management, see section 1.2 of the Gender Reassignment Health Services for Trans People within New Zealand guidelines.

Hormone manipulation:

1. For adults, refer for either psychiatric or psychological assessment **before** endocrine referral.
- Psychiatrists – initial assessments for approval before hormone manipulation are available through the public health system. Ongoing counselling is not provided by the public system.
- Psychologists with appropriate experience in gender dysphoria.

2. If aged between 15 and 18 years, two psychiatric or psychological assessments are desirable before an endocrinology referral.
3. For children aged < 15 years, refer to CAF. They will refer onto paediatric endocrinologists if appropriate for hormonal treatment to suppress puberty.
4. If a patient is accepted for hormone treatment, the Endocrinology Department or the paediatric endocrinologist will direct treatment with appropriate interim monitoring by general practice.
5. If gender reassignment surgery is requested, an endocrinologist makes a referral to the Ministry of Health High Cost Treatment Pool.

Request:

- Consider referral to a Psychologist.
- For psychiatrist assessment before hormonal manipulations, request non-acute adult specialised mental health assessment.
- For children aged < 15 years, refer to Child, Adolescent and Family Mental Health.
- For adults and if aged >15 years, request endocrinology assessment if the ***criteria*** are fulfilled and include the psychiatric or psychological reports.

Criteria

For adults, endocrine manipulation through hormone replacement is not undertaken lightly and usually only performed in adults who fulfil the following 3 criteria:

- Aged >18 years
- Has clear knowledge of the risks and benefits of endocrine therapy endocrine therapy (undertaken in secondary care).
- Has either a documented real life experience of consistently filling the desired gender role for at least 3 months before the administration of hormones, or has a minimum of 3 months of regular psychotherapy with the conclusion that the gender reassignment and endocrine manipulation is appropriate.

Note: If aged 15 to 18 years, endocrine therapy may be considered on a case-by-case basis after psychological assessment.

If sexual health check and blood tests are appropriate, but unable to be completed in general practice, request a sexual health assessment.

Canterbury District Health Board
Te Poari Hauora o Waitaha
CHRISTCHURCH HOSPITAL
CHILD & FAMILY SAFETY SERVICE

VIP violence intervention programme

SURNAME ..... NHI .....
FIRST NAME..... DOB .....
ADDRESS .....
..... POSTCODE .....
(or affix patient label)

IPV FV ASSESSMENT & INTERVENTION

Intimate Partner Violence (IPV) Family Violence (FV) Assessment and Intervention

Risk assessment	☐ Declined Please state reason:
IPV routine enquiry	☐ IPV+ (positive) Date: ..... / ..... / .....
Assess pregnancy risk	Are you pregnant? ☐ Yes ☐ No | EDD: | LMC:
	Have you ever been beaten by your partner while pregnant? ☐ Yes ☐ No ☐ Declined ☐ Not asked
Assess risk to children in the household	Have the children seen or heard the violence? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	Has anyone physically abused the children? ☐ Yes ☐ No ☐ Declined ☐ Not asked *If yes, who? (full name and relationship to the child)* ....
	Names and DOB of child(ren) living at home:
Assess person's health and risk	Full name and relationship of alleged abuser(s):
	Are there any current/previous orders on the alleged abuser? ☐ Yes ☐ No *If yes*, please indicate which apply: ☐ Trespass Notice ☐ Protection Order ☐ Bail conditions ☐ Police Safety Order ☐ Recent family violence charges ☐ Custody or parenting order
	A 'yes' answer to any of the health and risk questions requires further description in the history section and intervention as per the Intimate Partner Violence Intervention flowchart
	1. Is your partner here now? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	2. Are you afraid to go/stay home? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	For each of the questions 3, 4, 5 and 6 a 'Yes' answer requires further investigation
	3. Has the physical violence increased in frequency or severity over the past year? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	Has your partner ever choked you (one or more times)? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	A 'Yes' answer to question 4, requires intervention as per the Clinical Guideline: Assessment and Management of Strangulation
	4. Have you ever been knocked out by your partner? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	5. Has your partner ever used a weapon against you, or threatened you with a weapon? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	6. Has your partner ever threatened to kill you? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	7. Do you believe your partner is capable of killing you? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	8. Is your partner constantly jealous of you? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	9. If yes – has the jealousy resulted in violence? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	10. Have you recently left your partner, or are you considering leaving? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	11. Has your partner ever threatened to commit suicide? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	12. Have you ever considered hurting yourself/suicide? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	13. Is alcohol or substance misuse a problem for you or your partner? ☐ Yes ☐ No ☐ Declined ☐ Not asked
	14. Do you or your partner have a mental health condition(s)? ☐ Yes ☐ No ☐ Declined ☐ Not asked
Access to support services	What support (if any) is available to you?
	What services have you used in the past or are involved with currently?

COPY OF THE CLINICAL NOTES MUST BE ATTACHED TO THIS REFERRAL FORM

SURNAME ..... NHI .....
FIRST NAME..... DOB .....
ADDRESS .....
..... POSTCODE .....
(or affix patient label)

IPV FV
Assessment and Intervention

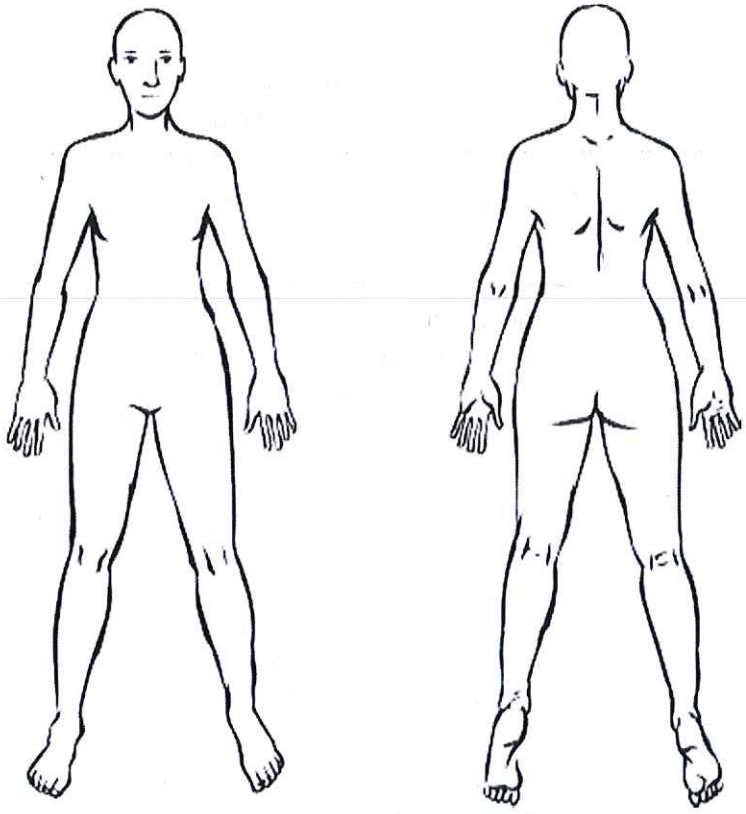
Referrals

- ☐ Referral(s) declined
- ☐ No referral or report made
- ☐ Internal referral
- ☐ External referral
- ☐ Police – with consent
- ☐ Police – without consent
- ☐ Social Work
- ☐ Oranga Tamariki
- ☐ Cultural Support Services
- ☐ Report of Concern completed and sent
- ☐ Mental Health Service
- ☐ Children's Team (if DHB has one)
- ☐ Sexual Health Service/Sexual Assault Assessment and Treatment Service
- ☐ Specialist Family Violence Agencies
- ☐ Provision of Family Violence Community Agency card/referral information
- ☐ Other *(please specify):* .....

Please state any referral service/agency the person engaged with either face-to-face or via phone at the time if this intervention

Body map

Measure, describe (incl. type, colour, texture, size) and mark location of each apparent injury (incl. bruising, scratches, abrasions, lacerations, areas of pain and tenderness)



Police/clinical photography offered: ☐ Yes ☐ No ☐ Accepted ☐ Declined

Photographs taken: ☐ Yes ☐ No

Safety plan

(Including discharge arrangements)

- ☐ Safety plan discussed
- ☐ Safety plan actioned

Name: ..... Date: ..... / ..... / .....

Designation: ..... Signature: .....

COPY OF THIS REFERRAL FORM AND COPY OF THE CLINICAL NOTES MUST BE SENT TO THE ORANGA TAMARIKI OR SMHS FST OR COMPLETED ON, OR ATTACHED TO, ePROSAFE REFERRAL

Family Violence – Partner Abuse Intervention Procedures

Contents

Purpose

Briefly explain why or when someone will do this procedure. Refer to the associated policy.

Scope/Audience

What risks will this procedure mitigate? Who will use this procedure? List role title(s). Include who should not be included, if appropriate. Does not include patient, visitors or family.

Associated documents

CDHB documents or other references directly applicable to this procedure, e.g.:

- CDHB Manual, Volume 2 - Legal and Quality Informed Consent
- Burwood Hospital Manual, Volume C - Health and Safety Hazard Identification
- Related policy documents, if any
- Flow chart related to this procedure, if applicable, contact your quality facilitator or document controller for assistance
- Relevant external documents

1.1 Guiding Principles

Family/whānau violence is violence or abuse of any type, physical, sexual or psychological, perpetrated by one family/whānau member against another family/whānau member. It includes child abuse, partner abuse and elder abuse.

CDHB staff with clinical care responsibilities will be competent in the identification and management of actual or possible family/whānau violence through the CDHB wide family/whānau policies, procedures and the education programme.

- The rights, needs, welfare and safety of the patient/client will be regarded as a priority.
- The rights, needs, welfare and safety of children are our first and paramount consideration. All cases where children and young people aged 0-17 years considered 'at risk' of family/whānau violence, must be referred to the CDHB Child Protection Co-ordinators and members of the Multi-Disciplinary Team as per divisional procedures.
- The right of patients/clients to confidentiality will be in accordance with the CDHB's policies on privacy of information. The CDHB will only divulge information or involve other agencies with the expressed consent of the patient/client unless deemed necessary in order to promote the welfare and/or safety of the patient/client or that of their childrenPatients/clients will receive an empathetic, supportive and non- judgmental response from CDHB staff. They will be treated in a manner sensitive to age, gender, culture, ethnicity and sexual orientation, while recognising that family/whānau violence is unacceptable in any relationship.

- A statement or disclosure of family/whānau violence will be sufficient in itself for the patient/client to be given information and assistance as a priority. No proof of violence will be requested to support a disclosure.
- Similarly, when a patient/client does not disclose family/whānau violence, but is observed with signs and/or symptoms indicative of abuse, that person will receive a non-judgemental response and will not be challenged to disclose.
- Family/whānau violence is a complex issue requiring a comprehensive approach regarding prevention and intervention. This approach requires the health sector to take a co-ordinated and collaborative response within the CDHB provider arm, government and specialist family violence services.

Stages of Inventions

The Family Violence Intervention involves a six-stage approach to identify, assess, offer referral and advocate for patents/clients of abuse within healthcare settings. The stages, roles and responsibilities assigned to each healthcare service and the intended outcomes are:

Stage	Intervention	Role & Responsibility	Outcome
1.	**Identify** Routine Screening and observation of signs and/or symptoms indicative of abuse	Clinical care staff, or front line healthcare practitioner Key/case worker in multi-disciplinary teams	• Appropriate environment ensured to screen • Family violence is /is not identified • Clinical treatment is carried out
2.	**Support and validation**	Clinical care staff, or front line healthcare practitioner Key/case worker in multi-disciplinary teams	• Trust engendered • Education message conveyed • Appropriate support within CDHB service is engaged
3.	**Preliminary Risk Assessment (PRA)**	Clinical care staff, or front line health professional	• Immediate risk is identified & managed

		Key/case worker in multi-disciplinary teams	• Risk factors & level of risk are ascertained • Children at risk are identified
4.	**Safety Planning** A safety plan is created and referrals made to internal services and external agencies.	Clinical care staff, or front line health professional Key/case worker in multi-disciplinary teams	• Children at risk will be managed by CP and MDT • The likelihood of harm or re-victimisation is reduced / minimised
5.	**Referral:** Community agencies: e.g. Women's Refuge, specialist family violence services, social services	Clinical care staff, or front line health professional Key/case worker in multi-disciplinary teams	• Fuller risk assessment & safety planning completed • Ongoing support & advocacy is available for increased safety • Further referrals as appropriate
6.	**Documentation**	Clinical care staff, or front line health professional Key/case worker in multi-disciplinary teams	• Ensure relevant information is accessible to staff • Information is protected from misuse • Information systems are able to be audited

1.2 Brief Intervention Model: A Six-Step Process

1.2.1. Step 1: Identify

- **All females** aged 16 years and older should be screened routinely for physical, sexual or psychological abuse, current

and/or within the last year. This includes female parents/carers of children accessing CDHB services.

- **Males** aged 16 years and older who present with signs and/or symptoms indicative of abuse should be screened.
- **Children** aged 0 – 17 years who disclose, are exposed to or present with indicators of abuse, must be referred to the CDHB Child Protection Co-ordinators and members of the Multi-Disciplinary Team as per divisional procedures.

Due to the strong correlation between partner/ex-partner abuse and child abuse, consideration must be given to the age and developmental stage of children in contact with abused persons. As forms of physical, sexual and psychological abuse commonly co-exist, assessment for all three types need to occur.

When is Screening Carried Out?

CDHB staff who have completed the CDHB Family Violence Intervention Programme education should screen for partner abuse, using the Brief Intervention Process and the Preliminary Risk Assessment form is to be completed for positive disclosures.

Screen for family/whānau violence in the following situations:

- At every Emergency Department visit (adult patients and parents/carers of child patients).
- At Inpatient settings.
- Incorporate into the admission assessment and discharge process.
- Maternity and Sexual Health settings:
  - At every prenatal and postpartum visits
  - On notification of the patient/client entering a new intimate relationship.
  - At every routine gynaecological visit.
  - At Termination of Pregnancy and Sexually Transmitted Infections health visits.
- Specialist Mental Health Services:
- As part of every initial assessment.
- On notification of the patient/client entering a new intimate relationship.
- Annually, if receiving ongoing or periodic treatment.

Screening in Child Health Settings

- All female parents/carers accompanying a child/young person accessing child health services are routinely screened as part of their health assessment.
- As part of Public Health Nurse Well Child assessments.
- All male parents/carers accompanying a child/young person accessing child health services observed with indicators of family/whānau violence, are screened.

Note: All screening must take into account the safety aspects listed in the following section.

Safety aspects of screening

The screening questions are **only asked** when the patient/client is:

- alone (or with an official interpreter) and in private; or
- with children present, only if they are non verbal or under 2 years old.

The screening questions **are not asked** in the following circumstances:

- When urgent clinical treatment is required.
- When the patient/client is under the influence of drugs or alcohol.
- When patient/client comprehension is too limited to effectively participate in the screening process e.g. mentally unwell, cognitive disability.
- When patient/client is too sick, or exhibiting a high level of emotional trauma, or in established labour.
- Language barriers exist and a suitable interpreter is not able to be located.
- No facility for privacy – the area is too public, and partner or family/whānau will not leave patient/client alone.
- In the presence of a verbal child or child is over the age of two years.
- When as a staff member, you are concerned for your safety.

Note: If screening is unable to occur, arrangements should be made to undertake screening at a later time and place.

Language and Hearing Barriers

The screening questions **cannot be asked** without a appropriate interpreter available if:

- A patient/client is not conversant in the English language, or
- Is not able to fully comprehend English, or
- A patient/client has impaired hearing.

Only official CDHB interpreters should be used. Patient/client preferences, and age, gender, and ethnic origins should always be given consideration when requesting an interpreter.

Note: Do not use children, friends or family/whānau members who are related to the patient/client.

Framing, Confidentiality and Screening Questions

When assessing for family/whānau violence and specifically partner /ex-partner abuse, in most circumstances, it is best to use simple, direct questions, asked in a non-threatening manner.

Framing or Lead in Statement

"We know that family/whānau violence is common and affects people's health so we ask some questions about violence in the home."

Confidentiality Statement

- *"You don't have to answer if you don't want to."*
- *"What you say will be treated confidentially in the same way as your other health information except when you give information that indicates there are serious safety concerns for you or your children."*
- *"We would always try to let you know if we had to tell someone else."*

Screening Questions

It is important that screening questions are formed in a realistic and comfortable manner. The screening questions to ask are:

- *"In the last 12 months have you been in a relationship with someone who has physically hurt you?"*
- *"Have you been made to do something sexual you didn't want to?"*
- *"Have you felt threatened, controlled, or criticised by your partner (or ex-partner)?"*
- *"Is it safe for you to go home?"*

Staff Affected by Family/Whānau Violence

CDHB staff members who identify as being affected by family/whānau violence can expect to be treated in a respectful and professional manner. In the first instance the staff member should tell their line manager so support can be offered. This is important as it may affect the staff member's ability to ask the screening questions. In this situation staff will be offered further assistance as provided by the CDHB including:

- Support from your service manager or senior staff member.
- the Employment Assistance Programme (EAP). All staff are able to access and self-refer to EAP which is a free confidential service – phone 0800 327 669.
- Workplace Support Service (on sites where the Service is available).
- Hospital Chaplains (on sites where Chaplains are available).
- Community based specialist family violence services and national Helplines.

Family/Whānau Violence Abusers

In the event that a patient/client or other person may disclose to a CDHB staff member that they have harmed another person (including a child), it is important to use elements of the 6 step brief intervention. These include:

- Support and validate their disclosure.
- Give a clear message that family/whānau violence is never acceptable.
- Assess immediate and future risk which may include creating a basic safety plan to ensure others are kept safe.
- Provide information on and the contact details of specialist family violence services.
- Provide the contact details available services that can assist.

Refer to Appendix 5 – Referrals – Family/Whānau Services

1.2.2. Step 2: Support and Validation

Disclosure of any form of abuse is a difficult step, and many people may feel shame and a sense of guilt. People of all ages need to be reassured that it is not their fault and that help is available. Hearing these messages from a health care professional can be a powerful intervention, especially when

these messages are consistent messages throughout healthcare settings.

For the CDHB Family Violence Intervention it is not necessary to take a full history of the abuse as a key aim is for patients/clients to be empowered to actively take steps to keep themselves safe. The health professional's role is to provide sufficient support, information and resources.

It is important to recognise the shift to living in safer environment is a process, not a one-off act. Interventions should assist to make patients/clients and their children, if they are at risk, safer. The intervention aims are not to 'rescue' patients/clients, or be directive about their relationship. Such actions need to be taken in the patient's/client's level of understanding and in their own sense of time.

Responding to Disclosure

Follow the steps below to respond efficiently to disclosures:

- **Actively listen** to the person's experiences: be empathetic, non-judgemental and non blaming.
- **Seek clarification** using the person's own words e.g.:
  - *"Tell me about that…"*
- **Acknowledge** that what has been said has been heard. Take care not to avoid or minimise e.g.:
  "Thank you for telling me…that can't have been easy for you"
- **Validate** the difficulties involved in the person's experience e.g.
  - *"You're not to blame for the abuse"*
  - *"Abuse is never justified"*
  - *"It's not OK"*
- **Inform** the person of possible options e.g.
- *"Let's talk about some ways you can get some support"*
- *"There are services available that can help you"*

Signs/Symptoms Indicative of Abuse

If signs and/or symptoms indicative of abuse are present, but no abuse is disclosed:

- Tell the patient/client of your concern.
- Tell the person that if family violence does become an issue for them they can contact you.

- Offer the person a pamphlet or community resource card which list available support services and a safety plan.
- Document your concerns on the Preliminary Risk Assessment Form and list the information provided.

Responding to Historical Abuse

When historical abuse is disclosed and patient/client is identified **as still being** 'at risk' (especially when contact with children is problematic):

- Tick +ve box on the audit box, complete the 6 step brief Intervention Process and the Preliminary Risk Assessment Form.

When historical abuse is disclosed and the patient/client **is no longer** 'at risk':

- Acknowledge the disclosure.
- Ask if they would like to discuss the abuse with a professional.
- Offer an appropriate pamphlet or community resource card.

Note: If a child has been subjected to historical family/whānau abuse, refer to the CDHB Child Protection Co-ordinators and members of the Multi-Disciplinary Team as per divisional procedures.

Refer to

Appendix 1 – Signs and Symptoms associated with Partner Abuse

1.2.3. Step 3: Preliminary Risk Assessment

A Preliminary Risk Assessment Form must be completed for **all** disclosures of abuse.

The Preliminary Risk Assessment Form will assess the level of immediate risk for the patient/client either in or leaving a health care setting. This includes the risk of homicide, the risk of suicide and any risk(s) to children.

Therefore the risk assessment should only be undertaken when it is safe for both the patient/client and the health professional.

A brief explanation should be made to the patient/client before asking the questions on the Preliminary Risk Assessment Form, e.g.:
"Because someone has been hurting you, we need to get some more information so we can assist you (and your children) in the best possible way."

Health care professionals are responsible for conducting a preliminary risk assessment with patients/clients about their abuse in order to identify appropriate referral options dependent on the level of risk. There are no absolute indicators that can predict risk. Assessment of the following factors can assist in assessment of urgency, danger and risk to children. The greater the number of indicators, the greater the risk.

A more detailed risk assessment may subsequently be undertaken by a specialist family violence service.

For patients/clients presenting with signs and/or symptoms indicative of abuse, e.g. injuries inconsistent with the explanation, the Preliminary Risk Assessment Form must be completed with as much detail as possible including the use of the body map.

The Family Violence Preliminary Risk Assessment form is held in each CDHB service and is processed as per specific departmental procedures.

Refer to Appendix

Immediate Safety Risk

- Establish if the abuser is present in the healthcare setting now.
- Does the abuser have a weapon?
- Is the patient/client afraid of their partner (or ex-partner)?
- Is the patient/client afraid to go and remain at home?

High Safety Risk

- Severe or life threatening assaults: e.g. choking, strangulation, beatings.
- Physical violence has increased in severity (upward trend).
- A threat to harm/ kill or a threat with a weapon has been made.
- Abuser's access to (lethal) weapons.
- Threat of suicide.

- The patient/client has recently separated from the partner, or is considering separation.
- The patient/client is a child/young person, elderly or disabled in any way.
- Alcohol misuse involved.
- Drug misuse is involved.
- Known mental health indicators or evidence of irrational/chaotic behaviour.

Risk of Suicide or Self-Harm

There is a strong association between abuse from a partner/ex-partner with self-harm or suicide. Health care professionals need to consider assessing possible suicide of identified persons.

Signs associated with high risk of suicide include:

- Previous suicide attempts.
- Stated intent to die/attempt to kill oneself.
- A well developed concrete suicide plan, or access to a method to implement their plan.
- Planning for suicide (e.g. putting personal affairs in order).

Other factors that are frequently associated with the risk of suicide or self-harm may themselves be symptoms of abuse. Factors include depression, extreme anxiety, agitation or enraged behaviour, excessive drug and/or alcohol use or abuse. Make simple, direct inquires to assess if the abused person is thinking about committing suicide, or has made previous suicide attempts.

Preliminary Child Risk Assessment

Partner/ex-partner abuse and child abuse frequently co-exist. When partner/ex-partner, historical or suspected abuse is identified, it is essential that clarification of the existence of children in the family/whānau is sought.

Using the section on children and risk on the Preliminary Risk Assessment Form, expand on the questions to establish risk factors. Use simple, direct questions such as:

- *"Are you worried about your children's safety?"*

- *"Has anyone harmed them in any way?"*

Pregnant Women and Risk

In the case of women who are pregnant there are two potential lives to consider, therefore the following additional questions need to be asked:

- *"Have you been physically assaulted while pregnant?"*
- *"Has anyone tried to stop you from accessing medical treatment?"*
- *"Has anyone threatened to harm your unborn baby?"*

1.2.4. Step 4: Safety Planning

Safety Planning

Safety planning is a process of thinking through risks and potential dangers and planning for ways to prevent or minimising harm and maximising safety.

A safety plan deals with immediate risk and on-going issues. It is central to the support of abused patients/clients. While a safety plan in itself will not prevent actions of violence, it will help patients/clients make some key decisions in how they respond.

Immediate Safety Concerns

If there are immediate concerns for or threats to the safety of staff or patients/clients within CDHB health settings, follow established service emergency procedures. Contact CDHB Security if applicable.

Acute safety concerns may warrant calling services with statutory responsibilities: the Police or in the case of children, Child, Youth and Family. If possible, consult first with experienced staff members.

High Risk

When high risk abuse is identified a safety plan needs to be made following the preliminary risk assessment. If at all possible use a multidisciplinary team approach including the Child Protection Co-ordinators, social work staff, senior colleagues and/or specialist family violence services. While a safety plan is

being developed and executed, the patient/client must be kept in a safe area.

Low to Medium Risk

Unless there is a risk to a child or a clear and immediate risk to the patient/client, she/he has the right to determine a course of action. The role of the health professional is to support this decision. Supportive intervention can make it easier for the patient/client to seek assistance in the future when she/he is ready to take action. Provide information on the potential for abuse to increase in severity and frequency without intervention. Ensure that the patient/client is offered information for a further point of contact.

Risk to Children

Provide information on the impact on children of witnessing, hearing or knowing of abuse, which is considered psychological abuse under the Domestic Violence Act 1995. Refer to the CDHB Child Protection Co-ordinators and members of the Multi-Disciplinary Team as per divisional procedures.

Safety and Security Procedures

At times it may be necessary to temporarily change a patient/client's details and provide a secure admission and discharge process for patients/clients considered at high risk.

Refer to Appendix 2 – Safety and Security Guidelines

Disclosure of Information without Consent

Decision regarding contacting the Police should, in most instances, be made in consultation with the patient/client. This is to ensure their safety, as reporting the incident may increase the risk to the patient/client from the abuser.

On the rare occasion that the healthcare professional believes a person's life is in immediate danger, or has good reason to believe that the person is unable to extricate themselves from a high level of ongoing, life-threatening danger, the Police or relevant agency capable of assisting to prevent harm occurring, may be notified without patient's/client's permission. Whenever

possible, the patient/client should be informed that this will occur or has occurred.

Neither the Privacy Act 1993 nor the Health Information Privacy Code 1994 is breached if the disclosure of information is necessary to prevent or lessen a serious and imminent threat to:

- Public health or public safety; or
- The life or health of the individual concerned or another individual, and it is not desirable or not practicable to obtain authorisation from the patient/client.

For any serious events involving staff or patients/clients, including events where staff intend to notify Police, Service Manager or (Duty Manager if after hours) and CDHB Security (if applicable) must be notified immediately. The order of this chain of events is dependent on the severity of the presenting situation. Whenever possible staff should consult with senior staff.

When Help is Declined

In a situation where a health professional forms a belief that a patient/client is at risk of harm from self or another person, and the patient/client refuses further assistance or support, the staff member may consider:

- Making a referral to a consulting medical professional, and/or
- Disclosing the information to a CDHB social worker for follow up.
- Contacting the Police or another person/organisation that maybe required to assist – if imminent danger exists.
- Notifying CYF in situations where children are deemed at high risk and refer to the CDHB Child Protection Co-ordinators and members of the Multi-Disciplinary Team as per divisional procedures.

Clinical staff should document information received from the patient/client, information given and actions taken, and tick 'Help declined' box on the bottom of page 1 of the Preliminary Risk Assessment Form.

1.2.5. **Step 5: Referrals**

The CDHB screening process is based on an empowerment model, therefore dependant on the situation, patients/clients (and staff affected by abuse) should be given relevant information,

and encouraged to make contact with specialist family violence services.

These services are vital for the support of patients/clients who have been abused. Many of the specialist family violence services within Canterbury also offer assistance to people who are or have been abusive. Some services are free while others have a financial cost.

Free national telephone help-lines exist which specialise in providing family/whānau violence information and details of service providers.

When the Preliminary Risk Assessment indicates high risk for the patient/client to be at home or in the community, the health professional should contact the appropriate service. E.g. when a Women's Refuge is contacted to provide a 'safe house' placement, the health setting will provide a safe place for the patient/client to wait until picked up or can leave safely.

Refer to Appendix 5 – Referrals – Family/Whānau Services

1.2.6. Step 6: Documentation

Accurate and timely documentation is fundamental and an important element in keeping patients/clients safe. The clinical record may later be used in litigation, or relied on as evidence for court orders such as Protection Orders or Restraining Orders. Clinical records may also be relied on to justify or explain actions taken by staff. An objective systematic history and risk assessment is therefore essential and staff are expected to comply with the Documentation Policy and standard professional requirements.

- Family/whānau violence disclosures must be documented and the patient/client made aware that information is being documented and patients/clients must also be made aware of the purpose of collecting the information.
- How the information will be used.
- The right to access information held about them and
- Correct inaccurate information and
- The possible reasons that their information may be disclosed.

Confirmation of Screening

Documentation begins with confirmation that the routine screening has been carried out. The coded section below must be completed on the relevant CDHB clinical forms.

Screening Record:

FVSQ ☐ +ve ☐ -ve ☐ S ☐ N → ☐ Preliminary Risk Assessment Form completed
☐ Not asked screening questions → ☐ No training ☐ No time ☐ No privacy

Not asked screening questions

☐ No training ☐ No time ☐ No privacy

Screening Code:

FVSQ = Family Violence Screening Questions

+ve = Positive

-ve = Negative (no abuse)

S = Signs/symptoms indicative of abuse exist

N = No (did not ask screening questions)

Documentation Procedures

For the documentation procedure of family/whānau violence disclosures or signs/symptoms indicative of abuse, follow the steps below:

- Complete the coded section for screening questions on the appropriate admission forms
- For **disclosed abuse** complete the Preliminary Risk Assessment Form, accurately documenting the disclosure, history, verbatim quotes and observations
- When **signs/symptoms** indicative of abuse exist complete relevant sections of the form– document what was said and observed, use the body map as appropriate including what information or resources were provided
- **Historical abuse** should only be recorded if presenting as a current problem; complete the Preliminary Risk Assessment Form.

Refer to Appendix 2 – Safety and Security Guidelines

Collection of Physical Evidence

In certain circumstances collection of evidence may be required for legal proceedings.

Steps to take in the collection of evidence include:

- Place torn or blood stained clothing and/or weapons in individual bags, which are sealed
- Mark bag with date, patients name and the name of the person who collected the items
- Keep the bag(s) in a locked place until they are turned over to the Police or the patient/client's solicitor.

Photographs

The use of photographs to document injuries may be appropriate in some circumstances. Medical Illustrations operates 24/7 and should be contacted to provide a Medical Photographer. If this service is not available within the health setting, then the existing service policy will be adhered to.

1.3 Staff Support and Safety

In any case where staff have been involved in the reporting and/or management of partner abuse they should have opportunity for peer support/clinical supervision. This support should be sought from a colleague/clinician, Child and Family Safety Service, Line Manager or EAP Services Counsellor who has received appropriate training. (CDHB Volume 2 Legal and Quality – Incident Management)

1.4 Appendices

1.4.1. Appendix 1 – Signs and Symptoms associated with Partner Abuse

Physical Injuries

- Injuries to the head, face, neck, chest, breast, abdomen or genitals.
- Bilateral distribution of injuries, or injuries to multiple sites.
- Confusion, lacerations, abrasions, ecchymoses, stab wounds, burns, human bites, petechiae around the eyes indicating strangulation, fractures (particularly of the nose and orbits) and spiral wrist fractures.
- Complaints of acute or chronic pain, without evidence of tissue injury.
- Multiple injuries, such as bruises, burns and scars, in different stages of healing.
- Sexual assault (including unwanted sexual contact by a husband/partner).
- Injuries or vaginal bleeding during pregnancy, spontaneous or threatened miscarriage.
- Tufts of hair pulled out.

Patient's/client's manner

- Hesitant or evasive when describing injuries.
- Distress disproportionate to injuries: e.g. extreme distress over minor injury.
- Dismissive or minimising injury.
- Explanation does not account for injury: e.g. "I walked into a door".

Illnesses

- Headaches, migraines
- Musculoskeletal complaints
- Gynaecological problems
- Chronic pain
- Malaise, fatigue
- Depression
- Insomnia
- Anxiety
- Chest pain, palpitations

- Gastrointestinal disorders
- Hyperventilation
- Eating disorders

Serious Psychosocial Problems

- Alcohol abuse or addiction.
- Drug abuse or addiction.
- Severe depression.
- Suicidal ideation or previous attempts.

History

- Record or signs/symptoms of previous abuse.
- Substantial delay between time of injury and presentation for treatment.
- Multiple presentations for unrelated injuries.

1.4.2. Appendix 2 – Safety and Security Guidelines

This guideline sets out the CDHB procedures when there are

- confidentiality issues or
- a need to access support to maximise the safety of patients/clients of family/whanau violence and/or
- when the risk to the their safety is assessed to be a very high risk

Whenever practicable the procedures outlined should be discussed with the patient/client who is the victim of abuse and consent obtained.

The safety of the patient/client is the paramount consideration. When a patient/client expresses fear of an (alleged) abuser or others s/he must be taken seriously. In this case it is defensible for health care professionals to refuse public access to patient/client information and to facilitate the patient/client leaving the health setting via a safe exit for a place of safety.

The below procedures are dependent on the type of Patient Management System services use and include Homer, SAP and CareSys.

1. HOMER Procedure to establish patient/client information suppression

- The patient/client discloses to the staff member concerns around his/her safety.
- Refer to social work service at the earliest opportunity if access to a social work service is available.
- The staff member discusses with the patient/client the potential to suppress patient's/client's details from being released publically – consent to proceed is given by patient/client.
- The admitting clerk/ward clerk is informed and places a '"No details to be released" which places a red flashing code on the Patient's Condition Screen of Homer and also the switchboard screen. The clerk enters an appropriate code (1, 2 or 3) on to the confidentiality field on the Patient Condition Screen and will ensure details are accurate.
- The legal name of the patient/client remains as a true and accurate record on the clinical record.
- Babies admitted with a patient/client should similarly have their details suppressed.
- The information on the PMS will not be changed when patient/client is discharged.

2. SAP and CareSys Procedures for name suppression and pseudonym addition:

- The patient/client discloses to the staff member concerns around his/her safety
- Refer to social work service at the earliest opporutnity if access to a social work service is available
- The staff member discusses with the patient/client the potential to suppress patient's/client's details from being released publically – consent to proceed is given by patient/client
- Complete disclosure options (full, none or partial)
- Gain patient/client's instructions regarding 'partial' dsclosure is completed
- Babies admitted with a patient/client should similarly have their details suppressed.
- Should it be deemed necessary, complete documentation to give the patient a pseudonym
- Upon discharge, complete documentation to change patient/client name back to their legal name

3. Non disclosure of patient/client information

- Inform the enquirer that patient/client details are not able to be provided
- Ask for the caller's name and record if provided
- Notify the key nurse/person responsible for the patient's/client's care
- Notify CDHB Security (if applicable) if for protection reasons the caller is the (alleged) abuser and if Police followup is likely.

4. Procedure used to discharge patient/client in a safe manner from a health setting when high-risk safety issues exist:

- Arrange the discharge plan in consultation with the patient/client including the service/agency
- The patient/client is referred to. Ensure the patient/client speaks with staff members from that service concerned and that all parties are in agreement with the discharge plan.
- Complete the documention regarding name suppression/pseudonym process as appropriate.
- Ensure the appropriate clinical staff are informed of the discharge plan process which may include:
  - Ward administrator/clerk

- Police
- CDHB Security (if available in work area)
- Switchboard operator

- The discharge plan may include the patient/client leaving the health setting escorted by a staff member via a safe exit.
- Document the discharge plan on the Family Violence Preliminary Risk Assessment Form
- Advise senior staff member of the discharge outcome.

Note: Consult with a senior staff member whether a Quality Improvment Event Reporting Form should be completed for situations when extreme risk, danger etc is involved.

5. Police Procedure for Family/Whanau violence:

Safety for the patient/client, children, staff and members of the public must be the primary consideration in high risk situations. In such situations, when issues of patient/client or staff safety are identified secondary to a disclosure of family violence, the below steps are to be followed:

- The Police should be the first point of contact as further Police response may subsequently be required. Consent by the patient/client for staff to contact the Police may not be given or practicable.
- The Police may be contacted by health professionals without the consent or knowledge of the patient/client under Rule 11 of the Health Information Privacy Code 1994.
- In regions where CDHB Security Service exist, they should be contacted as soon as possible.

There are no legal requirements to report crimes (eg assaults) to the Police. However professionally and ethically staff may have a reponsibility to notify the Police in the following events:

- Injuries may be life threatening
- Ongoing safety issues, such as further violence to the patient/client or others if the abuser remains at large
- Criminal charges may ensue

If uncertainty exists regarding what action to take, staff should consult with team members and senior staff to obtain a consensus-based decision regarding the best course of action to take.

1.4.3. Appendix 3 – Preliminary Risk Assessment Form

Canterbury District Health Board Te Poari Hauora ō Waitaha

Patient Label

Family Violence Preliminary Risk Assessment

FVSQ: ☐ **FV + (Positive)** ☐ **FV (Signs/Symptoms?)** **Patient/client pregnant?** ☐ **Yes** ☐ **No**

1. Assess Patient/Client Safety:

Full name of person disclosing information _____

Full name and relationship of alleged abuser(s) _____

Address of alleged abuser _____

Is the alleged abuser here now? ☐ Yes ☐ No _____

Is patient/client afraid of alleged abuser? ☐ Yes ☐ No _____

Is patient/client afraid to go/stay home? ☐ Yes ☐ No _____

Has the violence increased in severity? ☐ Yes ☐ No _____

Specify type of violence: ☐ Physical ☐ Sexual ☐ Psychological _____

2. Is there an immediate need for help?

Threats of homicide? ☐ Yes ☐ No If yes, by whom: _____

Threats of suicide? ☐ Yes ☐ No If yes, by whom: _____

Alcohol/substance abuse? ☐ Yes ☐ No _____

Is there a history of choking/strangulation? ☐ Yes ☐ No _____

Is there a gun/weapon in the house? ☐ Yes ☐ No _____

Name any other lethal weapons in the house _____

Safety plan for patient/client discussed? _____

If you have answered YES to any of the questions in 1 or 2 discuss safety concerns, document overleaf and refer to CDHB internal services and external agencies listed below.

3. Child Risk Assessment:

a. Do you have children in your care? ☐ Yes ☐ No

b. Has anyone harmed the children? ☐ Yes ☐ No ☐ Physical ☐ Sexual ☐ Emotional

Relationship of alleged abuser to children? _____

Have the children been exposed to violence in the home? ☐ Yes ☐ No

Safety plan for children discussed? ☐ Yes ☐ No (If Yes, document safety plan on the next page)

If you have answered YES to question 3b –

- **Refer all high risk cases to CYF immediately.**
- **Refer all child protection cases to the CDHB Child & Family Safety Service or the Child Protection Co-ordinators (Mental Health) and members of the Multi-Disciplinary Team as per divisional procedures.**

CDHB Internal referrals made:	External referrals made:	Information provided:
☐ Child Protection Coordinators	☐ CYF	☐ Family Violence pamphlet
☐ Child Health	☐ Police	☐ Women's Refuge
☐ Social Work	☐ Women's Refuge	Refuge name: .....
☐ Maori Health Services	Refuge name:	☐ Family Violence Service
☐ Mental Health Services	☐ Family Violence Service	☐ Other (please specify)
☐ Security	☐ GP Notified	
☐ Other (please specify)	☐ Other (please specify)	

☐ **Help Declined**

Name _____ **Signature** _____

Designation _____ **Department/Service** _____

Date _____ **Time** _____

Send a copy of all completed forms to the Child & Family Safety Service, 41 St Asaph Street, ChCh Hospital

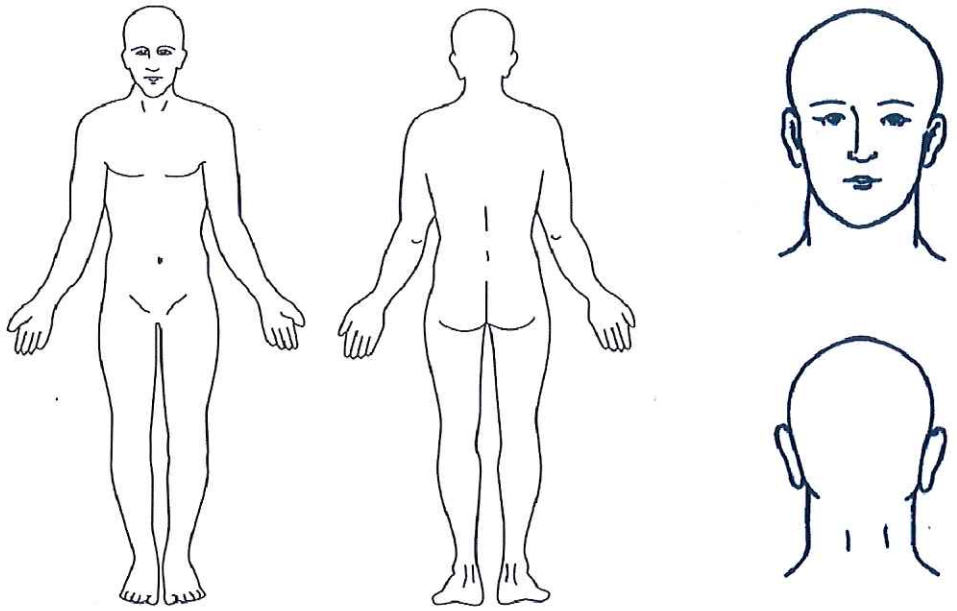
Ref 2458 Authorised by: Page 1 of 2 April 2011

FAMILY VIOLENCE PRELIM RISK ASSESS C140055

The latest version of this document is available on the CDHB intranet/website only.

Printed copies may not reflect the most recent updates.

Measure, indicate and describe: abrasions, lacerations, areas of pain and tenderness, sites of trace evidence, tattoos, scars and birthmarks



Was a safety plan discussed? ☐ Yes ☐ No

If not, why not? .....

Please record history including:

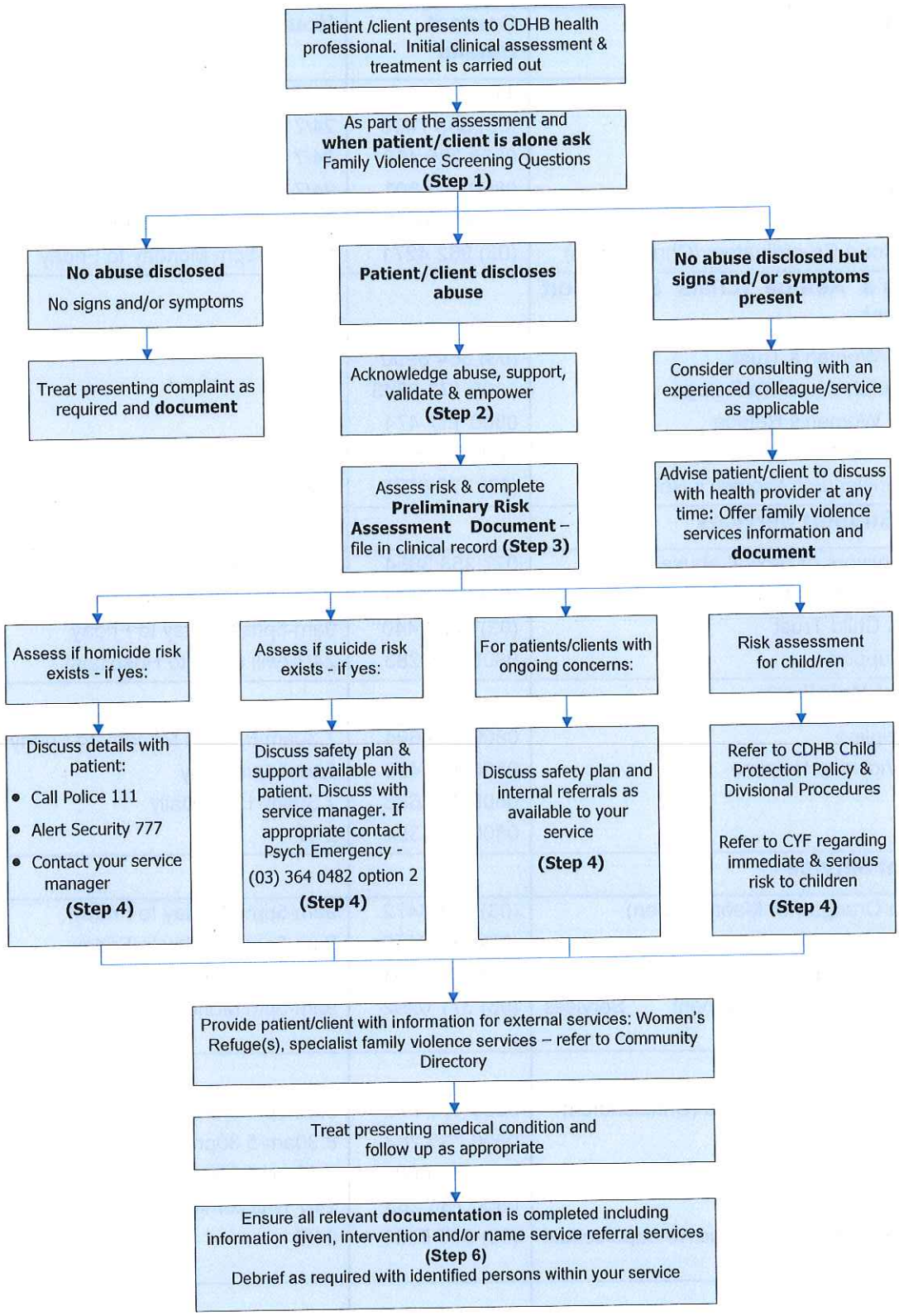
- *Verbatim quotes*
- *Description of injuries*
- *Observations, ie. Patient/client's demeanor*
- *How injury occurred: eg punched with closed fist, kicked in stomach by foot*
- *Weapon used eg knife, gun, baseball bat*

Notes:

The latest version of this document is available on the CDHB intranet/website only.

Printed copies may not reflect the most recent updates.

1.4.4. Appendix 4 – Family Violence Screening and Response Flowchart



1.4.5. Appendix 5 – Referrals – Family/Whānau Services

Government Services	Contact Details	Hours of work
Police (Emergency)	111	24/7
Police (Canterbury)	(03) 363 7400	24/7
Child, Youth and Family	0508 326 459	24/7
Housing New Zealand	0800 801 601	24/7
Work and Income	0800 559 009	7am-6pm Monday to Friday
Family Court Co-ordinators (Christchurch)	(03) 962 4271	8.30am-5pm Monday to Friday
Women's Refuge (crisis & support Services)		
Battered Women's Trust	(03) 364 8900	24/7
Christchurch Women's Refuge	0800 173 3843	24/7
Otautahi Women's Refuge	0800 117 474	24/7
Shakti Ethnic Women's Support	0800 742 584	24/7
West Christchurch Women's Refuge	(03) 379 0575	24/7
Men's Support Services		
Male Survivors of Sexual Abuse Trust	027 353 3854	9am-5pm Monday to Friday
Canterbury Men's Centre	(03) 940 9487	9am-5pm Monday to Friday
Father & Child Trust	(03) 982 2440	9am-5pm Monday to Friday
Victim Support	0800 735 283	24/7 (will come to Hospitals)
National Helplines		
Child Helpline	0800 366 694	7.30am-5.30pm Monday to Friday
Family Violence Helpline	0800 457 450	9am-11pm Daily
SHINE	0508 744 633	7.30am-11pm Daily
Lifeline	0800 543 354	24/7
Cultural Services		
Te Puna Oranga (for Maōri women)	(03) 381 8472	9am-5pm Monday to Friday
He Waka Tapu (for Maōri)	(03) 373 8150	9am-5pm Monday to Friday
Pacific Trust Canterbury	(03) 363 0761	9am-5pm Monday to Friday
Christchurch Resettlement Services (Interpreters provided)	(03) 377 0292	9am-5pm Monday to Friday
Other Services		
Stopping Violence Services (Christchurch)	0800 478 778	9am-5pm Monday to Friday
Relationship Services	0800 735 283	8.30am-5.30pm Monday to Friday
Age Concern Canterbury	(03) 366 0903	8.30am-4.30pm Monday to Friday
Victim Support	0800 735 283	24/7 (will come to Hospitals)
SAFECARE (Acute service re rape/sexual assault)	(03) 377 5401	24/7
Legal Service (free)		
Community Law Canterbury	(03) 366 6870	9am-5pm Monday to Friday

Procedure Owner	Role title, no names, no departments
Procedure Authoriser	CMO & EMT
Date of Authorisation	January 2011

Appendix 3

Northern Regional Advisory Group for Transgender Advisory Services – recommendation terminology

Gender identity: A person's innermost concept of self as male, female, a blend of both or neither. One's gender identity can be the same or different from their sex assigned at birth.

Gender expression: The external presentation of one's gender, as expressed through one's name, clothing, behaviour, hairstyle or voice, and which may or may not conform to socially defined behaviours and characteristics typically associated with being either masculine or feminine.

Gender diverse: A term to describe people who do not conform to their society or culture's expectations for males and females. Being transgender is one way of being gender diverse, but not all gender diverse people identify as being transgender. Gender creative or gender expansive are other terms that are used when referring to children

Assigned male at birth: A person who was thought to be male when born and initially raised as a boy.

Assigned female at birth: A person who was thought to be female when born and initially raised as a girl.

Trans or transgender: A term for someone whose gender identity does not align with their sex assigned at birth. This term is often used as an umbrella term, recognising that people may describe themselves in many ways including the use of indigenous terms such as; Whakawāhine, Tangata ira tāne (Māori), Mahu (Hawai'i and Tahiti), Vakasalewalewa (Fiji) Palo- pa (Papua New Guinea) Fa'afafine (Samoa) Akava'ine (Rarotonga), Fakaleiti (Tonga) Fakafifine (Niue)

Cis or cisgender: A term for someone whose gender identity aligns with their sex assigned at birth.

Trans boy/male/man: A term to describe someone who was assigned female at birth who identifies as a boy/male/man.

Trans girl/female/woman: A term to describe someone who was assigned male at birth who identifies as a girl/female/woman.

Non-binary: A term to describe someone who doesn't identify exclusively as male or female.

Gender fluid: A person whose gender identity varies over time.

Agender: A term to describe someone who does not identify with any gender.

Gender dysphoria: A term that describes the distress experienced by a person about the incongruence between their gender identity and their sex assigned at birth.

Social transition: The process by which a person changes their gender expression in social situations to better align with their gender identity.

Gender affirming healthcare: The process by which a person may change their secondary sex characteristics via hormonal intervention and/or surgery to more closely align with their gender identity.