**ATTACHMENT MH 2**

This is the attachment marked "**MH 2**" referred to in the witness statement of Dr Pat Tuohy, Ms Helen Fraser and Ms Miranda Ritchie dated 11 August 2015.

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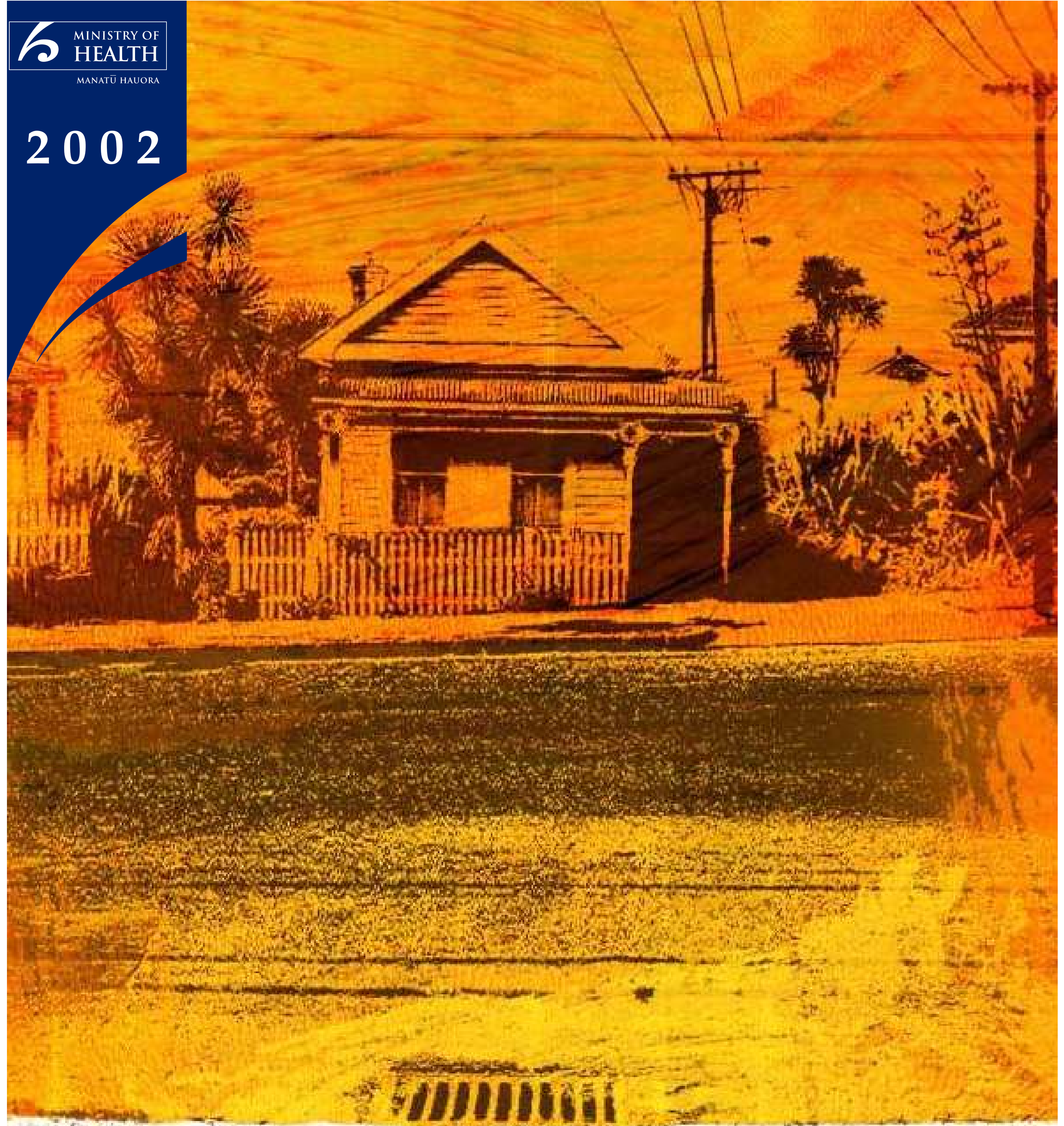


Family Violence Intervention Guidelines

# Child and Partner Abuse

# Foreword

The reduction of interpersonal violence is a key objective of the New Zealand Health Strategy. I am therefore pleased to release the *Family Violence Intervention Guidelines,* which have been developed to help you, as health professionals, to deal with this sometimes difficult area of health care.

The guidelines were produced in consultation with health professional leaders and Māori and Pacific peoples. These groups were concerned that health workers ensure the safety and well being of both women and children when abuse occurs in the same family. The integration of child and partner abuse intervention strategies is a major achievement of the guidelines.

We know that violence and abuse in families can have damaging cumulative physical and mental health effects that can last for many years after abuse has ended. These include depression, suicidality, alcohol and drug abuse, post traumatic stress disorder, eating and sleeping disorders, anxiety disorders, miscarriage, gynaecological problems, sexually transmitted infections and injuries.

As health professionals you will see many victims of abuse during the early stages of their victimisation, often before the abuse is reported to justice or child protection agencies. You can prevent much of the suffering and health problems that result from abuse by identifying abuse early; offering skilled and compassionate support, and referral to specialist intervention services.

In addition to publishing these *Guidelines,* the Ministry of Health will be working on family violence prevention, and the provision of health professional training opportunities. I encourage health professionals to take up this training and I urge health care providers to support clinicians by endorsing family violence intervention in the clinical setting.

Family violence is unacceptable. We need commitment by health professionals and many other groups working together if we are to make a difference.

**Karen O Poutasi (Dr)**
Director-General of Health

# Acknowledgments

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We appreciate the assistance and advice of the following Advisory Committees in the production of these guidelines:

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# Endorsements

The following organisations have endorsed these Family Violence Intervention Guidelines:

- Aotearoa New Zealand Association of Social Workers
- Australasian College of Emergency Medicine Specialists (New Zealand Faculty)
- Child, Youth and Family
- College of Emergency Nurses New Zealand
- College of Nurses, Aotearoa (New Zealand), Inc.
- Doctors for Sexual Abuse Care
- Family Planning Association New Zealand
- National Collective of Independent Women's Refuges
- National Network of Stopping Violence Services
- New Zealand College of Midwives
- New Zealand Guidelines Group
- New Zealand Nurses Organisation
- Nursing Education in the Tertiary Sector
- Paediatric Society of New Zealand

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# Preface

In 1995 the New Zealand Government requested all departments to prepare a response plan to family violence. In 1998 the Ministry of Health published a document titled *Family Violence: Guidelines for the Development of Practice Protocols*.[1] In 2001, the Ministry of Health Family Violence Project was instigated to develop these practice guidelines and begin training of health care providers. The project is envisaged to run from 2001 to 2004.

These *Family Violence Intervention Guidelines* are part of this project. Based on an extensive review of local and international protocols of care and consultation with health care providers, health professional bodies, and family violence advocates, it presents a six-step model for identifying and responding to family violence within health care settings. Given the high co-occurrence of partner abuse and child abuse, the guidelines also outline an integrated response to addressing both of these issues. The guidelines have been endorsed by a number of health professional and family violence intervention organisations.

There is nothing new about violence within families. What is new is to treat it as a health issue and to develop policy and interventions to prevent it. These guidelines are part of that emerging intervention framework. Health care providers are increasingly recognised as having a key role to play in the early intervention and prevention of family violence.[2] In the *New Zealand Health Strategy*[3] and in consultations with health consumers,[4] family violence has been consistently ranked as one of the top priorities for health care providers to address.

## How to use the guidelines

These *Family Violence Intervention Guidelines* are a practical tool to help health providers make safe and effective interventions to assist victims of violence and abuse. It has been written as a generic health professional guideline, setting out principles of intervention that will apply to a number of health professions and a number of clinical settings. It is expected that in due course individual health professions may formulate their own profession-specific child and partner abuse guidelines.

The guidelines are intended for use in conjunction with health professional training offered through the Ministry of Health Family Violence Project 2001-2004. Colleges and organisations endorsing the guidelines were involved in its development, and will be conducting and participating in the development of training programmes in child and partner abuse intervention.

### Layout

This document is presented in two sections related to child abuse and partner abuse. Because of the high co-occurrence of these forms of abuse, a process for dual risk assessment is recommended in these sections. Each section includes a six-step approach to identifying and responding to victims of abuse within health care settings. A summary of the steps can be found on pages 24 and 40.

The six steps are:

( 1 ) Identify

( 2 ) Support and Empower

( 3 ) Assess Risk

( 4 ) Safety Planning and referral

( 5 ) Document

( 6 ) Referral Agencies

### Quick Reference

In the back of the document you will find a pocket containing lift-out sheets for daily use (these are also printed as appendices in the document).

These include:

- Indicators of child and partner abuse
- Recommended guidelines for screening for partner abuse in different health care settings
- Injury documentation forms and body maps for children and adults
- A list for recording local referral agency contact information
- Patient handouts on safety strategies and dynamics of partner abuse
- A permission form for photographing injuries
- A referral form for Child, Youth and Family Services.

## Health professionals' role in assisting victims of family violence

To date, the majority of societal efforts to address family violence in New Zealand have been concentrated in crisis intervention through community organisations such as Women's Refuge and government agencies such as Child, Youth and Family and the Police. While these agencies provide critical assistance in responding to family violence, this is often only invoked for the most extreme cases. Government agencies are reliant on notification of abuse from outside sources. As a consequence, they may be responding to only about 10 percent of the violent incidents that are occurring.[5]

Health care providers are in an ideal position to assist victims of family violence before the abuse reaches crisis point. Health providers come into contact with the majority of the population for routine health care, pregnancy, illness, and injury, or by bringing children to health care services. Victims of abuse seek care from health care providers far more often for a range of health problems than do individuals who have not experienced abuse.[6] Health care providers are therefore well placed to engage in early identification, support and referral of victims of abuse, before it escalates to severe or life-threatening levels.

When we think about family violence, we usually think about physical violence, yet the experience of abuse impacts equally on mental, social, and spiritual health. The Māori model of health, Te Whare Tapa Whā,[7] is probably the most helpful in understanding the impact of abuse (Appendix N, p.78). It is made up of the following four dimensions:

- taha wairua (spiritual) – the capacity for faith and wider communion
- taha hinengaro (mental) – the capacity to communicate, think and feel
- taha tinana (physical) – the capacity for physical growth and development
- taha whānau (extended family) – the capacity to belong, to share and to care.

All of these capacities are diminished by the experience of abuse and violence. Early identification and intervention is important to minimise damage to all these aspects of health.

# A population health / ecological model of family violence

Family violence is a global issue and is not limited to any one gender, religious, cultural or income group. A wide range of studies agree that the causes of violence are multi-factorial, and that the co-occurrence of factors may increase the likelihood that a person will abuse a family member, such as a parent, partner or ex-partner, child or sibling. Ultimately we need to intervene at multiple levels in order to be effective in reducing family violence. By combining individual-level risk factors with findings of cross-cultural studies, a population health or ecological model[8] has been developed that contributes to understanding why some societies and some individuals are more violent than others.

At the individual level these include:

- being abused as a child or witnessing violence in the home
- being a very young, under-resourced or ill parent (in the case of child abuse)
- sexist attitudes about the role of men and women (in the case of partner abuse).

At the level of the family and relationship, there are risk factors present where:

- family members are vulnerable, disempowered or in a dependent position, for example, women with very young children, or children themselves
- families have a lack of practical, social, psychological and financial support
- there is parental incapacity, parental illness, or a basic lack of parenting skills and support (in the case of child abuse)
- there is male control of wealth and decision-making within the family (in the case of partner abuse)
- one or both caregivers abuse substances.

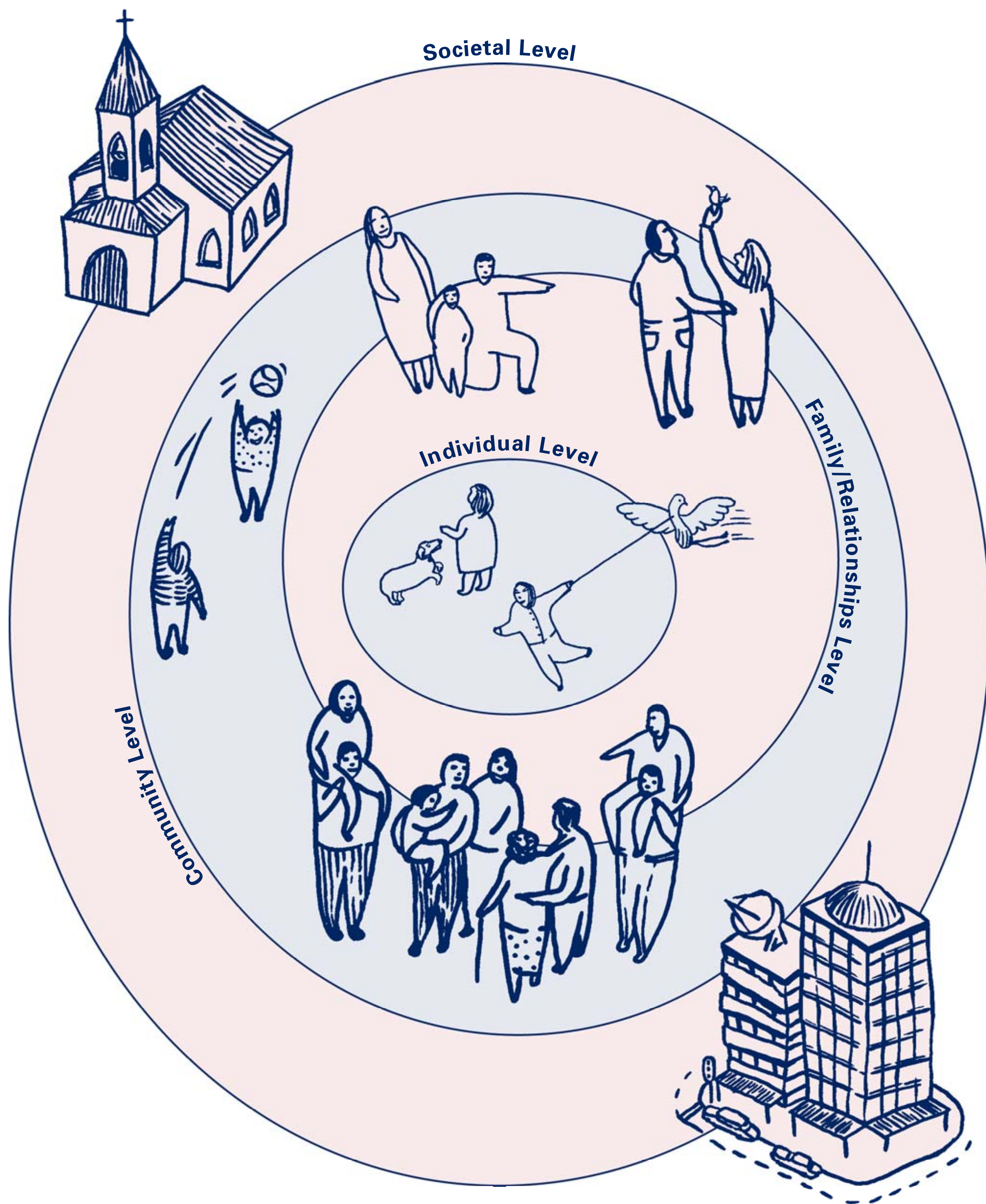
At the community level, risk factors include:

- the lack of safe, inclusive and nurturing communities, which may minimise opportunities for intervention and the transmission of non-violent norms of behaviour and contribute to the isolation and lack of social support for both victims and caregivers
- peer groups that condone and legitimise violence towards women and children
- barriers to community participation, such as poverty, cultural alienation, and racism that create and sustain social isolation.

At the societal level, risk factors exist where there is:

- acceptance of violence as a means to settle interpersonal disputes
- reinforcement of violence as glamorous and exciting through film and television
- social tolerance of physical punishment of women and children
- a lack of effective sanctions against intra-familial violence (New Zealand law allows physical punishment of children)
- rigidly defined and enforced gender roles
- the linkage of the concept of masculinity to toughness and dominance
- the perception that men have 'ownership' of women, or parents have 'ownership' of children
- barriers to independence, participation, self-fulfilment, dignity and the resulting isolation and low self esteem
- a cultural norm about women's role as caregivers
- lack of funding for family violence prevention programmes.

For society to achieve a reduction in family violence requires much more than the publication of guidelines such as these. The Ministry of Health is committed to undertaking a population health approach to the problem of family violence. This includes the development of training for health professionals, public education, information systems and public policy that support reduction of family violence. The Ministry of Health welcomes partnerships with other Government departments, District Health Boards, health professionals and professional organisations, NGOs and communities to reduce violence within New Zealand families.



# Prerequisites for identifying and responding to family violence

Due to the high prevalence of family violence in the population and the negative health effects of this abuse, health professionals need to become competent in abuse intervention. This includes knowing how to ask questions to identify the presence of abuse, and having the procedures in place to support brief intervention and appropriate referral of identified victims. The *Family Violence Intervention Guidelines* ensure health care providers are equipped with the necessary framework for undertaking these steps.

The guidelines are intended to be used only by health care providers who have received appropriate training on how to ask about family violence and how to respond when it is identified. Health care providers should also have received appropriate training on issues of:

- cultural competency
- principles of increasing safety and respecting autonomy of abused women[a]
- care and protection issues related to abused children.

These are considered to be core competencies that should have been achieved as part of any clinical training. In the event that an individual provider does not have these skills, assistance should be sought from a more experienced colleague and the provider should take active steps to acquire the necessary knowledge and skills.

Good practice will be best achieved and maintained in settings where there is sufficient organisational and institutional support for addressing abuse as a critical health care issue, and where health care providers work in partnership with community-based service providers who can provide other support to abuse victims.

**Health care providers should have established working relationships and referral pathways with local family violence agencies in their community prior to undertaking intervention for family violence.**

Additionally, the following conditions should apply to interviews relating to family violence.

- Assessment and intervention should take place as part of a face-to-face health care encounter.
- The health care provider should be direct and non-judgemental.
- The interview should take place in private.
  - *For partner abuse:* It should be the policy of the health care facility that questioning about violence is conducted in private. No friends or relatives of the patients should be present during the violence questioning and preferably no children over two should be present. If violence is disclosed, risk assessment should also take place in private, unless the woman requests the presence of a friend or family member for support.
  - *For child abuse:* Young people and older children may be interviewed alone, if there is suspicion of abuse. Parents/caregivers should also be interviewed.

[a] Because of the difference in the extent and pattern of violence committed by men against women, in this document victims of partner abuse will most often be referred to as female, and perpetrators of partner abuse will be referred to as male. In the more unusual case where partner abuse is perpetrated by women against their male partners in a context of coercive control, the same procedures outlined in this document should be applied.

- Be confidential. Patients and their caregivers should be told of the confidentiality of the conversation and the limits of that confidentiality, including the limits of confidentiality of medical records. Limitations of confidentiality include the following two points.
  - There is a legal and ethical obligation to take action if serious harm is likely to arise through not doing so.
  - A court may order disclosure of transaction details whether they have been recorded or not, although this rarely occurs.
- All communication with children should be conducted in an age-appropriate manner.
- Always use professional interpreters, rather than a patient's friend or family member.

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## Notes

# Māori

## Māori and family violence

This section of the *Family Violence Intervention Guidelines* provides some background and context around family violence for Māori, and suggests some principles and actions for effective screening and intervention with Māori women and children experiencing family violence. The aim is to enable health care providers to have some understanding of the issues that underpin family violence for Māori, and of strategies to improve their responsiveness to Māori.

Violence within the whānau was not the norm for traditional Māori society.[9,10]

Loss of land and urbanisation distanced Māori whānau from their whakapapa, and the support of their extended family. Traditional roles within whānau have changed, family violence is no longer viewed as prohibited behaviour, and traditional sanctions are no longer in place.

### What do we know about Māori and whānau violence?

The experience of family violence by Māori is complex. It occurs within the historical context that reshaped the foundations of Māori society through the process of colonisation. It also occurs within a contemporary context of socio-economic disadvantage, which can be linked to a health status that is poorer than other ethnic groups within the New Zealand population. The development of health care providers' abilities to respond effectively is vital in improving the effectiveness of identification and the appropriate referral of Māori women and children who are victims of family violence.

Violence has been consistently identified as negatively impacting on health by whānau, hapū and iwi[11] The occurrence of violence in Māori whānau has both historical and contemporary causes, and can be attributed to the complex interaction of many factors. For Māori these factors may include:

- the breakdown of traditional Māori way of life through the process of colonisation, including social structures and systems of discipline and justice
- loss of te reo Māori, traditional beliefs, values and philosophy, the breakdown of traditional social structures, and the loss of identity for many Māori
- movement of concern with family violence from a public iwi and hapū concern to a private whānau issue, mirroring Pākehā attitudes
- urbanisation and associated isolation of Māori throughout city suburbs, resulting in social isolation and dislocation from vital support networks for some Māori
- hardship experienced by many Māori associated with low educational achievement, low income and restricted employment opportunities.

Māori are significantly over-represented as both victims and perpetrators of whānau violence. In the National Survey of Crime Victims, Māori women reported violence at a higher rate than non-Māori.[5]

It is important that health care providers gain an understanding about the dynamics of family violence, and the historical socio-cultural influences and context for contemporary Māori. This understanding can assist them to demonstrate attitudes and actions toward Māori women and children that are supportive and encourage Māori women to seek help.

## Treaty of Waitangi

The Government is working to address the health needs of Māori, including the inequalities in health status experienced by many Māori. Health services should benefit the health of all peoples. Health care providers are encouraged to contribute to ensuring that Māori are able to enjoy the same level of health as non-Māori by:

- taking account of Māori health needs and perspectives
- developing of culturally appropriate practices and procedures
- engaging with whānau, hapū and iwi
- developing partnerships with Māori providers
- recruiting and supporting Māori personnel/health workers.

## Māori health holistic model and quality framework

There are several Māori models and frameworks that illustrate Māori holistic approaches to health and wellbeing. The most well-known of these is Te Whare Tapa Whā which represents the aspects of health and wellbeing for Māori. The strong and solid walls of the house reflect the four dimensions of health and wellbeing: taha wairua (spiritual), taha hinengaro (mind), taha tinana (physical), and taha whānau (extended family). A person's synergy relies on these foundations being secure[7] (see Appendix N, p.78).

The Western application of health sometimes considers only the tinana (physical) aspect of being unwell. For Māori, the inclusion of wairua (spiritual), the role of the whānau (extended family) and the hinengaro (mind) is as important as the tinana (physical) aspect. Health care providers are encouraged to familiarise themselves with Te Whare Tapa Whā (or other Māori health models, for example, *Te Wheke,*[12] Jones' Five Cornerstones of Healing[13]) and use this framework in their interaction with Māori. Health care providers should be mindful that these models are very simplified expressions of Māori wellbeing. Where possible service providers should engage with local hapū and iwi so that unique hapū perspectives can inform services in an ongoing way.

A second area of focus for health providers is to improve their service delivery to Māori. *He Taura Tieke*[14] released by the Ministry of Health in 1995 (see Appendix N) provides a detailed checklist for providers to plan, develop, and manage effective health services for Māori.

## Forms of whānau abuse

The experience of family violence by Māori women and children is complex. Anecdotal evidence suggests that Māori women and children often present late to health services and when they do their injuries and health issues are more serious.

### *Partner abuse*

Approximately 45 to 50 percent of battered women using Women's Refuge services are Māori.[15] Where women are at risk, their children may also be at risk.

### *Child abuse*

Approximately 50 percent of children who come into contact with Women's Refuge are Māori[15] Children being raised within violent family environments may not understand the negative consequences of the use of violence.[16] It is a concern that as they mature they may adopt the learned behaviour of violence and abuse within their own families.

## Principles for action

Health care providers should ensure the service they provide is safe and respectful of Māori women's beliefs and practices. The following whakatauki highlights the importance of respectful practice in optimising the effectiveness of health care providers and their actions:

*E tau hikoi i runga i oku whariki*

*E tau noho i toku whare*

*E hau kina ai toku tatau toku matapihi*

Your steps on my whariki (mat), your respect for my home,

Opens my doors and windows[17]

The delivery of a culturally safe and competent intervention that responds to Māori victims of family violence should be underpinned by the following principles.[18,19]

- Victim safety and protection should be paramount.
- Māori-friendly environment.
- Culturally safe and competent interactions (guided by kaumātua support Te Whare Tapa Whā[7] and *He Taura Tieke*[14]).
- Engagement with local iwi, hapū and Māori.
- Knowledge of community.
- Intersectorial collaboration.
- Monitoring and evaluation of family violence interventions with Māori women and children.

### *( 1 ) Victim safety and protection must be paramount*

While cultural safety is desirable, maintaining the safety of women and children must be paramount.[20,21] Any practices or interventions that health care providers engage in should not further endanger or disadvantage Māori women or children. The physical, emotional and cultural safety of mothers is important for the safety of their children.

**Actions and behaviours to ensure victim safety and protection:**

- Your communication style is important. Your language and tone should convey respect and a non-judgmental attitude.
- Affirm women and children's right to a safe, non-violent home.
- Have Māori staff available. This may include kaumātua who can provide support to Māori women and children.

For women:

- Routinely screen Māori women for violence.
- Offer women options about possible plans of action they would like to take.

### *( 2 ) The provision of a Māori-friendly environment*

Health care providers should ensure that they provide a Māori-friendly environment, including the physical environment and the behaviour and attitudes of the health care providers. Māori images, signage and designs (such as kowhaiwhai) are important in putting Māori at ease. These could also include images that promote a violence-free home, such as:

*Ko te tapu, o te whare tangata, me te ahua atua, o nga tamariki*[22]

All children and women have the right to a violence-free home

The first point of contact is important in building trust, together with an atmosphere that conveys openness, caring and one that will not judge.[23] It is important to recognise that Māori women and children experiencing abuse are spiritually, physically and emotionally vulnerable. It is also important to not rush Māori women and children, to provide them with adequate explanations of what is happening, allow the women time to respond, and to explore options for action. A positive encounter includes being asked open-ended questions about what plan of action they would like to take, and being offered resources, support and guidance.

**Actions and behaviours that contribute to Māori woman and children feeling comfortable in the environment (Māori-friendly environment):**

- Ensure there are Māori images within the environment of the health service, such as posters, signage and Māori designs.
- Having Māori on staff.
- 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.

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

Health care providers responding to Māori women and children who are victims of family violence should have an understanding of the application of the Treaty of Waitangi and its principles in a health context. Health care providers are encouraged to seek training to develop their cultural safety and competence in working with Māori.

Health professionals should be aware of their own culture, values, and beliefs, as well as Māori culture and beliefs. Understanding the dynamics of family violence for Māori involves understanding the effects of both the colonisation process and socio-economic disadvantage on many Māori.

The hallmarks of a culturally competent system requires health care providers to demonstrate:

- accessibility of their service to Māori victims of family violence
- recognition of the diversity of Māori women and children in their culture and their experience of violence
- knowledge and understanding of Māori holistic frameworks of health
- knowledge and development of responsive services for Māori
- accountability
- partnerships with iwi, hapū and Māori that are sustained
- that the context of the whānau and the community are incorporated within the delivery of services.[19]

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

- Explore your own cultural values and beliefs and develop an understanding of the value of other peoples culture.
- Familiarise yourself with Te Whare Tapa Whā (see Appendix N, p.78) and apply the model in your personal practice with Māori.
- Engage with local hapū to provide ongoing feedback on the cultural appropriateness of your services.
- Apply the quality framework He Taura Tieke to ensure that your services are effective for Māori.
- Engage kaumātua to provide cultural guidance.
- Be cognisant of the effects of hardship experienced by many Māori.
- Develop knowledge and understanding about the dynamics of family violence and victims who are Māori.

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

The implementation of interventions for women and children should occur in collaboration with other agencies or sectors to ensure that the needs of Māori women and children who are victims of violence are adequately addressed. Sectors working in isolation may result in Māori women being forced into taking options that are less than desirable. Women and children often need support with affordable housing, income, childcare, and transportation, or they risk being placed in a worse situation.

The development of local community knowledge and collaboration in responding to victims of family violence is vital to support women and children to become free of violence. Health care providers can be important participants in intersectorial community networks for family violence.

**Actions and behaviours that contribute to a collaborative intersectorial approach to family violence:**

- Develop a knowledge of referral agencies appropriate for Māori women and children who are victims of violence.
- Become involved in intersectorial and community violence prevention networks.
- Take the time to know your local community and family violence referral agencies. If possible offer referral to Māori advocates with expertise in family violence.
- Do not assume that the whānau should be involved in supporting the women and child(ren) – ask the women what plan of action they want (it may or may not include the whānau).

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# Pacific

## Pacific peoples and family violence

This section provides some background and context around family violence for Pacific peoples. The aim is to enable health care providers to have some understanding of the complex issues that underpin family violence for Pacific peoples.

### What do we know about Pacific peoples and family violence?

Pacific peoples make up six percent of the total population in New Zealand, with about two-thirds of Pacific people living in Auckland. There are seven main Pacific communities represented in New Zealand: Tuvalu, Tokelau, Fiji, Tonga, Niue, the Cook Islands and Samoa. The New Zealand Women's Refuge, and Child, Youth and Family data confirm that family violence is prevalent among Pacific communities in New Zealand.[15,24]

Family violence among Pacific communities in New Zealand occurs in a context of social change brought about by migration from the Pacific. Migration has made recreating traditional social structures and support systems difficult.

> *"Research points to the breakdown of family structure when people migrate. People moving to a new country often attempt to hold on to their familiar ways of being and doing but those ways are not always successful in the new environment. Perhaps one of the most significant points about migration for Pacific families is the break in kinship ties and the loss of collective support."*[25]

This, combined with stress factors listed below, has resulted in the acceptance of family violence as a response to stress, anger and frustration.

- Lack of communication between parents and children.
- Change in the status of women and children.
- Urbanisation of Pacific peoples and the impact of alcohol and drugs.
- Low educational achievement, poor housing and overcrowding, poor health status.
- Low income.

Pacific families tend to be larger than the average New Zealand family, which means that scarce resources must be stretched between the demands of everyday living as well as customary obligations, such as those to the church and remittances to family members who have remained in the Pacific. Many Pacific peoples now have a diminished socio-economic status as a result of high unemployment and lower incomes, leading to poor housing and poor health status.

In 1994, consultations with the Pacific community found a widely held perception that family violence was more prevalent in New Zealand than in the Pacific. The community believed that this was due to the combination of stress caused by financial discontent as well as a lack of traditional social controls.[26] An alternative, and possibly contentious view, would refute this perception and argue that the level of family violence in New Zealand is perhaps no greater than its prevalence in the Pacific, but that in New Zealand there are better mechanisms for detecting family violence, more stringent legislation against it, and greater awareness of human rights.

Ministry of Justice data indicate that Pacific peoples have been over-represented in violence offence convictions throughout the 1990s. In 1996, 14 percent of the total of all violence cases involved Pacific peoples, while the 1996 projected Pacific population aged 17 years and over was only four percent. This data also indicate that Pacific peoples were involved in 15 percent of offences classified as 'male assaults female', most of which are family violence cases.[25]

## Forms of family violence

### *Partner abuse*

Women's Refuge statistics for 2000/01 show that of the 7766 women and 9241 children using their services, 466 (6%) were Pacific women and 739 (8%) were Pacific children.[15] These figures are considered to be under-representative of the actual prevalence in the population, reflecting reported cases only. There is some anecdotal evidence that Pacific women are reluctant to report abuse or injury and when they do, their injuries or situation is usually more severe or urgent.

Traditional protocols that once protected women from abuse have been eroded by the influence of Western social and religious values and beliefs.[b] The newcomers brought attitudes about the appropriate role of women (and the place of children) within family and society. The growing authority of the new religion also altered the traditional exercise of authority and decision-making in which women had been significant participants. In some Pacific societies these historical events resulted in profound changes in the position of women. Cross-cultural studies have found a consistent correlation between the status of women and the prevalence and severity of partner abuse.[8]

### *Child abuse*

The Biblical injunction 'spare the rod and spoil the child' is often interpreted literally and applied diligently. As a consequence, disciplining a child may take the form of a beating and be regarded as a parental or religious right or obligation. In this context, it is the victim rather than the abuser who is typically blamed.

However, rather than this being a traditional form of parenting, many would contend that the roots of child disciplining is within the attitudes that were brought to the Pacific Islands in the early nineteenth century.

## Principles for action

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

### *( 1 ) Victim safety and protection must be paramount*

The safety of women and children must be paramount. Any practices or interventions that health care providers engage in should not further endanger or disadvantage Pacific women and children. The physical, emotional and cultural safety of mothers is important for the safety of their children.

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

- Routinely screen Pacific women for violence.
- Ask women what 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 women and children's right to a safe, non-violent home.
- Offer referral to both specialist Pacific or mainstream family violence advocates for abused women and children.

[b] In Samoa the feagaiga (covenant) between husband and wife is particularly significant to partner abuse. The male partner who assaults his female partner breaches the feagaiga between himself and herself. It is disrespectful of her genealogy as well as his genealogy. Similarly, violence towards children is disrespectful not only to the children but to their past and future genealogy. Traditional remedies seek to re-establish and reconcile to wellbeing the breaches created to all these multiple relationships. The prevalence of family violence suggests that there would be benefits from re-establishing these covenants in the New Zealand setting.

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

Non-Pacific health care providers should ensure that they provide a Pacific-friendly environment, including attention to the physical environment and the behaviour and attitudes of the health care providers. If possible, an appropriately trained person with the same ethnicity as the victim is the best person to interview, assess or follow up Pacific women and children.

The first point of contact is important in building trust, together with an atmosphere that conveys openness, caring and one that will not judge. It is important to not rush the women and children, to provide them with adequate explanations of what is happening and allow the time to respond, and to explore what plan of action they would like to take. Some Pacific patients 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 women and children 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 woman and child.

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

Health care providers responding to Pacific women and children who are victims of family violence should have an understanding of the specific cultural needs of the victim. Health care providers are encouraged to seek training to develop their cultural safety and competence in working with Pacific peoples. The training should focus on exploring their own culture, values, and beliefs as well as the dynamics of family violence for Pacific peoples.

The hallmarks of a culturally competent system requires health care providers to demonstrate:

- accessibility of their service to victims of family violence
- recognition of the diversity of Pacific women and children in their culture and their experience of violence
- knowledge of referral services for Pacific peoples.

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

- Explore your own cultural values and beliefs and develop an understanding of other people's culture.
- Be cognisant of the effects of migration on Pacific peoples.
- Be cognisant of the effects of hardship experienced by many Pacific peoples.
- Develop knowledge and understanding about the dynamics of family violence and victims who are from a Pacific culture.
- Identify and remove barriers for Pacific women and children accessing health care services.
- Develop knowledge of referral agencies appropriate for Pacific women and children who are victims of violence.

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

The implementation of interventions for women and children should occur in collaboration with other agencies or sectors to ensure that the needs of Pacific women and children who are victims of violence are adequately addressed. Sectors working in isolation may result in Pacific women being forced into taking options that are less than desirable. Women and children often need support with affordable housing, income, childcare, and transportation, or they risk being placed in a worse situation.

The development of local community knowledge and collaboration in responding to victims of family violence is vital to support women and children to become free of violence. Health care providers can be important participants in intersectoral community networks for family violence.

**Actions and behaviours that contribute to a collaborative intersectoral approach to family violence:**

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

## Notes

# Section 1: Child Abuse

## Introduction

Health care providers are increasingly recognised as key players in New Zealand's effort to eliminate family violence. In recent policy documents and consultations with health consumers, family violence was consistently ranked as one of the top priorities for health care providers to address.[2,3] This section of the document is intended to outline practical strategies by which health care providers can fulfil this role, and actively assist in the identification, assessment and referral of victims of child abuse and neglect.

### Child abuse in New Zealand

Lifetime estimates of child abuse suggest that four to 10 percent of New Zealand children experience physical abuse[27] and approximately 18 percent experience sexual abuse. Among females alone, the lifetime prevalence of sexual abuse may be as high as 30 percent.[28] The majority of perpetrators of child abuse are family members. Males are more frequently responsible for the most serious and fatal forms of child abuse[29,30,31,32] and for the perpetration of sexual abuse.[33] Although Māori and Pacific peoples are over-represented in statistics related to child abuse, there is evidence that violence within families occurs in all ethnic and social groups.[33]

Child abuse has detrimental effects on children's physical, cognitive, emotional, behavioural and social development. The long-lasting and pervasive nature of the effects warrants a strong approach to early identification and intervention by the health sector.[34]

### Co-occurrence of partner abuse and child abuse

Available evidence indicates that there is substantial overlap between the occurrence of child abuse and partner abuse in families, with between 30 and 60 percent of families who report one type of abuse, also experiencing the other type of abuse.[35] The likelihood of co-occurrence of child abuse increases with increasing frequency of partner abuse. Males who have committed 50 or more acts of violence against their female partner, are almost certain to also have been physically abusive to their children. For females who have hit their partners, the association with perpetration of child abuse is less pronounced, with 30 percent of chronic female partner abusers likely to have physically abused their children.[36]

Recognition of the frequent co-occurrence of child abuse and partner abuse within families means that the issues cannot be addressed in isolation. Increasingly, there are moves to develop interventions that jointly address both issues. In reality, this often means developing interventions that seek to ensure the safety of the children by empowering and supporting the mother to a position of increased safety. Initial evaluations of this integrated approach show that they result in increased safety for both the woman and her child(ren), and reduce the rate of foster care placements for children, allowing them to safely stay with their mothers.[37,38,39]

### The health sector response

To date, the majority of societal efforts to address family violence in New Zealand have been concentrated through volunteer and advocacy groups, such as Women's Refuges, through the child protective services and through agencies of the criminal justice system, such as the Police. While these are critical agencies in responding to family violence, their assistance is often invoked only for the most extreme cases. Because government agencies are reliant on notification of abuse from outside sources, they may only respond to approximately 10 percent of the violent incidents that are occurring.[5]

Health care providers are in an ideal position to assist in the early identification of family violence because they come into contact with the majority of children for routine health care, illness, or injury. The two core ethical principles that guide medical practice, beneficence and non-malfeasance, are relevant to clinical practice in both child and partner abuse.[40] The principle of beneficence suggests that the duty to diagnose and treat is greater than simply addressing physical injury or disease; one must also address the cause because failure to do so is likely to lead to further injury. In addition, health providers have a statutory obligation to disclose information to Child Youth and Family or the Police where this information is needed to determine if the child is in need of care and protection (See Appendix K, p.72).

Policy makers, clinicians, and community members, all regard identifying and responding to violence as an important and appropriate role for health care providers.[2,3,41,42,43,44] However, health care providers often treat patients without enquiring about violence, and therefore may not recognise or address all of the important underlying causes of their health problems. Even when family violence results in injuries that were obviously inflicted by another person, health care providers often record the injuries and treat the presenting problem without enquiring about the cause of the injuries or making appropriate referrals. This lack of action has been cited as one of the factors in several recent high profile child abuse fatalities.[2]

Barriers to a more proactive response to family violence by health care providers have been identified as: lack of comfort with the issue, lack of training and information on the prevalence and health impact of family violence, lack of formal protocols and institutional support for responding, perceived lack of time to address the problem, and lack of confidence in referral agencies.[43,44] Efforts to counteract these barriers have included the development of protocols of care outlining recommended procedures for responding to child abuse, and efforts to offer training and education for providers on how to incorporate these steps into their current practice. Evaluations of related initiatives indicate that they can lead to improved care of victims of family violence, and, if supported by institutional procedures and appropriate referral agencies, can make health care providers a crucial link in a community-wide effort to intervene in family violence.[45,46]

## Child abuse : assessment and response – summary

### [ 1 ] Identify

It is recommended that a thorough history for child abuse and neglect be taken in high-risk groups and/or if there are signs or symptoms suggestive of abuse.

### [ 2 ] Provide emotional support for identified or suspected victims

- Tell the child that no one deserves to be hurt or neglected, and that it was not their fault.
- Tell them that you will seek help for them and their family/caregivers.
- Let the child know that they can come back and talk to you, the health care provider, at any time, if they need to.

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

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

If you have any doubts about discussing concerns about child abuse with the suspected victim's parents or caregivers, you should *first* consult with senior staff within your practice setting, with a health Social Worker, or with the duty Social Worker at Child, Youth, and Family.

*If circumstances permit* discussing concerns or child protective actions to be taken with a victim's parents or caregivers, broach the topic sensitively.

## [ 3 ] Assess risk

Immediate protection of children is required if:

- the child has been severely abused
- there is immediate danger of death or harm
- abuse has occurred and is likely to escalate or recur
- there is immediate risk to the child, or the environment to which the child is returning is unsafe.

Refer to Child, Youth and Family if:

- the child has injuries which seem suspicious, or are clearly the result of physical abuse
- interaction between the child and parent or caregiver seems angry, threatening, or aggressive
- the child states that they are fearful of parent/s caregivers, or have been hurt by parent/s or caregiver/s
- multiple risk indicators exist, for example, partner abuse in the relationship, alcohol/drug use by caregivers, caregivers avoidant of health agency contact.

Consider risk of self-harm or suicide.

Assess for co-occurrence of partner abuse.

## [ 4 ] Safety planning and referral

If there are concerns about immediate safety (including your own) contact the Police.

If there are no concerns about immediate safety contact Child, Youth and Family.

When child abuse is a possibility, but you are uncertain about what to do, consult:

- an experienced colleague
- a paediatrician
- Child, Youth and Family.

Take advice from the person you consult.

Decide if you are going to file a report now, or defer reporting at this stage.

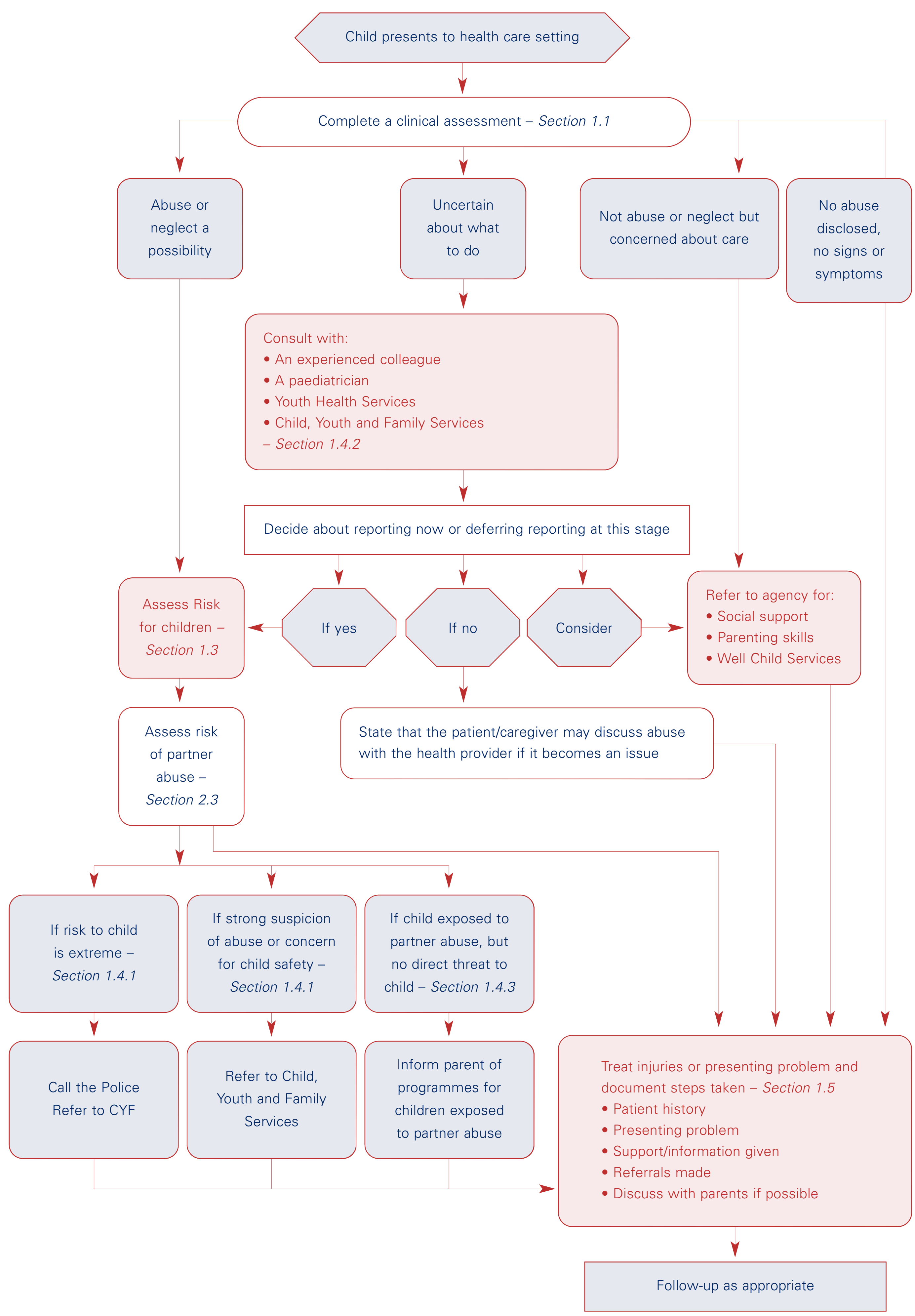
When you are concerned about the child's care, but not about abuse, refer to an agency for:

- social support
- parenting skills
- well child services.

[ 5 ] Document your concerns. Include relevant history, and any current or past injuries.

[ 6 ] Refer the patient to a specialist social service agency, legal agency or Child, Youth and Family if required.

# Child abuse: assessment and response – flowchart



## 1.1 Identify

The high number of victims of child abuse who present to health care settings yet who remain undetected indicates that more direct efforts are required to identify and address the problem, so that the health and safety needs of victims may be adequately met.

**The first point of contact influences the degree of trust that Māori may have in health care provider(s):**

- You should undertake training and a process of reflecting on how your personal beliefs and attitudes about both Māori and violence may impact upon your professional practice and interaction with Māori.
- Your communication style is important. Your language and tone should convey respect and a non-judgmental attitude for the child and caregiver.

Culturally safe and competent interactions:

- Engage kaumātua to provide cultural and spiritual guidance.
- Engage with local hapū, iwi and Māori.
- Apply the He Taura Tieke framework to improve your services for Māori.

### 1.1.1 Best practice guidelines

Questioning about suspected child abuse and neglect in high risk groups and questioning about abuse based on presence of signs and symptoms is recommended. Appendix A (p.55) lists factors related to the child and child's family that may increase the risk of child abuse and neglect. Possible indicators associated with abuse are presented in Appendix B (p.56). Review old notes and previous presentations or admissions, as often patients have presented previously. Multiple presentations for illnesses and injuries may indicate risk. Routine screening for child abuse using direct questions such as those outlined for partner abuse is not recommended.

### 1.1.2 Asking children about possible abuse and/or neglect

Be aware of the need to approach and talk with children at an age-appropriate level. If children are to be asked directly about abuse and/or neglect, the same conditions of privacy need to be observed as when asking adults about possible victimisation.

Older children may be asked:

- 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?

### 1.1.3 Questions for the caregiver

Use open-ended, non-judgmental questions about parenting and discipline,[47] for example:

- Do you ever fear for your children's safety?
- Have you ever been worried that someone was going to hurt your children?
- Who looks after your children when you are not home?

### 1.1.4 If you suspect the caregiver may be the abuser

- Do you ever worry about your children's safety when they are with you?
- What methods of discipline do you use with your children?
- What do you do when your child misbehaves?
- Are you ever afraid that you might hurt your child?
- Have you ever hurt your child?
- Do you know what practical help is available to assist you?

### 1.1.5 Asking adolescents/young people about possible abuse

The different profile of abuse that young people may experience (for example, violence by peers/bullying, violence by family/whānau, dating violence) requires a developmentally appropriate assessment to be undertaken if signs and symptoms of abuse are detected. Assessment of the causes of violence in this age group might be best accomplished as part of a thorough psychosocial assessment for adolescents such as the HEADSS assessment, which outlines a review of home environment, education and employment, peer activities, drugs, sexuality and suicide or depression (see Appendix C, p.57).

## 1.2 Support and empower victims of abuse

Disclosure of child abuse and/or neglect is a difficult step. Many victims feel shame and guilt, and have been told by the perpetrators that they are responsible for the abuse they experience. Victims of all ages need clear messages that support and reassure them that they are not at fault, and that help is available. Hearing these messages from health care providers is one of the most powerful interventions that health care professionals provide.

**The principles of the Treaty of Waitangi (partnership, protection and participation) provide a framework for ensuring Māori children and women are supported:**

- Provide a Māori-friendly environment – that is, ensure the environment has images that are Māori, including signage and kowhaiwhai, and also images that promote violence-free families and homes.
- Have Māori staff available. This may include kaumātua support.
- Provide unconditional support based on an understanding of the context for Māori and family violence. This includes the effects of colonisation, urbanisation, and socio-economic disadvantage experienced by many Māori. However do not assume that all Māori are disadvantaged.

### 1.2.1 Identified victims

- Tell the child that no one deserves to be hurt or neglected, and that it was not their fault.
- Tell them that you will seek help for them and their family/caregivers.
- Let the child know that they can come back and talk to you, the health care provider, at any time, if they need to.

### 1.2.2 Communication with victim's parents/caregivers

If you have any doubts about discussing concerns about child abuse and/or neglect with the suspected victim's parents or caregivers, you should *first* consult with senior staff within your practice setting, with the duty social worker at the Child, Youth and Family, or, if available, with the social work department or specialist child protection team for your service.

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

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

*If circumstances* permit discussing concerns or child protective actions to be taken with a victim's parents or caregivers, such as communicating with a non-abusive caregiver, follow these principles.

- Broach the topic sensitively.
- Help the parents/caregiver feel supported, able to share any concerns they have with you.
- Help them understand that you want to help keep the child safe, and support them in their care of the child.
- 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 approaching other agencies such as Police, social services, hospital staff, social workers, and other agencies.
- However, be clear that your role is to keep the child safe. Do *not* seek permission to consult with Child, Youth and Family. You may do this at any time.

### 1.2.3 Suspected victims

If child abuse is suspected, discuss the situation and suspicions with Child, Youth and Family to determine if a formal notification should be made.

- Leave the door open for further contact and state that if abuse does become a concern, you are available to discuss it with the caregivers if they would like to.
- Provide caregivers with the means of contacting appropriate parenting or other support agencies.
- Look for further indicators at the next consultation.

## 1.3 Assess risk

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 Child, Youth and Family or the Police.

If at all possible, it is best to work as part of a multidisciplinary team when conducting risk assessment. Detailed risk assessment can best be undertaken by agencies that specialise in responding to child abuse and neglect. If your health care setting has access to social worker services on-site, or specialist child protection teams or services, or has negotiated arrangements with local family violence prevention advocates, enlist this support whenever possible.

For those health care providers who do not have immediate access to these services however, this section outlines some of the primary risks associated with abuse that need to be considered, and suggests appropriate referral options. Note that the purpose of risk assessment and subsequent referral is to ascertain the likely level of immediate risk for a patient leaving the health care setting. Actual injuries or other evidence of abuse are not required for referral.

Offer reassurance that there are services that can help.

### 1.3.1 Danger assessment

Seek as much previous information about the child's medical history and family situation as possible. See Appendix A (p.55).

Immediate protection of children is required if:

- the child has been severely abused or neglected
- there is immediate danger of death or harm
- abuse has occurred and is likely to escalate or recur
- there is immediate risk to the child, or the environment to which the child is returning is unsafe.

Refer to Child, Youth and Family, your social work department (if available) or the local child protection team if:

- the child has injuries which seems suspicious, or are clearly the result of physical abuse
- interaction between the child and parent or caregiver seems angry, threatening, aggressive or coercive
- the child states that they are fearful of parent/s caregivers, or have been hurt by parent/s or caregiver/s
- multiple risk indicators exist, for example, partner abuse in the parents/caregivers relationship, alcohol/drug use by caregivers, caregivers avoidant of health agency contact, or caregivers have prior history of harming and/or neglecting children.

### 1.3.2 Risk of suicide/self-harm

The risk of suicide or suicide attempt is quite high in the adolescent/young person group, particularly for those who have experienced abuse. This risk needs to be assessed accordingly. At present, suicide or self-harm is rare among young children. However, recent data suggest that increasingly younger children are expressing the intent to kill themselves or others.

Signs associated with high risk of suicide include:[48]

- 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).

Other factors that are frequently associated with the risk of suicide or self-harm may themselves be symptoms of the abuse. Factors include depression, extreme anxiety, agitation or enraged behaviour, excessive drug and/or alcohol use or abuse. 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. Have you been thinking about 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 child or adolescent mental health service is required. Because of the abuse issues however, joint referral to Child, Youth and Family is also warranted in these cases, particularly if the child or young person cannot be cared for safely within their home. The most helpful intervention to reduce suicide risk may be to assist the person to obtain safety from the abuse.

### 1.3.3 Co-occurrence of partner abuse and child abuse

If child abuse is identified or suspected, it is imperative that some assessment of risk to other members of the family is conducted, because of the high co-occurrence of multiple types of violence within families. It is also important to establish the whereabouts and safety of other children in the home. *In all cases, the emphasis should be on keeping the child(ren) safe and enabling the abused partner to get real and appropriate help.*

### 1.3.4 If child abuse is identified, assess the mother's safety

Follow the procedures for identification, support, risk assessment, and referral of partner abuse outlined in Section 2 of this document.

### 1.3.5 If partner abuse exists, and action is needed to protect the children

Any concerns about the safety of the children should be discussed with the abused partner. If you or your colleagues decide to notify Child, Youth and Family, the abused partner should be informed, except in the circumstances noted in Section 1.2.2. Be aware that actions taken to protect the child may place the mother at risk. Always refer the mother to specialist family violence support services, and inform Child, Youth and Family about the presence of partner abuse as well as child abuse.

- Ask the abused partner how they think the abuser will respond.
- Ask if a child protection report has been made in the past, and what the abuser's reaction was.
- If the perpetrator is present in the health care facility, ask the abused partner whom they would like to inform the abuser about the report. For example, would they like the health care provider to do it? Does the abused partner want to be present when the abuser is told? Do they want to do it?
- Make sure the abused partner has information on how to contact support agencies (for example, Police, Refuge, Child, Youth and Family) if problems arise.

## 1.4 Safety planning and referral

If child abuse and/or neglect is identified or suspected, then some level of safety planning needs to occur. This is best accomplished as part of a multi-disciplinary team. Consult with an experienced colleague, a social worker in your agency, a specialist child protection team, paediatrician, a family violence prevention advocate or contact the duty social worker at Child, Youth and Family or Youth Health Service. Information from the risk assessment process described in the previous section will help to ensure that acute needs are identified and can be included in the safety plan.

Know your local community and the advocates and services that are available for victims of child abuse and family violence. This includes Māori child abuse, Māori family violence advocates and Māori family support services.

Do not assume that the whānau has the necessary skills and information to respond to the immediate or short-term needs of Māori children and women who are victims of violence in either crisis or need.

### 1.4.1 When child abuse and/or neglect is identified, or suspected

For victims or suspected victims of child abuse and/or neglect, the principles of care and protection and the need to ensure children's safety mandate early referrals to Child, Youth and Family. In consultation with the victim's family, Child, Youth and Family is responsible for planning for the safety of the child.

If there are concerns about immediate safety (including your own):

- contact the Police, or in-house security if available
- contact Child, Youth and Family.

If there are no concerns about immediate safety, but you have concerns about neglect or caregiver's ability to cope:

- contact Child, Youth and Family and refer for follow-up
- contact a health social worker or specialist child protection team.

### 1.4.2 When child abuse and/or neglect is suspected, but you are uncertain about what to do

Consult:

- an experienced colleague
- a Paediatrician
- Youth Health Service
- Child, Youth and Family
- Child Protection Services
- a health social worker.

Take advice from the person you consult.

Decide if you are going to make a referral now, or defer making a referral at this stage.

### 1.4.3 When you are concerned about the child's care but not about abuse

If possible refer to your agency's child protection protocol. Otherwise refer to an agency such as those outlined in Section 1.6 for:

- well child services
- social support
- parenting skills.

### 1.4.4 Co-occurrence of child abuse and partner abuse

*Joint* safety planning and referral processes need to be implemented when both partner abuse and child abuse are identified. Even if children are not directly abused, exposure to partner violence between their parents/caregivers has detrimental effects.

## 1.5 Document

A thorough physical examination, including appropriate laboratory tests and x-rays, is indicated in all cases of identified or suspected child abuse and/or neglect, to identify all current and past injuries. This is important because victims of abuse frequently minimise or deny the extent of violence they have experienced, or they may have been prevented from receiving appropriate medical care. In addition, careful documentation of injuries can assist Child, Youth and Family and Police investigations of child abuse.

### Confidentiality of abuse documentation on the medical record

Care must be taken to ensure the confidentiality of any information about abuse recorded on the medical record. If the perpetrator finds out that the victim has disclosed the violence, the victim may be at increased risk from retributive violence for having revealed the 'family secret'. Note that children's medical records are private to them. The medical notes for each individual should be stored in a separate file.

Record ethnicity of patient and cultural considerations included in the screening process

### 1.5.1 Documentation steps

- Mark the site(s) of old and new injuries on a body injury map (see Appendix D, p.60).
- Describe estimated age of injuries, colouration, and measure size.
- Record the history obtained. Note the stated or suspected cause of injuries, and when they allegedly occurred. Specify which aspects you saw or heard, and which were reported or suspected. Use the patient's or caregiver's own words as much as possible.
- State the identified perpetrator's name or relationship to victim.
- For suspected cases of abuse, record your opinion as to whether the injury is consistent or inconsistent with patient's explanation.
- Note the action taken by clinician, referral information offered, follow-up care arranged.
- Include the date and time of: your contact with the victim, when you wrote your notes (if different from the time of contact), and of referral or support actions that were taken.
- Include a legible signature and staff designation.

### 1.5.2 Collection of physical evidence

In some circumstances, collection of physical evidence may be required to assist in any legal proceedings that the patient or others choose to initiate. To avoid loss of relevant information, if at all possible, it is best if examinations for this purpose are conducted by specially trained health care providers. Doctors for Sexual Abuse Care are specially trained to undertake examinations for sexually abused patients, but would be unable to provide this level of service for all cases of physical abuse. In cases where this help is not available, with the patient's permission, collection of physical evidence associated with the assault can be undertaken.

Steps for collection and safe storage of evidence include:

- place torn or blood-stained clothing and/or weapons in a sealed envelope or bag
- mark the envelope with the date, the patient's name, and the name of the person who collected the items
- keep the envelope in a locked drawer until turned over to the Police or the patient's lawyer.

### 1.5.3 Photographs

Some health care settings may choose to develop a policy for photographing injuries from assault. Procedures for undertaking this step are outlined in Appendix E (p.62).

## 1.6 Referral agencies

As indicated in the sections on risk assessment and safety planning, external referral agencies are vital in providing support to actual or suspected victims of abuse. It is strongly recommended that you or your agency meet and develop referral relationships with local staff from the organisations listed here, before commencing use of this guideline.

It is vital that health care providers have knowledge of the people and groups within their local community who possess the necessary knowledge and skills for supporting Māori children and women who are victims of violence.

### 1.6.1 Child abuse and parent support services

*National Call Centre, Child, Youth and Family*

The Call Centre operates from 8 am to 5 pm, Monday to Friday, and is staffed by intake social workers. All after-hours calls are relayed, via the call centre, to an after-hours answering service which directs calls to the local office. The intake social worker will take direct referrals about cases of concern, or is available to discuss possible courses of action if you think child abuse is a possibility, or if you are uncertain what to do next. See Appendix F (p.63) for referral form. Telephone **0508 FAMILY** or **0508 326 459**, fax **09 914 1211**.

*Police*

The Police are trained to respond, and have the power to act, in circumstances of immediate threat. They are also trained in the investigation of crime.

*Doctors for Sexual Abuse Care (DSAC)*

DSAC is a national organisation of doctors, formed in 1988, to advance knowledge and improve standards for medical care of the sexually abused. DSAC doctors are specially trained in the sensitive treatment of sexually abused patients, and in the collection of forensic evidence, if required.

Additional social support and child health agencies (see a telephone book for contact details):

- Family Start
- Public Health nurses
- Plunket
- Child, Adolescent Mental Health Services
- Iwi/Māori Social and Health Services
- Parents as First Teachers (PAFT)
- Child Protection Services.

Services available in some areas:

- Domestic Violence Interagency Networks
- Barnardos
- Parentline
- Open Home Foundation
- Pacific Peoples Social Services
- The James Family Trust
- Catholic Social Services.

### 1.6.2 Partner abuse

*Women's Refuge and other Domestic Violence Prevention Agencies*

The National Collective of Independent Women's Refuges is a network set up across New Zealand. Women's Refuge is one of the key services for women and children, as it provides:

- 24-hour access to community based support services
- 24-hour access to emergency accommodation (and residential based support services).

Many refuges also provide childcare services, child advocacy, specialist children's programmes, women's education programmes and outreach services for rural areas.

In some areas of the country, other services provide crisis and ongoing advocacy and support to abused women and children. Local telephone books will provide contact details.

### 1.6.3 Perpetrators' services

*Child Abuse Prevention Society (CAPS)*

CAPS is a national organisation that provides programmes for parents who have been, or are at risk of being violent to their children. Contact the National Co-ordinator (free phone **0800 228 737**).

*National Network of Stopping Violence Services Programmes (NNSVS)*

These programmes are aimed at teaching men alternatives to abuse. Many programmes also offer a range of additional services, include support services for abused women. To find out who is providing Stopping Violence programmes in your area, contact the NNSVS National Office (telephone **04 499 6384**, fax **04 499 6387**).

*Family Court*

The local Family Court will have contact information on agencies that are approved to provide support and education programmes for abused women and children under the *Domestic Violence Act 1995.*

*Relationship Services*

Relationship Services is a national provider of individual programmes for perpetrators (telephone **0800 RELATE**).

# Section 2: Partner Abuse

## Introduction

Health care providers are increasingly recognised as key players in New Zealand's effort to eliminate family violence. In recent policy documents and consultations with health consumers, family violence was consistently ranked as one of the top priorities for health care providers to address.[2,3,4] This section of the document is intended to outline practical strategies by which health care providers can fulfil this role, and actively assist in the identification, assessment and referral of victims of partner abuse.

## Partner abuse in New Zealand

In New Zealand there is evidence that partner abuse affects a substantial number of individuals. Although definitional and methodological variations make consistent prevalence statistics difficult to come by, the best available population-based estimates of partner abuse suggest that 15[5] to 35[49] percent of women are hit or forced to have sex by their partners at least once in their lifetime, while seven percent of men report experiencing this type of abuse.[5] Between 15[50] to 21[49] percent of women report having experienced physical or sexual abuse, and 44 to 53 percent report having experienced psychological abuse in the previous 12 months.[49,50] The majority of perpetrators of partner violence, in both heterosexual and same-sex couples are men.[51]

The effects of male partner abuse against women can be extreme. Ninety percent of partner homicides in New Zealand were committed by men against their female partners or ex-partners.[52] Estimates from the New Zealand Women's Safety Survey indicate that one percent of all women with current partners had been treated or admitted to hospital as a result of their partner's violence, and one percent required treatment from a doctor for injuries inflicted by their partner.[50] Three percent reported being afraid their partners might kill them. In contrast, partner abuse perpetrated by women against men is likely to be less severe, less likely to result in injury, and more likely to be perpetrated in self-defence or as retaliation for previous violence.[53] Victims of partner abuse use health care services more than non-abused women, both for abuse-related, and non abuse-related complaints.[6,54,55]

## Co-occurrence of partner abuse and child abuse

Available evidence indicates that there is substantial overlap between the occurrence of child abuse and partner abuse in families, with between 30 and 60 percent of families who report one type of abuse also experiencing the other type of abuse.[35] The likelihood of co-occurrence of child abuse increases with increasing frequency of partner abuse. Males who have committed 50 or more acts of violence against their female partner, are almost certain to also have been physically abusive to their children. For females who have hit their partners, the association with perpetration of child abuse is less pronounced, with 30 percent of chronic female partner abusers likely to have physically abused their children.[36]

Recognition of the frequent co-occurrence of child abuse and partner abuse within families means that the issues cannot be addressed in isolation. Increasingly, there are moves to develop interventions that jointly address both issues. In reality, this often means developing interventions that seek to ensure the safety of the children by empowering and supporting the mother to a position of increased safety, and inviting the abuser to take responsibility for the violence he has committed. Initial evaluations of this integrated approach show that it can result in increased safety for both the woman and her child(ren), and reduce the rate of foster care placements for children, allowing them to safely stay with their mothers.[37,38,39]

## The health sector response

To date, the majority of societal efforts to address family violence in New Zealand have been concentrated through volunteer and advocacy groups, such as Women's Refuges and through child protective services and agencies such as the criminal justice system (for example, the Police). While these agencies provide critical assistance in responding to family violence, this is often invoked only for the most extreme cases. Often government agencies such as the Police are reliant on notification of abuse from outside sources so they may only respond to about 10 percent of the violent incidents that are occurring.[5]

Health care providers are in an ideal position to assist in the early identification of family violence because they come into contact with the majority of the population for routine health care, illness, or injury, or by bringing children to health care services. Women also present to health care providers for treatment related to pregnancy and childbirth. Victims of abuse seek care from health care providers at far greater rates than individuals who have not experienced abuse, not only for assault-related injuries, but also for a range of other health effects. For these reasons, health care providers are well placed to engage in early identification and appropriate referral of victims of abuse, before it escalates to severe or life-threatening levels. Policy-makers, clinicians, community members and patients all regard identifying and responding to violence as an important and appropriate role for health care providers to undertake.[2,3,4,56,57,58]

However, health care providers often treat patients without enquiring about violence, and therefore may not recognise or address an important underlying cause of health problems. Even when family violence results in injuries that were obviously inflicted by another person, health care providers often record the injuries and treat the presenting problem without enquiring about the cause of the injuries or making appropriate referrals.

The two core ethical principles that guide medical practice, beneficence and non-malfeasance, are relevant to clinical practice in both partner and child abuse.[40] The principle of beneficence suggests that the duty to diagnose and treat is greater than simply addressing physical injury or disease. One must also address the cause because failure to do so is likely to lead to further injury. The principle of non-malfeasance is the duty to do no harm. There is evidence that misdiagnosis of partner abuse leads to treatment that may do more harm than good, for example prescription of analgesic/sedative may lead to overdose,[59] increase a woman's vulnerability to injury by reducing ability to protect herself,[60] and produce increased helplessness and entrapment.[61]

Barriers to a more proactive response to family violence by health care providers have been identified as: lack of comfort with the issue, lack of training and information on the prevalence and health impact of family violence, lack of formal protocols and institutional support for responding, perceived lack of time to address the problem, and lack of confidence in referral agencies.[62,63,64,65] Efforts to counteract these barriers have included the development of protocols of care outlining recommended procedures for responding to partner abuse and efforts to provide training and education for providers on how to incorporate these steps into their current practice. Evaluation of these initiatives indicates that they can lead to improved care of victims of family violence, and, if supported by institutional procedures and appropriate referral agencies, can make health care providers a crucial link in a community-wide effort to intervene in family violence.[45,46]

## Effective identification of partner abuse means asking everybody

The rate of identification of victims of abuse is highly dependent on the method of identification employed within the health care setting.[66.67] Four levels of identification of victims of partner abuse are possible.

### Level 1 : Disclosure-related identification

This level of identification relies on the patient volunteering the information about abuse to the health care provider.

Reliance on disclosure as the principal technique for identification is likely to result in identification of partner abuse among approximately two percent of abused women who present to the health care setting. Few women volunteer information about abuse without being asked.[68,69]

## Level 2 : Signs and symptoms identification

This level of identification relies on health care professional awareness of signs and symptoms indicative of abuse.

Following training in the identification of partner abuse, including information regarding relevant signs and symptoms indicative of abuse, identification of victims of partner abuse remains in the region of approximately two percent of women who present to the health care setting (that is, no increase in identification).[46] Additionally, reliance on signs and symptoms such as the nature of the presenting injury, or the anatomic site of the injury have been shown to have limited sensitivity and low positive predictive value as indicators of assault.[70]

## Level 3 : Questioning of high risk groups

This level of abuse identification relies on questioning by the health professional among individuals who are likely to be at high risk of abuse.

There are few consistent demographic characteristics that reliably identify women who are likely to be victims of partner abuse. Assessing for evidence on the basis of these cues is likely to produce rates of identification which are not substantially greater than those obtained by reliance on spontaneous patient disclosure.[46,71] However, there are several health services that are likely to have a high prevalence of women presenting with partner abuse. These include, mental health, alcohol and drug treatment services, and emergency departments. Routine screening about partner abuse among clients in these health services as a way of conducting questioning of high-risk groups is likely to be warranted.

## Level 4 : Routine screening about abuse

This level of abuse identification means asking all patients, or all patients with particular characteristics (for example, women over the age of 16 years) about abuse.

Routine screening for partner abuse is recommended by government organisations and leading health professional bodies including the UK Department of Health[72] and the American Medical Association.[73] Screening for partner abuse has been shown to increase detection from minimal levels to the prevalence expected in the population.

Partner abuse can be considered to meet all the criteria necessary for adopting a screening programme, as set out by Wilson and Jungner.[74] This is the method of identification of partner abuse recommended in these guidelines.

A review of the available literature provided sufficient evidence to indicate that:

- partner abuse is a significant problem that is currently frequently missed in most encounters with health care professionals[75,76]
- identification of abuse based on signs and symptoms, or questioning of individuals/groups thought to be at high risk of partner abuse does not improve rates of identification[46,71,73]
- that early diagnosis in the form of discussion with health care professionals has the potential to improve outcomes for abused women and their children, both as an intervention in its own right[77] and as an avenue for assisting women to access help from other community organisations[78,79,80,81,82]
- screening tests, in the form of three brief questions, are sensitive, specific,[83,84] acceptable to women[68,69] and substantially improve detection[73,85,86,87,88,89,90]
- the resource implications for instituting such screening were not great, providing that staff were sufficiently well trained (eg. screening and intervention can take less then 15 minutes).[76,79,81]

# Partner abuse : assessment and response – summary

## [ 1 ] Identify

Use simple, direct questions, asked in a non-threatening manner.

- *All females* aged 16 years and older should be *screened routinely,* using validated screening tools, about physical and sexual partner abuse, or if they are afraid of a current or past partner.
- *All females* 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.
- *Males* aged 16 years and older who present with *signs and symptoms* indicative of partner abuse should be questioned.

## [ 2 ] Provide emotional support

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

If the patient does not acknowledge abuse as a problem, but you suspect it, provide options for further contact with you, or with other support agencies.

## [ 3 ] Assess risk

- Homicide or further assault.
- Suicide or self-harm.
- Risk to children.

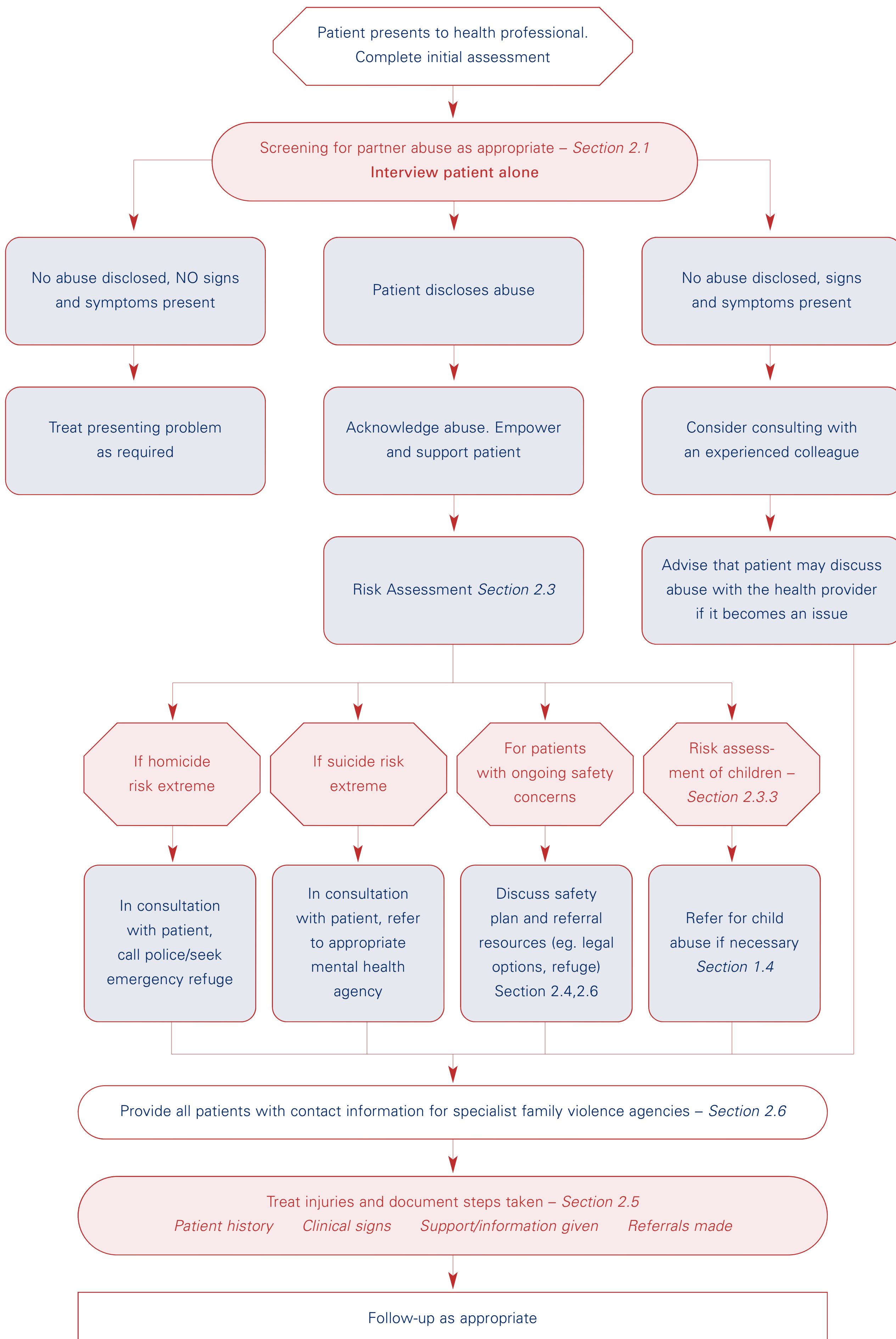
## [ 4 ] Safety planning and referral

- If safety concerns are acute, consult with the patient and contact the Police, if required.
- If safety concerns are ongoing, assist the patient to develop a safety plan, in consultation with specialist family violence support agencies.
- Educate and support the person, regardless of their choices.

## [ 5 ] Document any current or past injuries thoroughly.

## [ 6 ] Refer the patient to a specialist family violence agency, Police, lawyer or (for under 17-year-olds), child protection service such as Child, Youth and Family, if required.

# Partner abuse : assessment and response – flowchart



## 2.1 Identify

The high number of victims of partner abuse who present to health care settings yet who remain undetected indicates that more direct efforts are required to identify and address the problem, so that the health needs of victims may be adequately met.

**The first point of contact influences the degree of trust Māori women and children may have in the health care provider(s):**

- You should undertake training and a process of reflecting on how your personal beliefs and attitudes about both Māori and violence may impact upon your professional practice and interaction with Māori.
- You should ensure that the woman understands that this is a routine inquiry and that she is not being singled out for any reason (for example: because she is Māori).
- Your communication style is important. Your language and tone should convey respect for the woman and a non-judgmental attitude.

Culturally safe and competent interactions:

- Engage kaumātua to provide cultural and spiritual guidance.
- Engage with local hapū, iwi and Māori.
- Apply the He Taura Tieke framework to improve your services for Māori.

### 2.1.1 Best practice guidelines

- *All females* aged 16 years and older should be *screened routinely,* using validated screening tools, about physical and sexual partner abuse, or if they are afraid of a current or past partner.
- *All females* 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
- *Males* aged 16 years and older who present with *signs and symptoms* indicative of partner abuse should be questioned.

Because physical and sexual abuse co-occurs so commonly, *both* types need to be directly assessed for. At a minimum, health care providers should assess new female patients for current (past year prevalence) physical and sexual violence, and psychological abuse. A list of signs and symptoms indicative of abuse is presented in Appendix G (p.64).

For some practice settings it may also be appropriate to assess for partner abuse that occurred any time in a female patient's life. See Appendix H (p.65) for recommended partner abuse questioning guidelines for different health care settings.

When enquiring about partner abuse, in most circumstances, it is best to use simple, direct questions, asked in a non-threatening manner.

### 2.1.2 Asking adults about possible abuse

*Framing statements*

- Because violence is so common in many people's lives, I routinely ask all my patients about it.
- Many of the women I see as patients are dealing with abuse in their homes, so I ask about it routinely.

### 2.1.3 Asking adolescents/young people about possible abuse

The different profile of abuse that young people may experience (for example, violence by peers/bullying, violence by family/whānau, date violence) requires a developmentally appropriate

assessment to be undertaken if signs and symptoms of abuse are detected. Assessment of the causes of violence in this age group might best be accomplished as part of a thorough psychosocial assessment for adolescents, such as the HEADSS assessment, which outlines a review of home environment, education and employment, peer activities, drugs, sexuality, and suicide/depression (see Appendix C, p.57).

### 2.1.4 Validated partner violence screening questions

Two alternative sets of screening questions are presented. Both have been validated for sensitivity and specificity and used widely in clinical practice. Some practice settings may also wish to assess for emotional abuse, as emotional distress is a common presentation. Questions such as "Does anyone in your home make you feel no good or worthless?" can be useful to elicit reports of emotional abuse.

*Partner Violence Screening (1) (validated in USA emergency department setting)*[83]

{ 1 } **Have you been hit, kicked, punched or otherwise hurt by someone within the past year?**

- If so, by whom?
- A 'yes' response to this question is considered positive for partner abuse if the perpetrator was a current or former spouse or other intimate partner.

{ 2 } **Do you feel safe in your current relationship?**

{ 3 } **Is there a partner from a previous relationship who is making you feel unsafe now?**

*Partner Violence Screening (2)*[84]

{ 1 } **Have you ever been emotionally or physically abused by your partner or someone important to you?**

○ Yes ○ No

{ 2 } **Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?**

○ Yes ○ No If YES, by whom? ____________ Total Number of times: ____________

**Mark the area of injury on a body map. Score each incident according to the following scale:**

1 = Threats of abuse including use of a weapon
2 = Slapping, pushing, no injuries and/or lasting pain
3 = Punching, kicking bruises, cuts and/or continuing pain
4 = Beating up, severe contusions, burns, broken bones
5 = Head injury, internal injury, permanent injury
6 = Use of weapon, wound from weapon
If any of the descriptions for the higher number applies, use the higher number.

{ 3 } **Within the last year, has anyone forced you to have sexual activities?**

○ Yes ○ No If YES, by whom? ____________ Total Number of times: ____________

{ 4 } **Are you afraid of your partner or anyone you listed above?**

○ Yes ○ No

## 2.2 Support and empower victims of abuse

Disclosure of partner abuse is a difficult step. Many victims feel shame and guilt, and have been told by the perpetrators that they are responsible for the abuse they experience. Victims of all ages need clear messages that support and reassure them that they are not at fault, and that help is available. Hearing these messages from health care providers is one of the most powerful interventions that health care professionals provide. It is not necessary to take a full history of the abuse, and may be unhelpful.

**The principles of the Treaty of Waitangi (partnership, protection and participation) provide a framework for ensuring Māori women and children are not only supported but also empowered:**

- Provide a Māori-friendly environment – that is, ensure the environment has images that are Māori, including signage and kowhaiwhai, and also images that promote violence-free families and homes.
- Have Māori staff available. This may include kaumātua support.
- Ask the woman what plan she wants – health care providers should not make assumptions based solely on what they think is best.
- Provide unconditional support based on an understanding of the context for Māori and family violence. This includes the effects of colonisation, urbanisation and socio-economic disadvantage experienced by many Māori. However, do not assume that all Māori are disadvantaged.

### 2.2.1 Identified victims

- Listen to the person's story.
  - Acknowledge what they have told you. Be empathic, non-judgmental and non-blaming.
  - That must have been terrifying. You are a strong person to have survived that.
- Validate
  - You are not alone – others experience abuse in their homes.
  - You are not to blame for the abuse.
  - You did nothing to deserve or provoke this. Abuse is never justified.
  - Your reactions are a normal response to this sort of trauma.
- Inform
  - I can provide information/support that may help you.
  - What the perpetrator is doing is a crime. It is not just a family or private matter.
  - You have the right to live free of fear and abuse.

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

### 2.2.2 Suspected victims

If partner abuse is suspected, but the individual does not acknowledge that it is a problem:

- Leave the door open for further contact and state that if abuse does become a concern, you are available to discuss it with them if they would like to.
- Provide them with the means of contacting appropriate support agencies.

## 2.3 Assess risk

Health care professionals are responsible for conducting a preliminary risk assessment with victims of abuse in order to identify appropriate referral options. Health professionals are not responsible to determine who is responsible for perpetrating the abuse, which is the role of the Police.

If at all possible, it is best to work as part of a multidisciplinary team. Detailed risk assessment can be undertaken by agencies that specialise in responding to partner abuse. If your health care setting has access to social worker services on-site, or has negotiated arrangements with local family violence prevention advocates, enlist this support whenever possible. For those health care providers who do not have immediate access to these services however, this section outlines some of the primary risks associated with abuse that need to be considered, and suggests appropriate referral options. Note that the purpose of risk assessment is to ascertain the likely level of immediate risk for a patient leaving the health care setting. However, the presence of injuries or other evidence of abuse are not prerequisites for making a referral, particularly if there is risk to children. It is better to offer referral to support agencies early.

Offer reassurance that:

- you will not do anything to put her or her children in danger
- there are support networks and services in place that can help her.

### 2.3.1 Danger assessment

Assessment of the risk of homicide to the abused partner is necessary because of the strong association between prior abuse and later homicide for women. However, there are no absolute indicators that can determine the risk of homicide. Assessment of the following factors can assist in danger assessment, particularly if the woman is minimising or denying the extent of violence she has experienced. While there are no precise cut-off points to the following scale, in general, the greater the number of factors that are present, the greater the safety risk is likely to be.

An abbreviated version of the Danger Assessment Scale is presented on the sample documentation form (Appendix I, p.67). A lethality assessment for a perpetrator of abuse can be found in Appendix L (p.75).

*Immediate Safety Risk*

- Is the abuser present?
- Is the patient afraid of their partner?
- Is the patient afraid to go home?

*High Danger Risk*

- Life threatening injuries.
- Children, elders or disabled at risk.
- A threat to kill or a threat with a weapon has been made.
- The person has recently separated from the abusive partner, or is considering separation.
- Physical violence has increased in severity.
- Perpetrator's access to weapons, particularly firearms.

*Other Factors to Consider*

- Have there been threats of homicide?
- Have there been threats of suicide?
- Is alcohol or substance abuse involved?

### 2.3.2 Risk of suicide or self-harm

There is a strong association between victimisation from partner abuse and self-harm or suicide. Health care providers need to consider assessing possible suicide of identified victims. Signs associated with high risk of suicide include:[48]

- 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).

Other factors that are frequently associated with the risk of suicide or self-harm may themselves be symptoms of the abuse. Factors include depression, extreme anxiety, agitation or enraged behaviour, excessive drug and/or alcohol use or abuse. Make direct inquiries 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 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 obtain safety from the abuse.

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

### 2.3.3 If partner abuse is identified, assess the children's safety

If either partner abuse or child abuse is identified or suspected, it is imperative that some assessment of risk to other members of the family is conducted, because of the high co-occurrence of multiple types of violence within families. *In all cases, the emphasis should be on keeping the child safe and enabling the abused partner to get real and appropriate help.*

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

You should also assess the risk the abused partner may pose to the children.

- When women are experiencing the sort of abuse you have described to me, it can affect their ability to parent in the way they would if they were free from abuse. Is this true for you?

- Are you ever afraid that you might hurt your children?
- Have you ever hurt your children?
- Do you know what practical help there is to assist you?

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

### 2.3.4 If partner abuse exists, and action is needed to protect the children

Any concerns about the safety of the children should be discussed with the abused partner. If you have any doubts about discussing concerns about child abuse and/or neglect with the suspected victim's parents or caregivers, you should *first* consult with senior staff within your practice setting, and with the duty social worker at Child, Youth and Family. If available, consult with the social work department or specialist child protection team for your service.

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

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

*If circumstances permit* discussing concerns or child protective actions to be taken with a victim's parents or caregivers, such as communicating with a non-abusive caregiver, follow these principles.

- Broach the topic sensitively.
- Help the parents/caregiver feel supported, able to share any concerns they have with you.
- Help them understand that you want to help keep the child safe, and support them in their care of the child.
- 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 approaching other agencies such as Police, social services, hospital staff, social workers and other agencies.

However, be clear that your role is to keep the child safe. Do *not* seek permission to consult with Child, Youth and Family. You may do this at anytime. If you or your colleagues decide to make a report to Child, Youth and Family, the abused partner should be informed.

Be aware that actions taken to protect the child may place the mother at risk. Always refer the mother to specialist family violence support services, and inform Child, Youth and Family about the presence of partner abuse as well as child abuse.

- Ask the abused partner how they think the abuser will respond.
- Ask if a child protection report has been made in the past, and what the abuser's reaction was.
- If the perpetrator is present in the health care facility, ask the abused partner whom they would like to inform the abuser about the report. For example, would they like the health care provider to do it? Does the abused partner want to be present when the abuser is told? Do they want to do it?
- Make sure the abused partner has information on how to contact support agencies (for example, the Police, Refuge, Child, Youth and Family) if problems arise.

## 2.4 Safety planning and referral

If partner abuse is identified or suspected, then some level of safety planning needs to occur. This is best accomplished as part of a multi-disciplinary team. Consult with an experienced colleague or a family violence prevention advocate. Information from the risk assessment process described in the previous section will help to ensure that acute needs are identified and can be included in the safety plan.

Except in the rare cases where victims of partner abuse are in immediate danger, remember that for most adult victims of partner abuse, letting them know that they are not responsible for and do not deserve the violence they have experienced, and assisting them to contact support services and access legal options for protection, may be the most powerful interventions you can offer. A detailed safety plan designed as a handout for victims of partner abuse is presented in Appendix J (p.69).

**Know your local community and the advocates and services that are available for victims of family violence.**

- If a specialist Māori family violence advocate is available (for example, Māori Women's Refuge) refer there. Otherwise refer to a specialist family violence women or children's advocate.
- Do not assume that the whānau has the necessary skills and information to respond to the immediate or short-term needs of Māori women and children who are victims of violence in either crisis or need.

### 2.4.1 For the small proportion of patients with acute safety concerns

- Is the abuser present?
- Does the abused person have a safe place to go when leaving the consultation?
- Is emergency assistance required? (for example, Police, emergency shelter/Women's Refuge).

Any decision about reporting a suspected incident of abuse to the Police should be made in consultation with the patient. Reporting an incident to the Police without the patient's consent can endanger their safety, as filing charges may enrage the abuser. In cases where it is standard procedure to notify the Police, this should be explained to the abused patient. (Refer to the *Crimes Act 1961,* Appendix K, p.72). On the rare occasion that a health care provider believes a person's life is in immediate danger, or has good reason to believe that the patient is unable to extricate themselves from a high level of ongoing, life-threatening danger, the Police may be notified without patient permission. The *Privacy Act 1993* is not breached if the health care provider has acted in good faith to protect the patient from serious harm.

### 2.4.2 For patients with ongoing safety concerns

- If possible in your area, make contact *during* the consultation with a Women's 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.
- Provide abused patients with information that will help them plan for safely leaving an abusive situation.
- Ensure the patient is aware of the legal support available to them, and how to access it.
- If the woman feels that it is safe, give her a copy of the safety plan in Appendix J (p.69). If she doesn't want to take a copy, talk through some of the contents with her.

### 2.4.3 For all abused patients

- Educate the patient about the likely increase in frequency and severity of abuse, without outside help.
- Support the person, irrespective of their choices. Understand that it is important for each person to make their own choices. While frequently the person may not choose to take any action at this time, be aware that your support can make it easier for the person to seek further assistance when they are ready.
- Leave the door open so they have a future point of contact.
- Getting safer is a process, not an act. Your role is to assist the patient to make themselves (and their children, if they are at risk) safer, not to 'rescue' them, or insist they leave the relationship. Only the individual can decide when the timing is right for them to move on or make dramatic changes. Initially support may focus on identification that abuse is the responsibility of the abuser. Later it may be more appropriate to assist women with exit planning.
- Decide if you are going to make a referral now or defer making a referral at this stage.

### 2.4.4 Raising public awareness/prevention

Many health care providers who choose to develop an active response to partner abuse not only routinely question all women patients about abuse, but also routinely provide information about support services to all women in order to increase awareness of the issue. This also acknowledges the positive safety role that women can play within their family and their community. It is common for women to say, "Thanks, that's not happening to me, but it is to my sister/friend, I'll give her the information."

### 2.4.5 Co-occurrence of child abuse and partner abuse

*Joint* safety planning and referral processes need to be implemented when both partner abuse and child abuse are identified. It may be helpful to contact Child, Youth and Family to ascertain if they have any further information about risk to children in the family. It is important to establish the whereabouts and safety of other children in the home. In all cases, the emphasis should be on keeping the child(ren) safe and enabling the abused partner to get real and appropriate help.

## 2.5 Document

A thorough physical examination, including appropriate laboratory tests and x-rays is indicated in all cases of partner abuse to identify all current and past injuries. This is important because victims of abuse frequently minimise or deny the extent of violence they have experienced, or they may have been prevented from receiving appropriate medical care. Careful documentation of injuries can assist abused adults to obtain Protection Orders immediately or in the future.

Record ethnicity of the patient and cultural considerations included in the screening process

### Confidentiality of abuse documentation on the medical record

Care must be taken to ensure the confidentiality of any information about abuse recorded on the medical record, particularly if the notes for other members of the family are stored in the same file. If the perpetrator finds out that the victim has disclosed the violence, the victim may be at increased risk from retributive violence for having revealed the 'family secret'. It is best for notes for each individual to be maintained in a separate file.

### 2.5.1 Documentation steps

- Mark the site(s) of old and new injuries on a body injury map.
- Describe estimated age of injuries, coloration, and measure size.
- Note the stated or suspected cause of injuries, and when they allegedly occurred. Record history obtained. Specify which aspects you saw or heard, and which were reported or suspected. Use the patient's own words as much as possible.
- State the identified perpetrator's name or relationship to victim.
- For suspected cases of abuse, record your opinion as to whether the injury is consistent or inconsistent with the patient's explanation. Note the action taken by clinician, referral information offered, follow-up care arranged.
- Include the date and time of: your contact with the victim, when you wrote your notes (if different from the time of contact) and of referral or support actions that were taken.
- Include a legible signature and staff designation.

### 2.5.2 Collection of physical evidence

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

Steps for collection of evidence include:

- Place torn or bloodstained clothing and/or weapons in a sealed envelope or bag.
- Mark the envelope with the date, the patient's name, and the name of the person who collected the items.
- Keep the envelope in a locked drawer until turned over to the Police or the patient's lawyer.

### 2.5.3 Photographs

Some health care settings may choose to develop a policy for photographing injuries from assault. Procedures for undertaking this step are outlined in Appendix E (p.62).

## 2.6 Referral agencies

As indicated in the sections on risk assessment and safety planning, external referral agencies are vital in providing support to identified or suspected victims of partner abuse. It is strongly recommended that you or your agency meet and develop referral relationships with local staff from the organisations listed here, before commencing use of this guideline.

It is vital that health care providers have knowledge of the people and groups within their local community who possess the necessary knowledge and skills for working with Māori women and children who are victims of violence. This includes Māori family violence prevention advocates and services.

### 2.6.1 Partner abuse

*Women's Refuge and other Domestic Violence Prevention Agencies*

The National Collective of Independent Women's Refuges is a network set up across New Zealand. Women's Refuge is one of the key services for women and children, as it provides:

- 24-hour access to community based support services
- 24-hour access to emergency accommodation (and residential-based support services)
- access to professional and social services supportive of women dealing with abuse issues
- education.

In addition, many refuges also provide childcare services, child advocacy, specialist children's programmes, women's education programmes and outreach services for rural areas.

In some areas of the country, other services provide crisis and ongoing advocacy and support to abused women and children. Local telephone books will provide contact details.

*Doctors for Sexual Abuse Care (DSAC)*

DSAC is a national organisation of doctors, formed in 1988, to advance knowledge and improve standards for medical care of the sexually abused. DSAC doctors are specially trained in the sensitive treatment of sexually abused patients, and in the collection of forensic evidence, if required.

*Police*

Although partner abuse is a crime, health care providers are not required to report cases of abuse to the Police. The Police have a pro-arrest policy in cases of domestic assault, which mean that they can arrest and charge the abuser if they have evidence of partner assault, without necessarily requiring the victim to make a formal complaint or give evidence. If arrested, the abuser is placed in jail, without bail, until they can appear in court. If the Police do not arrest the abuser, or there is uncertainty about the abuser's location, the Police can accompany the abused person back to the house to collect their belongings, or to another safe location.

*Legal Options*

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

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

*Assault charges*

Assault charges can also be laid against the abuser. These charges are heard in the Criminal Court. Adequate documentation of the woman's past and present injuries can assist both these processes.

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

*Domestic Violence Education Programmes, Ministry of Justice*

Approved education programmes are available free of charge to individuals who have Protection Orders for themselves and their children. Access to programmes can be arranged through local Family Court co-ordinators: see listing under Department for Courts in the telephone directory.

*National Network of Stopping Violence Services*

In addition to providing services aimed at teaching men alternatives to abuse, many programmes also include support services for abused women. To find out who is providing Stopping Violence programmes in your area, contact the National Office (telephone **04 499 6384**, fax **04 499 6387**).

### 2.6.2 Child abuse and parent support services

*National Call Centre, Child, Youth and Family*

The Call Centre operates from 8 am to 5 pm, Monday to Friday, and is staffed by intake social workers. All after-hours calls are relayed, via the call centre, to an after-hours answering service that directs calls to the local office. The intake social worker will take direct referrals about cases of concern and is available to discuss possible courses of action if you think child abuse is a possibility, or you are uncertain what to do next. (Telephone **0508 FAMILY** or **0508 326 459**, fax **09 914 1211**).

*Domestic Violence Education Programmes, Ministry of Justice*

Approved education programmes are available free of charge for children whose parents have accessed Protection Orders. Access to programmes can be arranged through local Family Court co-ordinators.

*Doctors for Sexual Abuse Care (DSAC)*

DSAC is a national organisation of doctors, formed in 1988, to advance knowledge and improve standards for medical care of the sexually abused. DSAC doctors are specially trained in the sensitive treatment of sexually abused patients, and in the collection of forensic evidence, if required.

*Additional social support and child health agencies*
*(see a telephone book for contact details):*

- Family Start
- Public health nurses
- Plunket
- Child, Adolescent Mental Health Services
- Iwi/Māori Social and Health Services
- Parents as First Teachers (PAFT).

*Services available in some areas are:*

- Domestic Violence Interagency Networks
- Barnardos
- Parentline
- Rape Crisis
- Sexual Abuse Help Foundation
- Open Home Foundation
- Pacific Peoples Social Services
- The James Family Trust
- Catholic Social Services.

### 2.6.3 Perpetrator services

*Child Abuse Prevention Society (CAPS)*

CAPS is a national organisation that provides programmes for parents who have been, or are at risk of being violent to their children. Contact the National Co-ordinator (telephone **0800 228 737**).

*National Network of Stopping Violence Services programmes*

These programmes are aimed at teaching men alternatives to abuse. Many programmes also offer a range of additional services, include support services for abused women. To find out who is providing Stopping Violence programmes in your area, contact the National Office (telephone **04 499 6384**, fax **04 499 6387**).

*Family Court*

The local Family Court will have information on agencies that are approved to provide perpetrator programmes under the *Domestic Violence Act 1995.*

*Relationship Services*

Relationship Services is a national provider of individual programmes for perpetrators (telephone **0800 RELATE**).

# Notes

# Appendix A

## High risk indicators associated with child abuse

### Child characteristics which may predispose them to be at risk.

- Child with a congenital abnormality, either mental or physical.
- Premature infant or ill newborn who is separated during the neo-natal period.
- Colicky or irritable child.
- Child who is rigid or non-cuddly.
- Child who is unwanted.
- Child who is not the gender expected/desired by the parents.
- Foster child, adopted child, or step-child.
- Child who is intellectually impaired, highly intelligent or hyperactive.
- Child is particularly difficult (or is seen as difficult).

### Caregiver's perceptions of child that may predispose some children to be at risk.

- 'Bad', 'naughty', or 'manipulative'.
- 'Difficult' and unrewarding to care for.
- Unloving or rejecting of the parents.
- Resembling a disliked person in appearance, behaviour or temperament.
- A rival for attention or affection that parents themselves desire.

### Family factors that may place children at higher risk of abuse.

- Partner abuse is present.
- Parent was abused or seriously neglected as a child.
- Parent has serious mental health problems.
- Parent has had frequent trouble with the law.
- Parent has an alcohol or drug problem.
- Parent has rigid or unrealistic expectations of child.
- Previous abuse towards this or another child.
- Parent has violent temper or outburst towards things or people.
- Family socially isolated.
- Parents with low self-esteem.
- Parent is a teenager.
- Family suffers from multiple crises.
- Parent administers harsh or unusual punishment.

From: *Child Abuse Indicators: Information for General Practitioners and Community Workers.*
Child and Adolescent Health Service, Taranaki Healthcare (1993, Second Edition).

# Appendix B

## Signs and symptoms associated with child abuse and neglect

The signs, symptoms, and history described below are not diagnostic of abuse. However in certain situations, contexts and combinations they will raise the practitioner's suspicion of abuse. It is better to refer on suspicion. If you wait for proof, serious harm can occur.

### History

- History inconsistent with the injury presented.
- Past abuse or family violence.
- Exposure to family violence, pornography, alcohol or drug abuse.
- Isolation and lack of support.
- Mental illness, including post-natal depression.
- Inappropriate or inconsistent discipline (especially thrashings or any physical punishment of babies).
- Neglecting the child.
- Delay in seeking help.
- Disclosure by the child.
- Severe social stress.
- Parent/s abused as child/children.
- Unrealistic expectations of child.
- Terrorising, humiliating, or oppressing.
- Promoting excessive dependency in the child.
- Actively avoiding seeking care or shopping around for care (frequent changes of address).

### Physical Signs

- Multiple injuries, especially of different ages: bruises, welts, cuts, abrasions.
- Scalds and burns, especially in unusual distributions such as glove and sock patterns.
- Pregnancy.
- Genital injuries.
- Sexually transmitted diseases.
- Patterned bruising.
- Unexplained failure to thrive (FTT).
- Poor hygiene.
- Dehydration or malnutrition.
- Fractures, especially in infants or in specific patterns.
- Poisoning, especially if recurrent.
- Apnoeic spells, especially if recurrent.

### Behavioural and developmental signs

- Aggression.
- Anxiety and regression.
- Obsessions.
- Overly responsible behaviour.
- Frozen watchfulness.
- Sexualised behaviour.
- Fear.
- Sadness.
- Defiance.
- Self-mutilation.
- Suicidal thoughts/plans.
- Withdrawal from family.
- Substance abuse.
- Overall developmental delay, especially if also FTT.
- Patchy or specific delay: motor, emotional, speech and language, social, cognitive, vision and hearing.

From: *Recommended Referral Processes for GPs: Suspected Child Abuse and Neglect,* Ministry of Health, RNZCGPS, NZMA, CYF, 2000.

# Appendix C

## HEADSS Assessment

### Home

In home we cover family, culture, connections, looking for both resiliency and risk issues.

- Where do you live? Who do you live with?
- Ask about extended family links and culture – iwi, hapū, whānau.
- Where were you born? How long have you been here?
- Do you belong to a church? What activities and length of time have they been involved with church?
- Do you have jobs or responsibilities at your place?
- Who makes the rules? What happens if rules are broken?
- What happens when you fight at your house?
- Is there any violence occurring at your house?
- Who in your family do you get along well with? Not so well?
- Who is the person that you talk to most?

### Education

- Do you go to school/training course/work?
- If no – How long have you been out of school/work? Why? Plans? What do you do with your time now?
- If yes – Which school? What is good about school? Not so good?
- Do you have friends at school? Is there a teacher you get along well with?
- How do you do in your school work and classes?
- Do you have ideas about what you might like to do when you leave school?
- Do you miss much school? Why?
- Are you bullied at school?

### Activities

Here we cover what you do, for example, eating/sleeping/exercise/risk behaviour.

- What do you do out of school in the weekends (chores/homework/TV/sport/see friends/on the phone/going out at night)?
- How do you get money?
- How do you get around? Do you drive sometimes? Do friends drive? Have you sometimes been in a car where the driver was out of it or drunk? Do you wear a safety belt?
- What do you do for fun? For a buzz?
- Do you go to parties?
- Do you ever diet?
- What about sleeping? Do you sleep well?

## Drugs/Alcohol

Introduce, for example, we know that many young people try alcohol and drugs, is it all right if I ask you some questions about that now?

- Do young people at your school smoke/do your friends smoke? Do you smoke?
- Do your friends/parents ever drink alcohol? Do you?
- Have you ever used marijuana? What other drugs/solvents are young people using these days? What do you think about that? What have you tried?

If the young person is using:

- How much are they using? In what circumstances? What do they like and not like about using? What risks do they take when using? Have they ever considered using less?

## Sexuality

Introduce, for example, we ask everyone about sexuality because that is a very important aspect of young people's lives and can affect their health so much. Is that OK with you? You can 'pass' on questions if you want to.

- Have you had any sexuality education at school? What was that like?
- Do you friends have sexual relationships? Do you?
- Are any of them wondering about sexual orientation – liking girls or boys? Are you?
- What do you know about safe sex?
- What do you do (in terms of keeping sexually safe)? Do you use condoms? How much of the time (every time, just when you can get them, sometimes)?
- What could you do if you thought you might be pregnant?
- Has anybody ever touched you in a way that you don't like?
- If you ever felt uncomfortable or something unpleasant happened to you, is there anyone that you could tell?
- Are there adults you can go to for advice/help about sex and relationships?
- Do you want to talk about anything else about relationships or sex?

## Suicide

In this we cover issues of mental health and self-harm.

- How would describe your mood/feelings most of the time? (Scale 1–10)
- Do you have really good/bad times?

If low mood is an issue, review sleeping, eating, energy, concentration, feelings of guilt/worthlessness and safety.

- Do you ever have worries or hassles that bother you?

If yes:

- Do they keep you awake at night?
- Do you have to do anything to keep them under control?
- Do you sometimes feel that life is not worth it?
- Have you ever harmed yourself deliberately?

If no, you may not need to continue this line of questioning.

- Have you ever thought of ending your pain once and for all?
- Do you know anyone who has died from suicide? Who? When?

- How often do you think about doing it? How did you think you would do it?
- How strong are these feelings for you at the moment?
- Do you think you might try?
- What if something went wrong for you? (Relationship breakup, etc).
- Who could you tell about feeling suicidal?

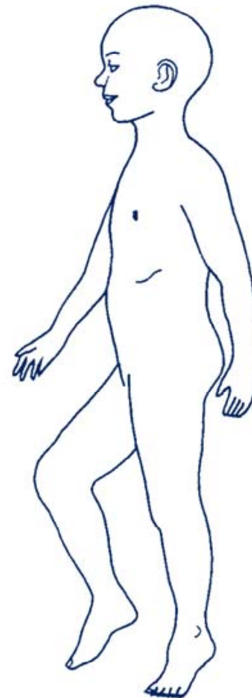
Regarding previous suicidal behaviour

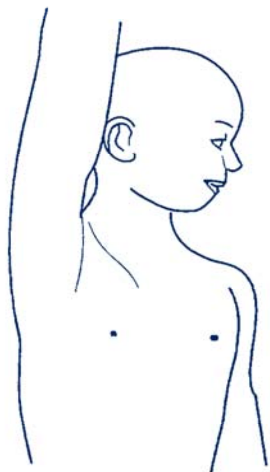
- What did they do? How many times? How long ago? What happened?
- How do they feel about the fact that they did not die?
- Do they wish they had died?
- Have things changed since then? What?
- Do they think that they might try again?

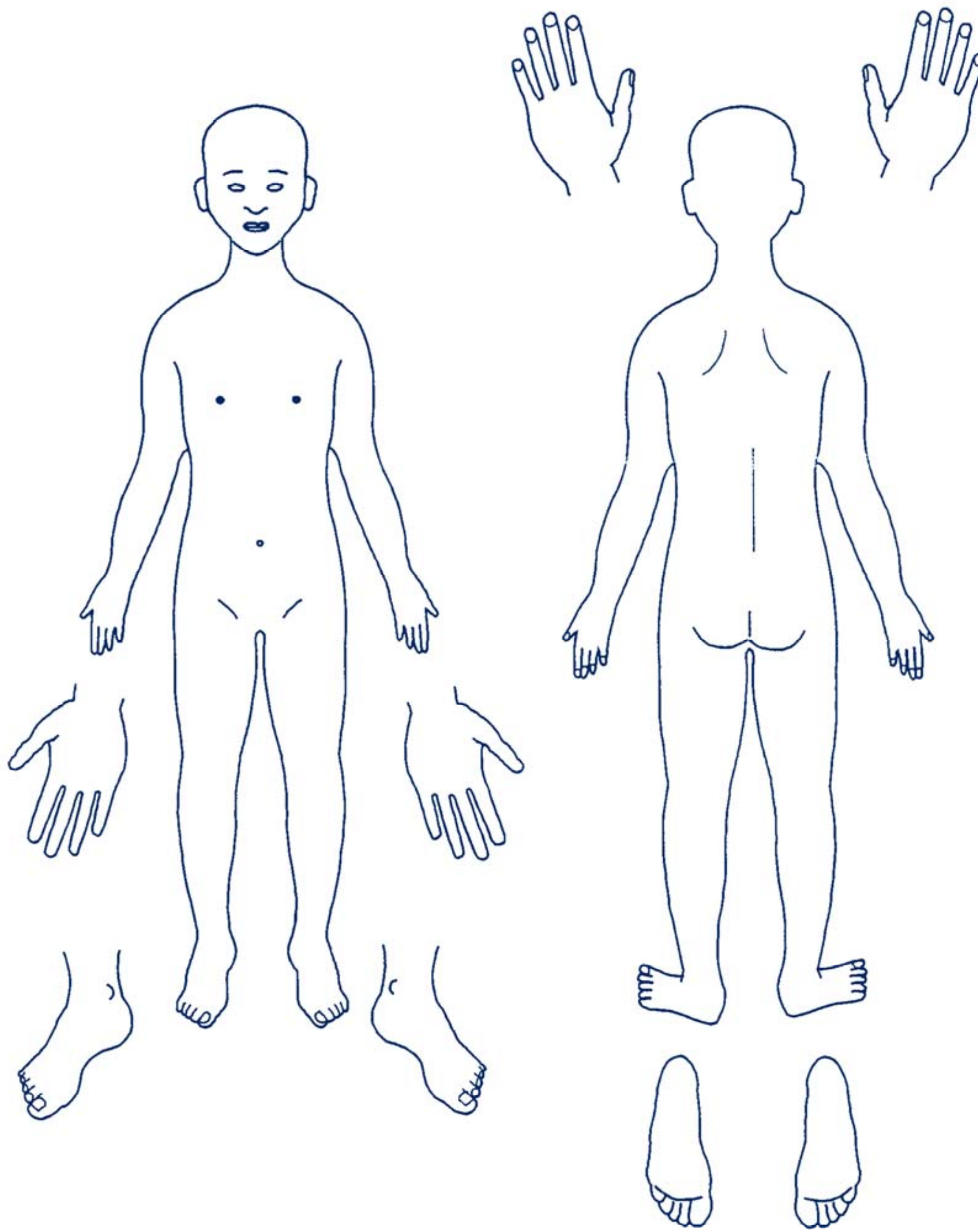
From: Goldenring, J.M., Cohen E. Getting into Adolescents' Heads, *Contemporary Paediatrics:* 1988, p 75-90.

# Appendix D

## Sample documentation form for child abuse







# Appendix E

## Photographing patient injuries

When offering to photograph injuries for documentation of assault, it is important to explain to the patient that:

- the photographs will become part of the patient's medical record, and can only be released to the Police or the person's lawyer with the patient's written permission
- the photographs will be very useful as evidence if the patient decides to prosecute the assailant
- The photographs may be used for further clinical diagnosis.

A request should be made to use photographs for teaching purposes.

The patient's permission to photograph must be obtained on a signed waiver (see below).

If possible, the photographs should be taken by the person who interviewed the patient, and should be taken at close range to the specific injury. Ideally each picture should contain an identifiable feature of the patient, such as the face, or hand holding an identifying document.

The back of each photograph should be signed and dated by the photographer and patient. The photograph should be put in a sealed envelope that can be attached securely to the patient's record. The envelope should be marked with the date and the notation, 'photographs of patient's injuries'. The release form should be kept next to the envelope.

## Permission to photograph

The undersigned hereby authorises: ______________________

Name of Practice

and the attending physician to photograph or permit other persons in the employ of this practice to photograph: ______________________

Name of Patient

while under the care of this facility, and agrees that the negatives or prints be stored in the patient's medical record, sealed in a separate envelope. The undersigned authorises the following uses to be made of these photographs.

## Permission to use photographs

These photographs may be released to the Police or patient's lawyer ○ Yes ○ No

These photographs may be used to assist with clinical diagnosis ○ Yes ○ No

These photographs may be used for teaching purposes ○ Yes ○ No

Date: / /

Patient's signature: ______________________

Witness's signature: ______________________

Name and address of minor patient's parent or legal guardian:

______________________

______________________

# Appendix F

## Referral fax to Child, Youth and Family National Call Centre Ph 0508 FAMILY (0508 326 459)

**To: Child, Youth and Family National Call Centre** **Fax: 09 914 1211**

From: ______________________ Date: / /

Provider's name: ______________________

Practice name: ______________________

Telephone: ______________________ Fax: ______________________

---

**Child's name:** ______________________ Also known as: ______________________

Contact address: ______________________

Date of birth: / / Ethnicity: ______________________

Date of presentation: / / Telephone: ______________________

---

Mother: ______________________ Telephone: ______________________

Address: ______________________

Father: ______________________ Telephone: ______________________

Address: ______________________

Caregiver: ______________________ Telephone: ______________________

Address: ______________________

---

History and physical findings:

______________________

______________________

______________________

______________________

______________________

---

Tick other agencies involved:

Name: ______________________ Telephone: ______________________

- ○ Paediatrician
- ○ Plunket
- ○ Open Home Foundation
- ○ Homebuilders
- ○ Police
- ○ Iwi/Māori Social Service
- ○ Family Start
- ○ Any others
- ○ Public Health Nurse
- ○ Barnardos
- ○ Pacific Peoples Social Service

Signed: ______________________ Date: / /

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The information contained in this and any attached pages are intended to be for the use of the addressee named on this transmitted 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.

# Appendix G

## Signs and symptoms associated with partner abuse

### Physical injuries

- Injuries to the head, face, neck, chest, breast, abdomen or genitals.
- Bilateral distribution of injuries, or injuries to multiple sites.
- Contusions, lacerations, abrasions, ecchymoses, 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 husband).
- Injuries or vaginal bleeding during pregnancy, spontaneous or threatened miscarriage.
- 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.

### Patient's manner

- Hesitant or evasive when describing injuries
- Distress disproportionate to injuries (for example, extreme distress over minor injury)
- Explanation does not account for injury (for example, 'I walked into a door')

### Illnesses

- Headaches, migraines.
- Musculoskeletal complaints.
- Gynaecological problems.
- Chronic pain.
- Malaise, fatigue.
- Depression.
- Insomnia.
- Anxiety.
- Chest pain, palpitations.
- Gastrointestinal disorders.
- Hyperventilation.
- Eating disorders.

### Serious psychosocial problems

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

### History

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

From: *The Oasis Protocol: Guidelines for identifying, treating and referring abused women.* Auckland: Injury Prevention Research Centre, 1996.

# Appendix H

## Recommended partner abuse screening guidelines for different settings

### Health care settings

Routine screening about partner abuse 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, screening for partner abuse should be taken once annually, unless circumstances suggest more frequent questioning is warranted.

### Primary care settings

*When should screening for abuse occur?*

- As part of routine health history.
- During visits for a new problem.
- Any new patient consultation.
- Any new intimate relationship.
- During any preventive care consultation (for example, cervical screening, mammography).

*What should patients be screened for?*

- At the first visit, female patients should be screened for any partner abuse, both physical or sexual, that occurred anytime in their lives.
- Annually, women should be screened for physical or sexual abuse over the past year.
- Male patients should be questioned about partner abuse when they present with signs or symptoms indicative of abuse.

### Emergency department/urgent care settings

*When should screening for abuse occur?*

- At every emergency department visit.

*What should patients be screened for?*

- Female patients should be screened for both physical and sexual abuse over the last year.
- Male patients should be questioned about partner abuse when they present with signs or symptoms indicative of abuse.

### Maternity and Sexual Health settings

*When should screening for abuse occur?*

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

*What should patients be screened for?*

- Screening should be about current (past year) and lifetime experience of both physical and sexual partner abuse.

## Paediatric settings

*When should screening for abuse occur?*

- As part of well child assessments.
- When family violence is suspected.

*What should patients be screened for?*

- Women should be screened for both physical or sexual abuse over the past year.
- Male patients should be questioned about partner abuse when they present with signs or symptoms indicative of abuse.

## Mental health settings

*When should screening for abuse occur?*

- As part of every initial assessment.
- At every new intimate relationship.
- Annually, if receiving ongoing or periodic treatment.

*What should patients be screened for?*

- At the first visit, patients should be screened for any partner abuse, both physical and sexual, that occurred anytime in the woman's life.
- Annually, women should be screened for physical and sexual abuse over the past year.
- Male patients should be questioned about partner abuse when they present with signs or symptoms indicative of abuse.

## Inpatient settings

*When should screening for abuse occur?*

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

*What should patients be screened for?*

- Female patients should be screened for both physical and sexual partner abuse over the last year.
- Male patients should be questioned about partner abuse when they present with signs or symptoms indicative of abuse.

Adapted from: *Family Violence Prevention Fund: Preventing Domestic Violence: Clinical Guidelines on Routine Screening*. San Francisco: Family Violence Prevention Fund, 1999. www.fvpf.org

# Appendix I

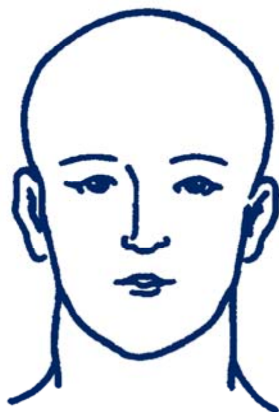
## Family Violence Identification/Documentation Form

Patient Name ______________________ Patient ID# ______________

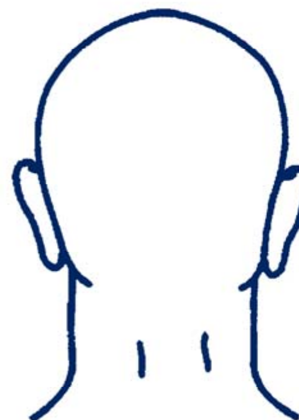
Provider Name ______________________ Time/Date ______________

FV Screen ○ FV+ (Positive) ○ FV? (Suspected)

Patient Pregnant ○ Yes ○ No



○ Face
○ Eyes
○ Nose
○ Mouth
○ Ears
○ Neck



○ Scalp
○ Ears
○ Neck

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

### Assess Patient Safety

○ Yes ○ No Is abuser here now?
○ Yes ○ No Is patient afraid to go home?
○ Yes ○ No Has partner physically abused children?
○ Yes ○ No Is there a gun in the home?
○ Yes ○ No Have children witnessed the violence?
○ Yes ○ No Threats of homicide?
○ Yes ○ No Threats of suicide?
○ Yes ○ No Is patient afraid of their partner?
○ Yes ○ No Has the violence increased in severity?
○ Yes ○ No Alcohol or substance abuse?
○ Yes ○ No Has a safety plan been discussed?

Describe ______________________

By whom ______________________

By whom ______________________

REFERRALS

○ Family violence referral agency number given
○ Police called
○ Legal referral made
○ Refuge number given
○ In-house referral made
○ Other referral made

REPORTING

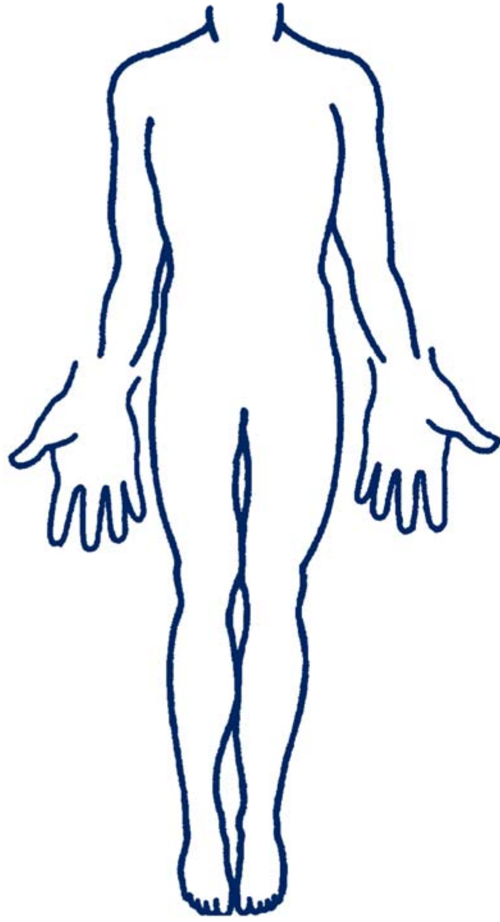
○ CYF Referral

PHOTOGRAPHS

○ Yes ○ No Consent to be photographed
○ Yes ○ No Photographs taken

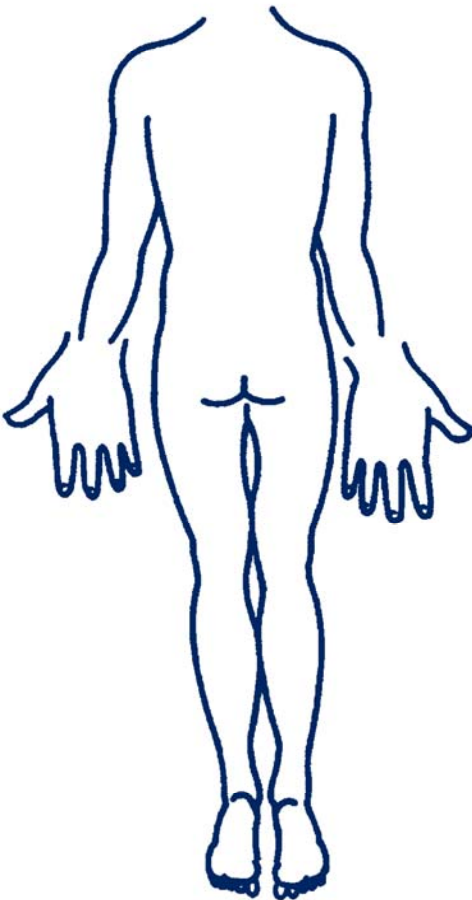
*Attach photographs and consent form*

Adapted from: *Family Violence Prevention Fund: Preventing Domestic Violence: Clinical Guidelines on Routine Screening.* San Francisco: Family Violence Prevention Fund, 1999. www.fvpf.org



## FRONT

- ○ Shoulders
- ○ Breast
- ○ Thorax
- ○ Upper Arm
- ○ Lower Arm
- ○ Hands
- ○ Abdomen
- ○ Upper Leg
- ○ Lower Leg
- ○ Feet



## BACK

- ○ Shoulders
- ○ Back
- ○ Upper Arm
- ○ Lower Arm
- ○ Hands
- ○ Buttocks
- ○ Upper Leg
- ○ Lower Leg
- ○ Feet

# Appendix J

## Safety plan – patient resource

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

### ( 1 ) Avoiding injury, escaping violence

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

- Leave if you can. Know the easiest escape routes – doors, windows, etc. What's in the way? Are there obstacles to a speedy exit?
- Know where you are running to and have a safe place arranged. You may want to organise this with a neighbour in advance of trouble. You may want to leave a spare set of clothes there.
- Always keep your purse, cash cards, keys, essential medications and important papers together in a place where you can get them quickly or have someone else fetch them.
- If you can't leave the house, try to move to a place of low risk. Try to keep out of the bathroom, kitchen, and garage, away from weapons, upstairs or rooms without access to outside.
- Talk to your children about getting help. Think of a code word you could say to your children or friends so they can call for help. Depending on age and ability they could:
    - Run to a neighbour and ask them to call the Police.
    - Call 111. Teach them the words to use to get help. ('This is Jimmy, 99 East Street. Mum's getting hurt. She needs help now.')
    - Go to a safe place outside the house to hide. Arrange this in advance.
- Try to leave quietly. Don't give your attacker clues about the direction you've taken or where you've gone to. Lock doors behind you if you can – it will slow down any attempt to follow you.
- Have refuge or safe house numbers memorised or easy to find.
- If you have to leave to save your life – leave fast. Take nothing and go to the nearest safe place and call for help.

### ( 2 ) Preparation for separation – advance arrangements and flight plans

- Get support from a Women's 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 Domestic Violence 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.
- Phone card and list of important addresses and phone numbers.
- For children take essential school needs, favourite toy or comforter.
- Photograph of your partner so that people protecting you know what he looks like.

**Playing it safe**

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

## ( 3 ) Living safely, after separation

*Children*

- Teach your children what to do if your ex-partner makes contact with them unexpectedly, breaching access arrangements, that is, rules about checking first before opening the door, coming inside or going to neighbours if 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 (for example, 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 Women's 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 WINZ, Housing New Zealand or other government departments you may need to deal with.
- Attend a women'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.

### *Protection Orders*

- Get a Protection Order from your local District Court. Make four copies – one for your handbag, one kept at home, and one at work. Make sure your local Police Station has a copy. If you move, remember to give a copy to your new local Police Station. Tell your employer that you have a Protection Order, or that you are afraid of your ex-partner.
- If your ex-partner breaches the Protection Order phone the Police and report it, contact your lawyer and your advocate.
- If the Police do not help, contact your advocate or lawyer for assistance to make a complaint.
- Keep a record of any breaches; noting the time, date and what occurred and what action you took.

### *Security*

- Consider installing outside lighting that lights up when a person comes near your house at night.
- If possible, use different shops and banks to those you used when you lived with your ex-partner.
- Ask Telecom to install 'Caller ID' on your telephone and ask for an unlisted number that blocks your caller ID 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 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 he is seen near your house.
- Ask your neighbours to contact the Police if they hear signs of an assault occurring.

From: Auckland Domestic Violence Centre. Safety Plan.

# Appendix K

## Excerpts from relevant legislation

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

Paramountcy Principle (section 6):

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

Reporting (section 15):

> *"Any person who believes that any child or young person has been, or is likely to be, harmed (whether physically, emotionally or sexually) ill-treated, abused, neglected, or deprived may report the matter to a Social Worker or a member of the Police."*

Protection when disclosing (section 16):

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

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

Responsibility for investigation (section 17):

> *"Where any Social Worker or member of the Police receives a report pursuant to Section 15 of this Act relating to a child or young person, that Social Worker or member of the Police shall, as soon as practicable after receiving the report, undertake or arrange for the undertaking of such investigation as may be necessary or desirable into the matters contained in the report and shall, as soon as practicable after the investigation has commenced, consult with a Care and Protection Resource Panel in relation to the investigation."*

### Crimes Act 1961

Inform the Police if you have information relating to crimes such as the following:

> *"...homicide, sexual abuse, any assault on a child under the age of 16 years, or any assault on any person where that person has sustained some serious wound, disfigurement, grievous bodily harm or serious injury, or the nature of the injury or circumstances of the injury indicate that Police intervention is necessary for the further protections of the victim or any other offence included in Part 8 of the Crimes Act (Sections 151-210).*
>
> *Failure to provide the necessities of life, abandonment, cruelty and abduction are offences in relation to children."*

### Domestic Violence Act 1995

Meaning of domestic violence as defined in the Domestic Violence Act 1995:

(1) 'domestic violence' in relation to any person, means violence against that person by any other person with whom that person is, or has been, in a domestic relationship with.

(2) In this section, 'violence' means:

- (a) Physical abuse
- (b) Sexual abuse
- (c) Psychological abuse, including but not limited to:
  - (i) intimidation harassment

(ii) damage to property

(iii) threats of physical abuse, sexual abuse or psychological abuse

(iv) in relation to a child, abuse of the kind set out in subsection (3) of this section.

(3) Without limiting subsection (2)(c) of this section, a person psychologically abuses a child if that person

(a) Causes or allows the child to see or hear the physical, sexual or psychological abuses of a person with whom the child has a domestic relationship; or

(b) Puts the child, or allows the child to be put, at real risk of seeing or hearing that abuse occurring;

But the person who suffers that abuse is not regarded, for the purposes of that subsection, as having caused or allowed the child to see or hear the abuse, or, as the case may be, as having put the child, or allowed the child to be put, at risk of seeing or hearing the abuse.

(4) Without limiting subsection (2) of this section

(a) A single act may amount to abuse for the purposes of that subsection

(b) A number of acts that form part of a pattern of behaviour may amount to abuse for that purpose, even though some or all of those acts, when viewed in isolation, may appear to be minor or trivial.

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

## Health Act 1956

Section 22C of the Health Act 1956 provides guidance on when a doctor can release health information.

(1) Any person (being an agency that provides health services, or disability services, or both, or being a funder) may disclose health information

(a) If that information

(i) Is required by any person specified in subsection (2) of this section; and

(ii) Is required for the purpose set out in that subsection in relation to the person so specified; or

(b) If that disclosure is permitted –

(i) By or under a code of practice issued under section 46 of the Privacy Act 1993…

(2) The persons and purposes referred to in subsection (1)(a) of this section are as follows: …

(c) A Social Worker or a Care and Protection Co-ordinator within the meaning of the Children, Young Persons, and Their Families Act 1989, for the purposes of exercising or performing any of that person's powers, duties, or functions under the Act.

## Health Information Privacy Code 1994

Rule 11 (Limits on disclosure of health information)

(1) A health agency that holds health information must not disclose the information unless the agency believes, on reasonable grounds: ...

(b) that the disclosure is authorised by:

(i) the individual concerned; or

(ii) the individual's representative where the individual is dead or is unable to give his or her authority under this rule; ...

(2) Compliance with paragraph (1)(b) is not necessary if the health agency believes on reasonable grounds that it is either not desirable or not practicable to obtain authorisation from the individual concerned and:

(a) that the disclosure of the information is directly related to one of the purposes in connection with which the information was obtained:

(b) that the information is disclosed by a registered health professional to a person nominated by the individual concerned or to the principal care giver or a near relative of the individual concerned in accordance with recognised professional practice and the disclosure is not contrary to the express wish of the individual or his or her representative; ...

(d) that the disclosure of the information is necessary to prevent or lessen a serious and imminent threat to:

(i) public health or public safety; or

(ii) the life or health of the individual concerned or another individual: …

(i) that non-compliance is necessary:

(i) to avoid prejudice to the maintenance of the law by any public sector agency, including the prevention, detection, investigation, prosecution, and punishment of offences; or...

(ii) for the conduct of proceedings before any court or tribunal (being proceedings that have been commenced or are reasonably in contemplation);

(3) Disclosure under subrule (2) is permitted only to the extent necessary for the particular purpose…

(5) This rule applies to health information about living or deceased persons obtained before or after the commencement of this code.

(6) (Despite subrule (5), a health agency is exempted from compliance with this rule in respect of health information about an identifiable deceased person who has been dead for not less than 20 years.)

**Note:** Except as provided in subrule 11(4) nothing in this rule derogates from any provision in an enactment which authorises or requires intonation to be made available, prohibits or restricts the availability of health information or regulates the manner in which health information may be obtained or made available – Privacy Act 1993, s7. Note also that rule 11, unlike the other rules, applies not only to information about living individuals, but also about deceased persons – Privacy Act 1993, s46(6).

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

## Other relevant legislation

### The Health and Disability Services Act 2001

This Act will focus on systems for preventing harm caused by providers of health and disability services and licensing requirements of service providers. This legislation (and related standards) may be relevant in cases of elder abuse and neglect in residential settings and/or abuse involving a contracted caregiver. The Bill provides for the Minister of Health to issue service standards which providers must comply with.

### Health and Disability Sector Standards

NZS 8134:2001: These standards contain generic provisions across the whole of the health and disability sector, including home-based health care service providers. The standards include issues of quality and safe practice.

Other standards: A number of other standards contain information that may be relevant to issues of abuse. These include the National Mental Health Standard NZS 8143, and the Restraint Minimisation and Safe Practice Standard NZS 8141:2000.

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

# Appendix L

## Responses to perpetrators of partner abuse

Intervention with the perpetrators of partner abuse is an area of expert practice. If you are providing support to the victim, it is vital that you maintain their complete confidentiality. In most cases it is best to simply refer to the National Network of Stopping Violence Services. However, the following guidelines can assist if the perpetrator brings up the abuse in consultation, or if other circumstances warrant such a discussion.

### Basic principles

- Information from the victim must be kept completely confidential.
- Discussions with the perpetrator about the partner abuse should never be done in the presence of the victim.

### If discussing partner violence with the perpetrator

- Frame discussion of abuse as a health care issue.
- Emphasise the routine nature of the discussion.
- Focus on descriptions of the abuser's behaviour, never on victim's reports of any incident.
- Focus on the abuser's behaviour, rather than the victim's behaviour.
- Use a direct and calm approach.

### If perpetrator displays anger, resists or rejects the discussions of abuse

Make a summary statement, calmly bring the subject to a close, and then move back to the presenting medical issue. For example, 'Your using force against your partner and/or child is damaging to everyone. I am concerned and will be glad to make a referral whenever you want it.'

### Lethality assessment with the perpetrator

The referral agency should carry out a detailed lethality assessment with the perpetrator. If you have knowledge about any of these factors, it is important to pass the information on to the referral agency.

*Pattern of abuse*

- Frequency and severity of abusive acts in current, concurrent and past intimate relationships.
- Possible escalation in frequency and severity.
- Availability and use of weapons.
- Threats to kill self or others; credible plans and means to kill.
- Stalking behaviour.
- Use of violence outside of the family.
- Hostage-taking behaviour.

*Factors that reduce cognitive controls*

- Alcohol/drug dependence or abuse.
- Certain medications.
- Psychosis or brain damage.

### *Perpetrator's state of mind*

- Obsession with victim.
- Increased risk-taking by perpetrator.
- Ignoring negative consequences of his abusiveness.
- Depression; desperation.
- Suicide potential.

### *Situational factors*

- Separation violence.
- Increased autonomy of victim.
- Other major stresses.
- Past failure of the community to respond.

From Ganley A. 1995. Health Care Responses to Perpetrators of Domestic Violence. In: *Improving the Health Care System's Response to Domestic Violence: A Resource Manual for Health Care Providers.* San Francisco: Family Violence Prevention Fund.

# Appendix M

## The power and control wheel

Domestic Abuse Intervention Project, 202 East Superior Street, Duluth, MN55802, USA.

# Appendix N

## The Whare Tapa Whā model

The Whare Tapa Whā is a model of health widely accepted by Māori. This model compares health to 'the four walls of a house, all four being necessary to ensure strength and symmetry, each wall representing a different dimension of health – taha wairua, taha tinana, taha hinengaro and taha whānau'.

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

## The He Taura Tieke – measuring effective health services for Māori

Traditionally, a taura tieke was a measuring line used in the building of a house. It was designed to check the symmetry of the diagonals, so that the walls would be even and the house would be strong. The aim of this taura tieke is to contribute to the strengthening of the whare hauora.

Māori consumers have clear expectations of the health services they use. Sometimes these expectations are the same or similar to those of other populations or communities. Sometimes they are different. Current health service policy focuses on improving access to services for Māori and other specific populations (for example, children) who, by comparison, fare less well in their health status.

'He Taura Tieke' identifies those key health service attributes that are effective for Māori consumers and presents them in a checklist framework. This checklist will help you to meet the needs and expectations of Māori consumers of health services. In particular, it will assist you to better plan, develop and manage health services for Māori consumers.

There are a number of potential frameworks for describing health service effectiveness. He Taura Tieke consists of three key elements which research tells us are consistent with Māori views. These elements are technical and clinical competence, structural and systemic responsiveness, and consumer satisfaction.

Ministry of Health. 1995. *He Taura Tieke: Measuring effective health services for Māori.* Wellington: Ministry of Health.

# Appendix O

## Local referral agency contact information

| **Child abuse referral agencies** | **Contact** | **Notes** |
|---|---|---|
| Child Youth and Family Service | | |
| Paediatrician | | |
| Police | | |
| Police Child Abuse Team | | |
| Child Abuse Prevention Society | | |
| Anger Change for Women | | |
| Doctors for Sexual Abuse Care | | |
| Barnados | | |
| Parentline | | |
| | | |
| | | |
| **Partner abuse referral agencies** | | |
| Women's Refuge | | |
| Family Violence Interagency networks | | |
| Women's Support Groups | | |
| Stopping Violence Services | | |
| | | |
| | | |
| **Māori, Pacific and other social service agencies** | | |
| Māori Social Services Organisations | | |
| Pacific Social Services Organisations | | |
| Asian and refugee social service organisations | | |
| Family Start | | |
| | | |
| | | |

# Appendix P

## Creating a Model Response to Child Abuse

### 29 Point Assessment of your Service's Response

Assess before any programme implementation and then every six months

| Date of Assessment: / / | Y/N | Y/N | Y/N |
|---|---|---|---|
| **PROTOCOLS** | | | |
| **Are policies and protocols specific to child abuse:** 1. in the official hospital or service policy? | | | |
| 2. present within relevant clinics, wards and other services? | | | |
| 3. officially adopted (with notation)? | | | |
| **Do these protocols:** 4. meet Ministry of Health standards? | | | |
| 5. define child abuse? | | | |
| 6. address documentation? | | | |
| 7. address referral? | | | |
| 8. Does the protocol clearly state the specific staff responsibility for child abuse? | | | |
| 9. Does the protocol have administrative support from the CEO? | | | |
| **CHILD ABUSE TASK FORCE** | | | |
| 10. Does the clinic/hospital/health care system have a child abuse task force? | | | |
| 11. Is the task force multi-disciplinary? | | | |
| **Does the child abuse task force:** 12. have goals and objectives? | | | |
| 13. meet at least every two months? | | | |
| 14. Has the child abuse task force established a relationship with the local CYF or have a member on its task force from CYF? | | | |
| 15. Does the protocol of Child Abuse Task Force or any of the activities of the Task Force have financial support from the CEO? | | | |

Assess prior to any programme implementation and then every 6 months

| Date of Assessment: / / | Y/N | Y/N | Y/N |
|---|---|---|---|
| **TRAINING IN CHILD ABUSE** | | | |
| 16. Has clinical staff training been scheduled in the past year? | | | |
| 17. Is there evidence clinical staff training will be ongoing? | | | |
| 18. Has non-clinical staff training been scheduled in the past year? | | | |
| 19. Is there evidence non-clinical staff training will be ongoing? | | | |
| 20. Are staff mandated to attend child abuse training? | | | |
| 21. Is new staff orientation mandated in the training protocol? | | | |
| 22. Is training held during paid working hours on all shifts? | | | |
| 23. Is there an evaluation of the training's effectiveness? | | | |
| 24. Has cultural competency training ever occurred in the past two years? | | | |
| **INTERVENTIONS IN CHILD ABUSE** | | | |
| 25. Are brochures related to child abuse on display anywhere in the clinic/hospital/health care system? | | | |
| 26. Are there any brochures about child abuse in the waiting rooms? | | | |
| 27. Are posters related to child abuse on display so that patients can see them? | | | |
| 28. Does the clinic/hospital/health care system have access to any off-site advocates or on-site social workers that can be used for further case management or in-depth advocacy? | | | |
| **EVALUATIONS OF CHILD ABUSE PRACTICE** | | | |
| 29. Has there been an evaluation of the quality of assessment and documentation completed through a review of the medical record? | | | |

Developed by the Family Violence Prevention Fund and the Centre for Violence and Injury Control, Allegheny University of the Health Sciences

# Creating a Model Response to Partner Violence

## 35 Point Assessment of your Service's Response

Assess before any programme implementation and then every 6 months

| Date of Assessment: / / | Y/N | Y/N | Y/N |
|---|---|---|---|
| **POLICIES and PROTOCOLS** | | | |
| Are policies and protocols specific to partner violence:<br>1. in the official hospital or service policy? | | | |
| 2. present within relevant clinics, wards and other services? | | | |
| 3. officially adopted (with notation)? | | | |
| Do these protocols:<br>4. meet Ministry of Health standards? | | | |
| 5. define partner abuse? | | | |
| 6. address documentation? | | | |
| 7. address referral? | | | |
| 8. Does the protocol specify screening for partner violence (who screens, how and when screening should occur)? | | | |
| 9. Does the protocol clearly state the specific staff responsibility for domestic violence? | | | |
| 10. Does the protocol have administrative support from the CEO? | | | |
| 11. Has your clinic/hospital/health care system established employee policies and procedures that respond to partner violence among employees? | | | |
| **DOMESTIC VIOLENCE TASK FORCE** | | | |
| 12. Does the clinic/hospital/health care system have a partner violence task force? | | | |
| 13. Is the partner violence task force multi-disciplinary? | | | |
| Does the domestic violence task force:<br>14. have goals and objectives? | | | |
| 15. meet at least every two months? | | | |
| 16. Has the partner violence Task Force established a relationship with the local partner violence program, or have a member of its Task Force from the local domestic violence program? | | | |
| 17. Does the protocol of Domestic Violence Task Force or any of the activities of the Task Force have financial support from the clinic/ hospital/ health care system CEO? | | | |

Assess prior to any programme implementation and then every 6 months

| Date of Assessment: / / | Y/N | Y/N | Y/N |
|---|---|---|---|
| **TRAINING IN PARTNER VIOLENCE** | | | |
| 18. Has clinical staff training been scheduled in the past year? | | | |
| 19. Is there evidence clinical staff training will be ongoing? | | | |
| 20. Has non-clinical staff training been scheduled in the past year? | | | |
| 21. Is there evidence non-clinical staff training will be ongoing? | | | |
| 22. Are staff mandated to attend partner violence training? | | | |
| 23. Is new staff orientation mandated in the training protocol? | | | |
| 24. Is training held during paid working hours on all shifts? | | | |
| 25. Is there an evaluation of the training's effectiveness? | | | |
| 26. Has cultural competency training ever occurred in the past two years? | | | |
| **INTERVENTIONS IN PARTNER VIOLENCE** | | | |
| 27. Are brochures related to partner violence on display anywhere in the clinic/hospital/health care system | | | |
| 28. Are there any brochures of partner violence information in the women's rooms? | | | |
| 29. Are posters related to partner violence on display so that patients can see them? | | | |
| 30. Does the medical record have partner violence screening questions or a place to record whether or not screening has occurred or a partner violence intervention check list? | | | |
| 31. Are 'Domestic Violence Kits' or other materials readily available that staff can use when a victim of partner violence is identified? | | | |
| 32. Are there patient discharge sheets or brochures with referrals to partner violence services available? | | | |
| 33. Does the clinic/hospital/health care system have access to any off-site advocates or on-site social workers that can be used for further case management or in-depth advocacy? | | | |
| 34. Is a respite room provided for victims of partner violence that cannot get to a shelter? | | | |
| **EVALUATIONS OF PARTNER VIOLENCE PRACTICE** | | | |
| 35. Has there been an evaluation of the quality of screening, assessment and documentation completed through a review of the medical record? | | | |

Developed by the Family Violence Prevention Fund and the Centre for Violence and Injury Control, Allegheny University of the Health Sciences

# Glossary

**Child:** 0–14 years old.

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

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

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

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

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

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

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

- *Physical abuse* includes acts of violence that may result in pain, injury, impairment or disease. This may include hitting, choking or in any way assaulting another person, and also under/over medication. There is usually visible evidence of physical abuse (bruising, fractures, burns lacerations, etc) though the differences between accidental injury and abuse can be slight and require expert investigation.

- *Psychological and emotional abuse* includes any behaviour that causes anguish or fear. Intimidation, harassment, damage to property, threats of physical or sexual abuse, the removal of decision-making powers (in relation to adults), and (in relation to a child) exposing the child to the physical, psychological or sexual abuse of another person. Concerted attacks on an individual's self-esteem and social competence results in increased social isolation.
- *Sexual abuse* includes any forced, coerced or exploitive sexual behaviour or threats imposed on an individual, including sexual acts imposed on a person unable to give consent, or sexual activity an adult with mental incapacity is unable to understand.

**Partner abuse** (also called intimate partner violence) is physical or sexual violence, psychological/ emotional abuse, or threat of physical or sexual violence that occurs between intimate partners.

- *Intimate partners include:* current spouses (including de facto spouses), current non-marital partners (including dating partners, heterosexual or same-sex), former marital partners and former non-marital partners.

**Routine screening** is a routine enquiry, either written or verbal, by health care providers to patients about personal history of partner abuse, child abuse or neglect. Unlike indicator-based questioning, routine questioning means routinely questioning all individuals, or specified categories of individuals, about abuse.

**Young person:** 14–17 years old.

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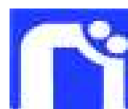

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