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19 December 2018

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RE Official information request CDHB 9989

We refer to your email dated 30 November 2018 requesting the following information under the Official Information Act from Canterbury DHB. I note your request was clarified on 3 December 2018 as below:

- **A written copy of the Canterbury District Health Board's internal protocols in regard to the treatment of patients who disclose that they are the victim of a sexual assault to a Canterbury DHB staff member at ChCh Hospital. In particular, I want to understand the specific steps that the hospital staff would be expected to take in order to follow the standard protocols as set out in your policy and practice documentation.**

If a patient discloses to a staff member that they are a victim of a sexual assault the following is the response expected from staff.

1. Children or a Young Person

The information related to this is found on the electronic system – Child Health e-Guidelines and the Canterbury Community HealthPathways. Please refer to **Appendix one** (attached) for a copy of the documents.

An outline of the process is that any staff member can complete a 'Report of Concern to Oranga Tamariki'. It is also mandatory for all staff within the Canterbury DHB provider arm to consult with our Child Protection Specialist within our Canterbury DHB Child and Family Safety Service so Specialist advice can be obtained. If the matter requires a multidisciplinary response the Canterbury DHB Child and Family Safety Review committee are also available for staff to discuss their concerns. A referral to the Social Work team is available to staff to assist them in the management of cases within the Canterbury DHB inpatient units.

However most staff and especially those in the Child Health Service will seek advice from the Social Work Team. Depending on the circumstances this may or may not be done with the knowledge of the parents. Children under 12 who require a medical review will be seen by the Canterbury DHB Child and Family Safety Service. Those over the age of 12 are referred to the Cambridge Clinic. <http://www.cambridgeclinic.co.nz/>. Canterbury DHB provides ongoing psychosocial support for children and young people as well as their families.

Parents or guardians seeking advice will be directed to approach the police to report an actual or alleged events. Staff may also ring the Police on their behalf.

2. An Adult

If an adult discloses that they have been the victim of a sexual assault the staff member is to encourage them to notify the Police and also to refer them to the Cambridge Clinic. It is mandatory for staff to consult with the Family Protection Specialist within the Canterbury DHB Child and Family Safety Services about concerns of this nature. The case can also be discussed at the Canterbury DHB Child and Family Safety Review Committee if the matter requires a multi-disciplinary response.

If the patient does not want the matter to be referred to the Police, but the patient's safety is seriously compromised, a referral will be made to the Police to ensure the patient's wellbeing. If as a result of the assault the person requires medical attention for any injuries then they will be treated for these in the Emergency Department, or an admission to an appropriate inpatient unit if required.

Urgent referrals to the Cambridge Clinic for acute and forensic management are made by the Police for the person to be seen the same day (the Cambridge Clinic will also see urgent cases on the Gynecology Ward). A Social Worker is on call at all times for the Emergency Department and also for elsewhere in the hospital should a patient disclose information some time after an event and advice or assistance is required.

There are also a range of policy and procedures that cover matters such as Elder Abuse, Family Violence, Intimate Partner Violence (IPV) and Family Violence Assessment and Intervention that are included as reference material.

Appendix one (attached) includes:

- Child Health e-Guidelines / Strangulation Prevention links / Canterbury DHB Management of Child Abuse / neglect flowchart
- Report of Concern Oranga Tamariki
- Cambridge Clinic Patient Information
- Management of Child Abuse Neglect
- Email referral to Child Youth and Family
- Medical Assessments Requested by CYF Consent
- Photographic documentation of injuries
- Partner Abuse Policy
- Elder Abuse Policy
- IPV Family Violence Assessment Intervention
- Intimate Partner Violence Intervention

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely



Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

- About the Paediatric Department
- Administrative and Other Guidelines
- Clinical Guidelines
 - Abuse and Neglect
 - Anaphylaxis
 - Asthma, Acute
 - Asthma, Life Threatening
 - Bronchiolitis
 - Cardiology
 - Congenital Hypothyroidism
 - Constipation
 - Croup
 - Cystic Fibrosis
 - Death of a Child
 - Diabetes
 - Down Syndrome
 - Eczema
 - Empiric Antimicrobial Guidelines (Christchurch)
 - End of Life (Palliative) Care
 - Gastroenteritis
 - Hemangioma - Treatment with Propranolol
 - Head Injury

Abuse and Neglect

See also Community HealthPathways – [Sexual Abuse of a Child or Young Person](#)

Forms for CYF Referral:

- [Referral to Child, Youth and Family](#)
- [Email Referral form](#)

Consent form for use by CYF or the Police (**not for internal CDHB use**):

- [Consent Form - Medical Assessments Requested by Child, Youth and Family \(CYF\)](#)

Strangulation – Training Institute on Strangulation Prevention:

- [Resources](#)
- [Signs and symptoms](#)

In This Section

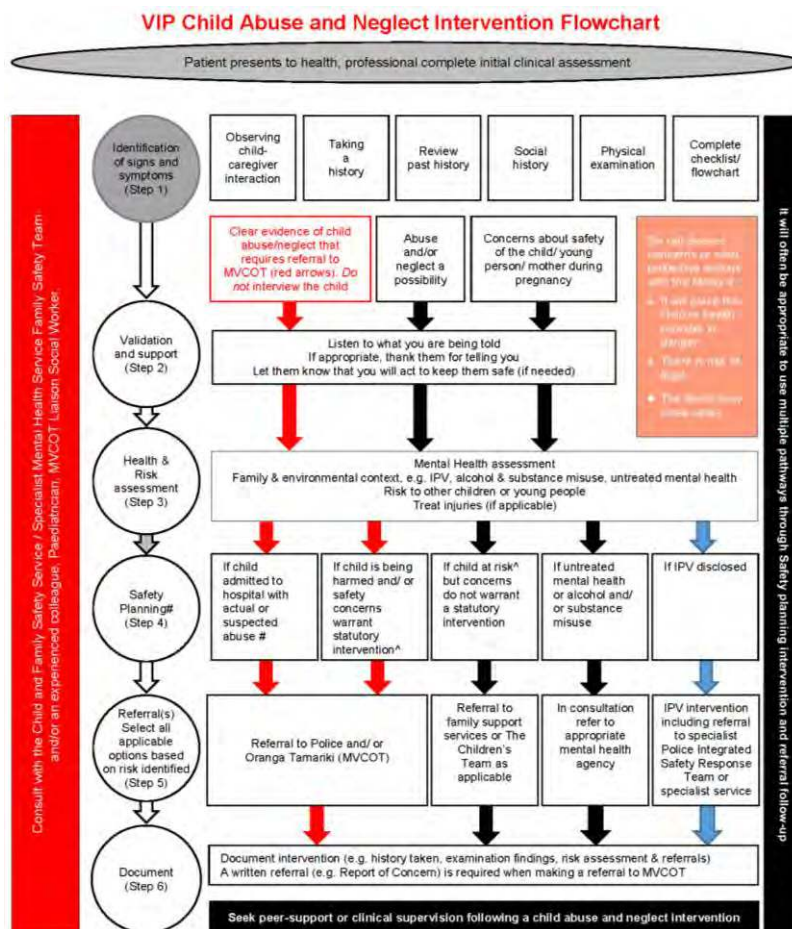
[Photographic Documentation of Injuries](#)

Strangulation – Training Institute on Strangulation Prevention

<https://www.strangulationtraininginstitute.com/resources/>

<https://www.strangulationtraininginstitute.com/resources/popular-handouts/>

The **CANTERBURY DHB Management of Child Abuse and Neglect** document also includes a flowchart with a red pathway for statutory intervention.





**ORANGA
TAMARIKI**
Ministry for Vulnerable Children

If you believe a child is in immediate danger or in a life-threatening situation contact Police immediately by dialling 111.

Report of Concern to Oranga Tamariki Ministry for Vulnerable Children

Call us on: 0508 326 459

Email address for sending the written referral: contact@mvcot.govt.nz

or Fax: (09) 914 1211 (telephone and e-mail is our preferred method)

*Before you make this referral we encourage you to speak to whānau about your concerns and let them know your plan to contact Oranga Tamariki. However if children (or you) are at **immediate** risk of harm, we understand you may make a referral without contacting the child's whānau.*

If you have spoken with a Oranga Tamariki social worker about this referral, please record

Name of Social Worker:

Date/time of conversation:

Outcome of the discussion:

Wherever possible we will work with you and will endeavour to make contact with you prior to visiting the whānau.

We prefer you speak to a social worker at our National Contact Centre by phone **0508 326 459**, so you can discuss your concerns and answer any questions the social worker may have to help inform their decision about the next step. Where your agency requires a written referral please send a copy of this document (we prefer an electronic word document).

This form may ask for information you do not have, that's okay. For these please write "not known/not applicable". The more information you can share, the better our decision making will be and the better the outcome for the child will be.

Your details

Date:

Your name and role:

Your email address:

Your contact phone number/s:

Your afterhours contact phone number: *(for emergency situations only)*

Your organisation:

Your postal address:

Alternate contact person:

Alternate contact person phone number/s:

Please advise if you wish your identity to remain confidential. We generally do not disclose your identity but there may be exceptional situations where we may have to. Should this occur we will let you know. Keep in mind that families may form their own views on who made contact with Oranga Tamariki.

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**ORANGA
TAMARIKI**
Ministry for Vulnerable Children

If you believe a child is in immediate danger or in a life-threatening situation contact Police immediately by dialling 111.

Have you informed the whānau that your concern is being reported to Oranga Tamariki?

What steps have you taken to discuss and address your concerns with the whānau or through referrals to other agencies before referring to Oranga Tamariki?

What was their response?

Key Information:

Please enter information below for all the children and young people in the whānau that you are concerned about including their siblings

Child's Name:

Also known as:

Date of Birth: *(or Expected Due Date)*

Unique identifier (e.g. NHI, NSN):

Gender:

Child's address: *(This is essential information to enable the MVCOT Contact Centre to refer the case to the appropriate MVCOT site)*

Ethnicity: *(include Iwi/Pacific Island Affiliation if known)*

Child's Name:

Also known as:

Date of Birth: *(or Expected Due Date)*

Unique identifier (e.g. NHI, NSN):

Gender:

Child's address: *(This is essential information to enable the MVCOT contact centre to refer the case to the appropriate MVCOT site)*

Ethnicity: *(include Iwi/Pacific Island Affiliation if known)*

Please add any additional children and their details below:

Mother's name:

Also known as:

Date of Birth: *(or approximate age)*

Phone number:

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ORANGA TAMARIKI

Ministry for Vulnerable Children

If you believe a child is in immediate danger or in a life-threatening situation contact Police immediately by dialling 111.

Address:

Father's name:

Also known as:

Date of Birth: *(or approximate age)*

Phone number:

Address:

Who else is living in the home *(name and age):*

If a child has a parent/carer different from those stated above please provide the details and their relationship to the child/ren:

Other whānau or people involved in the care of the child/young person: *(please include, name, relationship to the child, address and contact phone number)*

Early Childhood Education / School: *(please include, contact person and contact phone number)*

It is helpful to know who else is working with the whānau. We may need to talk to the agency before talking with the whānau. Please tell us about other agencies working with this whānau.

Agency	Contact name	Contact number	Why/how are they involved
General Practitioner			
Alcohol/Drug and Other addiction services			
Child and Adolescent Mental Health Service			
Community Mental Health or Addiction Services <i>(adult services)</i>			
Cultural Support			
DHB Social Worker			
Disability Services			
Family Start			

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ORANGA TAMARIKI

Ministry for Vulnerable Children

If you believe a child is in immediate danger or in a life-threatening situation contact Police immediately by dialling 111.

Maternity Service/Lead Maternity Carer <i>If antenatal referral, what is the expected date of delivery?</i>			
Plunket / Well Child / Tamariki Ora			
Police			
Public Health Nurse			
Special Education / School Counsellor / SWISS/MASSIS			
Children's Team			
Other e.g. Paediatrician, NGO social service (please specify)			

What was the outcome of your discussion with them about referring to Oranga Tamariki? *(It is helpful to know why they are involved and what they are working on with the whānau)*

Reason for referral

Please describe what your worries and concerns are for this child or young person, this group of children and their whānau:

What is your main concern for this child or young person?

Describe what you are observing, what you have heard or what you have been told rather than using general terms such as "emotional abuse"

Note in the child or young person's words anything they may have said to concern you *(When did they say it and to whom?)*

Make note of how recent and frequent any specific incidents or events are *(explain who, what, when, how?)*

Describe any other issues that could be impacting on the child or young person e.g. family violence, chronic ill health, disabilities, mental illness, substance misuse, lack of support, truancy, behavioural, family stress, transience, criminal history, non-engagement/avoidance of services and describe how this has affected the child or young person?

Source of the information (e.g. observed directly or name and contact details):

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**ORANGA
TAMARIKI**
Ministry for Vulnerable Children

If you believe a child is in immediate danger or in a life-threatening situation contact Police immediately by dialling 111.

What has prompted you to refer to Oranga Tamariki now? *(What are your immediate safety concerns for this child or young person?)*

Where is the child or young person now? *(e.g. school, hospital, home)*

Who in the whānau or friends of this whānau can help provide support around the concerns you have and how can they do this? *(Please provide contact details)*

What is working well for this whānau? *(What needs of the children and young people are being met and how does this happen?)*

What is in place to support the whānau and keep the children or young person safe currently? *(Services and agencies providing support, family and friends visiting, people providing care for the children)*

Tell us why you think Oranga Tamariki is the most appropriate agency to assess the needs and circumstances of this whānau now? *(What have you already tried to address the concerns? What is currently in place to address your concerns? What would you like Oranga Tamariki to do?)*

What other needs have you identified for this whānau? *(Disability, language, cultural)*

What happens next?

A social worker at our National Contact Centre will read your report of concern and make a decision as to the next best step to ensure the safety of the children or young people in this whānau.

They may need to talk to you to clarify some information to help them make the best decision for these children or young people. Please ensure you are available to be phoned by the social worker.

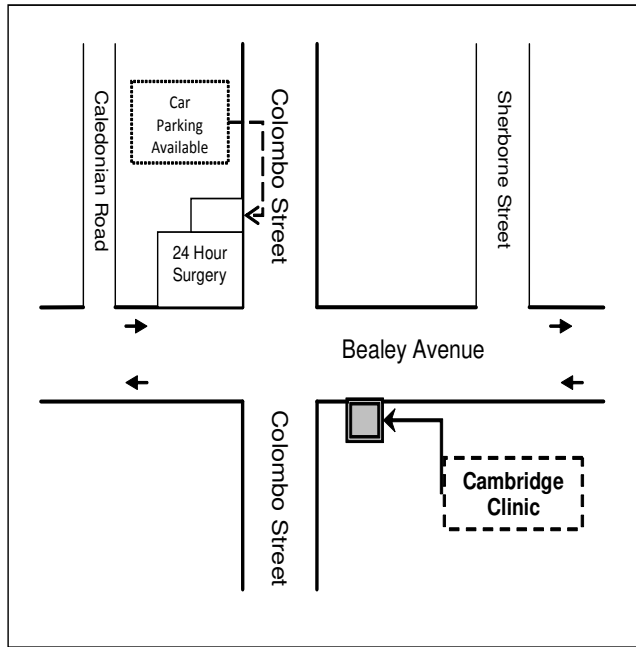
Developed in collaboration with New Zealand Police, Ministry of Health and Ministry of Education

Version 2 April 2017

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How to find us



Your appointment is

.....

With:

PLEASE: contact us if you need to change this appointment.

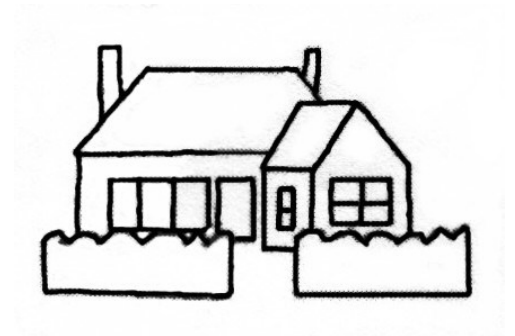
Other useful phone numbers / contacts.

- **Sexual Assault Support Service Canterbury (SASSC)**
Phone: 377 5402
- **Christchurch Police**
Phone: 363 7400
- **AVIVA**
Ph: 0800 AVIVA NOW (0800 28482 669)
Free 24 hour support line
E-mail: enquiries@avivafamilies.org.nz
www.avivafamilies.org.nz
- **West Christchurch Women's Refuge**
Phone: 379 0575
- **Battered Women's Trust**
Phone: 364 8900
- **Shakti Ethnic Women's Support Group**
Phone: 389 2028
- **Lifeline**
Free 24 Hour Phone Counselling
Phone Counselling - Phone: 366 6743
Call Free - Phone: 0800 543 354
- **Sexual Health Clinic (CDHB)**
33 St. Asaph Street, Christchurch
Phone: 364 0485
- **Rape Prevention Education Trust**
(to view written information / brochures)
www.rapecrisis.org.nz
- **To Find an ACC Registered Counsellor**
Go to www.findsupport.co.nz
→ Find a Therapist
From 'Where can we help you?' select - Canterbury
[Search]
This brings up a list of ACC Registered Counsellors

Cambridge Clinic

Sexual Assault Medical Services

THIS IS A FREE SERVICE



*The Cambridge Clinic
provides medical
services for anyone
in Canterbury or
the West Coast who
has been sexually
assaulted, whether
recently or in the past.*

Information about our services

We offer sensitive and appropriate medical advice to male and female adults, adolescents and children.

[N.B. Children are only seen after referral from another professional, e.g. Police, CYF, GP or Hospital doctor]

We provide specially trained and accredited doctors and nurses to provide medical and forensic examinations, practical and emotional support and referral to other agencies.

We can arrange for a support person from Sexual Assault Support Service Canterbury (SASSC) to attend the medical appointment.

What we do Immediate service

If you have been sexually assaulted we offer the following services:

- Acute (urgent) medical examinations and collection of samples by a trained doctor and nurse, carried out as sympathetically as possible and in private.
- Non-acute (booked) medical examinations including check-ups following past sexual abuse. If you have not informed the police about your sexual assault and are uncertain whether to do so there are many options to consider. You can discuss these confidentially with members of the Cambridge Clinic team. These are your choices and your wishes will be respected.
- Screening and treatment for sexually transmitted infections when required.
- Emergency contraception and pregnancy testing can be carried out if needed.

Follow up services

Support in the weeks following an assault.

- We realise that the after effects of sexual assault can take time to get over, people react differently, and we can assist in referral to other services if required such as support groups, counsellors, refuges, court support services and ACC.
- We may also be able to assist with finding a G.P. if required.

How to get an appointment

You will be offered an appointment by phoning the clinic or upon referral from your GP, counsellor, Family Planning Clinic, Police, CYF, the hospital, or the 24 Hour Surgery.

Phone For An Appointment
03 366 0067
THIS IS A FREE SERVICE



Cambridge Clinic

DSAC Canterbury Ltd
146 Bealey Avenue, Christchurch
Phone: 366 0067
Fax: 366 5448
Email: cambclin@xtra.co.nz

Management of Child Abuse and Neglect

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Purpose

The Canterbury District Health Board (CDHB) recognises that staff competence, and clarity of roles and responsibilities are essential to effective child protection interventions. This supports the accurate detection of suspected and or actual child abuse and neglect, the early recognition of children at risk of abuse and adults at risk of abusing children. This policy seeks to promote and ensure the safety and wellbeing of children and their whanau.

Associated procedures, referral pathways and electronic documentation requirements, eg. patient management systems, alert/memos and eProsafe requirements, provide CDHB community and hospital-based staff with a framework to identify, support, assess and respond to actual and/or suspected child abuse and neglect.

Overview

Family violence is a global issue and is not limited to one gender, sexual orientation, religious, cultural or income group.

The Canterbury District Health Board (DHB) is committed to a whole health systems population approach to the issue of child protection, ie. working across primary and secondary care. This is in recognition that child abuse and neglect are important health issues. They can lead to immediate physical and mental health consequences and are significant precursors to a range of poor health outcomes and long-term conditions. Health care providers are ideally placed for early identification of and intervention in family violence because most people use health services at differing times in their lives.

Principles

The rights, welfare and safety of the child/tamaiti, are our first and paramount consideration.

Health services should contribute to the nurturing and protection of children and advocate for them as part of their role to promote and preserve health.

Health services for the care and protection of children/tamaiti are built on a bicultural partnership in accordance with the Te Tiriti o Waitangi/Treaty of Waitangi.

Māori children/tamaiti, are assessed and managed within a culturally safe environment. The Māori Health Team/Pukenga Atawhai is available for cultural support.

Wherever possible the family/whānau, hāpu and iwi participate in the making of decisions affecting their child/tamaiti. Their primary role in providing the care, welfare and safety of their children must be valued.

All staff are to recognise and be sensitive to other cultures.

CDHB provides an integrated service and works with external agencies to provide an effective and coordinated approach to child protection.

Staff are competent in identification and management of actual or suspected abuse and/or neglect through the organisation's infrastructure including policy and procedural structures, workforce development and access to consultation.

It is important for children/tamaiti that services are provided in environments which are comfortable and appropriate to their needs and age.

Child Protection work is complex and stressful; a consultative and multi-disciplinary approach is considered best practice. Health care workers should not work in isolation.

Early intervention is recognised as best practice to maximise the opportunity for best outcomes.

Scope

This policy applies to all cases of actual and/or suspected child abuse and neglect encountered by all employees, students and people working at CDHB under a contract for service.

Terms and definitions

See Appendix 1: Terms and Definitions

POLICY

Organisational responsibilities

Executive responsibilities

The CDHB is responsible for ensuring:

- An organisation-wide policy for the management of child abuse and neglect and associated policies is implemented.
- Engagement with interagency processes such as Memorandum of Understanding between DHB, Ministry for Vulnerable Children, Oranga Tamariki/CYF (Oranga Tamariki/CYF)¹ and the Police that support effective collaboration.
- Processes are in place which reinforce staff compliance with the policy
- Regular workforce development for staff on the management of child abuse and neglect policy.
- Staff attend workforce development that comprises of Violence Intervention Program (VIP) mandatory core and refresher training. CDHB requires core training and at a minimum, refresher training every two years, for staff working in the MoH designated areas.
- Adequate support (eg. access to consultation) and supervision for staff.

These activities need to be properly resourced and evaluated.

¹ Ministry for Vulnerable Children, Oranga Tamariki/CYF (Oranga Tamariki/CYF)¹ formerly Child Youth and Family (CYF)

Steering Group responsibilities

- To meet on a regular basis
- To provide guidance and support to the Violence Intervention Programme (VIP) Child and Family Safety Service (C&FSS) / Specialist Mental Health Family Safety Team (SMHF FST).
- Participate in reviews and endorse the policy and procedures related to VIP/C&FSS/SMHF FST
- Advise and support the implementation and maintenance of violence intervention services within the CDHB
- Champion the service throughout the CDHB

Service responsibilities

- All services/departments will support the implementation of this policy within services. Divisions who provide care for children and youth can have divisional level child protection policies based on this policy which reflect their philosophy of care.

Employee responsibilities

All CDHB employees have responsibility for the management of actual or suspected abuse and neglect. Responsibilities are:

- To be conversant with DHB management of actual or suspected child abuse and neglect and associated policies
- To understand the referral and management process of actual or suspected abuse and neglect
- To take action when child abuse and or neglect is suspected or identified
- It is mandatory to refer to the Child and Family Safety Service (C&FSS)/Specialist Mental Health Family Safety Team (SMH FST) when there is suspected or actual child abuse and neglect of a child.
- To contact the C&FSS - Phone External 3640905 /Internal 80905 or Fax External 3641459/ Internal 81459.
- To contact the SMH FST Phone Cell 027 6872 304 or email familysafetysmhs@CDHB.health.nz
- To attend VIP mandatory core and refresher training appropriate to their area of work.
- To provide or access CDHB specialist health services that may include:
 - Cultural assessments
 - Mental health assessments
 - Diagnostic medical assessments
 - Social work services, counselling and therapy resources
 - Paediatric assessments
- To practice safely, for example consulting with a senior colleague during the intervention and seeking peer-support/supervision when child abuse is suspected or identified. This includes situations where child abuse is disclosed but the child may not be present (eg. child of an adult patient).

People and Capability responsibilities

CDHB recruitment policies will reflect a commitment to child protection by including comprehensive pre-employment screening procedures in accordance with the Vulnerable Children's Act 2014/ CDHB People and Capability Policies

Where suspicion exists of child abuse perpetrated by an employee or volunteer, the matter will be dealt with in accordance with the Human Resource disciplinary procedures, People and Capability Policies

Child and Family Safety Service (C&FSS)/Specialist Mental Health Family Safety Team (SMH FST) Responsibilities

- Coordinate Violence Intervention Programme (VIP) implementation within services, working with service leaders to ensure the system supports are readily available.
- Ensure the CDHB-wide policy remains current and aligned with national standards.
- Ensure provision of workforce development in accordance with the DHB VIP training plan; this will include ensuring that the VIP training is available cyclically.
- Ensure quality improvement activities in regard to policy compliance are undertaken and reported on at least biannually.
- Provision of consultation service for staff managing child protection cases.
- Provision of peer support for staff who have been involved in the reporting and management of child abuse and/or neglect.
- Management of eProsafe child protection and family violence application.
- Attendance at multi-disciplinary/multi-agency case management meetings.
- Attendance at multi-agency /multi-disciplinary groups working collaboratively to improve and introduce child protection initiative.
- Participation in VIP whānau ora meetings and initiatives.
- Support implementation of child protection audits.
- To facilitate communication with Oranga Tamariki/CYF and other key statutory and community agencies.

Māori and the violence intervention programme

Māori are significantly over-represented as both victims and perpetrators of whānau violence. This should be seen in the context of colonisation and the loss of traditional structures of family support and discipline. However, child abuse and neglect is not acceptable within Māori culture. The CDHB Management of Child Abuse and Neglect Policy has been developed in accordance with the principles of action including the Te Tiriti o Waitangi/Treaty of Waitangi principles, recognising Te Whare Tapa Wha and kaupapa practices. This is consistent with the eLearning Ministry of Health (MoH) endorsed Foundation course in cultural competency.

<https://learnonline.health.nz/login/index.php>

Family violence intervention for Māori is based on victim safety and protection being the paramount principle. The CDHB has Māori staff/services available to offer support to families. Whenever possible an appropriate staff member of the same ethnicity as the child/tamaiti should be involved in decision making and consultation.

See Appendix 2: Māori and family violence

Pacific peoples and the violence intervention programme

Family violence among Pacific communities in New Zealand occurs in the context of social change brought about by migration, alienation from traditional concepts of the village, family support, extended family relationships and in combination with socio-economic stresses.

Family violence intervention for Pacific peoples is based on victim safety and protection being the paramount principle. CDHB to access Pacific Services to offer support to the family whenever possible.

See Appendix 3: Pacific peoples and family violence

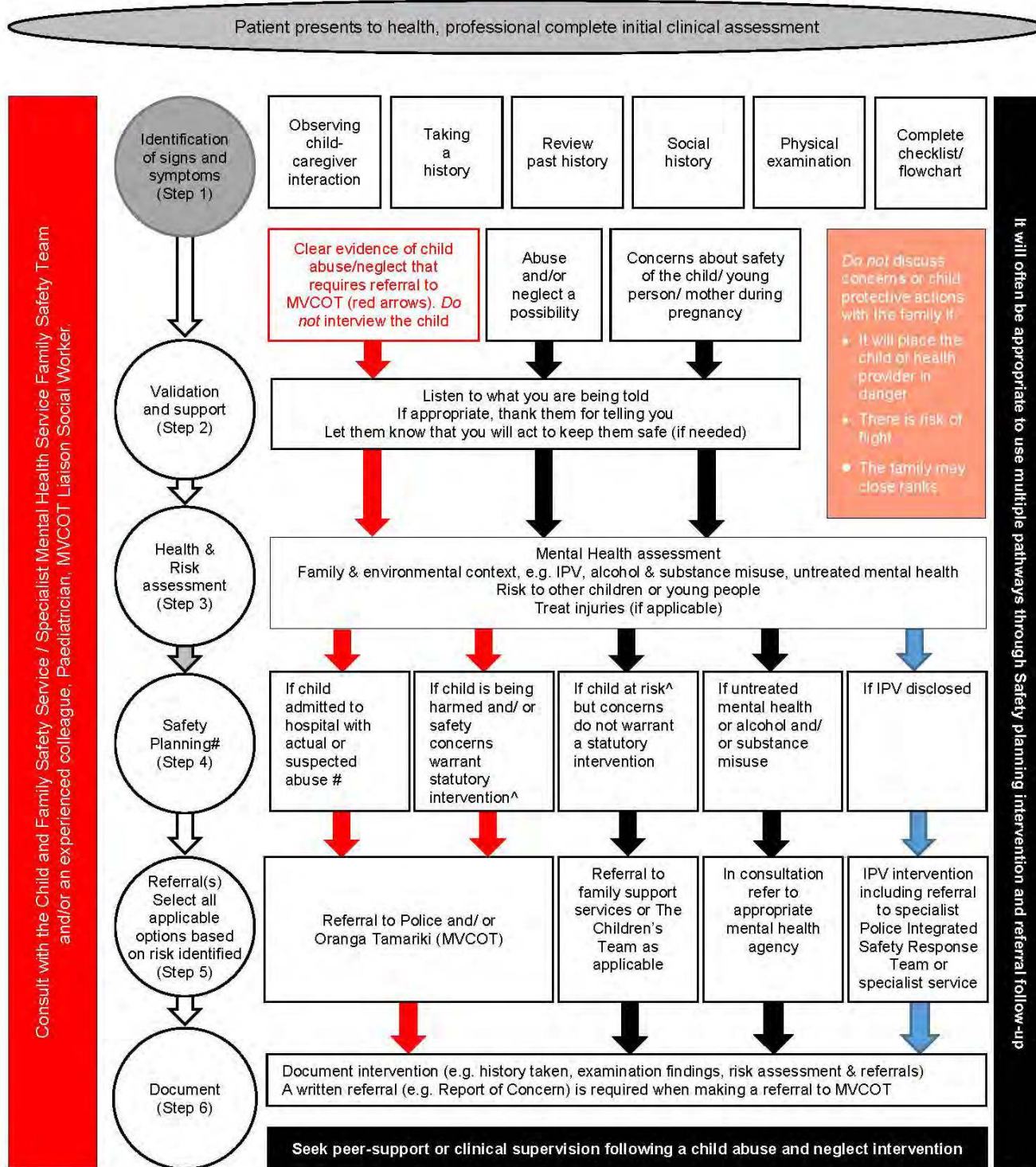
Minority ethnicities/refugees

Staff need to consider the increased isolation of patients/clients from minority ethnic groups. They may have few support structures outside of the direct family. Different cultures may have different value bases and this may differ from those predominately represented in New Zealand. The potential for minority ethnicities and refugees to identify as being abused and to access help may be difficult.

Staff are to be aware of the potential risks to the abused person when accessing interpreters from ethnic groups. A family member should **NOT** be used as an interpreter for the victim.

Flowchart for responding to actual or suspected child abuse and/or neglect

VIP Child Abuse and Neglect Intervention Flowchart



#Red pathway for statutory intervention
#Black pathway for non-statutory intervention
#Blue pathway specialist service, eg ISR
#Standard interagency protocol, Memorandum of Understanding between DHB, MVCOT, and Police and associated schedule 1
^Consult with the Child and Family Safety Service/Specialist Mental Health Service Family Safety Team and/or an experienced colleague, Paediatrician, MVCOT Liaison Social Worker

Six step child protection intervention

This policy outlines the intervention for identifying, assessing, responding to, and referring children who may be victims of violence and/or neglect. Appropriate documentation is also included in the six-step process.

All situations where recent or ongoing child abuse and/or neglect is disclosed, detected or suspected must be acted on and reported using the following procedure.

Routine enquiry about child abuse and neglect is not recommended. Health care providers do however need to respond to a disclosure, or be alert for signs and symptoms that require further assessment, or might indicate child abuse and neglect.

See Appendix 4: Four Recognised Categories of Child Abuse.

See Appendix 5: Signs and symptoms of Abuse and Neglect in Recognised Categories of Child Abuse

Consultation with and referral to key clinical staff is essential, ie.

- Supervisor/Manager
- Child and Family Safety Service (C&FSS)
- Specialist Mental Health Family Safety Team (SMH FST).
- DHB Social Worker
- Paediatrician
- Psychiatrist
- Psychologist
- Oranga Tamariki/CYF/ DHB Liaison Social Worker.
- Mental health case manager or duty person in team.
- Care and Protection Public Health Nurses

It is the health workers responsibility to raise concerns. You do not need absolute proof that child abuse and/or neglect is occurring. A referral to Oranga Tamariki/CYF may be made at any time

All health workers can refer a case for discussion to Child and Family Safety Review Panel's within General Health and Specialist Mental Health. They are interdisciplinary/interagency teams within CDHB who advise, support and assist staff regarding situations of abuse, alleged abuse or risk of abuse and offer advice on future options.

It is mandatory for all concerns about a child being or likely to be abused by an adult or another child, to be reported/referred to the C&FSS/SMH FST in a timely manner that allows for meaningful consultation.

eProsafes is the DHB Child Protection Intimate Partner Violence and Elder Abuse and Neglect Family Violence and Neglect database that is managed by the C&FSS/SMHS FST. A referral to eProsafes is a referral to the C&FSS/SMHS FST to enable advice, further consultation and follow up if required.

See Appendix 12: eProsafes

STEP 1 Identification of signs and symptoms

There is no 'one-size-fits-all' approach for the identification of children or young people at risk. The healthcare provider should begin with their first point of concern. However, they should also be aware that if they are concerned about a child all the aspects described in this first step 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 episode of intimate partner violence (IPV) may need formal physical examination and other investigations for injury, even if they appear physically unharmed.

The policy also applies to the unborn child. Management of risk to the unborn child should occur in close consultation with C&FSS/SMHS FST/Social Work/ Maternity Services and the Lead Maternity Carer. Early intervention where care and protection concerns are identified maximises the opportunity for best outcomes. A referral can be made to Oranga Tamariki/CYF/ during the antenatal period.

If there is clear evidence of child abuse or neglect, sufficient in your opinion to justify referral to Oranga Tamariki/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.

1.1 Observing child–caregiver interactions

- Observe the caregiver–child interactions at any clinical encounter; 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 record, 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.

1.2 Taking a history from parents and caregivers

- Your ability to interpret signs and symptoms in a child is 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 did they fall; were they stationary or already moving; how did they fall (head first, feet first, arms out); what was the height of the fall (estimated on the eyewitness' own body); what surface did they fall onto; 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?
 - 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.

1.3 Asking children about possible abuse and/or neglect: an area of specialist practice

- If a child has an injury, it is perfectly all right to ask open, non-leading questions, eg. 'how did this happen?' 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 seek advice from your DHB C&FSS/SMHS FST, on call paediatrician, psychiatrist, psychologist, social worker with experience in child protection, care and protection public health nurse, mental health case manager or Oranga Tamariki/CYF.
- 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 is unlikely to create the time and space necessary for disclosure by an anxious child.
- Use age-appropriate language; children may not know what to say and use different words to express what is going on. 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.’

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?*

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.

1.4 Asking adolescent child about possible abuse

- Ask in a place that is private, and confidentiality of information needs to be discussed.
- Use a developmentally appropriate assessment 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.
- If the adolescent child 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.

See Appendix 7: HEEADSSS assessment

1.5 Past history

- Review the child’s clinical record (previous presentations or admissions, particularly multiple presentations for illnesses and injuries, may indicate risk).
- Check for the presence of a National Child Protection Alert/Local Child Protection Memo; if a national alert exists, follow the CDHB Child Protection Alert Policy to access the health information, and take this information into consideration when assessing the child. If a local memo is present access eProsafe for CDHB child protection notes.
- N.B. the specialist mental health service computer system (SAP) does not show these alerts. eProsafe should be accessed for all assessments.

See Appendix 12: eProsafe

1.6 Social history

- Take a social history; a variety of factors may have an effect on the risk of child abuse and neglect, eg. IPV, 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, they do not necessarily predict abuse or neglect in any individual case.

1.7 Physical examination

- 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.
- 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. Full blood count and coagulation studies may be required in the presence of bruising
- Cases of sexual abuse, or suspected sexual abuse, should always be discussed with a doctor specifically trained in this field. Always refer to Cambridge Clinic for children aged 13 years and above, the Child and Family Safety Service (during working hours) and the Paediatrician on call (after hours) for children 12 years and younger, before you decide whether or not to examine the child.
- Consent to examine a competent child (regardless of age) is required before any examination is undertaken.
Refer to CDHB [Informed Consent Policy](#)

1.8 Using a child protection checklist for children under aged 15 years and younger.

- All children 15 years and younger presenting to the Emergency Department should have the Child Protection Checklist as below completed. 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.

See Appendix 11: Emergency Department Child Protection Checklist

1.9 Collection of physical evidence

In some circumstances, collection of physical evidence may assist a criminal investigation ('forensic evidence'). If you consider that forensic evidence is required, you should be discussing the matter with the C&FSS (during working hours), the Paediatrician on call and the Police.

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.

STEP 2 Validation and support

- If you have concerns about the safety of a child then you will need to act on these. At some time, someone will need 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 they may not (depending on the circumstances) be seen as supporting or validating their caregiver(s).
- Do 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.
- 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

2.1 Talking with the parents/caregivers of the child

- If you are unsure about how to talk with the parents/caregivers; consult with health professionals as appropriate to your area of work ie. C&FSS, SMHS FST, paediatrician, psychiatrist, psychologist, social worker, mental health case manager, care and protection public health nurse, supervisor/manager,.
- 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"
 - access cultural support, eg. Māori Health Unit. It is important that contacting such support does not delay any referral to Oranga Tamariki/CYF.
 - use interpreters (not family members) if there are language barriers
 - be transparent about what happens next.
- 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 their child safe, and support them in the care of their child

2.2 Health care provider response to child's disclosure of abuse

- Listen. Do not put words in a child's mouth. Allow them to tell only as much as they want. Act on the assumption that the child is telling the truth
- Keep any questions to a minimum. Use open ended questions and use age appropriate language
- Do not over-react
- Do not panic
- Do not criticise
- Do not make promises you can't keep
- Ensure the child's immediate safety. Try not to alert the alleged abuser

2.3 Health care provider response to parents/caregivers 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.

STEP 3 Health and Risk Assessment

3.1 Risk to the child

A 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 Oranga Tamariki/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 make decisions about risk in isolation
 - do not jump to conclusions
 - consult with experienced staff, eg. C&FSS/SMHS FST, a paediatrician, a health/mental health social worker, psychiatrist, psychologist, or with the duty social worker at Oranga Tamariki/CYF as you work to determine what level of risk the child might be facing

- appreciate that other organisations (eg. Oranga Tamariki/CYF/) may hold information that is crucial to determining the safety of the child.
- You do not need proof of abuse or neglect, and do not need to seek permission from a child's family, prior to talking with colleagues or a Oranga Tamariki/CYF social worker about a child
- Early communication with Oranga Tamariki/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 Oranga Tamariki/CYF, which is a decision that ideally should only be made after a thorough assessment
- **Subsequent children** – Section 18A of the Oranga Tamariki Act 1989, outlines the requirement for parents/caregivers to demonstrate to Oranga Tamariki/CYF that they are safe to parent subsequent child/ren when a child has been previously removed from their care or they have been convicted of the murder, manslaughter or infanticide of a child.

If you are aware, or suspect, that a parent or caregiver meets the criteria of 18B or has had a child permanently removed from their care, consult with your C&FSS/SMH FSC and discuss any concerns you have with Oranga Tamariki/CYF.

3.2 Mental health assessment

- The health assessment should include an assessment for signs and symptoms of mental health concerns; risk of suicide or self-harm can themselves be symptoms of abuse
- Signs associated with risk of suicide include:
 - 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)
- 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.

See Appendix 8: Assessment and Referral for Children under 12 at Risk of Suicide

- The level of assessed risk (based on the assessment) will inform the referrals required. A referral to the appropriate child or adolescent mental health service may be indicated, but if abuse or neglect issues are also present, referral to Oranga Tamariki/CYF is also warranted, particularly if the child 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.

3.3 Risk to other children or young people

- Consider possible risk to other members of the family because of the high co-occurrence/entanglement of multiple types of violence within families. This includes establishing the whereabouts and safety of other children in the home.
- Oranga Tamariki/CYF should be able to determine if previous concerns have been raised about the safety of other children in the family.

3.4 Co-occurrence of intimate partner violence

- If child abuse is identified, assess the victim's (mother/father/caregiver) safety. Follow the procedure outlined in Intimate Partner Violence (IPV) policy (REF 4616).
- Victims of IPV are frequently threatened by the perpetrator that if they disclose the violence, s/he will tell Oranga Tamariki/CYF that the non-abusive partner is a bad parent/abusive to the children, and that Oranga Tamariki/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.

3.5 Other risk factors

- If the social history identified other risk factors (see 1.6), then refer to other services, eg. serious untreated mental illness should be referred to the mental health crisis team (Crisis Resolution), alcohol and drug addiction via referral to Alcohol and Drug Central Coordinator or Community Alcohol and Drug service.

STEP 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.

If there are concerns about immediate safety (including your own), contact the Police 111 (or in-house security if available 777) and contact Oranga Tamariki/CYF (0508326459).

- Information from the health and risk assessment process will help to ensure that acute needs are identified and can be included in the safety plan.
- All healthcare providers can undertake basic intervention and safety planning activities if they have received training, and have access to support
- Note that the purpose of risk assessment 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 Oranga Tamariki/CYF, particularly if there is risk to children

- Assessing for positive/protective factors, eg. family's efforts to actively pursue the safety and well-being of the child and their willingness and capacity to respond or engage, is an important part of identifying resources that may help improve the situation during safety planning
- 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. The key issue is whether the child is 'at risk' or whether the child is actually already coming to harm.

4.1 Child being harmed

- A child who, in the opinion of the healthcare provider, is already coming to harm, should be notified to Oranga Tamariki/CYF as a 'report of concern'. Oranga Tamariki/CYF will form their own opinion on the level of risk for the child and triage accordingly.
- Children admitted to hospital with actual or suspected child abuse or neglect should be managed in accordance with the Memorandum of Understanding (2011) between DHBs, Oranga Tamariki/CYF and the NZ Police

<https://www.starship.org.nz/media/287442/mou.pdf>

and the associated Schedule 1 (Children admitted to hospital with suspected or confirmed abuse or neglect).

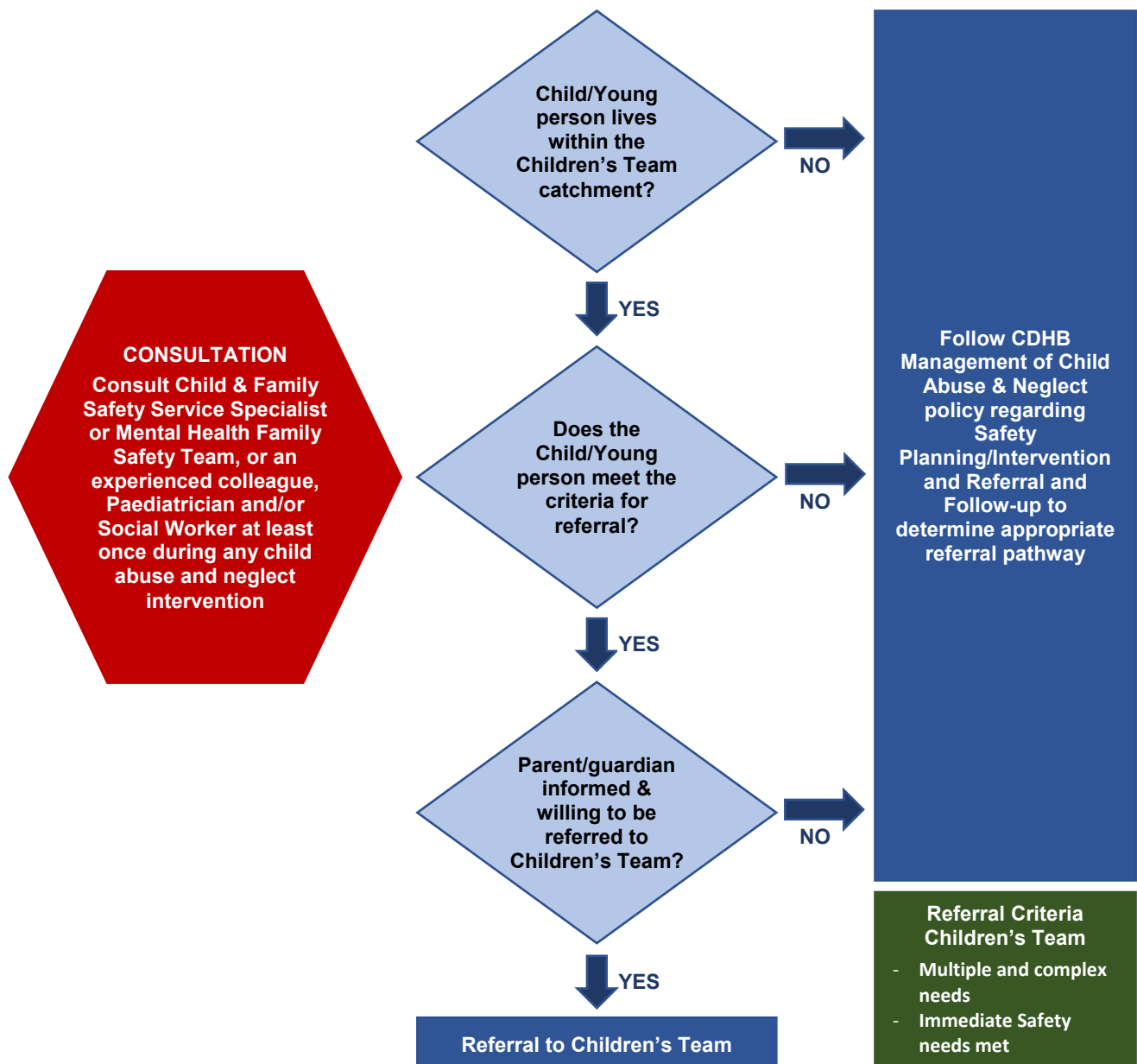
https://www.starship.org.nz/media/287445/schedule_one.pdf

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 Oranga Tamariki/CYF to determine if a formal report of concern should be made.
- If Oranga Tamariki/CYF determine that the whānau is actively pursuing the safety and well-being of the child and has the willingness and capacity to respond then a report of concern to Oranga Tamariki/CYF may not be indicated. Likewise if you consider that engagement by an agency with the family is likely to achieve positive outcomes and the

family is willing to accept the referral(s), Oranga Tamariki/CYF is also likely to suggest that a formal report of concern may not be necessary. There are currently three Children's Teams operational within the CDHB. They are the Ashburton, Rangiora, and Canterbury Children's Team. Not all of the CDHB has a Children's Team operational within it. Ring the Vulnerable Children's Hub on 0800 FOR OURKIDS/ 0800 367 687 to establish if the family you would like to refer are in a catchment for one of the CDHB Children's Team. This may provide another avenue for effective action. (FSC in below diagram)

Child/Young Person identified as possible case for referral to the Christchurch Children's Team



4.3 Co-occurrence of child abuse and Intimate partner violence

Remember, JOINT safety planning and referral processes need to be implemented when both IPV and child abuse and or neglect are identified.

- 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 Oranga Tamariki/CYF or the Police Integrated Safety Response (ISR) team, 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 Oranga Tamariki/CYF and ISR about the presence of IPV as well as child abuse.
- Ask the abused partner how they think the abuser will respond (risk that the abuser will retaliate for disclosure of the family secret).
- Ask if Oranga Tamariki/CYF has been previously involved, and what the abuser's reaction was.
- If the abuser is present in the health care facility, ask the abused partner whom they would like to inform the abuser about the Report of Concern to Oranga Tamariki/CYF and referral to the Integrated Safety Response team, eg. 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 if problems arise (eg. Police, Women's Refuge, Oranga Tamariki/CYF).
- If the woman is pregnant refer her to C&FSS/ SMHS FST/Social Work who will refer to the vulnerable women's pathway.

4.4 Talking to parents and caregivers about referral to the statutory authorities

If it is safe to do so, discuss referral to Oranga Tamariki/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 their child safe, and support them in the care of their 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 Oranga Tamariki/CYF.
- However, be clear that your role is to keep the child safe. Do not seek permission to consult with Oranga Tamariki/CYF. You may do this at any time.

See Appendix 9: Legal and Privacy Issues

At times it may be necessary to suppress patient details and or provide secure processes at the time of discharge. The guidelines for use when staff assess the safety of a victim of abuse to be high risk are outlined in Appendix 10.

STEP 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 risk assessment and safety planning, and the collaborative planning undertaken.

The tasks at this stage are:

Make referrals as appropriate, and ensure that relevant information is appropriately and accurately transferred to receiving individuals/agencies.

Oranga Tamariki/CYF should be notified of all cases where there is actual or suspected harm or safety concerns for child abuse and neglect. Memorandum of Understanding between DHB, Oranga Tamariki/CYF and Police (2011).

5.1 Child being harmed

- To support follow-up, consider if and how the information should be transferred to the GP (eg. written discharge summary, telephone call, other procedure, ie. eProsafe follow up letter to be sent).
- Continue to provide follow-up to children and families notified to Oranga Tamariki/CYF; the DHB remains responsible for the follow-up of the health care needs of the child and family.

5.2 Child at risk

- If you have concerns about risk, but there has been no disclosure, and no definitive signs or symptoms, consult with Supervisor/Manager, an experienced colleague and/or Oranga Tamariki/CYF.
- Document Child Protection concerns in eProsafe and in clinical record as is appropriate to your service.
- There are opportunities for early intervention (even when a report of concern is not made) so:
 - 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. GP, Well-Child provider) 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, eg. the Children's Teams, 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, alcohol and drug addiction services, mental health services).

- Consider referring to Right Service Right Time to access an appropriate agency for the family/whānau's concern/s in a timely manner.

Referral to Children's Teams:

Professionals and practitioners can contact the Vulnerable Children's Hub: **Call 0800 FOR OURKIDS (0800 367 687)**

Download the

[Vulnerable Children's Hub referral form](#)

Complete the downloaded referral form and post to: **The Hub, PO Box 78013, Grey Lynn, Auckland 1245**

For all vulnerable children

- 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?
- When referring to Oranga Tamariki/CYF, a written referral (eg. report of concern) must be sent to Oranga Tamariki/CYF and a copy placed in the clinical record of the child (or mother when the concerns reported relate to the antenatal period).
A copy must be entered into eProsafe or sent to the C&FSS/SMHS FPT.

5.3 Co-occurrence of child abuse and intimate partner violence

- Make sure that the abused partner has contact details for local support agencies.
- Provide the abused partner with a private area to make phone contact with a family violence service.

STEP 6 Documentation

- Thorough documentation on eProsafe and relevant clinical record of all steps of the health consultation is necessary.
- Always include the date and time that you saw the child and when you wrote your notes (if different from the time you saw the patient).
- Always include name, legible signature and practice designation in the clinical notes.
- Clearly and thoroughly document the behaviours, signs and symptoms you observed.

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 where possible.

6.2 Examination

- Note the time and date of examination.
- Use simple body diagrams to improve accurate documentation.
- Document the following features for each injury: site, shape, size (use a tape measure), characteristics (eg. colour, depth, edges, surroundings, margins, swelling, tenderness).
- Aging of injuries is a difficult and potentially contentious issue, as many factors influence healing such as site of injury, force applied, age and health of patient and infection.

6.3 Photographs

- Many DHB's now regard photography as a routine supplement to the medical records (refer to CDHB [Informed Consent policy](#) regarding consent to photograph (Ref.4618)
- The taking of photographs should be done by a suitably qualified person in accordance with CDHB [Informed Consent policy](#) (Ref.4618) and the [Agreement to Clinical Imaging Form](#) is to be used.
- Note that thorough documentation and body maps are always required, and cannot be replaced by photographs.

6.4 Document the results of your 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).

6.5 Document the consultative process you undertook

- Who did you speak with? At what points?

6.6 Document the support agencies, referrals and follow-up plan agreed to

- Record the actions taken, referral information offered, follow-up care arranged (eg. report of concern to Oranga Tamariki/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 or inform C&FSS or FST (SMHS) when follow up is not possible.

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 abuser finds out that the victim has disclosed child abuse/neglect, the victim may be at increased risk of retribution for having revealed this abuse.
- 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. All requests to access health records should be managed in accordance with CDHB [Release of Patient](#)

[Information policy](#) there may be grounds for withholding information when the healthcare provider believes that it is not in the child's best interests to give the parents access.

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

Staff support and safety

In any case where staff have been involved in the reporting and/or management of abuse or neglect they should seek debriefing, supervision or counselling from an appropriately trained senior colleague. Staff may access Peer Support or the Employee Assistance Programme and can also access support following a critical incident (see CDHB [Debriefing and Defusing Policy](#)).

Death of a child and sibling assessment

In the event that a child is brought into the DHB and is deceased on arrival or the child dies in the DHB and the cause of death is suspicious, then an assessment of the safety of any siblings should be urgently undertaken. The Paediatrician on-call should determine if there are other siblings and if so report to Oranga Tamariki/CYF. It is also important for the CDHB to work closely with the Police, and Oranga Tamariki/CYF in accordance with the MOU between Oranga Tamariki/CYF, the Police and CDHB, 2011.

<https://www.starship.org.nz/media/287442/mou.pdf>

References

Associated documents

Organisation documents

- [Child Protection Alerts Management Policy](#)
- [Debriefing and Defusing Policy](#)
- [Incident Management Policy](#)
- [Informed Consent policy](#)
- DHB Unit Specific procedures/policies.
- [Agreement to Clinical Imaging Form](#)
- [Privacy Policy](#)
- [Release of Patient Information policy Clinical Record Management](#)
- [Tikanga Policy](#)
- [Security Policy](#)

Legislation

- Health Act (1956)
- Oranga Tamariki Act (1989) (and Amendments 1994/95/2016)
- Privacy Act (1993) and Health Information Privacy Code (1994)
- Code of Health and Disability Services Consumers Rights (1996)
- New Zealand Bill of Rights (1990)
- Crimes Act (1961) (and Amendments 2011)
- Domestic Violence Act (1995)
- Summary Offences Act (1981)

- Care of Children Act (2004)
- Vulnerable Children's Act (2014)

Other

- Breaking the Cycle Interagency Protocols for Child Abuse Management. New Zealand CYPS 1996
- Breaking the Cycle An Interagency guide to Child Abuse New Zealand CYPS 1997
- Family Violence. Guidelines for Health Sector Providers to Develop Practice Protocols. Ministry of Health 1998
- Ministry of Health. Family Violence Assessment and Intervention Guideline; Child abuse and intimate partner violence. Wellington, Ministry of Health, 2016.
- Memorandum of Understanding between Child, Youth and Family, New Zealand Police and Canterbury District Health Board. August 2011

For further information contact the Child Protection Coordinator

Measurement or evaluation

Clinical Record Audit

Annual audits of clinical records are to be carried out to determine compliance with this policy using an approved VIP audit tools.

APPENDIX 1 Terms and definitions

Child	Unborn children and children aged 0–18 years old.
Child Protection	Means the activities carried out to ensure the safety of the child/tamaiti/rangatahi in cases where there is abuse or risk of abuse.
Child Abuse	Refers to the harming (whether physically, emotionally, or sexually), ill treatment, abuse, neglect, or serious deprivation of any child/tamaiti/rangatahi (Section 14b Children, Youth and their Families Act 1989). This includes actual, potential and suspected abuse.
Physical Abuse	Child physical abuse is any act or acts that may result in inflicted injury to a child.
Sexual Abuse	Child sexual abuse is any act or acts that result in the sexual exploitation of a child, young person, whether consensual or not.
Emotional/ Psychological Abuse	Child emotional/psychological abuse is any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child.
Neglect	Child neglect is any act or omission that results in impaired physical functioning, injury, and/or development of a child.
Elder Abuse and Neglect	Elder abuse is the wilful or unintentional harm caused to an older person by another person with whom they have a relationship implying trust. Categories of abuse include financial or material abuse; psychological abuse; physical abuse; and sexual abuse.
Intimate Partner Violence (also called Partner Abuse)	Physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners. Intimate partners include current spouses (including de facto spouses), current non-marital partners (including dating partners, heterosexual or same-sex), former marital partners and former non-marital partners.
VIP Violence Intervention Programme	The MoH VIP Violence Intervention Programme supports health sector family violence programmes throughout New Zealand.
MEDSAC formerly DSAC	MEDSAC Medical Sexual Assault Clinician Aotearoa National organisation advancing knowledge and improving medical care for those affected by sexual abuse. Only MEDSAC trained practitioners should perform medical examinations for child sexual assault.
Ministry for Vulnerable Children Oranga Tamariki formerly Child, Youth and Family	Government agency that carries out the legislative requirements of the Oranga Tamariki Act 1989. Responsibilities are: <ul style="list-style-type: none"> • To investigate cases of actual and suspected child abuse and/or neglect • To complete diagnostic interviews • To complete evidential interviews in cooperation with NZ Police • To provide care and protection for children found to be in need.

New Zealand Police	<p>Government agency responsible for:</p> <ul style="list-style-type: none"> Working cooperatively with Oranga Tamariki in child abuse and/or neglect protection work Investigating cases of abuse and/or neglect where an offence has or may have been committed Prosecuting offenders where an offence has been committed Accepting reports of suspected abuse and or neglect and referring these to Oranga Tamariki/CYF.
eProsafte	<p>eProsafte is a Health electronic application that has been specifically designed to promote the health and wellbeing of children, adults, and their families who are experiencing abuse and neglect. It ensures that frontline staff, managing acute and at times severe situations of violence and abuse, can obtain information held by the DHB in a timely manner.</p>
Local memo	<p>A local memo can be viewed in local DHB patient management systems (PMS) demographic screen, ie. If the word memo is flashing access the information relating to this. If the words SCAN notes are recorded this indicates to staff that local Child Protection information is held in eProsafte.</p> <p>N.B. the specialist mental health service computer system (SAP) does not show these alerts. eProsafte should be accessed for all assessments.</p>
NCPAS	<p>National Child Protection Alert System – A National Child protection alert will be considered for; Any child up to 18 years of age where child abuse is suspected and/or confirmed and a referral is made to Oranga Tamariki/CYF; a Gateway referral; a Medical Assessment request by Oranga Tamariki/CYF; or a pregnant woman where there are identified vulnerabilities.</p> <p>This alert can be viewed on the National Medical Warning System and local DHB patient management systems, ie. CDHB CHILD PROTECTION CONCERNS CONTACT CDHB CLINICAL RECORDS.</p>
Children's Team	<p>A Children's Team is not a new service but a new approach. It works with existing resources and provides the opportunity for practitioners and professionals in government agencies, iwi and non-government organisations to bring their services together into one personalised plan for each child and their family/whānau.</p>
Gateway Service	<p>Collaboration between Health, Education and Oranga Tamariki/CYF. This service assesses the needs of children engaged with Oranga Tamariki/CYF.</p>
Integrated Safety Response Pilot	<p>Police, CYF, Corrections, Health, specialist family violence NGOs and kaupapa Māori services work as a team to support victims. The ISR focuses on the joined-up support and services that families, including victims and perpetrators, receive following family violence reported to NZ Police and high risk prison releases. Cases deemed high risk are discussed further at a weekly intensive case management meeting. Additional agencies involved in planning for these cases are the Ministry of Justice, Accident Compensation Commission, Housing New Zealand, Ministry of Education, Work and Income.</p>

APPENDIX 2 Māori and family violence

This section is drawn from the Family Violence Assessment and Intervention Guideline¹. This was developed with leadership from the roopu, Te Korowai Atawhai. This appendix offers some background and context for family violence in relation to Māori, and identifies key principles and actions for effective identification and intervention. To strengthen the way health services respond to Māori individuals who are experiencing violence within their whānau, it is recommended that DHBs continue to implement He Korowai Oranga, the Māori Health Strategy in their planning, governance, ethos, and staff development.

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

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

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

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

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

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

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

Safety first

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

Equity of Health Care for Māori

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

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

Health organisations can champion, consider and apply these actions across their practice to facilitate responsive, appropriate and effective care for Māori. This can contribute to

improved patient care pathways for Māori patients, and effective identification and response processes to family violence.

Principles for action

Te Tiriti o Waitangi/Treaty of Waitangi/ principles of Partnership, Participation and Protection should underpin efforts to achieve equitable Māori Health outcomes.

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

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

Ways to put this into practice:

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

2. **Whakapapa** – refers to the genealogical descent of all living things from Ranginui (the Sky Father), 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.

See www.health.govt.nz/publication/increasing-violence-intervention-programme-vip-programmes-responsiveness-Māori

APPENDIX 3 Pacific peoples and family violence

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

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

What family violence means in a Pacific context

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

Risk factors for family violence amongst Pacific people

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

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

Protective factors for Pacific families

- Reciprocity
- Respect
- Genealogy
- Observance of tapu relationships
- Language and belonging are concepts that are shared across the seven ethnic specific communities as elements that protect and strengthen family and individual wellbeing.

Transformation and restoration

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

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

Principles for action

1. **Victim safety and protection must be paramount**

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

Actions and behaviours to ensure victim safety and protection:

- 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-judgmental 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-judgmental and respectful – first contact is vital.
- Do not rush – leave time to think about and respond to questions.
- Ask open-ended questions.
- Offer resources and support that meets the ethnic-specific needs of the victim.

3. **The provision of culturally safe and competent interactions**

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

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

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

4. **A collaborative community approach to family violence should be taken**

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

Actions and behaviours that contribute to a collaborative intersectoral approach:

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

APPENDIX 4 Four recognised categories of child abuse

These frequently overlap in individual cases. Refer to the “Recognition of Child Abuse and Neglect” published by the Risk Management Project, Children/young person’s and Their Families Agency 1997.

1. **Physical abuse**

Child physical abuse is any act or acts that may result in inflicted injury to a child. 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
- Non organic failure to thrive
- Fabricated Or Induced Illness By Carers (formerly Munchausen Syndrome by Proxy)

2. **Sexual abuse**

Child sexual abuse is any act or acts that result in the sexual exploitation of a child 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
- Inappropriate photography

Contact abuse

- Touching breasts
- Genital/anal fondling
- Masturbation
- Oral sex
- Object or finger penetration of the anus or genitalia
- Penile penetration of the anus or genitalia
- Encouraging the child to perform such acts on the perpetrator
- Involvement of the child in activities for the purposes of pornography or prostitution

3. **Emotional/Psychological abuse**

Child emotional/psychological abuse is any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child. 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, expectations of, or towards, the child.
- Exposure to family violence.
- Corruption of the child 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.

4. **Neglect**

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

- Physical neglect - failure to provide the necessities to sustain the life or health of the child.
- Neglectful supervision - failure to provide developmentally appropriate and/or legally required supervision of the child leading to an increased risk of harm.
- Medical neglect - failure to seek, obtain or follow through with medical care for the child resulting in their impaired functioning and/or development.
- Emotional neglect – not giving children the comfort, attention and love they need through play, talk, and everyday affection.
- Educational neglect – allowing chronic truancy, failure to enrol children in school, or inattention to special education needs.
- Abandonment - leaving a child 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.

APPENDIX 5 Signs and symptoms of abuse and neglect in recognised categories of child abuse

Physical abuse: injuries that don't make sense

- **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
- **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
- **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. 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.
- **Unexplained burns** anywhere on the body. Burns may be difficult to interpret, and if you are concerned they should be referred early to a Paediatrician.
- **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.

Sexual abuse

- In sexual abuse particularly, physical signs or symptoms are usually absent and behavioural changes may not be evident.
- If a child tells you they have been abused (ie. 'makes a disclosure'), this should always be taken seriously and referred to Oranga Tamariki/CYF.
- 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.
- Behaviour changes after sexual abuse may not be evident and if they do occur they may be highly variable. 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, but can be very difficult to define. It is useful to consider:
 - 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.
- Neglect can consist of:
 - **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.
If neglect of medical care is identified or suspected refer to *Shedule Three Guideline for the Neglect of Medical Care* within the *Memorandum of Understanding between DHBs, Police and Oranga Tamariki/CYF*
<https://www.starship.org.nz/media/520385/neglect-of-medical-care.pdf>
 - Educational neglect – allowing chronic truancy, failure to enrol children in school or inattention to special education needs.

See Appendix 6: Child Neglect Assessment Guideline

APPENDIX 6 Child neglect assessment guideline

Two primary questions 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. 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.

APPENDIX 7 HEEADSSS: Psychosocial interview for adolescents

Key: *Green = essential questions* *Blue = as time permits* *Red = optional or when situation requires*

Home

Who lives with you? Where do you live? Do you have your own room?
What are relationships like at home?
To whom are you closest at home?
To whom can you talk at home?
Is there anyone new at home? Has someone left recently?
Have you moved recently?
Have you ever had to live away from home? (Why?)
Have you ever run away? (Why?)
Is there any physical violence at home?

Education and employment

What are your favourite subjects at school? Your least favourite subjects?
How are your grades? Any recent changes? Any dramatic changes in the past?
Have you changed schools in the past few years?
What are your future education/employment plans/goals?
Are you working? Where? How much?
Tell me about your friends at school.
Is your school a safe place? (Why?)
Have you ever had to repeat a class? Have you ever had to repeat a grade?
Have you ever been suspended? Expelled? Have you ever considered dropping out?
How well do you get along with the people at school? Work?
Have your responsibilities at work increased?
Do you feel connected to your school? Do you feel as if you belong?
Are there adults at school you feel you could talk to about something important? (Who?)

Drugs

Do any of your friends use tobacco? Alcohol? Other drugs?
Does anyone in your family use tobacco? Alcohol? Other drugs?
Do you use tobacco? Alcohol? Other drugs?
Is there any history of alcohol or drug problems in your family? Does anyone at home use tobacco?
Do you ever drink or use drugs when you're alone?
(Assess frequency, intensity, patterns of use or abuse, and how youth obtains or pays for drugs, alcohol, or tobacco)
(Ask the CRAFFT questions)

Sexuality

Have you ever been in a romantic relationship?
Tell me about the people that you've dated. OR Tell me about your sex life.
Have any of your relationships ever been sexual relationships?
Are your sexual activities enjoyable?
What does the term 'safe sex' mean to you?
Are you interested in boys? Girls? Both?
Have you ever been forced or pressured into doing something sexual that you didn't want to do?
Have you ever been touched sexually in a way that you didn't want?
Have you ever been raped, on a date or any other time?
How many sexual partners have you had altogether?
Have you ever been pregnant or worried that you may be pregnant? (females)
Have you ever gotten someone pregnant or worried that that might have happened? (males)
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?

Key: **Green = essential questions** **Blue = as time permits** **Red = optional or when situation requires**

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?

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?

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?

Source: Goldenring and Rosen 2004

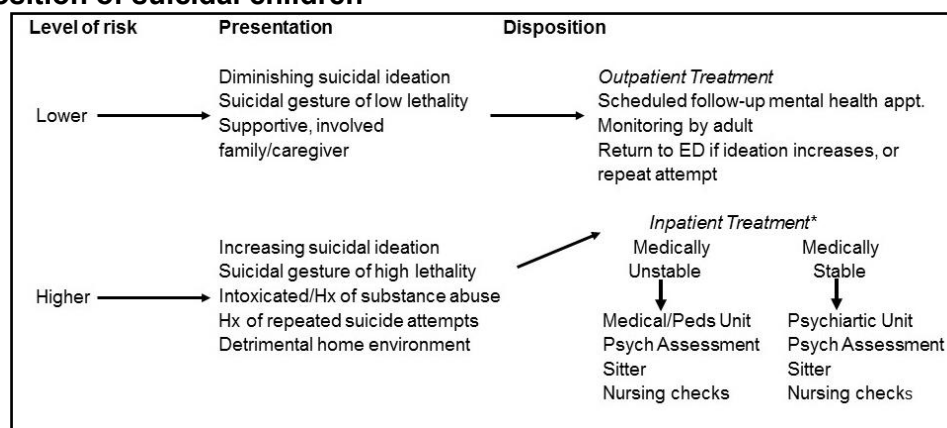
APPENDIX 8 Assessment and referral for children under 12 at risk of suicide

Factors to consider when assessing the child's level of risk of suicidal behaviour

<p>Seriousness of injury</p>	<p>Current presentation Intend to die¹ Child's intent to die² Suicide plan, method, access to method¹ Current psychiatric symptoms (depression, psychosis, etc.)^{1,2} Child's reasons for living¹ Current substance intoxication Cognitive level of child</p>
<p>Suicidality history History (Hx) of prior suicide attempts¹ Child's Hx of prior suicide attempts² Hx of suicidal ideation¹ Child's Hx of suicidal ideation²</p>	
<p>Medical history² Hx of psychiatric diagnoses Hx of mental health treatment and/or psychotropic drug use Hx of substance use or abuse Number of previous ED visits for suspicious accidents Chronic illness-frequency requiring compliance</p>	<p>Environmental factors^{1,2} Family Unsecured potential suicide methods (guns, medications, etc.) Recent suicide, death, or loss in family Suicidal ideation or suicidal attempts in family Presence of child abuse or neglect Supportiveness of parents or caregivers Family turmoil Marital problems Domestic violence Financial crisis Incarceration Alcohol and substance use Child Social isolation (ask about the effects) Bullying or being bullied (ask about the effects) 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?)

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.

APPENDIX 9 Legal and privacy issues

Since the introduction of the Privacy Act (1993) and the Health Information Privacy Code (1994), agencies and individuals have become concerned about how much information can be given to statutory social workers or the Police. Both documents make provision for the disclosure of information necessary to prevent harm to any individual.

As well, all privacy restrictions are over-ridden by certain sections of the Oranga Tamariki Act (1989). These provide for the reporting of child abuse, protection of an individual from proceedings when disclosing child abuse to either a statutory social worker or police, and government agency obligations.

CDHB encourages good communication between CDHB staff and Oranga Tamariki/CYF or the police to keep children safe. Requests for information should be referred directly to the CDHB Patient Information Service who are responsible for ensuring such requests are dealt with promptly and appropriately. Information must only be released to a Oranga Tamariki/CYF social worker, police officer or care and protection coordinator (s66 Oranga Tamariki Act: see below).

Each DHB is therefore, able to give information to Oranga Tamariki/CYF or the Police when reporting abuse or when requested by either agency.

CHILDREN, YOUNG PERSON'S AND THEIR FAMILIES ACT 1989

S6 Paramountcy principle

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

S15 Reporting of ill treatment or neglect of a child

Any person who believes that any child 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 member of the police.

S16 Protection of person reporting ill treatment or neglect of a child

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 this Act of information concerning a child (whether or not that information also concerns any other person), unless the information was disclosed or supplied in bad faith.

S66 Government Departments may be required to supply information

- (1) Every Government Department, agent, or instrument of the Crown and every statutory body shall, when required, supply to every Care and Protection Co-ordinator, Oranga Tamariki/CYF social worker, or member of the police such information as it has in its possession relating to any child where that information is required -
 - (a) For the purposes of determining whether that child is in need of care or protection (other than on the ground specified in section 14 (1)(e) of this Act): or
 - (b) For the purposes of proceedings under this part of this Act.

Section 66 means that where a care and protection coordinator, Oranga Tamariki/CYF social worker or police officer requires information about a child for the purposes of determining whether the child is in need of care and protection, or for proceedings under the Oranga Tamariki Act 1989, DHB staff must provide that information. A staff member may be asked to provide this information in an affidavit. The DHB recommends that the staff member seeks the support and advice of the unit manager, C&FSS/SMH FSC and/or the DHB's legal adviser.

PRIVACY ACT

Principle 11 (f) (ii)

An agency may disclose information if that agency believes, on reasonable grounds that the disclosure of the information is necessary to prevent or lessen a serious threat to the life or health of the individual concerned or another individual

PRACTICE NOTE: INTERAGENCY INFORMATION SHARING

Information is available regarding interagency information sharing from the Privacy Commission website, follow the following links to the Sharing personal information of families and vulnerable children: A guide for inter-disciplinary groups

(www.privacy.org.nz/assets/InteractiveEscalationLadder/Escalation-Ladder-FINAL-HiRes.pdf) and the Escalation ladder regarding 'Sharing information about vulnerable children' (www.privacy.org.nz/how-to-comply/sharing-information-about-vulnerable-children).

HEALTH INFORMATION PRIVACY CODE

Rule 11 subsection 2 (d) (ii)

An agency that holds personal information must not disclose the information to a person or body or agency unless – the disclosure of that information is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or another individual

HEALTH ACT 1956

Section 22 (2) (c) Disclosure of health Information

Any person being an agency, that provides health services or disability services ... may disclose health information ... to a social worker or a Care and Protection Coordinator within the meaning of the Oranga Tamariki Act 1989, for the purposes of exercising or performing any of that person's powers under that Act.

Always seek advice prior to release of information (refer to Privacy policies)

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.

APPENDIX 10 Safety and security guidelines

This guideline sets out CDHB's procedures for staff when there is a need to access support to optimise the safety for victims of family violence when the risk to the victim's safety is assessed to be a high risk. These guidelines will provide information to support staff to:

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

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

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

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

- 1.1 The guardian of/or victim of abuse identifies that s/he is concerned that the perpetrator may trace them to the hospital.
- 1.2 The staff member discusses with the victim/guardian the potential to place name suppression on the patient's details. The victim/guardian consents to this name suppression being actioned.
- 1.3 The Shift Co-ordinator/ Team Leader/ Clinical Charge Nurse is informed and s/he directs the Unit Receptionist to place the "No details to be released" flag against the patient details on the patient inquiry screen. Only the Shift Co-ordinator/ Team Leader/ Clinical Charge Nurse may direct this action.
- 1.4 The patient's name is replaced with a pseudonym on all patient details boards in the department/ward.
- 1.5 The following staff are informed of this name suppression being actioned:
 - 1.5.1 Duty Manager
 - 1.5.2 Switchboard staff
 - 1.5.3 Security
 - 1.5.4 All relevant staff within the department. This information transfers if the patient is admitted to a ward
- 1.6 This directive against the patient details is valid for the duration of the patient's hospital visit or until appropriate personnel remove the directive.
- 1.7 Complete the name suppression documentation form.
- 1.8 The Shift Co-ordinator/ Team Leader/ Clinical Charge Nurse responsible for the patient's care and/or Duty Manager will remove the name suppression at discharge or when the patient requests this.

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

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

- 2.1 Ask for the caller’s name and write this down (if provided).
- 2.2 Inform the caller s/he is unable to provide any information.
- 2.3 Notify the Shift Co-ordinator/Team Leader/Clinical Charge Nurse responsible for the patient’s care.
- 2.4 Notify security (eg. if the caller is the suspected perpetrator of an assault and police charges are likely).

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

- 3.1 Arrange the discharge plan in consultation with the guardian/patient and the discharge agency concerned, eg. ensure the guardian speaks to the agency concerned and that all parties are in agreement with the discharge plan.
- 3.2 Complete the name suppression process as above if appropriate.
- 3.3 Ensure that the following people are informed of the discharge plan process:
 - 3.3.1. Duty Manager
 - 3.3.2. Security +/- the Police (if risk is considered high by department staff and security)
- 3.4 The discharge plan may include the leaving the ED/ward or other department by a safe route, in consultation with security staff.
- 3.5 Document the discharge plan. NB. Complete an Incident Reporting Form if any unexpected outcomes occurred.
- 3.6 Advise the Duty Manager of the discharge outcome.

APPENDIX 11 Emergency Department Child Protection Checklist

Is there a Child Protection Alert?

Yes – review eProsafe notes

Are there any concerns for the child's safety and/or wellbeing?

Yes – discuss Senior Doctor and Social Worker

Does the child have an injury?

Yes – complete injury assessment proforma

Date and time of injury?

History taken from?

Place of injury?

History/mechanism of injury, what actually happened?

Was the injury witnessed?

Yes – by whom?

Consistent with developmental stage of child?

Rolling / Crawling / Standing / Walking / Climbing

Was there adequate supervision at time of injury?

Yes / No / Unclear

Previous injury history?

Clinical Impression

Clearly accidental/concern regarding supervision/unclear/inflicted

The following situation must also be discussed with a Senior Doctor

Any child < 18 months

Any child with unclear, neglectful or inflicted injury

Any child where there is a supervision issue

Any child where the developmental capabilities do not fit with the injury explanation

Any child you are concerned about

APPENDIX 12 eProsaf

Introduction

eProsaf is an electronic application that has been specifically designed to promote the health and wellbeing of children, adults, and their families who are experiencing abuse and neglect. It is a purpose built (web) application intended to address and overcome the fractured information technology systems both within the District Health Boards (DHBs) and across DHBs. It ensures that frontline staff, managing acute and at times severe situations of violence and abuse, can obtain information held by DHBs in a timely manner. This enables staff to address safety concerns for children, families and staff appropriately. It also allows those DHB staff employed specifically to provide advice and oversight of these complex cases the ability to track the work undertaken, assess risk more accurately and ensure appropriate measures are implemented.

eProsaf is a standalone web-based application for child protection and family violence that:

- Allows DHB staff to create and manage referrals.
- Allows DHB staff to share cases across local DHB users.
- Allows C&FSS and SMHS FST staff to view referrals from other DHBs.
- Provides numeric statistic reports.
- Generates sophisticated surveillance audit log reports.
- Produces announcements to local or other DHB users.
- Is placed within a connected health network.
- Can be accessed via Health Connect South (Orion Health)/SAP /DHB Intranet page.

eProsaf enhances practice by:

- Collating child protection and family violence information in one place which enhances risk assessment and intervention plans.
- Cross referencing family information to allow health staff to see the whole picture in relation to what has occurred in the context of the family environment.
- Providing staff with the ability to track cases through the use of a reminder system. This means that health staff are prompted electronically to ensure follow up tasks occur.
- Assisting with ensuring that patients receive a more holistic assessment and interventions which are designed to address medical and psycho - social needs.
- Improving communication between health professionals
- Improving record keeping and accuracy with child protection and family violence information.
- Ensuring accurate statistical information that is readily available assists with the identification of trends and patterns which allows the DHB to shape future development within services.
- Providing the ability to attach documents or other related files (picture, audio) to ensure that child protection information is better collated and referrals take minimal time
- Ensuring there is a quick and simple way to share child protection and family violence information between DHBs whilst maintaining security and privacy.
- It will be a quick and easy way to share National Alert Information in a secure and private manner.



NATIONAL CALL CENTRE

EMAIL REFERRAL TO CHILD YOUTH & FAMILY

Call Centre Telephone: Toll Free 0508 326 459 or (09) 912 3820

Call Centre Fax: (09) 914 1211

Call Centre Email Address: CyfCallCentre@cyf.govt.nz

Details of person sending the email:

DATE:

TO: Child Youth and Family Call Centre

FROM:

NOTIFIER'S EMAIL ADDRESS:

Note: Emails sent to CYF National Call Centre address generate an automatic reply advising if you are an authorised user/ have the appropriate form. If you do not receive this auto-reply then your email has not been received.

If you have spoken to an Intake Social worker about this notification, please complete the following details:

NAME OF ISW: _____

DATE/TIME OF THE CONVERSATION: _____

Type of Abuse

(Please identify category/categories.)

Physical

Sexual

Emotional

Neglect

Other

STATEMENT OF CONFIDENTIALITY

The information contained in this and any attached pages is intended to be for the use of the addressee named in this transmittal sheet. If you are not the addressee, note that any disclosure, photocopying distribution or use of the contents of this faxed information is prohibited. If you have received this facsimile in error, please notify us by telephone (collect) immediately so that we can arrange for the retrieval of the original documents at no cost to you.

FOR **EACH** CHILD BEING REFERRED PLEASE SUPPLY FULL CONTACT DETAILS INCLUDING:

Full Name:

Date of Birth:

Gender:

Ethnicity (incl Iwi if known):

Home address and contact telephone numbers:

Mother's name:

(and address if different from child's)

Father's name:

(and address if different from child's)

Step parents:

[address(es) if different from child's]

Caregiver:

Siblings:

[Full Names, Dates of Birth, Schools, address(es) if different from child's.]

Other Members of Immediate Household:

(Relationship to child)

Other Family/Whanau:

(Full Name, Age, Address, contact telephone number, contact person):

Pre-School / School:

(Address, contact telephone number, contact person):

Other Agencies Involved with Child and Child's Family:

(Address, contact telephone number, contact person):

Medical & Social Work Contacts at Agency:
(Names, Contact telephone/Locator Numbers)

REASON FOR REFERRAL

Concerns:

(Please identify concerns. As far as possible give time, date, and place for each. Use additional pages as necessary.)

Background:

(Relevant child / family medical and social history, other background matters of importance to investigation of abuse or neglect.)

To your knowledge, has CYF had previous involvement with this child or member of its family? Please give details.

MEDICAL REFERRAL

Is the child / young person a:

(Please circle)

Current In-Patient

Current Patient - not admitted

Other

IS CYF REQUESTED TO ATTEND A DISCHARGE/ PLANNING MEETING?

YES/NO

Date

Time

Venue

WHAT SERVICES EXACTLY DO YOU ENVISAGE CYF PROVIDING? PLEASE BE SPECIFIC.

1)

2)

Your Name:

Designation:

Service/Group:

Address, Usual Contact Numbers:

WHERE CAN YOU BE REACHED NOW?

LIMITED CONFIDENTIALITY

Do you wish (as far as is legally possible) departmental social workers not to tell any person being investigated as a result of the information you have given, that you are the source of that information?

NO

YES – Because

DATE:

SIGNED:

CONSENT FORM

I _____
consent to a medical assessment of

Name: _____ DOB: ____/____/____

Name: _____ DOB: ____/____/____

Name: _____ DOB: ____/____/____

The medical assessment will include the documentation of any injuries and photographs of injuries.

Blood tests may be required.

Name: _____

Signature: _____

Relationship to child: _____

Date: ____/____/____

Witness name: _____

Signature: _____

Witness designation/agency: _____

Date: ____/____/____

Canterbury DHB

Photographic Documentation of Injuries

When a child is referred by Child Youth and Family (CYF) or another referrer for assessment of soft tissue injuries or is found coincidentally to have injuries that are unexplained or concerning, these should be documented by Medical Illustrations.

The on call paediatrician will always be involved in reviewing such cases and will make the final decision about requesting photographic documentation.

Request

The Medical Illustration, Agreement to Clinical Imaging form must be signed by the child's guardian or CYF must obtain consent.

The request form must be completed by medical staff outlining in specific detail what views are required to fully document injuries.

Medical Illustrations will ensure a facial photo is taken (for identification purposes) and each injury is documented with a view that shows the location of the injury and detailed close up views. In instances where cooperation is difficult, the scale may be omitted.

In working hours, a request is made by phoning the Medical Illustration Department.

After hours, Medical Illustration staff can be contacted via switchboard.

Location of Photography

Photographs can either be taken in the Medical Illustration Department or at the patient's bedside.

Photography in the studio is preferred as studio lighting will result in optimal results.

However, the location will depend upon:

- Any associated medical problems which preclude the patient going to the department.
- The time of day.
- The co-operation of the patient – young children may be easiest photographed at the bedside and Medical Illustration staff are able to be present during the examination to minimise time required.

Any queries about the best location and concerns about patient co-operation should be discussed with Medical Illustration staff.

An adult able to co-operate with Medical Illustration staff must be present when a child is photographed either in the department or in the studio. A decision will be made for each child regarding the appropriate person to accompany them – this may be a co-operative caregiver, the CYF social worker, a nurse or RMO. Views will often be optimised, particularly with younger children, by the presence of a nurse / RMO to assist the photographer and ensure they are aware of photographs needed.

Inadequate Views

As some of these referrals will result in police involvement and potentially criminal proceedings, it is important that optimal views are obtained. If the photographer is experiencing difficulty with this, they will contact the responsible paediatrician to discuss options (which include the child returning the following day, or the child having a break).

After discussion, a decision may be made to obtain non-standard views if child is uncooperative / distressed by having the child sit on parent / guardian's knee thus allowing adequate close up views.

Finished Images

Images will be processed and emailed to the responsible paediatrician and Child & Family Safety Service as soon as possible (same day if during working hours, next day if taken after hours, or Monday morning if taken at weekend).

Printed copies will be sent to the requesting SMO and Patient Information Office (CYF and police are able to make a formal request to access these).

Information about this Canterbury DHB document (141311):

Document Owner: Clinical Director, Paediatric Medicine (see Who's Who)

Issue Date: December 2014

Next Review:

Keywords:

Note: Only the electronic version is controlled. Once printed, this is no longer a controlled document.

Partner Abuse Policy

Contents

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Purpose

The policy provides guidelines for the development of service specific pathways relating to the identification and management of the partner abuse screening programme.

Scope/Audience

Routine Screening

The policy applies to all CDHB employees with clinical care responsibilities who will be trained to provide routine screening for partner abuse of all female patients/clients aged 16 years and over accessing CDHB healthcare services.

The policy also pertains to female parents/carers of children accessing CDHB healthcare services.

Indicator-Based Screening

The policy applies to all CDHB employees with clinical care responsibilities to provide screening for partner abuse of male patients/clients aged 16 years and over accessing CDHB healthcare services who present with signs and/or symptoms of partner abuse.

**The latest version of this document is available on the CDHB intranet/website only.
Printed copies may not reflect the most recent updates.**

The policy also pertains to male parents/carers of children accessing CDHB healthcare services.

Children/Young People 0–17 years

In all cases where children/young people under the age of 17 years disclose, witness or present with indicators of family violence, when accessing CDHB healthcare services, staff must refer to the CDHB Child Protection Policy.

Roles and responsibilities

Executive Responsibilities

- Ensure there are organisation-wide policies for the appropriate response to and management of partner abuse
- Support initial partner abuse training for all clinical staff in CDHB healthcare services and regular updates in the responsibilities and actions as required by the policy and procedures
- Ensure that the partner abuse policy and procedures comply with legislative requirements, the principles of the Treaty of Waitangi, clinical audits and best practice standards
- Ensure organisation-wide procedures exist to provide appropriate, adequate support for and supervision of staff affected by partner abuse.

Departmental and Service Provider Responsibilities

- All CDHB departments and service providers are to ensure that staff responsible for clinical care of patients/clients will be familiar with and adhere to the Partner Abuse policy and the Family Violence policy
- Ensure clinical care staff attend training regarding partner abuse
- Ensure staff follow the brief intervention model for screening of partner abuse as outlined in the procedures section
- Ensure interventions for patients/clients who present with a positive screen follow Partner Abuse procedures section
- Ensure reporting and auditing procedures to the FVIP-PA Co-ordinator are effected
- Ensure staff as victims or perpetrators of partner abuse are supported
- Ensure support systems and/or supervision is available for staff when a patient/client has a positive screen for family violence.

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Employee Responsibilities

All health professionals employed by the CDHB who are associated with the clinical care of patients/clients have a responsibility for the safe management of identified and suspected cases of child, partner and elder abuse.

Responsibilities include:

- To be conversant with the CDHB Family Violence Policy, CDHB Child Protection Policy and the CDHB Policy and Procedures for Partner Abuse and Elder Abuse
- To be conversant with the Ministry of Health *Family Violence Guidelines* and *Elder Abuse and Neglect Guidelines*
- To attend initial training, refresher training and regular updates relevant to their area of work
- To identify, assess, manage and refer victims of abuse and document all actions taken
- To provide or access CDHB specialist services as per procedures

CDHB Child and Partner Abuse Steering Group Responsibilities

- Meet on a regular basis as agreed in the CDHB Family Violence Child and Partner Abuse Steering Group Terms of Reference, 2010
- To support and guide the planning, development, implementation, management and evaluation for the CDHB Family Violence programmes
 - Policies and procedures
 - Information technologies and documentation
 - Projects initiated within the CDHB
- To analyse systems and collaboratively work towards best practice standards

FVIP-Partner Abuse Co-ordinator Responsibilities

- Review Family Violence policy and Partner Abuse policy and procedure as required
- Coordinate a CDHB-wide systems response to partner abuse
- Develop a training plan and ensure initial refresher and advanced training of staff is available cyclically
- Ensure documentation, audit and evaluation tools are in place and accessible to staff for the recording of positive partner abuse screenings

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- Ensure regular audits occur in services where screening occurs
- Ensure regular audits occur with relevant partner agencies (for example, Women's Refuges) to assess the effectiveness of the programme
- Access and provide resources required to support the programme and make these available for staff and patients/clients in all CDHB clinical care settings
- Develop functional internal and external relationships with key stakeholders (government, local government and community based organisations).
- Provide support and advice to CDHB staff regarding family violence matters and specifically partner abuse.

Associated documents

CDHB Clinical Board Policies:

- Child Protection Policy
- Child Guardianship/Kaitiakitanga Policy
- Elder Abuse Policy
- Co-ordinated Care Planning for Patients/Consumers Policy

CDHB Organisational Documents

- Memorandum of Understanding, CDHB, Child Youth & Family and NZ Police 2008

Legislation

- Children, Young Persons & Their Families Act 1989
- Domestic Violence Act 1995
- Harassment Act 1997
- Care of Children Act 2004
- Victims' Rights Act 2002

Training of Staff

All CDHB staff with clinical care responsibilities are required to undertake partner abuse intervention training. The training will consist of:

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- A four hour training session including pre and post training questionnaires
- Refresher training as per divisional requirements
- Advanced trained will be offered to designated staff

Each service will endeavour to release senior staff for training in the first instance to enable them to provide support for frontline staff.

Partner Abuse Resources

All clinical areas and public areas within the CDHB will display information, brochures and posters pertaining to accessing support and interventions for partner abuse. These must be provided in a range of languages that reflect the cultural diversity of the wider Canterbury region and replenish/update on a regular basis.

References

- Fanslow, J.L. Family Violence Intervention Guidelines: Child and Partner Abuse, Wellington, Ministry of Health, 2002
- He Korowai Oranga Maori Health Strategy, Ministry of Health, 2002

Policy Authoriser	CMO & EMT
Date of Authorisation	July 2010

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Elder Abuse

Policy

Introduction

Elder Abuse, and Self Neglect, is common in our community, affecting between 3-5% of all people over the age of 65 years, but is often unrecognised. Abuse may involve combinations of verbal, physical, financial, and sexual abuse or neglect. All health care providers need to be able to recognise when abuse may be occurring, yet many feel at a loss to know how best to tackle the abuse situation. The guidelines (See page 5) to this policy, developed by a team of experienced professionals from both hospital and community sectors provides guidance in this complex area.

The information in the guidelines emphasises that abuse issues are complex, time consuming, seldom solved simply, and that they require *close collaboration of staff at both interdisciplinary and interagency levels*. A collaborative approach is essential.

Elder Abuse issues often raise conflicts over safety versus autonomy. The document stresses the importance of empowering the elderly person themselves, when they are competent to do so.

Policy

When Elder Abuse or Neglect is suspected, staff are to work as a multi-disciplinary team involving the appropriate health professionals working in accordance with the guidance in the attached appendix and, ensuring the elder abuse principles outlined below are being met.

Details regarding any suspicions are to be documented in the patient's clinical record.

Elder Abuse Principles

- Safety of ALL concerned must be considered
- Assume client competency until proven otherwise
- Never work alone
- The interests of the client should take precedence over those of the client's family or of other members of the community.
- Confidentiality of information is to be respected in accordance with professional ethics, agency policy and legal obligations.
- Self determination is to be encouraged. Individuals are to be encouraged and assisted to make their own decisions and to be provided with information about all relevant options. The individual may choose to decline intervention. Where people are capable of making their own decisions, their views must be taken into account.

- Least disruption of life style.
- Cultural needs of client should be respected.
- Least restrictive intervention.
- Clients should be informed of protection through legal remedies for violence, abuse, threats, intimidation and harassment.
- Assault and some other forms of abuse (eg. theft and fraud) are criminal offences.

Legislation

- Domestic Violence Act 1995
- Harassment Act 1997
- Health Act 1956
- Health and Disability Act 1993
- Mental Health Compulsory Assessment and Treatment Act 1992
- Privacy Act 1993
- Protection of Personal and Property Rights Act 1988
- Trespass Act 1980

Worker Accountability

CDHB workers are expected to:

- Practise within the framework and boundaries of their own professional body.
- Follow the policies and procedures of their own agency / organisation.
- Use the guidelines contained in the appendix attached when working on a case of elder abuse / neglect or suspected elder abuse / neglect.

Definitions

Elder Abuse

Elder abuse is the wilful or unintentional harm caused to an older person by another person with whom they have a relationship implying trust. Categories of abuse include financial or material abuse; psychological abuse; physical abuse; and sexual abuse.

Self Neglect

Self neglect is the failure of a person to provide for their own needs and well-being. Self neglect can be intentional or unintentional.

Neglect

Neglect is the failure of a carer to provide the necessities of life to a person for whom she or he is caring. Neglect can be intentional or unintentional.

Client

For the purposes of elder abuse work 'client' denotes the older person being abused.

Primary Worker

The primary worker needs to be able to accept and retain, in most instances, responsibility for the client and her/ his needs throughout the episode of abuse work.

Co-Worker

The co-worker may be from within the primary worker's own workplace or from another agency. His/her role is to provide support and consultation and share some of the tasks. It is expected that regular, ongoing contact will be maintained between primary worker and co-worker.

Elder Abuse Practitioner's Group

The forum is a representative group of people, from various agencies, who have had experience of working with elder abuse and neglect. Its purpose is to provide support and education and be a resource to others working with elder abuse and neglect.

SafeHouse

A SafeHouse is a place of safety for the person allegedly being abused. Consult with Elder Abuse Practitioners Group.

Guidelines

Assessment Guidelines

Assessment should commence as soon as possible after the agency becomes aware that abuse may be taking place.

When making an assessment of the situation the following should always be considered and documented.

- The competence of the person concerned. Although accurate determination of competency is a complex process which may require a referral to an appropriate agency, an initial judgement may need to be made. The following is a guide.

Competent

The client is capable of making decisions and understands what has happened (is happening)

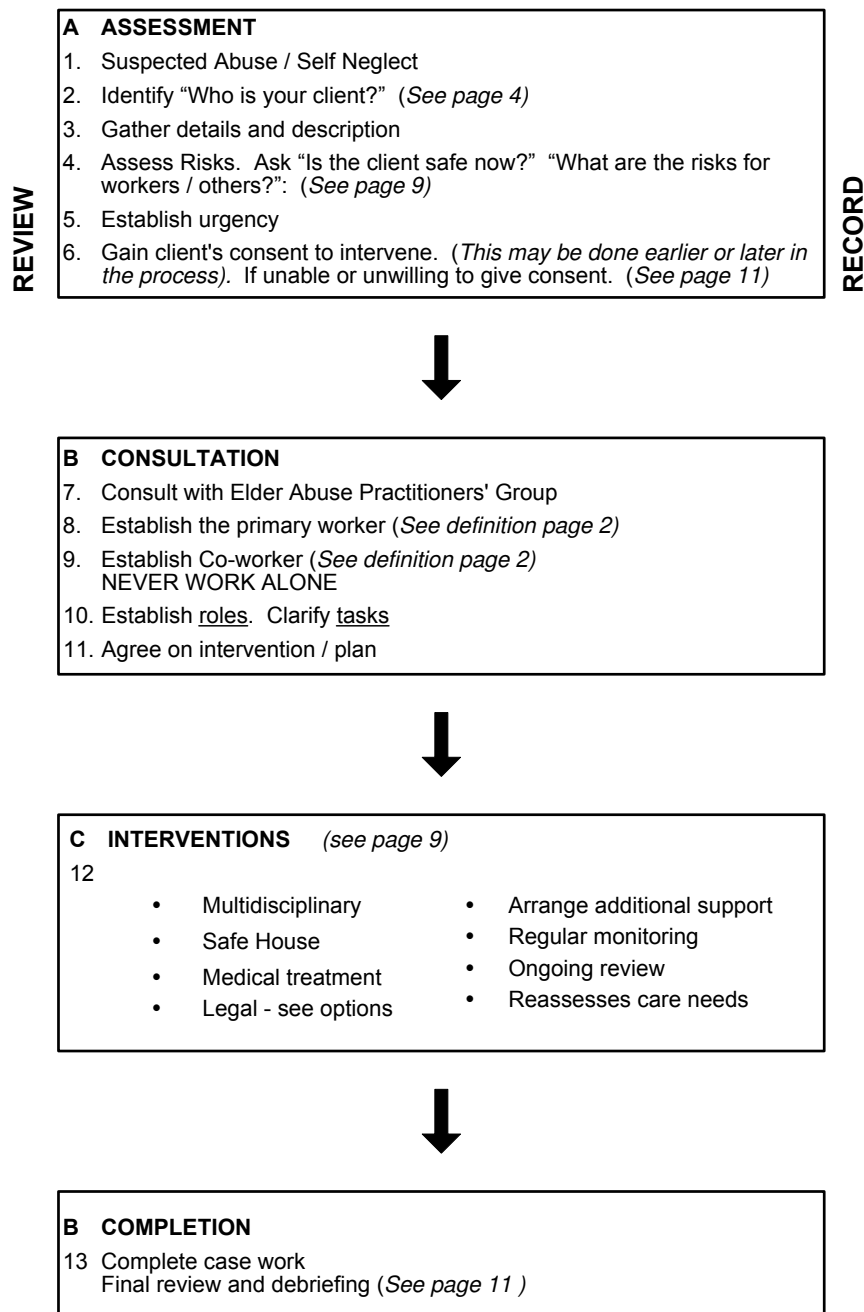
Not competent:

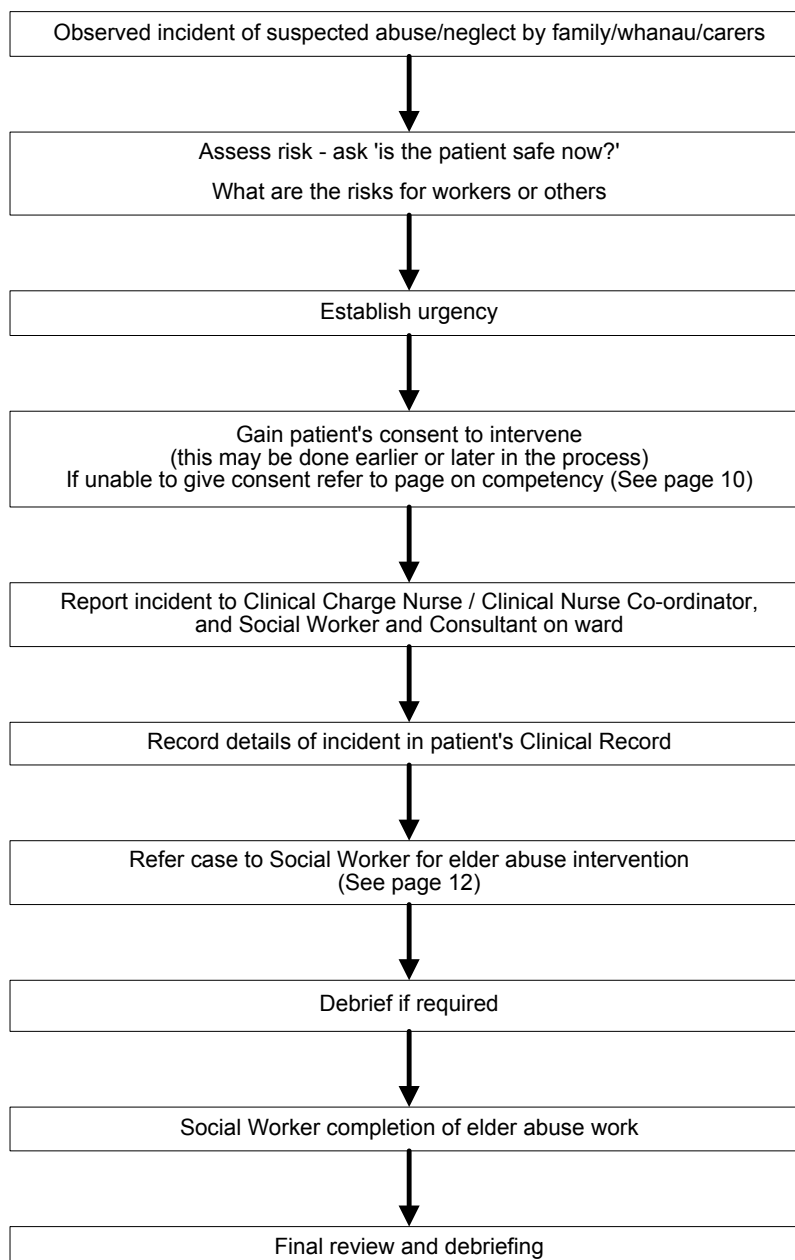
The client has demonstrated an impaired understanding of what has happened (is happening). (*See chart - clients competency*)

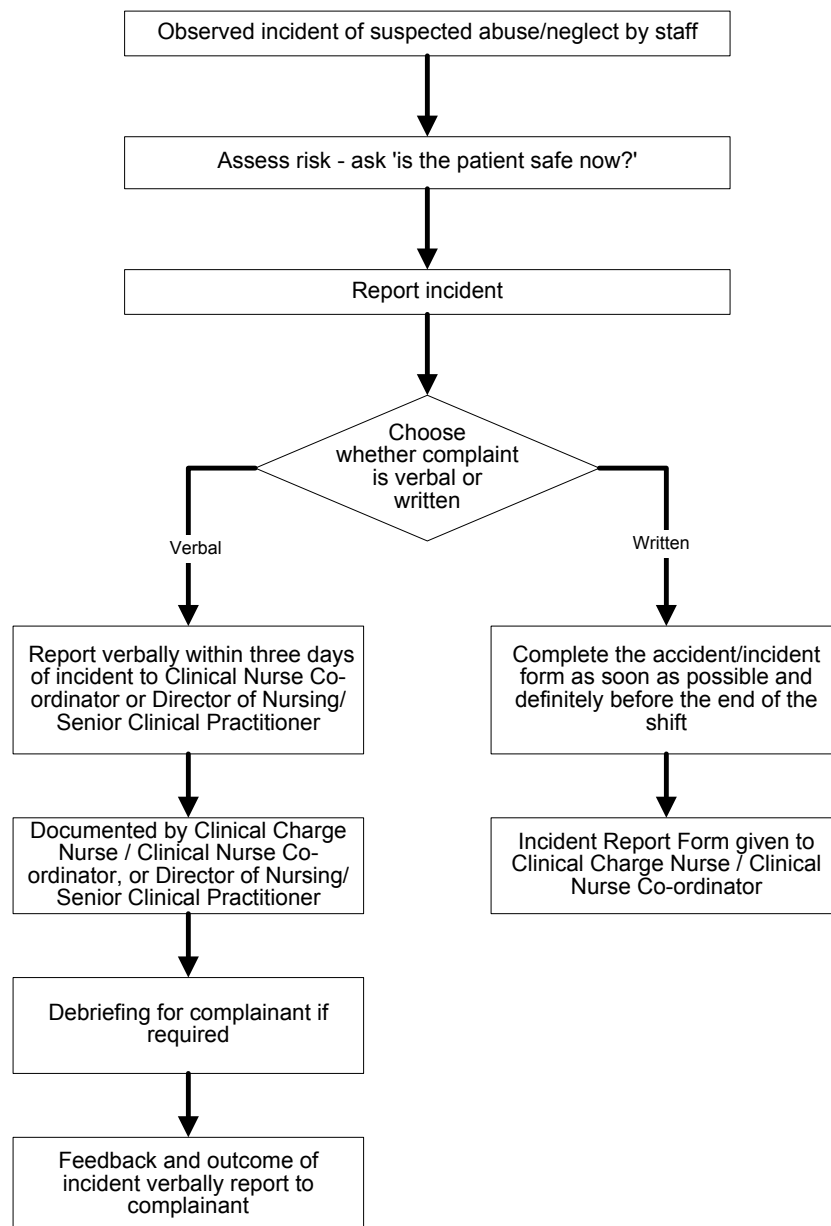
- The consent of the person Is the person prepared to accept initial assistance to terminate the abuse? The person's right to refuse assistance should be recognised. If permission for intervention is denied the worker has a responsibility to continue to support the victim or carer, as able.
- The level of risk It is essential to note the type, frequency, duration and severity of the abuse in order to assess the level of risk to both client / carer and worker.
- The health and functional status of the client.
- The relationship of the abuser to the client The nature of the relationship of the abuser to the client and their social context.
- The supports currently used by the client The range of informal as well as formal supports should be noted.
- The role of other services involved If other services are involved it is important to clarify their roles.
- Clarify family / client / professional understanding of the problem and possible resolutions.
- Identify primary and co-workers

Elder Abuse and Neglect, Flowchart of Processes (Community)

Note: The order of progression through these steps may change according to circumstances, but no steps should be missed

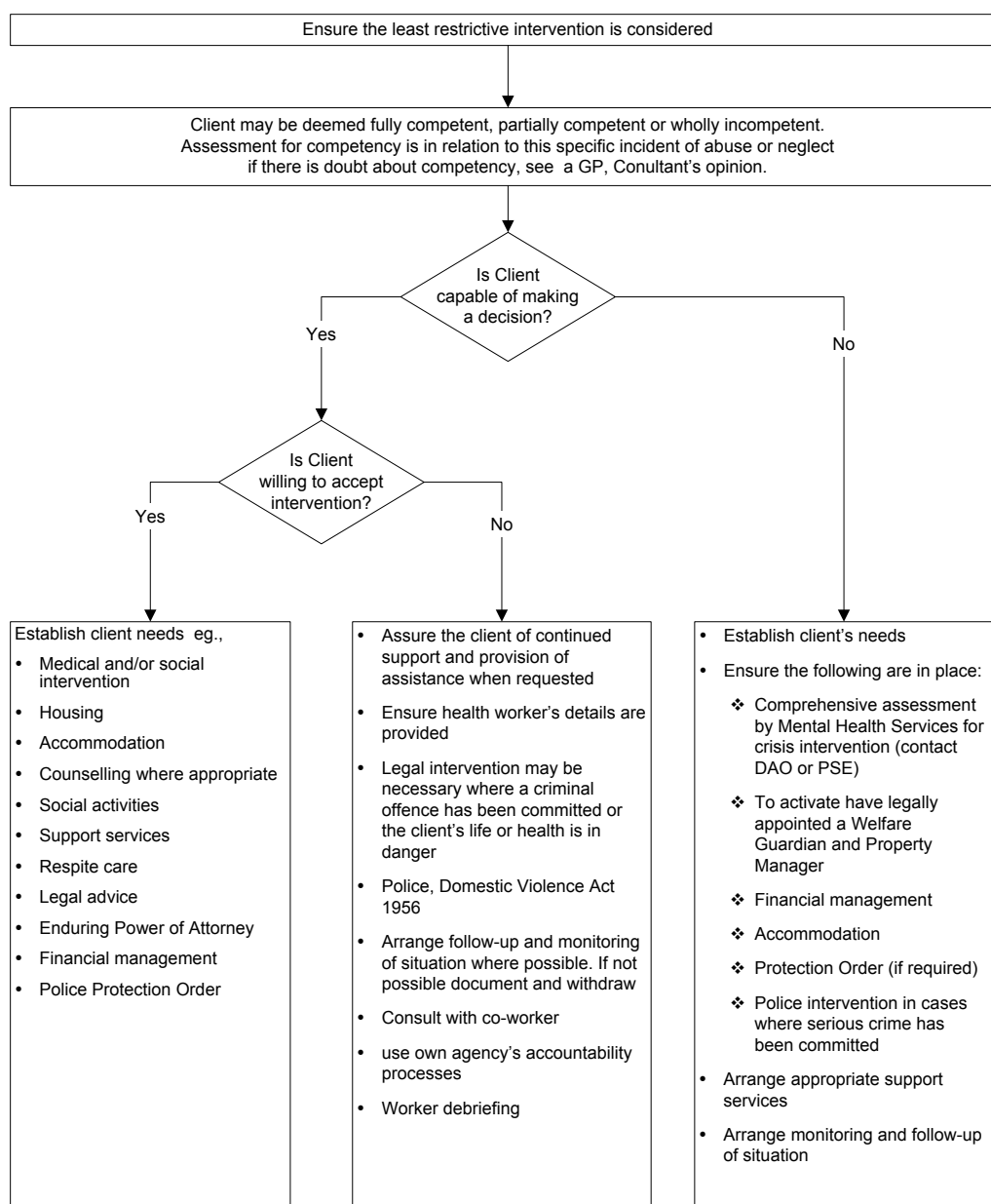


Flowcharts - Elder Abuse within Inpatient Setting**Abuse to patient by family/whanau/carers**

Abuse to patient by staff

Competency and Interventions

Flowchart - Assessment for Competency



Options for At-Risk Clients

- Family / Friends ~ for support, information, accommodation, care
- Other community support options, eg., disability support services such as personal care, day care, carer support.
- Hospital admission (*Acute or Assessment Treatment and Rehabilitation*)
 - Contact GP if available
 - Contact Psychiatric Service for the Elderly duty person, or
 - Older Persons Health duty consultant
- Legal options (refer to legislation listed on page 2)
- Police
 - Domestic Violence Act
 - Support for the use of the Mental Health Act or Infirm Persons Act
 - To assist in relocating client
 - To gain access to client's property
 - For removal of weapons
 - In financial abuse - protection and investigation
 - For consultation
 - For worker's support

Intervention

When planning the Intervention always ask

- Have the rights of the client been considered?
- Has client confidentiality been maintained?
- Has the client been consulted throughout the process?
- Will the action cause further harm to an already traumatised client?
- Does the client fully understand and consent to interventions?
- Can the client make these decisions or, if not, is everyone in agreement with the proposed intervention?
- Have Family Court applications been considered?
- What is the minimum intervention for the maximum effect?
- Have you recorded everything?

Intervention Options

Crisis Care.

This might involve admission to an acute hospital bed, or perhaps urgent respite care in a rest home, private hospital depending on the needs of the client.

Alternative accommodation.

This may be necessary on a temporary / permanent basis.

Provision of community support services.

The full range of community support services and Health Funding Authority funded services are actioned through Assessment Treatment and Rehabilitation Services, eg., respite.

Counselling.

This may involve individual counselling or family therapy. The aim is to help clients cope with their situation and assist them to find a way to be safe from abuse.

Treatment of the abuser.

In cases where the abuser's mental state is a major causative factor, referral for treatment may be necessary to address psychiatric illness or substance abuse problems.

Legal interventions.

These are hopefully a last resort, but may be the first line of intervention where criminal charges need to be laid in cases of financial abuse or physical abuse (particularly where there is a history of domestic violence). (Refer legal checklist page 2).

Agencies that provide Legal Assistance

- Client's own solicitor
- Legal Services Board to pay for legal costs when client unable to pay legal service
- Community Law Centre: Assist clients with legal advice
- Women's Refuge. Assist women seeking protection orders under Domestic Violence Act
- Social Work Services.
- Presbyterian Support are registered providers of individual programmes for adult protected persons under the Domestic Violence Act

Final Review and Debriefing

Closure is mutually agreed by all parties and planned

Debriefing may be with the following people:

- The primary worker and co-worker
- or, the multidisciplinary team
- or, with representatives of other agencies involved
- or, with someone from own team
- or, through a case presentation to the Elder Abuse Practitioners Group

The Elder Abuse Practitioners Group is a group of people with experience and interest in elder abuse work. It is composed of representatives from Presbyterian Support, Nurse Maude Association, Canterbury DHB, Age Concern Canterbury and the Medical Officer of Health.

Nurse Maude Assn.
PO Box 36 126, Christchurch
355 0047

Presbyterian Support,
PO Box 13171, Christchurch
366 5472 (03) 313 8588

Age Concern Canterbury
PO Box 2355
Christchurch
336 0903

Social Work Department
Christchurch Hospital
Private Bag 4710, Christchurch
364 0420

Older Persons Health
The Princess Margaret
Hospital
Private Bag 731, Christchurch
337 7899

Psychiatric Service for the Elderly
The Princess Margaret Hospital
Private Bag 731
Christchurch
337 7997

Procedure

Step	Action
1.	Staff need to be aware of potential risks to themselves and work in a safe manner. This may, in some circumstances, involve:
	For Community: <ul style="list-style-type: none"> • Being accompanied by another staff member or professional when doing a home visit and parking out of view • Leaving the address and telephone numbers of home visits at the office • Carrying a cellphone with you on home visits • Requesting that the client be seen at the office
	For Inpatients <ul style="list-style-type: none"> • Ensuring that other staff are present in the building when seeing a client at your office and that those staff are aware of any risks
2.	<p>All staff have a responsibility to immediately report to a senior staff person any potential risk or danger to themselves, other staff or clients. Others who may also be at risk are to be alerted to the nature of the risk. A plan of action may need to be put in place should there be a potential rather than an actual risk.</p> <ul style="list-style-type: none"> • Never work alone when suspected abuse has occurred to client by family/whanau/carers/visitors • Consult with a Senior Staff member following observed incident of abuse/neglect • Ensure another staff member is present when gaining client's consent to intervene following an abusive episode
3.	Staff must seek immediate support where a client's or their own safety is in jeopardy. Emergency services may need to be called.
4.	The incident must be fully and accurately reported (both verbally and written) following the Incident and Accident procedure of your agency as soon as practicable after the event.
5.	Where safety concerns have given rise to stress or distress in the staff member concerned and/or other members of the team, the Elder Abuse Practitioner Group will organise for appropriate debriefing to take place as soon as possible.

Worker Safety

All employees have the right to a safe working environment. Their safety and that of their clients is paramount. Where there are concerns about safety the appropriate protection of individuals and reduction of risk factors can be put in place.

Safety concerns arise when:

- A staff person is at risk of harm by a client or other person
- The agency is at risk of harm

Procedures about safety issues:

- Manage the level of risk in the agency
- Support staff through shared responsibility
- Maintain a high level of accountability

Staff being treated in a threatening manner

Trespass Act:

Contact Security Manager to arrange a Trespass Notice to be served on abuser or prevent entering hospital grounds.

Abusive Phone Call:

Option 1: - Make contact with abuser and inform that the call will be discontinued should they persist in such a manner

Option 2:

Notify police of harassment

Suspicion of coercion to sign documents when under assessment and may not have competency

If you suspect that family/whanau/carers and /or solicitor are trying to have legal documents signed when the client/patient appears to be unable to make an informed decision, then it is your responsibility to report this incident immediately to

- Clinical Nurse Co-ordinator
- Ward Consultant
- Social Worker

If these staff cannot be located then request that documents are not signed until completion of clinical assessment has been completed.

The Signs of Abuse

One of the major problems in dealing with abuse is the difficulty in recognising it. It is necessary to be on the alert because symptoms and signs are subtle and are attributed to the ageing process (eg. because the person is old and frail) or to the disability. People may be reluctant to admit that they are being abused by a person on whom they rely for their basic needs.

It is important to remember that the presence of one or more of the signs listed below does not necessarily establish that abuse is occurring.

It should also be noted that the severity of abuse can vary substantially. In some cases one incident may constitute abuse (eg. theft or physical assault), in other cases one incident may not be abuse (eg. the case of a stressed carer shouting once at a relative with dementia). However, the presence of any of the signs listed below should alert you to the possibility of abuse.

Behavioural Signs

Abuse and neglect can sometimes be detected from the behaviour of people involved as well as the more obvious signs and symptoms. It is important to be aware of sudden and unusual behaviour patterns in the client, not only at home, but in other situations and settings - for example, suddenly not attending church or a group after regular attendance.

Behavioural Signs Of Victims

Behaviours that a person may exhibit can include:

- Showing signs of being afraid of a particular person/people
- Appearing worried and/or anxious for no obvious reason
- Becoming irritable or easily upset
- Appearing depressed or withdrawn
- Losing interest
- Sleep disturbances
- Changed eating habits
- Having thoughts of suicide
- Frequent shaking, trembling and/or crying attacks
- Rigid posture
- Presenting as helpless, hopeless or sad
- Making contradictory statements not resulting from mental confusion
- Reluctance or hesitation to talk openly
- Waiting for the carer to answer
- Avoiding physical, eye or verbal contact with carer or service provider

It is more effective to observe these behaviours in the home. However, it is important to be aware of them in other situations as well.

It is also important to observe the behaviour of people with whom the client has contact. Are they willing to touch, talk, listen to or look at the client? Do they react strongly to suggestions regarding the client care? Do they use discriminatory remarks or put-down comments?

Behavioural Signs Of Abusers

Behaviours that may be exhibited by a person inflicting abuse can include:

- Blaming the victim for his/her behaviour (eg, wandering, incontinence)
- Not wanting the older person to be interviewed alone
- Refusing treatment for the victim
- Seeking medical attention from a variety of doctors/medical centres
- Responding defensively, making excuses, being hostile or evasive
- Being excessively concerned or unconcerned
- Minimal eye, physical or verbal contact
- Treating the victim like a child
- Using threats, insults or harassment
- Taking control of the victim's money or other resources
- Difficulty managing his or her own life

Environmental Signs

Living arrangements and standards will vary. What is acceptable for one person may not be for another. It is therefore important that personal standards do not influence our judgement. Consideration should be on the effect the living arrangement or standards have on the client or carer.

Environmental signs include:

- If the home is hazardous to the client's or carer's health or safety due to disrepair, level of cleanliness, fire safety etc, this may be a sign that the carer is unable or unwilling to provide adequate care and may signal abuse or neglect.
- Inadequate heating, inability to reach food or water, inadequate sleeping or sanitary facilities are other signs that may indicate abuse or neglect.
- The presence of any of the above behavioural or environmental indicators does not necessarily imply that abuse or neglect is taking place, but it does mean that further investigation is warranted.

Signs of Material and Financial Abuse

This is the improper use of a person's money, property, or assets by someone else. Money can be a very sensitive subject. Fear of not having enough money for future care or feeling obligated to others can leave a person vulnerable. These feelings can be reinforced and used as a threat. This may be more easily detected when clients are visited in their own homes.

Signs include the following:

- A loss of money ranging from removal of cash from a wallet to the cashing of cheques for large amounts of money
- Sudden or unexplained withdrawal of money from a bank account
- A sudden inability to pay bills, buy food or participate in social activities
- Failure to pay rent or other bills on behalf of the person being cared for
- Loss of bank books, credit cards and cheque books
- The reluctance to make a will or have budget advice
- Loss of jewellery, silverware, paintings or furniture
- An unprecedented transfer of money or property to another person
- The making of a new will in favour of a new friend or another family member. Power of Attorney may be obtained improperly from a person who is not mentally competent.
- Management of a competent person's finances by another person.

Signs of Psychological Abuse

This is said to have occurred when a person suffers mental anguish as a result of being shouted at, threatened, humiliated, emotionally isolated by withdrawal of affection, or emotionally blackmailed. It may be verbal or non-verbal. Psychological abuse is usually characterised by a pattern of behaviour repeated over time and intended to maintain a hold of fear over the victim.

Signs may include:

- The person may be huddled when sitting and nervous with the family members or carer nearby
- Insomnia, sleep deprivation and loss of interest in self or environment
- Fearfulness, helplessness, passivity, apathy, resignation, withdrawal.

Look for paranoid behaviour or confusion. Look for anger, agitation, or anxiety. Many of these signs may be attributed to psychiatric disorders.

Watch how the person behaves when the client/carer enters or leaves the room. There may be ambivalence towards a family member or carer. Often there is reluctance to talk openly, and the person will avoid eye contact with both practitioner and client/carer.

Signs of Physical and Sexual Abuse

Because the results of physical abuse are often visible, this can be one of the easiest forms of abuse to identify. However, the signs of physical pain, injury or force may not always be visible so the general appearance, attitude and behaviour of the client should be taken into account.

This type of abuse includes punching, kicking, beating, biting, burning, pushing, dragging, scratching, arm twisting, sexual assault and any other physical harm to a person. It includes physical restraint such as being tied to a bed or chair, or being locked in a room.

Sexual abuse can include rape, sexual assault, sexual harassment and inappropriate touching. It can be very difficult to identify as embarrassment and shame may prevent the subject from being raised.

- Look for a history of unexplained accidents or injuries. Has the person been to several different doctors or hospitals? It is important to check on conflicting stories from the client and carer, and on discrepancies between injury and the history. There may have been a long delay between the injury occurring, and reporting for treatment.
- Any person labelled as “accident prone” should be viewed with suspicion, as should multiple injuries, especially at different stages of healing, and untreated old injuries.
- Medical and nursing staff should undertake a good physical examination where possible. However, in the absence of a formal physical examination, other practitioners can note the presence of bruising and abrasions on exposed areas such as the face, neck, forearms and lower legs.
- On the head, look for bald patches, and signs of bruising on the scalp. This may be indicative of hair pulling.
- Watch for black eyes and bleeding in the white part of the eye. Look at the nose and lips for swelling, bruising and lacerations. Are there any missing teeth? Fractures of the skull, nose and facial bones, should always alert one to the possibility of abuse.
- On the arms look for bruising, especially bruises of an unusual shape. Think of belt buckles, walking sticks, hair brushes or ropes as instruments of injury. Look for pinch marks and grip marks on the upper arms. Victims of abuse are sometimes shaken. Look for bite marks or scratches.
- Look for burns from cigarettes, or chemical burns from caustic substances. Glove or stocking burns suggest immersion in hot or boiling water.
- Look for rope or chain burns, or other signs of physical restraint, especially on the wrists or around the waist. A victim of abuse may be tied to a bed, to a chair, even to a toilet.
- On the trunk look for bruises, abrasions and cigarette burns. Ribs may be fractured if the victim is pushed or shoved against an object or a piece of furniture.

- Medical or nursing staff should examine the genital areas for bruising, bleeding, and painful areas. Check for torn, stained or blood stained underwear. Look for evidence of sexually transmitted disease. Watch for difficulty in walking or sitting. Any of these signs may be indicative of sexual abuse.
- On the lower limbs observe for bruising, rope burns, abrasions, lacerations, or evidence of past or present fractures.

Neglect

This is where a person is deprived by the carer, or the carer is unable to provide the necessities of life.

- If food or drink are being withheld, there is malnutrition, weight loss, wasting and dehydration, all without an illness-related cause. The person may have constipation or faecal impaction.
- Isolation, lack of mental, physical, social or cultural contact.
- Inadequate supervision, the person is abandoned/unattended for long periods or locked in the house without any supervision.
- There may be evidence of inadequate or inappropriate use of medication, for instance, the person may be over-sedated in the middle of the day.
- There may be evidence of unmet physical needs such as decaying teeth or overgrown nails.
- The person may be lacking necessary aids such as spectacles, dentures, hearing aids or walking frame.
- Clothing may be in poor repair or inadequate for the season.
- There may be poor hygiene or inadequate skin care. The victim may be very dirty, smell strongly of urine or be infested with lice. There may be a urine rash with abrasions and chafing.
- In some cases when people are immobile, they may develop pressure areas over the pelvis, hips, heels or elbows.
- Hypothermia, recent colds, bronchitis or pneumonia.

Self Neglect

Self-neglect is often reported by neighbours because they are concerned about the safety of the person or because they find the behaviour difficult to understand or cope with. The dilemma that self-neglect raises is the effect this lifestyle has on the safety of others versus the person's right to determine how he/she lives.

The following signs do not necessarily indicate self-neglect, and even when they do, careful consideration should be given to the consequences that may result from any intervention.

- Reclusive behaviour
- Frugality
- Shrewdness, fear, distrust
- Inappropriate eating habits
- Malnutrition, dehydration
- Filthy and unhealthy living environments
- Collecting and/or hoarding rubbish
- Absence of basic hygiene and personal care
- A menagerie of pets
- Inability and/or refusal, to pay bills
- Fierce guarding of independence and privacy

Policy Owner	Corporate Quality and Risk
Policy Authoriser	Clinical Board
Date of Authorisation	5 August 2005
Date of Last Review	July 2010

SURNAME	NHI
FIRST NAME	DOB
ADDRESS	
.....	POSTCODE

(or affix patient label)

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

Risk assessment	<input type="checkbox"/> Declined Please state reason:
IPV routine enquiry	<input type="checkbox"/> IPV+ (positive) Date: / /
Assess pregnancy risk	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No EDD: LMC: Have you ever been beaten by your partner while pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked
Assess risk to children	Have the children seen or heard the violence? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked Has anyone physically abused the children? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate which apply: <input type="checkbox"/> Trespass Notice <input type="checkbox"/> Protection Order <input type="checkbox"/> Bail conditions <input type="checkbox"/> Police Safety Order <input type="checkbox"/> Recent family violence charges <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 2. Are you afraid to go/stay home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 4. Has your partner ever choked you? (one or more times) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked A 'yes' answer to question 4, requires intervention as per the Clinical Guideline: Assessment and Management of Strangulation 5. Have you ever been knocked out by your partner? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 6. Has your partner ever used a weapon against you, or threatened you with a weapon? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 7. Do you believe your partner is capable of killing you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 8. Is your partner constantly jealous of you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 9. If yes – has the jealousy resulted in violence? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 10. Have you recently left your partner, or are you considering leaving? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 11. Has your partner ever threatened to commit suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 12. Have you ever considered hurting yourself/suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 13. Is alcohol or substance misuse a problem for you or your partner? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 14. Do you or your partner have a mental health condition(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> 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 THE ePROSAFE REFERRAL

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

IPV FV Assessment and Intervention

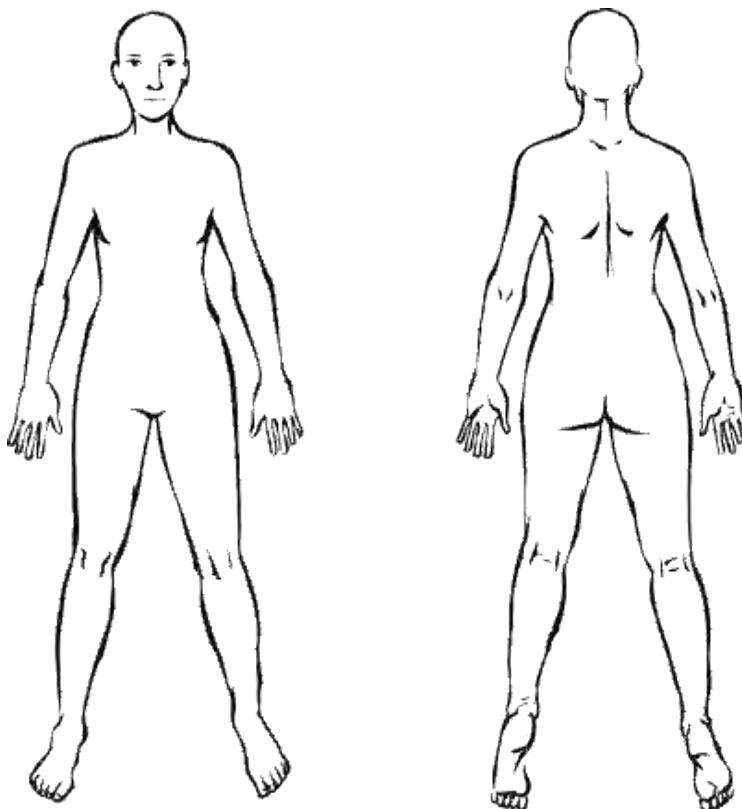
Referrals

- | | |
|--|--|
| <input type="checkbox"/> Referral(s) declined | <input type="checkbox"/> No referral or report made |
| <input type="checkbox"/> Internal referral | <input type="checkbox"/> External referral |
| <input type="checkbox"/> Police – with consent | <input type="checkbox"/> Police – without consent |
| <input type="checkbox"/> Social Work | <input type="checkbox"/> Oranga Tamariki – Ministry for Children/CYF |
| <input type="checkbox"/> Cultural Support Services(Please specify) | <input type="checkbox"/> Report of Concern completed and sent |
| <input type="checkbox"/> Mental Health Service | <input type="checkbox"/> Children's Team (if DHB has one) |
| <input type="checkbox"/> Sexual Health Service/Sexual Assault Assessment and Treatment Service | |
| <input type="checkbox"/> Specialist Family Violence Agencies | |
| <input type="checkbox"/> Provision of Family Violence Community Agency card/referral information | |
| <input type="checkbox"/> 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 (please specify):

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)



Note:

Document history on clinical notes and attach to eProsafe.

Include:

- verbatim quotes
- observations
- patients demeanour
- description of injuries
- mechanism of injury, eg. punched with a closed fist
- weapon used, eg. knife, gun, baseball bat

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

Photographs taken: ☐ Yes ☐ No

Safety plan (Record in clinical notes and attach to eProsafe)

(Including discharge arrangements)

- ☐ Safety plan discussed ☐ Safety plan actioned

Name: Date: / /

Designation: Signature:

A COPY OF THIS REFERRAL FORM AND A COPY OF THE CLINICAL NOTES MUST BE SENT TO THE CHILD AND FAMILY SAFETY SERVICE OR SMHS FST OR COMPLETED ON OR ATTACHED TO AN ePROSAFE REFERRAL

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Overview

Family violence is a global issue and is not limited to any one gender, sexual orientation, religious, cultural or income group.

The Canterbury District Health Board (CDHB) is committed to a whole health systems population approach to the issue of family violence, ie. working across primary and secondary care. This is in recognition that family violence and Intimate Partner Violence (IPV) are important health issues. They can lead to immediate physical and mental health consequences and are significant precursors to a range of poor health outcomes and long-term conditions.

Health care providers are ideally placed for early identification of and intervention in family violence because most people use health services at differing times in their lives. Prevalence rates of violent victimisation are higher among those attending health care services compared with individuals in the general population. Groups identified as being at higher risk of victimisation from IPV include; females, Māori, people with disabilities, gay, lesbian, bisexual and transgender.

Purpose

This policy, associated procedures, referral pathways and electronic documentation requirements eg, patient management system alert and/or eProsafe requirements, provides CDHB primary and secondary staff with a framework to identify, manage and respond to Intimate Partner Violence (IPV).

The CDHB recognises staff competence, clarity of roles and responsibilities as essential for effective and safe family violence interventions

Principles

Family violence is violence or abuse of any type, perpetrated by one family member against another family member. It includes child abuse, IPV and elder abuse and neglect (EAN).

The Ministry of Health's Family Violence Assessment and Intervention Guideline guides this policy.

When managing issues of family violence the rights, welfare and safety of the child/tamariki, young person/rangatahi are our first and paramount consideration.

Health services and providers will undertake to actively identify the person's experiences of violence, and work with them to assess their risk and provide information about options for further support and referral.

Health services that care and protect victims of family violence are built on a bicultural partnership in accordance with the Treaty of Waitangi. All people using the services of the CDHB are assessed and managed in a culturally safe environment through active involvement of the Māori Health Services. All staff are to recognise and be sensitive to other cultures.

A key element of protection is the requirement to integrate care through a coordinated approach with community providers.

Staff are competent in identification and management of actual or suspected abuse and/or neglect through the organisation's infrastructure including policy and procedural structures, workforce development and access to consultation. Workforce development comprises core and refresher training. The CDHB requires mandatory VIP core training and at a minimum, biennial refresher training for staff working in the designated areas.

Scope

The policy applies to all cases of actual and/or suspected IPV encountered by employees, students and people working at the CDHB or under contract for service.

The policy specifically relates to the identification, assessment, management and referral of victims of intimate partner violence. It is recognised that other forms of family violence may be disclosed during the course of the intervention and the procedural framework outlined may be applicable to these other forms of family violence.

See also Management of Child Abuse and Neglect and Elder Abuse and Neglect Policy.

Definitions

All terms and definitions related to this document have been defined.

See *Appendix 1*

Roles and responsibilities

Organisational responsibilities

CDHB Executive responsibilities

- Ensure there is an organisation-wide policy for the appropriate response to and management of intimate partner violence.
- Regular workforce development for staff in the policy.
- Ensure staff attend workforce development that comprises of mandatory core and refresher training. CDHB requires VIP core training and refresher training every two years at a minimum. Advanced training will be offered to staff working in the MoH designated areas.
- Processes to ensure the policy is adhered to, such as quality improvement activities.
- Adequate support (eg. access to consultation) and supervision for staff managing IPV cases.
- Ensure organisational procedures exist to provide appropriate, adequate support for and supervision of staff affected by IPV.
- Ensure that IPV policy and procedures comply with legislative requirements, the principles of Te Tiriti o Waitangi and best practice standards.

These activities need to be properly resourced and evaluated.

Steering Group responsibilities

- Meet on a regular basis.
- Provide guidance and support to the Violence Intervention Programme (VIP).
- Participate in reviews and endorse the policy and procedures related to VIP.
- Advise and support the planning, development, implementation, management and evaluation of violence intervention services within the DHB.
- Analyse systems and collaboratively work towards best practice standards
- Champion the service throughout the DHB.

Service responsibilities

- All departments and service providers are to ensure that staff responsible for clinical care of patients/clients will be familiar with and adhere to the IPV and related policies.
- Ensure clinical care staff attend VIP core training and refresher training regarding IPV.
- Ensure staff follow the brief intervention model for routine enquiry of IPV as outlined in the procedures section.
- Ensure reporting and auditing procedures and recommendations are effected.
- Ensure staff as victims or perpetrators of IPV are supported.
- Ensure support systems and/or supervision is available for staff when a individual discloses IPV.

Employee responsibilities

All health professionals employed by the CDHB who are associated with the clinical care of patients/clients have a responsibility for the safe management of identified and suspected cases of IPV, child and elder abuse and neglect.

Responsibilities include:

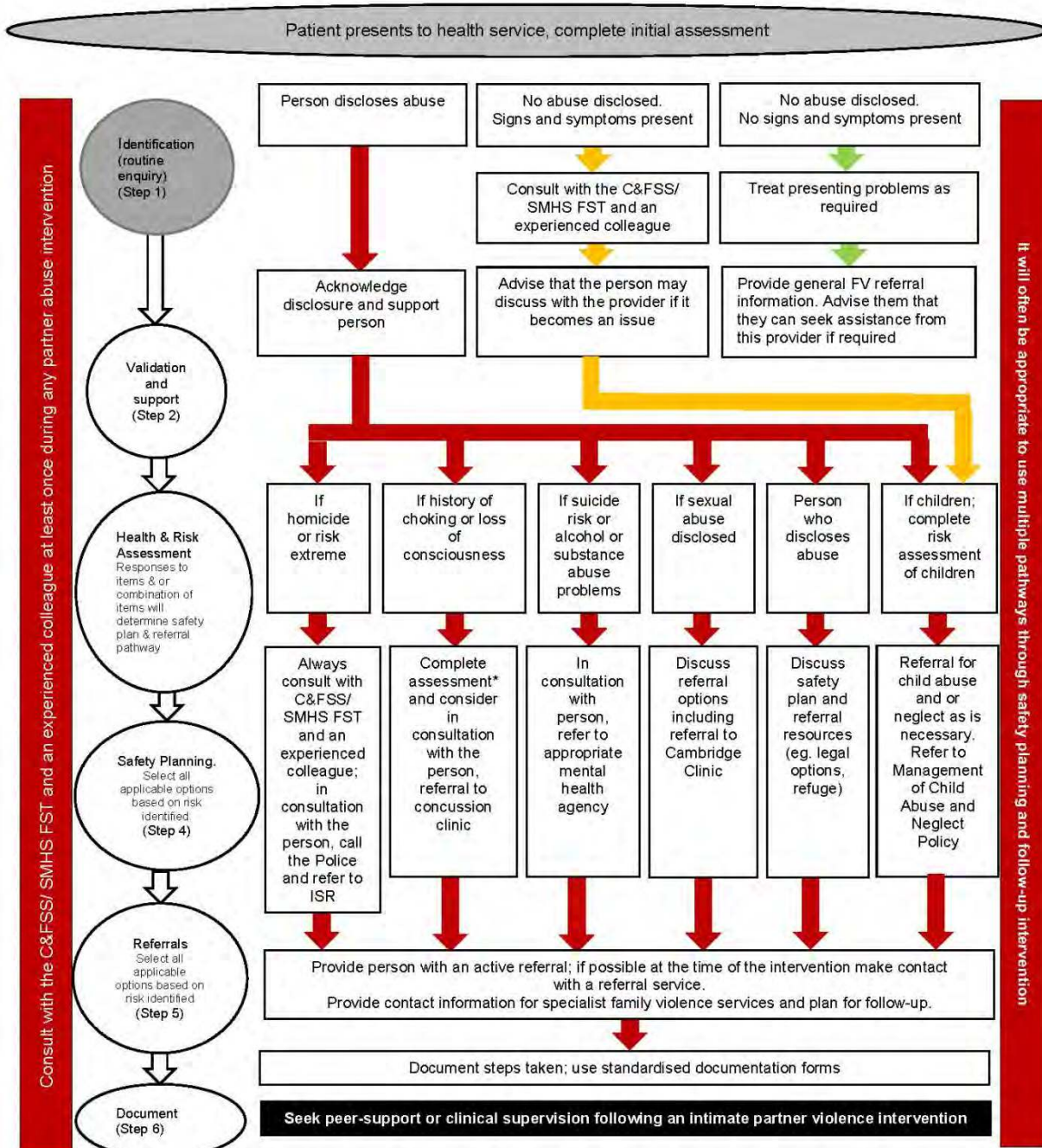
- To be conversant with CDHB IPV and related policies.
- To identify, assess, manage and refer victims of abuse and document all actions taken.
- To attend VIP core mandatory training and regular updates appropriate to their area of work.
- To provide or access CDHB specialist health services that may include:
 - Cultural assessments
 - Mental Health assessments
 - Older Persons Health assessment
 - Diagnostic medical assessments
 - Social work services, counselling and therapy resources
 - Paediatric assessment for any children who may be at risk
- To practice safely, for example consulting with the Child and Family Safety Service (CDHB C&FSS), Specialist Mental Health Service Family Safety Team (SMHS FST) or senior colleague during the intervention process and seeking peer-support/supervision after each disclosure of IPV.

Child and Family Safety Service (CDHB C&FSS)/Specialist Mental Health Service Family Safety Team Responsibilities

- Coordinate programme implementation within services, working with service leaders to ensure the system supports are available.
- Ensure the CDHB-wide policy is current and aligned with national standards.
- Ensure provision of training in accordance with the DHB VIP training plan; this will include ensuring that the VIP training is available cyclically
- To be available to staff for consultation regarding IPV concerns.
- To contact the C&FSS – phone external 364 0905, internal 80905 or fax external 364 1459, internal 81459.

- To contact the SMH FST – phone cell 027 687 2304 or email familysafetysmhs@CDHB.health.nz
- Ensure regular audits and other quality improvement activities in regard to policy compliance are undertaken and reported on at least bi-annually.
- Develop functional internal and external relationships with key stakeholders (government, local government and community based organisations).

VIP intimate partner violence intervention flowchart



^A In imminent threat and or high risk the Police/ISR can be notified without the person's consent.

Indicators of High Risk

Life threatening injuries.
Children, elders or individuals with a disability at risk.
A threat to kill or a threat with a weapon has been made.
The person has recently separated from the abusive partner, or is considering separation.
The person is afraid to go home or stay home.
Physical violence has increased in frequency or severity.
The abuser has attempted to strangle the person (loss of consciousness).
The person has been knocked out.
The person has been physically assaulted while pregnant (f 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?

*Strangulation assessment (clinical decision tree and documentation form)
#Cambridge Clinic sexual assault assessment and treatment service.

Māori and the violence intervention programme

Māori are significantly over-represented as both victims and perpetrators of whānau violence. This should be seen in the context of colonisation and the loss of traditional structures of family support and discipline. Violence is not acceptable within Māori culture. This CDHB Intimate Partner Violence Policy has been developed in accordance with the principles of action including Te Tiriti o Waitangi/The Treaty of Waitangi principles, recognising Te Whare Tapa Whā and Tikanga practices. This is consistent with cultural training offered and mandated within the CDHB.

Family violence intervention for Māori is based on victim safety and protection being the paramount principle.

- Ensure practice is safe clinically and culturally;
- Affirm with the person(s) being abused of their right to be safe in their home; and
- Have Māori staff available to offer support to the family whenever possible.

Routinely enquire about intimate partner violence (IPV) for all Māori women over the age of 16 years; ask men and adolescents, over 12yrs, when signs and symptoms are present. If abuse is disclosed talk about possible plans of action they would like to take, including appropriate referral options.

See Appendix 2 – Māori and family violence

Pacific peoples and the violence intervention programme

Intimate partner violence (IPV) and family violence among Pacific communities in New Zealand occurs in the context of social change brought about by migration, alienation from traditional concepts of the village, family support, extended family relationships and in combination with socio-economic stresses.

Routinely enquire about intimate partner violence (IPV) for all Pacific women over the age of 16 years; ask men and adolescents age 12 and over when signs and symptoms are present. If abuse is disclosed talk about possible plans of action they would like to take, including appropriate referral options.

See Appendix 3 – Pacific peoples and family violence

Minority ethnicities/refugees and the violence intervention programme

Staff need to consider the increased isolation of patients/clients from minority ethnic groups. They may have few support structures outside of the direct family. Different cultures may have different value bases and this may differ from those predominately represented in New Zealand. The potential for minority ethnicities and refugees to identify as being abused and to access help may be difficult.

Staff are to be aware of the potential risks to the abused person when accessing interpreters from ethnic groups. A family member should NOT be used as an interpreter for the victim.

Lesbian/Gay/Bisexual/Transgender (LGBT)

Particular consideration should be given to accessing appropriate supports and referrals for people who identify as gay, lesbian, bisexual, transgender when they disclose or are suspected of being victims of abuse.

Brief intervention model: a six-step process

Consultation should occur at least once when intimate partner violence is disclosed or suspected.

The following staff are available:

- Child and Family Safety Service (CDHB C&FSS) and Specialist Mental Health Service Family Safety Team staff SMHS FST)
- Social Worker
- Clinical Champions
- A senior/experienced colleague
- Older Persons health
- Domestic violence advocate, eg. women's refuge

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

1. Routine enquiry

IPV occurs in heterosexual and in lesbian, gay, bisexual and transgender relationships.

Routine enquiry should only occur when the adult is alone or accompanied by non-verbal age children. Do not ask routine enquiry question:

- 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 routine enquiry process, eg. 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.
- When as a staff member, you are concerned for your safety.

When child abuse is suspected or disclosed the caregiver/protective parent is to be questioned for IPV.

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

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

Males who present with signs and symptoms indicative of intimate partner violence should be questioned.

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

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

See Appendix 4 – Recommended Intimate Partner Violence (IPV) Routine Enquiry Guidelines for Different Settings

See Appendix 5 – Signs and Symptoms of Intimate Partner Violence (IPV)

See EAN Policy – Signs and symptoms of elder abuse

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

2. Validation and support

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

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

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

3. Health and risk assessment

The Health and Risk Assessment – Intimate Partner Violence (IPV) – Family Violence (FV) Assessment and Intervention form includes immediate risk, the risk of homicide, the risk of suicide and any risk to children.

The Health and Risk Assessment – Intimate Partner Violence (IPV) – Family Violence (FV) Assessment and Intervention form must be completed when there are signs and symptoms indicative of abuse, disclosures of abuse, or historical abuse within the last 12 months. This will support the healthcare worker to establish the level of risk and inform followup actions and referrals. The completed assessment must be entered on eProsafe.

See Appendix 8 – Guidelines on Health and Risk Assessment (Intimate Partner Violence (IPV) – Family Violence (FV) Assessment and Intervention form).

See Appendix 15 – Clinical Guideline: Assessment and Management of Strangulation (The post strangulation documentation form can be used to assist the completion of the risk assessment)

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

When IPV is identified and there are children in the person's care, it is imperative that an assessment of risk to children is conducted. In all cases, the emphasis should be on keeping the child safe and supporting the abused person to engage with appropriate services. For the assessment and management of children who may be at risk of abuse refer to the CDHB Policy on the Management of Child Abuse and Neglect.

4. Safety planning

The experience of any violence within relationships is damaging to health and wellbeing, so some level of safety planning is always required. Without intervention,

violence within relationships may increase in frequency and severity over time. Safety planning needs to be guided by consideration of a number of factors including degree of risk (high versus moderate), immediacy of the risk (acute, chronic or historic), as well as consideration of protective factors that already exist, or those that can be engaged to support the victim.

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

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

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

See Appendix 9 – Guidelines on Identifying and Responding to Safety Needs

See Appendix 10 – Safety Plan Resource

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

See Appendix 11 – Guidelines for notifying the police

5. Referral and follow-up

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

When the danger is not imminent and risk is not high, referrals and follow-up plans need to be made in consultation with the person who has disclosed the abuse.

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

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

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

All victims of IPV should be provided with assistance to contact support services and access legal options for protection. Check if the patient is already linked in to appropriate services/agencies.

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

While follow-up will vary depending on the needs of the individual, the resources and training of the health care provider, and the point at which the person has entered the health system (eg. well-health services, primary or secondary care), at least one follow-up appointment (or referral) with a health care provider, social worker, or IPV advocate should be offered after disclosure. If a patient is linked in with another service/agency advise them of the current circumstances with the patient's consent.

See Appendix 12 – Guidelines on referral and follow-up

CDHB has established interagency processes with a range of organisations and agencies

6. Documentation

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

Health professionals should record the outcome of the routine enquiry, the findings of the health and risk assessment, the safety planning and referrals made. This documentation process is standard practice in regard to recording the health intervention, and it is an important part of keeping victims safe because the clinical record may help in future legal action. For example the documentation can be used as evidence in an assault prosecution or when securing a Protection Order. A comprehensive, objective, systematic history and health and risk assessment is therefore essential. Standard professional requirements also apply (eg. a legible signature and designation). The Intimate Partner Violence (IPV) – Family Violence (FV) Assessment and Intervention form must to be completed along with concerns/safety plan noted in the clinical notes. It is mandatory for the the Intimate Partner Violence (IPV) – Family Violence (FV) Assessment and Intervention form to be referred to the CDHB C&FSS or the SMHS FST. The Intimate Partner Violence (IPV) – Family Violence (FV) Assessment and Intervention form can be filled in on eProsafe or sent via fax or internal mail to the to the CDHB C&FSS or SMHS FST.

See Appendix 13 – Guidelines for Documentation of Family Violence

See Appendix 15 – Clinical Guideline: Assessment and Management of Strangulation (The post strangulation documentation form can be used to assist the completion of the risk assessment)

To ensure the safety and confidentiality of the information, IPV disclosures are managed in the following way; Health and risk assessments are to be entered in eProsafe or a hard copy sent to the CDHB C&FSS or SMHS FST, they are not filed in the patient notes. The CDHB C&FSS or SMH FST will place an SCAN memo in the Patient information system and notify the patients GP practice as appropriate. This case may also be discussed at the appropriate Child and Family Safety Review Meeting or Interdisciplinary Team (IDT) meeting.

See Appendix 17 – eProsafe

This ensures that (a), the information is kept confidential (minimises the risk that the perpetrator of the abuse can access/see the information), (b) the right information is stored in the right file, and, (c) the information is available to clinical staff who provide care in the future. (The eProsafes file is part of the patient's clinical notes and can be released to the patient if they make an official information request.)

Safety and security

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

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

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

Staff resources

Training

Attendance at the Violence Intervention Program (VIP) core training day is mandatory for all clinical staff working with children and women. This includes staff who work within the MoH six designated services; Emergency, Maternity, Paediatrics, Mental Health, Alcohol and Drugs and Sexual Health.

The training includes:

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

Access to the VIP training can be obtained for General Health (all areas apart from Mental Health) by phoning **364 0905 ext.4** or for Mental Health staff by accessing the:

- **Intranet**
- **Learning and Development Administrator, ext.2922**
- **SMHS FST staff, ext.2752/2652**

Staff are also required to undertake in-service training as indicated and refresher training biennially.

Advanced training will be offered to designated staff.

Supervision and/or peer support

Clinical supervision and or peer support for staff is recognised as an important requirement to ensure the practice of routine enquiry for IPV remains safe for the individual and staff.

Clinical supervision and or peer support is mandatory for staff to whom a disclosure has been made and is available within the service/department, clinical champions or via the CDHB C&FSS or SMHS FST.

CDHB employees and family violence

The CDHB EAP is available to support employees experiencing or perpetrating family violence. Contracted professional staff provide confidential offsite services and employees are encouraged to self-refer to this programme. To access the service please call **EAP Services Ltd on 0800 327 669**.

MoH Family Violence Assessment and Intervention Guideline (2016)

This resource is available at: <http://www.health.govt.nz/publication/family-violence-assessment-and-intervention-guideline-child-abuse-and-intimate-partner-violence>

Other resources

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

Reference documents

Type	Document Title(s)
Organisational Policies	<ul style="list-style-type: none">• Child Abuse and Neglect Management Policy• Event Reporting Policy• Interpreter Service Policy• Elder Abuse and Neglect Policy
Legislation	<ul style="list-style-type: none">• Privacy Act (1993)• Crimes Act (1961)• Crimes Amendment Act (No. 3) 2011• Domestic Violence Act 1995• Vulnerable Children's Act 2014• Sentencing Act 2002 (protection orders can be made in criminal court)
Associated Documents	<ul style="list-style-type: none">• Fanslow JL, Kelly P, & Ministry of Health. 2016. <i>Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence</i>. Wellington: Ministry of Health• Ministry of Health He Korowai Oranga, the – Māori Health Strategy

For further information contact the VIP staff

APPENDIX 1 Terms and Definitions

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

Child	Unborn children and children aged 0–18 years old.
Child Protection	Activities carried out to ensure the safety of the child in cases where there is abuse or risk of abuse.
Child Abuse	The harming (whether physically, emotionally, or sexually), ill treatment, abuse, neglect or deprivation of any child/tamaiti, or young person.
Child Physical Abuse	Child physical abuse is any act or acts that may result in inflicted injury to a child or young person.
Child Sexual Abuse	Child sexual abuse is any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not.
Child Emotional/ Psychological Abuse	Child emotional/psychological abuse is any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person.
Child Neglect	Neglect is any act or omission that results in impaired physical functioning, injury, and/or development of a child or a young person. This includes physical and medical neglect, neglectful supervision, abandonment and refusal to assume parental responsibility.
Family Violence	Violence or abuse of any type, perpetrated by one family member against another family member. It includes but is not limited to child abuse, intimate partner violence, elder abuse, sibling abuse and parental abuse.
Physical Abuse	Includes acts of violence that may result in pain, injury, impairment or diseases, may include hitting, choking or in any way assaulting another person, and also under/over medication. There is usually visible evidence of physical abuse (bruising, fractures, burns, lacerations etc) though the difference between accidental injury and abuse can be slight and require expert investigation.
Psychological/Emotional Abuse	Includes any behaviour that causes anguish or fear. Intimidation, harassment, damage to property, threats of physical or sexual abuse, removal of decision-making powers (in relation to adults) and (in relation to a child) exposing the child to physical, psychological or sexual abuse of another person. Concerted attacks on an individual's self-esteem and social competence results in increased social isolation.
Sexual Abuse	Includes any forced, coerced or exploitive sexual behaviour or threats imposed on an individual, including sexual acts imposed on a person unable to give consent, or sexual activity when an adult with mental incapacity is unable to understand.

Intimate Partner Violence (also called Partner Abuse)	Physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners. Intimate partners include current spouses (including de facto spouses), current non-marital partners (including dating partners, heterosexual or same-sex), former marital partners and former non-marital partners.
Routine Enquiry	Routine enquiry, either written or verbal, by health care providers to individuals about personal history of IPV. Unlike indicator-based questioning, routine enquiry means routinely questioning all women aged 16 years and over about abuse. The enquiry is usually made within the social history.
Elder Abuse and Neglect	Elder abuse is the wilful or unintentional harm caused to an older person by another person with whom they have a relationship implying trust. Categories of abuse include financial or material abuse; psychological abuse; physical abuse; and sexual abuse.
Violence Intervention Program	The MoH VIP Violence Intervention Programme supports health sector family violence programmes throughout New Zealand.
Intergrated Safety Response Pilot	Police, Oranga Tamariki/CYF, Corrections, Health, specialist family violence NGOs and kaupapa Māori services work as a team to support victims. The ISR focuses on the joined-up support and services that families, including victims and perpetrators, receive following family violence reported to NZ Police and high risk prison releases. Cases deemed high risk are discussed further at a weekly intensive case management meeting. Additional agencies involved in planning for these cases are the Ministry of Justice, Accident Compensation Commission, Housing New Zealand, Ministry of Education, Work and Income.
Childrens Team	A Children's Team is not a new service but a new approach. It works with existing resources and provides the opportunity for practitioners and professionals in government agencies, iwi and non-government organisations to bring their services together into one personalised plan for each child and their family/whānau.
eProsafe	eProsafe is an electronic application that has been specifically designed to promote the health and wellbeing of children, adults, and their families who are experiencing abuse and neglect. It ensures that frontline staff, managing acute and at times severe situations of violence and abuse, can obtain information held by DHBs in a timely manner.
Local memo	A local memo can be viewed in DHB patient management systems, ie. Inpatient Management System (IPM) alert sign indicates to staff that local Family violence information is held in eProsafe. If the words SCAN notes are recorded this indicates to staff that local Child Protection or Family Violence information is held in eProsafe.

NB. the specialist mental health service computer system (SAP) does not show these alerts. eProsafé should be accessed for all assessments.

NCPAS

National Child Protection Alert System – A National Child protection alert will be considered for; any child up to 18 years of age where child abuse is suspected and/or confirmed and a referral is made to Oranga Tamariki – Ministry for Children (formerly Child Youth & Family (CYF)); A Gateway referral; a Medical Assessment request by Oranga Tamariki/CYF; or a pregnant woman where there are identified vulnerabilities.

This alert can be viewed on the National Medical Warning System and local DHB patient management systems, ie. IPM.

N.B. the specialist mental health service computer system (SAP) does not show these alerts. eProsafé should be accessed for all assessments.

APPENDIX 2 Māori and family violence

This section is drawn from the MoH Family Violence Assessment and Intervention Guideline¹. It was developed with leadership from the roopu, Te Korowai Atawhai. This appendix offers some background and context for family violence in relation to Māori, and identifies key principles and actions for effective identification and intervention. To strengthen the way health services respond to Māori individuals who are experiencing violence within their whānau, it is recommended that DHBs continue to implement He Korowai Oranga, the – Māori Health Strategy in their planning, governance, ethos, and staff development.

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

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

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

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

- Promoting family environments that are safe and nurturing for children
- Identifying abuse early
- Offering skilled and compassionate support
- Making timely referrals to specialist intervention services

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

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

Safety first

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

Equity of Health Care for Māori

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

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

Health organisations can champion, consider and apply these actions across their practice to facilitate responsive, appropriate and effective care for Māori. This can contribute to

improved patient care pathways for Māori patients, and effective identification and response processes to family violence.

Principles for action

Te Tiriti o Waitangi/Treaty of Waitangi principles of Partnership, Participation and Protection should underpin efforts to achieve equitable Māori Health outcomes.

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

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

Ways to put this into practice

- Know that spiritual wellbeing is of key importance within Māori models of health. For example, under the Whare Tapa Wha model, wairua, tinana (physical health), hinengaro (mental health), and whānau are all considered vital for health and wellbeing.
- Be aware that a person's wairua (soul or spirit) is likely to have been damaged as a result of emotional, physical and/or sexual abuse. Take care to treat victims of family 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. See www.health.govt.nz/publication/increasing-violence-intervention-programme-vip-programmes-responsiveness-Māori

APPENDIX 3 Pacific peoples and family violence

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

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

What family violence means in a Pacific context

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

Risk factors for family violence amongst Pacific people

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

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

Protective factors for Pacific families

- Reciprocity
- Respect
- Genealogy
- Observance of tapu relationships
- Language and belonging are concepts that are shared across the seven ethnic specific communities as elements that protect and strengthen family and individual wellbeing.

Transformation and restoration

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

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

Principles for action

1 **Victim safety and protection must be paramount**

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

Actions and behaviours to ensure victim safety and protection:

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

2 **The provision of a Pacific-friendly environment**

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

Actions and behaviours that contribute to Pacific people feeling comfortable:

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

3 **The provision of culturally safe and competent interactions**

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

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

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

4 **A collaborative community approach to family violence should be taken**

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

Actions and behaviours that contribute to a collaborative intersectoral approach:

- Recognise that for solutions to be meaningful to Pacific victims of FV, other sectors may need to be involved
- Take the time to know your local community and FV referral agencies. If possible, offer referral to Pacific advocates with expertise in FV

- Do not assume that the family or church should be involved in supporting the Pacific victim of FV – ask what plan of action they want (it may or may not include the family and the church).

APPENDIX 4 Recommended intimate partner violence routine enquiry for different clinical settings

The MoH Family Violence Assessment and Intervention Guideline (2016), offer a range of recommended routine enquiry guidelines for various services, which are repeated here. Each service and unit may develop a unit-level procedure, specifying where, when, how often and by whom routine enquiry will be undertaken. The following are guidelines only.

Health care settings

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

Males and females over 12 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
- Knowledge of a 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.
- 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 16 years and over, should be questioned about physical, sexual and/or psychological abuse over the last year. Males who present with signs and symptoms should be questioned.
- All young people, 12-15 years, should be questioned about IPV when they present with signs or symptoms indicative of abuse.

Maternity and sexual health

When should routine enquiry for IPV occur?

- prenatal and postpartum visits (minimum three opportunities)
- knowledge of a new intimate relationship
- at every routine gynaecological visit
- at family planning visits
- at sexually transmitted disease/sexual health visits clinics/visits
- at termination 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 IPV.

Paediatric settings

When should routine enquiry for IPV occur?

- As part of Well Child assessments
- As part of routine health history
- During visits for a new problem
- During any new patient consultation
- Knowledge of a new intimate relationship
- When family violence is suspected

What should individuals be questioned about?

- All mothers and caregivers 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(including Alcohol and Drug Services)

When should routine enquiry for IPV occur?

- As part of every initial assessment
- Knowledge of a new intimate relationship
- Quarterly, if receiving ongoing or periodic treatment

What should individuals be questioned about?

- At the first visit, all patients should be questioned about any IPV, physical, sexual, and psychological abuse that occurred anytime in their lifetime.
- Quarterly all patients should be questioned about physical, sexual and/or psychological abuse over the past year.

Inpatient settings

When should routine enquiry for abuse occur?

- As part of admission to hospital
- As part of discharge from hospital

What should patients be questioned about?

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

APPENDIX 5 Signs and symptoms associated with intimate partner violence (IPV)

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

Physical injuries

- Injuries to the head, face, neck, chest, breast, abdomen or genitals
- Bilateral distribution of injuries, or injuries to multiple sites
- Contusions, lacerations, abrasions, ecchymosis, stab wounds, burns, human bites, fractures (particularly of the nose and orbits) and spiral wrist fractures
- Complaints of acute or chronic pain, without evidence of tissue injury
- Sexual assault (including unwanted sexual contact by a partner)
- Injuries or vaginal bleeding during pregnancy, spontaneous or threatened miscarriage, low birth weight babies
- Multiple injuries, such as bruises, burns, scars, in different stages of healing
- Substantial delay between time of injury and presentation for treatment
- Tufts of hair pulled out
- Strangulation/choking

Patient's manner

- Hesitant or evasive when describing injuries
- Distress disproportionate to injuries (eg. extreme distress over minor injury, or apparent lack of concern about a serious injury)
- Explanation does not account for injury (eg. 'I walked into a door')
- Different explanation for same injury at different presentations

Illnesses

- Headaches, migraines
- Musculoskeletal complaints
- Gynaecological problems
- Sexually transmitted infections.
- Chronic pain/undiagnosed causes for pain
- Malaise, fatigue
- Depression
- Insomnia
- Anxiety
- Chest pain, palpitations
- Gastrointestinal disorders
- Hyperventilation
- Eating disorders

Serious psychosocial problems

- Alcohol abuse or addiction
- Severe depression
- Drug abuse or addiction
- Suicidal ideation or attempts
- Continued alcohol, tobacco or substance abuse during pregnancy
- Inappropriate attempts to lose weight, development of eating disorder during pregnancy

History

- Record or concerns about previous abuse (eg. injuries inconsistent with explanation)
- Substantial delay between time of injury and presentation for treatment
- Multiple presentations for unrelated injuries

Source: Injury Prevention Research Centre 1996

APPENDIX 6 Guidelines for identifying victims of abuse (Step 1)

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

A IPV Health and Risk assessment Intimate Partner Violence (IPV) – Family Violence (FV) Assessment and Intervention form is to be completed when IPV is disclosed or when a health professional suspects abuse has occurred.

Only routinely enquire about IPV if the Women is alone or has a pre-verbal infant with her.

Do not routinely enquire if – urgent clinical treatment is required; individual is under the influence of drugs or alcohol; Cognitive disability or mentally unwell; High level of emotional trauma; Established labour

Note: the safety of both the health professional and the women is a primary consideration.

If routine enquiry is unable to occur, arrangements should be made to complete this at a later time and place if possible.

Asking adults about possible abuse

Framing statements

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

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

‘I notice...I’m worried...’ statements, eg. ‘I notice you look sad/have a bruise. I’m worried someone might be hurting you/has caused this.’

Recommended intimate partner violence routine questions

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

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

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

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

Practice note: while the purpose of these questions is to ascertain experience of ‘violence’ or ‘abuse’, people experiencing the violent behaviour seldom apply these terms to what is happening to them.

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

Confidentiality

In many health care settings, confidentiality may have been explained or be understood already, as part of the provider–patient relationship (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 individual and health care provider, and is inconsistent with screening practices for other health issues, where confidentiality of the information disclosed is not explicitly stated at the outset.

If information disclosed by the person during routine enquiry, history taking and careful assessment indicates that there is sufficient risk to warrant further action, there is scope to point out the limits of confidentiality of information during the course of the consultation (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').

APPENDIX 7 Guidelines for validating and supporting victims of abuse (Step 2)

The 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 – good listening with supportive, minimal encouragers allows the person space to say all they need.

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

Acknowledge – you are glad the person told you:

- ‘Thank you for telling me.’
- ‘Family violence is never OK.’
- ‘You are not alone – others experience abuse in their homes.’
- ‘You are not to blame for the abuse.’
- ‘You have the right to live free of fear and abuse.’

Inform – let them know that their experiences of violence may be relevant to their health, that help is available, and that you will support them and help them to consider their options.

- ‘Family violence happens in all kinds of relationships.’
- ‘This sort of behaviour (abuse) can affect your health in many ways.’
- ‘Without getting help, this behaviour (violence) can keep happening, and it can get more frequent, and more serious.’
- ‘You are not to blame, but exposure to violence in the family can emotionally and physically hurt your children or others in the family who are dependent on you.’

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

Signs and symptoms indicative of IPV, no disclosure (see Appendix 5)

If IPV 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.

Complete the Intimate Partner Violence (IPV) – Family Violence (FV) Assessment and Intervention Documentation form and send to the CDHB C&FSS or SMHS FST team and/or create an eProsafe referral.

Responding to people who say 'no, that never happened to me'

'I'm glad, that's good to hear. But if anything changes, please know that we are here to offer help and support if you need it.'

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.' If you suspect **that IPV has occurred** complete the Intimate Partner Violence (IPV) – Family Violence (FV) Assessment and Intervention Documentation form and send to the CDHB C&FSS or SMHS FST team and/or create an eProsafe referral.

Early intervention (health promotion approach)

There may be circumstances where intimate partner violence is not occurring, but where there still may be opportunities for early intervention. For example, cases where there are high-risk indicators such as alcohol or drug abuse 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.

APPENDIX 8 Guidelines for health and risk assessment (Step 3)

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

Thorough risk assessment needs to be conducted prior to the development of appropriate intervention plans. Health care providers must complete the Intimate Partner Violence (IPV) – Family Violence (FV) Assessment and Intervention Documentation form and send to the CDHB C&FSS or SMHS FST team and/or create an eProsafe referral (pg.29) to identify appropriate referral options.

Note that this is different from the role of conducting investigations to determine who is responsible for perpetrating the abuse and/or neglect, which is the role of the Police.

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

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

Health and risk assessment

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

Introducing the health and risk assessment

a) Health and risk assessment questions

1. Is your partner here now?
2. Are you afraid to go/stay home?
3. Has the physical violence increased in frequency or severity over the past year?
4. Has your partner ever choked you (one or more times?)
5. Have you ever been knocked out by your partner?
6. *(if applicable)* Have you ever been beaten by your partner while pregnant?
7. Has your partner ever used a weapon against you, or 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?

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

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

Sexual and reproductive health assessment

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

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

Cases of sexual abuse, or suspected sexual abuse, should always be discussed with a doctor specifically trained in this field. Always refer to Cambridge Clinic for adults, children aged 13 years and above. Refer to the Child and Family Safety Service (during working hours) and the Paediatrician on call (after hours) for children 12 years and younger, before you decide whether or not to examine the child.

Mental health assessment

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

Risk of suicide or self-harm

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

- Suicidal thoughts
- Previous suicide attempts
- Stated intent to die/attempt to kill oneself
- A well-developed 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/killing 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.

Crisis resolution contact details

In Canterbury, Crisis Resolution assess and manage all psychiatric emergencies in the adult population both inpatient and outpatient.

To obtain a response from Crisis Resolution:

- Within working hours (0800–1630 hours), excluding weekends and public holidays, phone:

East Adult Community CR team	ext.34335	027 532 7106
South Adult Community CR team	ext.34011	027 532 7105
North Adult Community CR team	ext.34393	027 532 7104
West Adult Community CR team	ext.34347	027 532 7108
- Out of hours (0700–0800 hours; 1630–2300 hours); weekends and public holidays (0700–2300 hours) contact the Hillmorton Hospital Operator and ask for crisis resolution duty person
Pager no. 8128
- Overnight (2300hrs – 0700hrs): contact Christchurch Hospital Operator and ask for the mental health duty person
Pager no. 7060

Physical health assessment

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

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

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

If IPV exists, and action is needed to protect the children, follow the procedures outlined in the Child Abuse and Neglect Management Policy

Remember, if possible, any concerns about the safety of the children should be discussed with the abused person. If you have any doubts about discussing concerns about child abuse and/or neglect with the IPV victim, you should consult with CDHB C&FSS, SMHS FST or a senior colleagues within your practice setting.

Do not discuss concerns or child protective actions to be taken with the IPV victim 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 Oranga Tamariki – Ministry for Children/CYF about the presence of IPV as well as child abuse.

- Ask the abused person/partner how they think the abuser will respond.
- Ask if a child protection 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 person/partner who they would like to inform the abuser about the Report of Concern to Oranga Tamariki/CYF. For example, would they like the health care provider to do it? Does the abused person/partner want to be present when the abuser is told? Do they want to do it?

Canterbury
District Health Board
Te Poari Hauora o Waitaha

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(or affix patient label)	

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

Risk assessment	<input type="checkbox"/> Declined Please state reason:
IPV routine enquiry	<input type="checkbox"/> IPV+ (positive) Date: / /
Assess pregnancy risk	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No EDD: LMC: Have you ever been beaten by your partner while pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked
Assess risk to children	Have the children seen or heard the violence? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked Has anyone physically abused the children? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate which apply: <input type="checkbox"/> Trespass Notice <input type="checkbox"/> Protection Order <input type="checkbox"/> Bail conditions <input type="checkbox"/> Police Safety Order <input type="checkbox"/> Recent family violence charges <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 2. Are you afraid to go/stay home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 4. Has your partner ever choked you? (one or more times) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked A 'yes' answer to question 4, requires intervention as per the Clinical Guideline: Assessment and Management of Strangulation 5. Have you ever been knocked out by your partner? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 6. Has your partner ever used a weapon against you, or threatened you with a weapon? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 7. Do you believe your partner is capable of killing you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 8. Is your partner constantly jealous of you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 9. If yes – has the jealousy resulted in violence? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 10. Have you recently left your partner, or are you considering leaving? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 11. Has your partner ever threatened to commit suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 12. Have you ever considered hurting yourself/suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 13. Is alcohol or substance misuse a problem for you or your partner? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked 14. Do you or your partner have a mental health condition(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> 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?

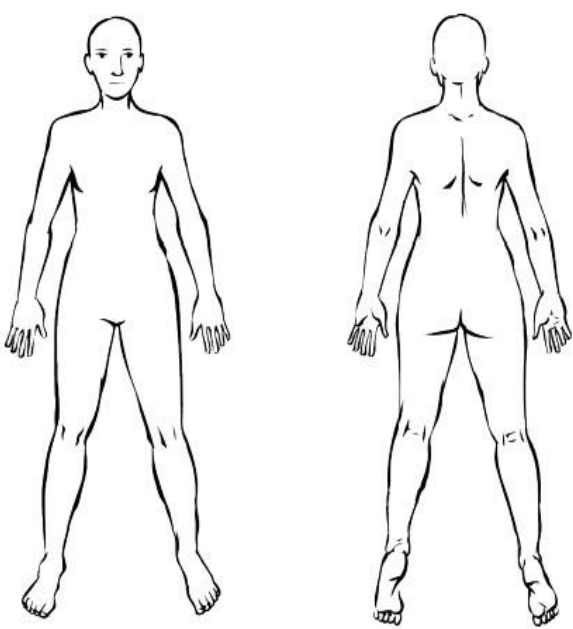
COPY OF THE CLINICAL NOTES MUST BE ATTACHED TO THE ePROSAFE REFERRAL

Ref.239449

Approved by: Chief Medical Officer and Executive Director of Nursing

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July 2018

SURNAME NHI FIRST NAME DOB ADDRESS POSTCODE (or affix patient label)	IPV FV Assessment and Intervention
Referrals	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> Referral(s) declined <input type="checkbox"/> Internal referral <input type="checkbox"/> Police – with consent <input type="checkbox"/> Social Work <input type="checkbox"/> Cultural Support Services(Please specify) <input type="checkbox"/> Mental Health Service <input type="checkbox"/> Sexual Health Service/Sexual Assault Assessment and Treatment Service <input type="checkbox"/> Specialist Family Violence Agencies <input type="checkbox"/> Provision of Family Violence Community Agency card/referral information <input type="checkbox"/> 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 (please specify): </div> <div style="width: 50%;"> <input type="checkbox"/> No referral or report made <input type="checkbox"/> External referral <input type="checkbox"/> Police – without consent <input type="checkbox"/> Oranga Tamariki – Ministry for Children/CYF <input type="checkbox"/> Report of Concern completed and sent <input type="checkbox"/> Children's Team (if DHB has one) </div> </div>
Body map	<p>Measure, describe (incl. type, colour, texture, size) and mark location of each apparent injury (incl. bruising, scratches, abrasions, lacerations, areas of pain and tenderness)</p> <div style="text-align: center;">  </div> <p>Note: Document history on clinical notes and attach to eProsafe. Include: - verbatim quotes - observations - patient's demeanour - description of injuries - mechanism of injury, eg. punched with a closed fist - weapon used, eg. knife, gun, baseball bat</p>
	<div style="display: flex; justify-content: space-between;"> <div>Police/clinical photography offered:</div> <div> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Accepted <input type="checkbox"/> Declined </div> </div> <div style="display: flex; justify-content: space-between;"> <div>Photographs taken:</div> <div> <input type="checkbox"/> Yes <input type="checkbox"/> No </div> </div>
Safety plan (Record in clinical notes and attach to eProsafe)	<p>(Including discharge arrangements)</p> <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> Safety plan discussed <input type="checkbox"/> Safety plan actioned </div>
Name: Date: / /	
Designation: Signature:	
A COPY OF THIS REFERRAL FORM AND A COPY OF THE CLINICAL NOTES MUST BE SENT TO THE CHILD AND FAMILY SAFETY SERVICE OR SMHS FST OR COMPLETED ON OR ATTACHED TO AN ePROSAFE REFERRAL	

APPENDIX 9 Guidelines for safety planning (Step 4) ISR inclusion

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

Safety planning needs to be done in consultation with the person who has experienced the violence, because they know the situation they are in better than anyone else, and they are likely to have the clearest awareness of actions that might create further risk for them and their children. Respectful and considerate engagement with the person related to the development of their safety plans is also important, because IPV is often characterised by high levels of controlling behaviour on the part of the perpetrator, and health care providers need to be aware of, and not replicate this pattern of behaviour.

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

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

Remember, safe practice involves consulting with the person, CDHB C&FSS/SMHS FST, senior colleagues and/or community agency advocates, to determine safety options for the future.

A multidisciplinary team approach is the preferred option.

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

Imminent threat/extremely high-risk situations

In situations of imminent threat, or extremely high risk (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 (eg, the Police or on-site security)?**

Actions to take

Securing immediate safety for the person may include calling on-site security (call 777) or the Police (call 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.

High risk

Indicators of high risk

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

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

Other factors to consider

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

Actions to take (high risk)

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

Any decision about reporting a suspected episode of abuse to the Police /ISR 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 high risk situation, then you can discuss the need for additional support with the person, 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).

When the health care provider believes a person's life is in immediate danger, or has good reason to believe that the person is unable to extricate themselves from an ongoing, life-threatening situation, or the situation is high risk the Police/ISR 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. Where it is possible make sure

that you inform the person after the Police have been notified. In cases where it is standard procedure to notify the Police, this should be explained to the person.

See Appendix 11 – Guideline for Notification of Police for Family Violence

Health care provider options include:

- Express your concern for the person's safety (and that of their children, if relevant).
- If possible and applicable initiate an internal multidisciplinary response or refer to ISR.
- Depending on the person's health needs, and the resources available, consider arranging inpatient care, which can allow the person both temporary respite and further opportunity to connect with in-house support services (eg. social workers) or external support agencies (eg. refuge). If inpatient care cannot be arranged, help the person access emergency shelter/refuge.
- Active referral to a community agency that specialises in responding to family violence is required.
- Encourage the person to seek help from family or friends (or other safe housing).
- If they insist on going home, make sure they have information on safe exit planning if they need to leave a violent situation in a hurry. A detailed safety plan designed as a handout for victims of IPV is presented in Appendix 10.
- Make sure the person has information about, and contact details for, other legal and support options that may assist them.

Further information is available regarding interagency information sharing from the Privacy Commission website, follow the following links to the Sharing personal information of families and vulnerable children: A guide for inter-disciplinary groups

(www.privacy.org.nz/assets/InteractiveEscalationLadder/Escalation-Ladder-FINAL-HiRes.pdf) and the Escalation ladder regarding 'Sharing information about vulnerable children' (www.privacy.org.nz/how-to-comply/sharing-information-about-vulnerable-children).

Moderate risk

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

- Let them know that you are concerned about their safety, and that without help violence can increase in frequency and severity.
- Talk to them about what help and support they might get from family and friends.
- Let them know about options for help and support from the community (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.
- 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.
- Ask about any current services/agencies providing support and with the patient's consent update them about the current events.

For all abused individuals

- Educate the person about the likely increase in frequency and severity of abuse, without outside help.
- Support the person, irrespective of their choices. Understand that it is important for each person to make their own choices.
- Let the person know that they can come to you for help with violence, if they need to in the future.
- Help the person work through options for increasing safety. These can include:
 - Actions that s/he can take (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).
 - Help from police (eg. police safety orders), courts (eg. protection orders), and other government agencies (eg. Work and Income and Housing New Zealand).
 - Help from you, and or from others in the health or social services.

Historic abuse

In some cases, individuals may tell you about violence that they have experienced in the past (not within the previous year) 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 historic 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 feel safe when this contact occurs? 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.

APPENDIX 10 Safety plan – resource

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

1. Avoiding injury, escaping violence

During an episode of violence at home you will want to do everything you can to avoid serious injury. Think ahead and plan. Make allowance for those living in rural settings where neighbours are not close, cell phone coverage is patchy or support services can be limited.

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 essentials for school needs, favourite toy or comforter
- a photograph of your partner/abuser 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/abuser 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/abuser breaches the protection order, phone the Police and report it, contact your lawyer and your advocate.

If the Police do not help, contact your advocate or lawyer for assistance to make a complaint.

Keep a record of any breaches, noting the time, date and what occurred and what action you took.

Security

Consider installing outside lighting that lights up when a person comes near your house at night.

If possible, use different shops and banks to those you used when you lived with your ex-partner.

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

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

Contact the Electoral Enrolment Centre on 0800 367656 or contact online and ask for your name and address to be excluded from the published electoral roll.

Tell neighbours that your partner does not live with you, and ask them to call the Police if s/he is seen near your house.

From: Auckland Domestic Violence Centre. Safety Plan.

APPENDIX 11 Guideline for notification to police for family violence

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

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

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

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

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

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

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

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

- b) Injuries that may be life-threatening
- 6. If there is uncertainty amongst the team about the actions required the case can be referred to a Child and Family Safety Review Meeting. If the matter is high risk and urgent action is required a referral to Social Work on call should be made if this is available to your service/department. Consultation with the CDHB C&FSS and SMHS FST during working hours Monday–Friday 8:30am to 5:00pm is available to all CDHB staff. If you are not able to access either of these services a decision should be made with the senior clinician/management of your service.

Actions

1. Notification to Police due to an individual's safety

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

- a) Advise the person of the need to notify the police and that an ongoing safety plan will be discussed
- b) Inform Security and Acting Charge Nurse Manager (if after-hours) of the concerns regarding safety. Acting Charge Nurse Manager to inform Duty Manager when safety issues are a concern to the department/hospital.
- c) Ring the Police (111) and advise them of the current situation with information disclosed
- d) On the arrival of the Police to the department, the Police need to provide an official information request form.
- e) Once this form is completed, staff can provide the appropriate and relevant information without concerns regarding breach of privacy. Information shared should be related to the referral to the Police and should include:
 - i. The disclosure of abuse, including all relevant history and verbatim statements
 - ii. The injuries sustained pertinent to their inquiries
- f) Staff should facilitate the introduction of the Police to the individual and ensure privacy for their ongoing discussions.

2. Notification to Police for staff safety reasons

- a) Advise the individual (abused person) of the need to notify the police and that an ongoing safety plan will be discussed
- b) Inform security and Acting Charge Nurse Manager (if after-hours) of the concerns regarding safety within department. Acting Charge Nurse Manager to inform Duty Manager when safety issues are a concern to the department/hospital.
- c) Ring the Police and advise them of the current situation within the department and concerns regarding safety based on assessment and information disclosed as appropriate.
- d) On the arrival of the Police to the department, provide them with a summary of the issues of safety, as they are known. There is no breach of privacy in the provision of information to the Police if wider safety concerns are identified based on general observations.
- e) If the report/information provided to the Police includes information disclosed by a person then the Police need to provide an official information request form.
- f) Once this form is completed, staff can provide the appropriate and relevant information without concerns regarding breach of privacy. Information shared should be related to the referral to the Police and can include:
 - i. The disclosure of abuse
 - ii. The injuries sustained as pertinent to their inquiries

- g) Facilitate the introduction of the Police to the abused person and ensure privacy for their ongoing discussions.

APPENDIX 12 Guideline for referral and follow-up

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

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

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

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

Appropriate follow-up also needs to be undertaken. IPV is a health issue that merits appropriate follow-up in its own right. Additionally, the presence/history of IPV may affect the way in which follow-up is delivered when responding to other health issues. If IPV is currently an issue, safety procedures for re-contacting the person, as well as implications for the person's ability to adhere to treatment regimes 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, ISR or IPV advocate should be offered after disclosure. (Check if there are already agencies/services involved.)

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

Imminent danger/high risk

a) Referral

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

See Appendix 16 – Strangulation discharge information: discharge advice to patients and their families and friends.

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).

Moderate risk, or persons with ongoing safety concerns

a) Referral

- If possible in your area, make contact during the consultation with a refuge or other 24-hour family violence service.
- Suggest the person consider obtaining a protection order through the Family Court. Refuge and other family violence prevention advocates can provide assistance with obtaining such orders.
- Identify an ongoing support system (for example, family, friends who may help).
- Ensure that the person has a list of contact numbers for specialist family violence agencies, and a means of contacting them.
- Provide abused person with information that will help them plan for safely leaving an abusive situation.
- Ensure the person is aware of the legal support available to them, and how to access it.
- If the person feels that it is safe, give them a copy of the safety plan in Appendix 11. If they don't want to take a copy, talk through the contents of the plan.

b) Follow-up

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

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

Sharing of information between clinicians

Developing and implementing safe and appropriate systems for sharing information about IPV between clinicians (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).
- Individuals need to have a role in determining who information should be shared with. They can best be supported to make these decisions if the health care provider explains to them why the information should be shared and how this might take place.

Examples

'Is it OK if we let your GP, Dr X, know that you have been to see us and what we talked about in relation to your partner's behaviour? That way, your GP will be informed about what is going on for you, and can help you with your health needs better (help you plan for your safety).'

'It would be helpful for your midwife to know what you have been going through so she can help support you. I can write her a separate note with the referral.'

After disclosure of current or past IPV

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

‘If you like, we can set up a follow-up appointment (or referral) to discuss this further.’

‘Is there a number or address where it is safe to contact you?’

‘Are there days/hours when we can reach you alone?’

‘Is it safe for us to make an appointment reminder call?’

Responding to abused persons at follow-up

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

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

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

‘I am concerned about you, and your health and safety.’
- Repeat the routine enquiry questions.
- Provide intervention again, complete the IPV health and risk assessment Intimate Partner Violence (IPV) – Family Violence (FV) Assessment and Intervention form.
- Review the person’s options for increasing safety (individual safety planning, talking with friends or family, seeking support from advocacy services and support groups, legal options, transitional/temporary housing, seeking support from Work and Income, etc.).

For current and previous victims of IPV

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

Co-occurrence of child abuse and IPV

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

Remember: when the IPV risk assessment identifies child protection concerns, consultation and a referral (eProsfe) should occur with the Child and Family Safety Service or Specialist Mental Health Service Family Safety Team with all cases. It is also important in all situations to review the eProsafe information and consult with the Oranga Tamariki/CYF Liaison Practice Leader to review whether there are concerning patterns.

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

Note that:

- a) All adults who disclose IPV should be offered referral to specialist family violence support services.
- b) Receiving a positive response to IPV routine enquiry does not necessarily require a referral to Oranga Tamariki/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 seeing and hearing 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 person and a worker at the family support service. This intervention allows for the adult to take responsibility for engaging with the family support service.

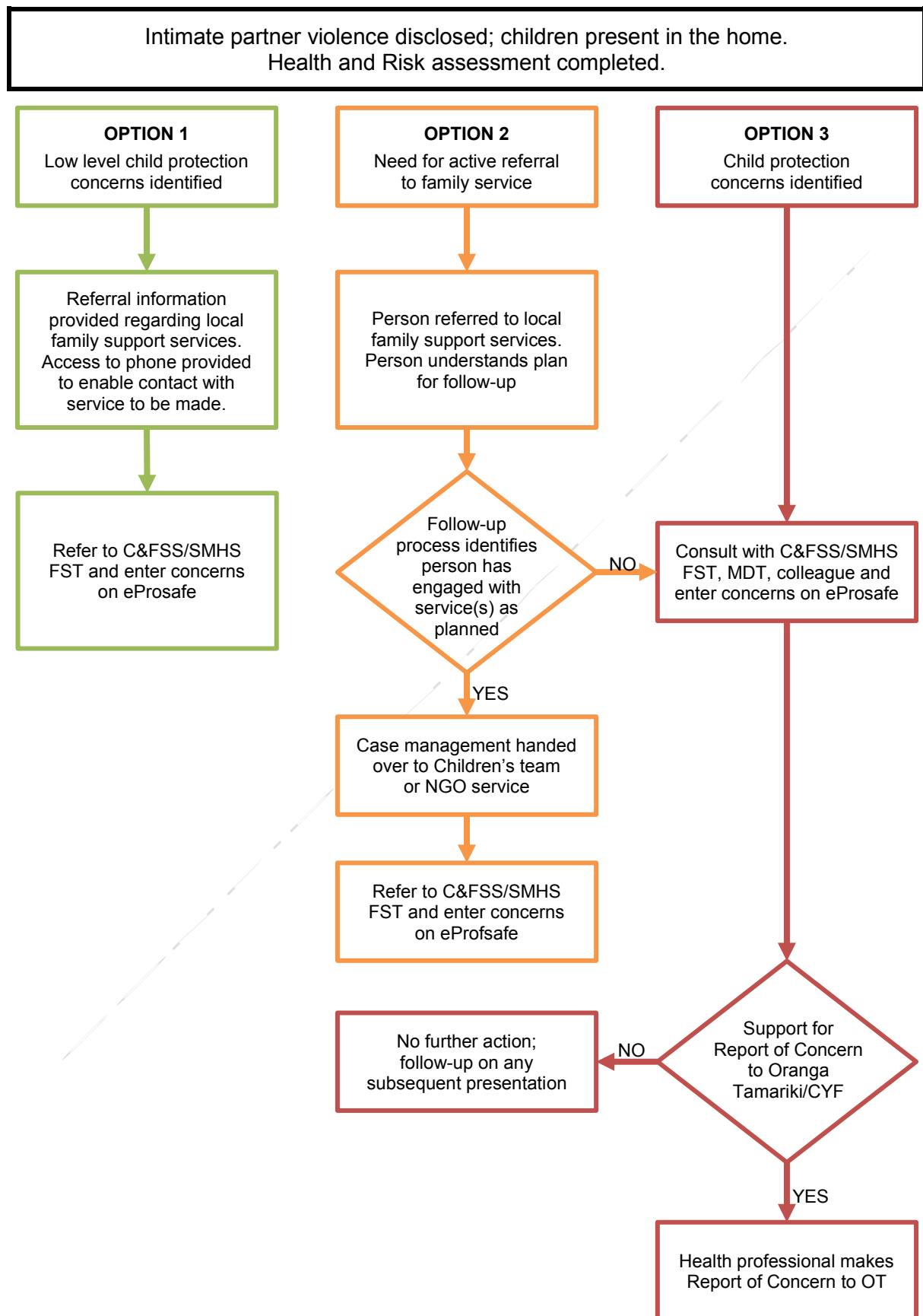
The health professional needs to note the agreed meeting time, and subsequently contact the family support service to confirm that the appointment was attended. In the follow-up process, if it is identified that the person did not engage with services (and no alternative appointment has been made or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

Remember: when the IPV risk assessment identifies child protection concerns, consultation and a referral (eProsfe) should occur with a Child and Family Safety Service or Specialist Mental Health Service Family Safety Team with all cases. It is also important in all situation to review the eProsafe information/consult with the Oranga Tamariki/CYF Liaison Practice Leader to review whether there are concerning patterns.

3. Statutory intervention

Based on the information disclosed to health care providers and/or CDHB C&FSS/SMHS FST, 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 Oranga Tamariki/CYF is required.

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



APPENDIX 13 Guidelines for documentation of intimate partner violence (Step 6)

6.1 Documentation steps

Record the disclosure on the Intimate Partner Violence (IPV) – Family Violence (FV) Assessment and Intervention form (available on Intranet under Forms and Templates, also attached to policy on Intranet).

- 6.1.1 Note the stated or suspected cause of the injuries and when they allegedly occurred. “**Assaulted** by partner” is not sufficient. A vague history is readily challenged in court and therefore would not help keep a victim safe. Be specific, eg. “Miss X alleges she was hit with a closed fist/kicked by John Smith”. Document where, when, how.
- 6.1.2 Record history obtained. Specify aspects you saw and heard, and which were reported or suspected. Use the individual’s words as much as possible. Use quotation marks for specific disclosures where appropriate, eg. “John punched me”.
If the risk assessment identifies a history of choking/strangulation record findings on the Post Strangulation Documentation form.
- 6.1.3 State the identified perpetrator’s name and relationship to the person
- 6.1.4 Mark site(s) of old and new injuries on the body injury map
- 6.1.5 Describe estimated age of injuries, coloration and measure size (bruises can not be aged)
- 6.1.6 For suspected cases of abuse, record your opinion as to whether the injury is consistent or inconsistent with the person’s explanation
- 6.1.7 Note the action taken by the clinician, referral information offered and follow-up arranged
- 6.1.8 Include the date, time, a legible signature and designation
- 6.1.9 Indicate in notes discreetly that IPV has been disclosed. For example, ticking the coded box in the notes
- 6.1.10 Enter information in eProsafe or attach the Intimate Partner Violence (IPV) – Family Violence (FV) Assessment and Intervention form to the attachment section of eProsafe or send to CDHB C&FSS or SMHS FST.

6.2 Collection of Physical Evidence

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

- 6.2.1 Place torn or blood-stained clothing and/or weapons in a sealed envelope or bag (these can be provided by the Police).
- 6.2.2 Mark the envelope with the date and time, the person’s name, and the name of the person who collected the items. Sign across the seal.
- 6.2.3 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

6.3 Photographs

Photographs of injuries should be routinely offered. The use of photographs to document injuries may be appropriate in some circumstances. To ensure the photographs are appropriate, accurate and admissible as evidence in legal proceedings CDHB Medical Illustrations or the Police should be contacted.

APPENDIX 14 Safety and security guidelines

This guideline sets out the CDHB procedure for staff when there is a need to access support to optimise the safety for victims of family violence when the risk to the victim's safety is assessed to be a high risk.

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

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

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

- 1.1 The victim of abuse identifies that s/he is concerned that the perpetrator may trace them to the hospital.
- 1.2 The staff discuss with the victim the potential to place name suppression on the patient's details. The victim consents to this name suppression being actioned.
- 1.3 The Shift Co-ordinator/Team Leader /Acting Charge Nurse Manager is informed and s/he directs the Unit Receptionist to place the "No details to be released" flag against the patient details on the patient inquiry screen. Only the Shift Co-ordinator/Team Leader/Acting Charge Nurse Manager may direct this action.
- 1.4 The patient's name is replaced with a pseudonym on all patient details boards in the department/ward.
- 1.5 The following staff are informed of this name suppression being actioned:
 - 1.5.1 Duty Manager
 - 1.5.2 Switchboard staff
 - 1.5.3 Security and Orderlies
 - 1.5.4 All relevant staff within the department including social work. This information transfers if the patient is admitted to a ward, or changing hospitals.
- 1.6 This directive against the patient details is valid for the duration of the patient's hospital visit or until appropriate personnel remove the directive.
- 1.7 **Complete the name suppression documentation form (available on Intranet under forms and templates or attached to this policy on Intranet).**
- 1.8 The Shift Co-ordinator/Team Leader/Acting Charge Nurse Manager responsible for the patient's care will remove the name suppression at discharge or when the patient requests this.
- 1.9 The Team Leader /Acting Charge Nurse Manager/Duty Nurse Manager is responsible for informing the police as required

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

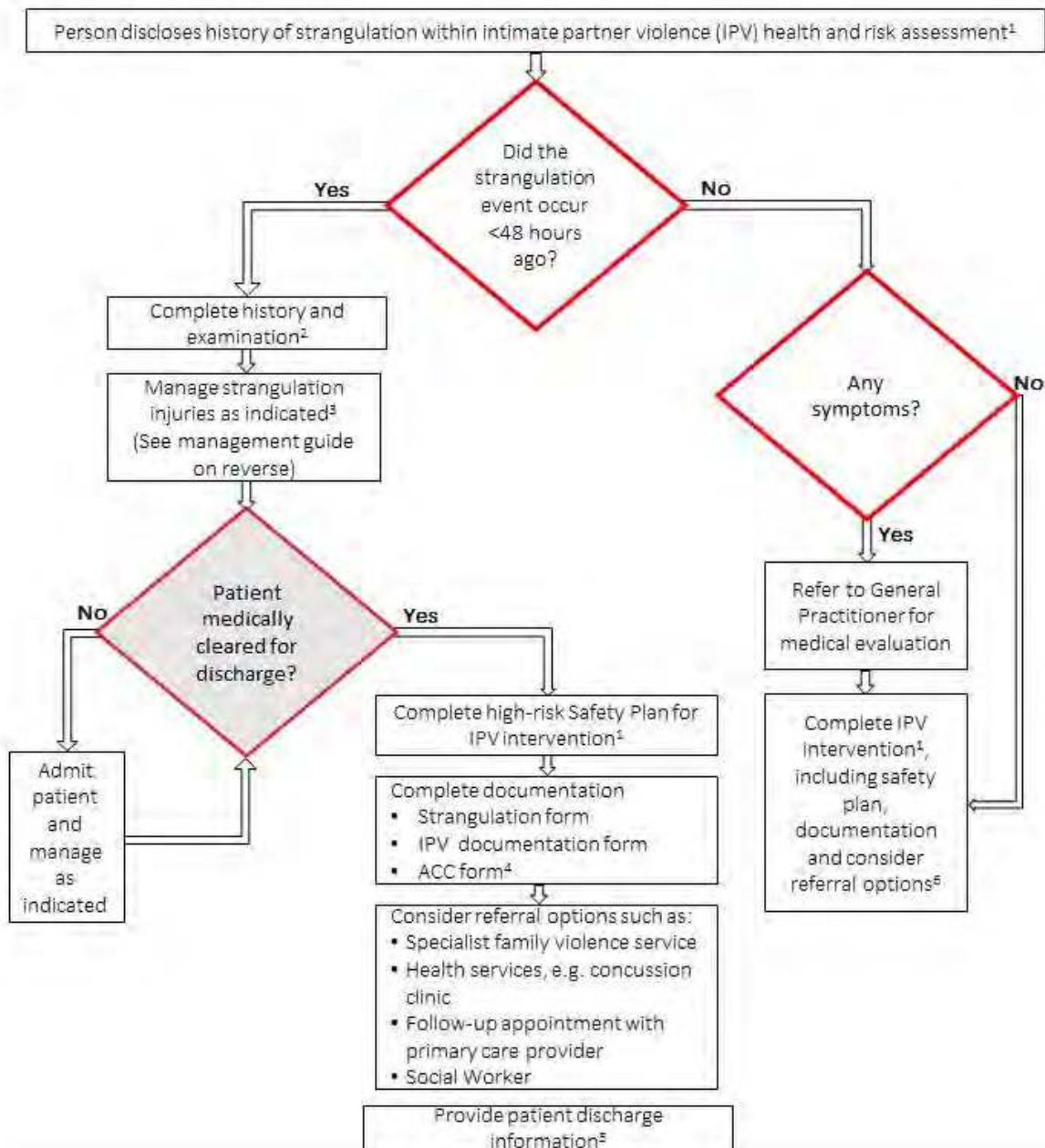
When any staff member (including switchboard, clinical staff and volunteers) receives an enquiry about a patient for whom a "No details to be released" flag is active s/he will:

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

- 2.2 Ask for the caller's name and write this down (if provided)
- 2.3 Notify the Acting Charge Nurse Manager/Shift Co-ordinator/Team Leader responsible for the patient's care
- 2.4 Notify security (eg. if the caller is the suspected perpetrator of an assault and police charges are likely).
3. **Process used to discharge a victim of abuse in a safe manner from a department or ward setting when there are high-risk safety issues**
 - 3.1 Arrange the discharge plan in consultation with the patient and the discharge agency concerned, eg. ensure the victim speaks to the agency, ie. Womens Refuge, Age Concern concerned and that all parties are in agreement with the discharge plan.
 - 3.2 Complete the name suppression process as above if appropriate
 - 3.3 Ensure that the following people are informed of the discharge plan process this may include:
 - Appropriate clinical staff, Social Work, Clinical Nurse Manager, Duty Manager, CDHB C&FSS or SMHS FST
 - Security +/- the Police (if risk is considered high by department staff and security)
 - 3.4. The discharge plan may include leaving the ED/ward or other department by a safe route, in consultation with security staff.
 - 3.5 Document the discharge plan on eProsafe and the Intimate Partner Violence (IPV) – Family Violence (FV) Assessment and Intervention Form (available on the Intranet under Forms and Templates, also attached to policy on Intranet).
 - 3.6 Advise the Duty Manager of the discharge outcome.

NB: Complete an Incident Form if any unexpected outcomes occurred

APPENDIX 15 Clinical guideline: assessment and management of strangulation



Notes

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

Strangulation (choking) management

Management of strangulation depends upon the mechanism of injury, clinical picture of the patient and time since the strangulation event. The Post-Strangulation Documentation Form guides clinicians through the processes of care.

The Acute Post-Strangulation Document form (Ref.239448) can be found on the Child Protection Forms page in the [Tiaki Whanau team site](#) and in [eProsafe](#).

Be aware that many victims of strangulation have minimal symptoms and signs following the event.

- If patient is alert, orientated, no loss of consciousness, no signs of compromised airways +/- superficial injuries to neck:
 - ensure home support
 - provide post-strangulation information sheet to patients
 - consider referral to primary care for re-evaluation of signs and symptoms that may emerge within 48 hours of the event.
- History of loss of consciousness more than a few hours ago, but is currently clinically stable – assess and treat as for any other head injury:
 - ensure home support
 - provide post-strangulation information sheet to patient
 - consider referral to primary care for re-evaluation of signs and symptoms that may emerge within subsequent days.
- Significant neck pain, dysphagia or dysarthria – discuss/manage with emergency department support.
- Reduced level of consciousness, confusion or compromised airway – usual emergency care provided and refer to the Emergency Department for urgent assessment/management.

APPENDIX 16 Strangulation discharge information: discharge advice to patients and their families and friends

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

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

Serious problems

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

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

Milder problems

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

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

What you can do to help yourself

Medication and drugs:

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

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

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

Driving – DO NOT drive for at least 24 hours.

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

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

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 17 eProsafe

Introduction

eProsafe is an electronic application that has been specifically designed to promote the health and wellbeing of children, adults, and their families who are experiencing abuse and neglect. It is a purpose built (web) application intended to address and overcome the fractured information technology systems both within the District Health Boards (DHBs) and across DHBs. It ensures that frontline staff, managing acute and at times severe situations of violence and abuse, can obtain information held by DHBs in a timely manner. This enables staff to address safety concerns for children, families and staff appropriately. It also allows those DHB staff employed specifically to provide advice and oversight of these complex cases the ability to track the work undertaken, assess risk more accurately and ensure appropriate measures are implemented.

eProsafe is a standalone web-based application for family violence that:

- Allows DHB staff to create and manage referrals.
- Allows VIP DHB staff to share cases across local DHB users.
- Allows us to view referrals from other DHBs.
- Provides numeric statistic reports.
- Generates sophisticated surveillance audit log reports.
- Produces announcements to local or other DHB users.
- Is placed within a connected health network.
- Can be accessed via Health Connect South the DHB Intranet and SAP.

eProsafe enhances practice by

- Collating child protection and family violence information in one place which enhances risk assessment and intervention plans.
- Cross referencing family information to allow health staff to see the whole picture in relation to what has occurred in the context of the family environment.
- Providing staff with the ability to track cases through the use of a reminder system. This means that health staff are prompted electronically to ensure follow up tasks occur.
- Assisting with ensuring that patients receive a more holistic assessment and interventions which are designed to address medical and psycho - social needs.
- Improving communication between health professionals.
- Improving record keeping and accuracy with child protection and family violence information.
- Ensuring accurate statistical information that is readily available and assists with the identification of trends and patterns which allows the DHB to shape future development within services.
- Providing the ability to attach documents or other related files (picture, audio) to ensure that child protection and family violence information is better collated and referrals take minimal time.
- Ensuring there is a quick and simple way to share child protection and family violence information between DHBs whilst maintaining security and privacy.
- It is an efficient way to share National Alert Information in a secure and private manner.