TABLE OF CONTENTS

Purpose		2
Principles		2
Scope		2
Terms and Definitions		3
Organisation Responsibilities		3
Partner Abuse: Assessment and Response – Flowchart		4
Maori and the Family Violence Intervention Programme		5
Pacific Peoples and the Family Violence Intervention Programme		5
Brief Intervention Model, A Six Step Process		5
Safety and Security Procedures		7
Staff Resources		7
Reference Documents		8
Appendix 1 -	Terms and Definitions	9
Appendix 2 -	Maori and Family Violence	11
Appendix 3 -	Pacific Peoples and Family Violence	13
Appendix 4 -	Recommended Partner Abuse Screening Guidelines for Different Settings	14
Appendix 5 -	Signs and Symptoms Associated with Partner Abuse	17
Appendix 6 -	Guidelines for Identifying Victims of Abuse (Step 1)	18
Appendix 7 -	Guidelines to Support and Empower Victims of Abuse (Step 2)	19
Appendix 8 -	Guidelines for Risk Assessment (Step 3)	20
Appendix 9 -	Guidelines for Safety Intervention (Step 4)	21
Appendix 10 -	Safety Plan – Patient Resource	23
Appendix 11 -	Guidelines for Documentation of Family Violent (Step 5)	26
Appendix 12 -	Safety and Security	27

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PURPOSE

This policy provides all District Health Board (DHB) staff with a framework to identify and manage family violence.

The policy also provides guidelines for the development of unit specific policies relating to identification and management of family violence.

PRINCIPLES

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.

The Ministry of Health's Family Violence Intervention Guidelines [1] guide this policy.

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

Health services should identify, assess, offer referral and advocate for victims of family violence.

Staff will be competent in identification and management of actual or potential family violence through the organisation's family violence intervention policies, procedures and education programme.

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

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

SCOPE

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

The policy specifically relates to the identification, assessment, management and referral of victims of Partner Abuse. See also Management of Child Abuse and Neglect Policy (DHB).

[1] This policy, including the flowchart is based on Fanslow, J. L. Family Violence Intervention Guidelines. Wellington: Ministry of Health, 2002.

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TERMS AND DEFINITIONS

All terms and definitions related to this document have been defined. See Appendix 1.

ORGANISATIONAL RESPONSIBILITIES

Executive Responsibilities

DHB is responsible for:

- Ensuring there is an organisation-wide policy for the management of partner abuse
- Regular training for staff in the policy
- Processes to ensure the policy is adhered to, such as clinical audit
- Providing adequate support and supervision for staff.

These activities need to be properly resourced and evaluated.

Unit Responsibilities

All units that provide care to patients and families will have a unit-level partner abuse policy based on the organisational policy. Implementation will include a process for monthly reporting to the Co-ordinator of FVIP.

Employee Responsibilities

All employees of DHB have a responsibility for the management of suspected abuse and neglect.

Responsibilities include:

- To be conversant with DHB policy
- To understand how to identify, manage and refer victims of suspected partner abuse.
- To attend initial training and regular updates appropriate to their area of work
- To provide or access DHB specialist health services that may include:
  - Cultural assessments
  - Mental Health assessments
  - Diagnostic medical assessments
  - Social work services, counselling and therapy resources
  - Paediatric assessment for any children who may be at risk
- Safe practice, for example seeking supervision after each disclosure of partner abuse, or consulting with a senior colleague in complex cases.

Co-ordinator of the Family Violence Intervention Programme Responsibilities

- Provide monthly analysis of clinical management processes
- Ensure provision of training in Partner Abuse is available cyclically
- To be available to staff for consultation regarding family violence concerns
- Will provide an annual report on policy compliance.

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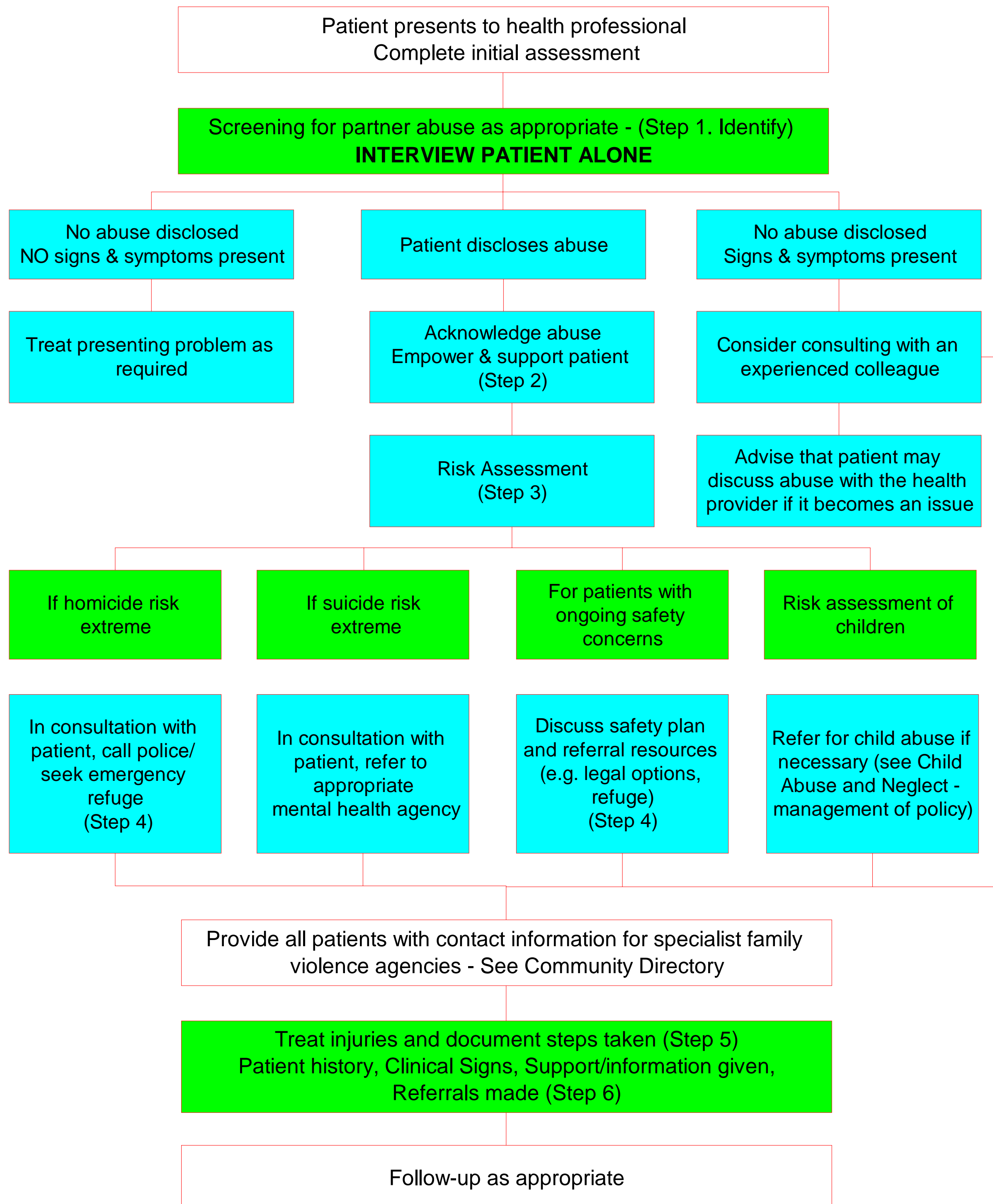
PARTNER ABUSE: ASSESSMENT AND RESPONSE FLOWCHART



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MAORI AND THE FAMILY VIOLENCE INTERVENTION PROGRAMME

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

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

Routinely screen Maori women for violence. Offer women options about possible plans of action they would like to take, including appropriate referral options.
See Appendix 2 for Maori and family violence

PACIFIC PEOPLES AND THE FAMILY VIOLENCE INTERVENTION PROGRAMME

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

See Appendix 3 for Pacific peoples and family violence.

BRIEF INTERVENTION MODEL, A SIX-STEP PROCESS

1. Identify

All females aged 16 years and older should be *screened routinely.* This includes questioning about physical and sexual partner abuse, or if they are afraid of a current or past partner. See Appendix 4 for validated questions.

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 abuse should be questioned.

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

See Appendix 4 for Recommended Partner Abuse Screening Guidelines for Different Settings.

See Appendix 5 for Signs and Symptoms of Partner Abuse.

See Appendix 6 for Guidelines on Identifying Abuse.

2. Support and Empower Victims of Abuse

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

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professionals can provide. It is not necessary to take a full history of the abuse and it may be unhelpful.

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

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

See Appendix 7 for Guidelines on Supporting and Empowering Victims of Abuse.

3. Assess Risk

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

See appendix 8 for Guidelines on Risk Assessment.

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

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

When partner abuse is identified a history of child abuse must be sought. For the assessment and management of children who may be at risk of abuse refer to the DHB Management of Child Abuse and Neglect, Policy.

4. Safety Planning and Referral

If partner abuse is identified or suspected a plan for safety needs to be made following the risk assessment. A multidisciplinary team approach is the preferred option.
Except in rare cases where victims of partner abuse are in immediate danger, for most adult victims of partner abuse, affirmation may be the most powerful intervention you can offer.
Women's refuge is available as a safe place for women who wish to leave.
See the Family Violence Community Directory in your department for contact details including phone numbers.

See Appendix 9 for Guidelines on Identifying Safety Needs.

See Appendix 10 for Guidelines on Safety Planning.

5. Document

Accurate documentation is an important part of keeping victims safe because the clinical record may help in future legal action, for example securing a Domestic Protection Order or prosecuting assault. An objective, systematic history and risk assessment is therefore essential. Standard professional requirements also apply (e.g. a legible signature and designation).

See Appendix 11 for Guidelines for Documentation of Family Violence.

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Confidentiality is paramount. An Accessory File for Family Violence disclosures should be created and held in medical records (identifiable on the medical records screen). The Family Violence Identification/Documentation Form should be completed, placed in a sealed envelope, marked “Confidential” and forwarded to the Medical Records Manager. This information will be loaded onto to the IBA system and is the available to designated DHB computer users.

6. Referral Agencies

Referral agencies are a vital service for the support of victims of abuse. DHB has established interagency processes with a range of organisations and agencies (refer to the Family Violence Community Directory in your Department).

SAFETY AND SECURITY PROCEDURES

At times it may be necessary to suppress patient details and provide secure processes for discharge of women. The guidelines for use when staff assess the safety of a victim of abuse to be high risk are outlined in Appendix 12. In these circumstances, staff may choose, in consultation with the victim, to:

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

STAFF RESOURCES

1. Training

Family Violence training is mandatory for all Health*care* Services staff working with children and women.

The training includes:

- A one hour introduction session or pre-reading
- A full day (8 hour) training session.

Access to the Family Violence Intervention Programme training can be obtained through:

- Education Administrator
- Family Violence Intervention Programme Service Administrator
- Co-ordinator of Family Violence Intervention Programme
- Child Protection Co-ordinator

Staff are required to undertake refresher training annually.

Advanced training will be offered to designated staff.

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2. Supervision

Clinical supervision for staff is recognised as an important requirement to ensure the practice of routinely questioning women for partner abuse remains safe for patients and staff.

Clinical supervision is mandatory for staff to whom a disclosure has been made and is available within the service/ department. The staff counsellor is available should further counselling be required.

3. MoH Family Violence Intervention Guidelines

This resource is available in all departments and services. For copies access can be made online at: http://www.moh.govt.nz

4. Other resources

A number of other resources have been written to support safe practice in family violence. These include a Directory of Community Services, cue cards with sample framing and risk assessment questions, specific partner abuse documentation and a support card for victims.

REFERENCE DOCUMENTS

Type	Document Title(s)
Organisational Policies	• Child Abuse and Neglect, Management of Policy (DHB). • Event Reporting Policy (DHB) • Interpreter Service Policy (DHB) • Photograph policy (DHB) • Police-Release of Health Information and Patient Property Policy, (DHB).
Legislation	• Privacy Act (1993) • Crimes Act (1961)
Associated Documents	• Fanslow, J. L. Family Violence Intervention Guidelines. Wellington: Ministry of Health, 2002.

For further information contact the Co-ordinator of Family Violence Intervention Programme.

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APPENDIX 1

TERMS AND DEFINITIONS[1]

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

Child	In this document the word child refers to children/tamariki aged 0-14 years inclusive. Note that the Child, Young Persons and their Families Act covers young people up to their 17th birthday.
Child Protection	Activities carried out to ensure the safety of the child in cases where there is abuse or risk of abuse.
Child Abuse	The harming (physically, emotionally, or sexually), ill treatment, abuse, neglect or serious deprivation of any child/tamaiti, or young person (Section 14b Children, Young Persons and their Families Act 1989).
Physical Abuse	Child physical abuse is any act or acts that may result in inflicted injury to a child or young person.
Child Sexual Abuse	Child sexual abuse is any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not.
Child Emotional/ Psychological Abuse	Child emotional/psychological abuse is any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person.
Neglect	Child neglect is any act or omission that results in impaired physical functioning, injury, and/or development of a child or a young person. This includes physical and medical neglect, neglectful supervision, abandonment and refusal to assume parental responsibility.
Family Violence	Violence or abuse of any type, penetrated 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 diseases, may include hitting, choking or in any way assaulting another person, and also under/over medication. There is usually visible evidence of physical abuse (bruising, fractures, burns, lacerations etc) though the difference between accidental injury and abuse can be slight and require expert investigation.

[1] Fanslow, J. L. Family Violence Intervention Guidelines. Wellington: Ministry of health, 2002.

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

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APPENDIX 2

MAORI AND FAMILY VIOLENCE

This section from the Family Violence Intervention Guidelines[1] was developed with consultation from the Ministry of Health Family Violence Maori Advisory Committee. This appendix offers some background and context for family violence in relation to Maori, and identifies key principles and actions for effective screening and intervention.

The experience of family violence for Maori is complex. The historical context and process of colonisation have distanced Maori from their traditional roles and social supports. With the breakdown of traditional whanau structure, loss of beliefs and values, including te reo Maori, patterns of behaviour have emerged. For some Maori family violence is no longer viewed as prohibited and the traditional sanctions are no longer in place. Violence impacts negatively on whanau, hapu and iwi.

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

Principles of Action

E tau hikoi I runga I oku whariki
E tau noho I toku matapihi
E hau kina ai toku tatau toku matapihi.
Your steps on my whariki (mat), your respect for my home,
Opens my doors and windows.

Health care providers should ensure the service they provide is safe and respectful of Maori women's beliefs and practices. The delivery of culturally safe and competent intervention that responds to Maori victims is supported by the following principles:

- Victim safety and protection are paramount
- Maori-friendly environment
- Culturally safe and competent interactions
- Engagement of local iwi, hapu and whanau
- Knowledge of the community
- Intersectorial collaboration
- Monitoring and evaluation of family violence interventions with Maori women and children.

Victim Safety

- Maintaining safety of women and children is paramount. This includes only questioning women about abuse when they are alone or accompanied by children under 2 years
- Affirm women's and children's right to a safe, non-violent home
- Have Maori staff available when possible, this may include Kaumatua or Kuia who can provide support.
- Routinely screen Maori women for violence
- Offer women options about possible plans of action they would like to take.

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The provision of a Maori-friendly environment

- Ensure there are Maori images within the environment of the health care service, such as posters, signage and Maori designs
- Having Maori on staff
- Convey a genuine attitude that is gentle, welcoming, caring, non-judgemental and respectful
- Do not rush. Leave time to think about and respond to questions
- Ask open-ended questions
- Offer resources and support.

The provision of culturally safe and competent interactions

- Engage the DHB Maori Health Unit to provide cultural guidance during the planning, implementation and evaluation of the Family Violence Intervention Programme
- All DHB staff are required to attend cultural training.

A collaborative community approach to family violence should be taken

- Staff should be aware of the referral agencies appropriate for Maori women and children who are victims of abuse
- Do not assume that the whanau 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 whanau).

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APPENDIX 3

PACIFIC PEOPLES AND FAMILY VIOLENCE

There are seven main Pacific communities represented in New Zealand, Samoa, Tuvalu, Tokelau, Fiji, Tonga, Niue, and the Cook Islands. Family violence among Pacific communities in New Zealand occurs in the context of social change brought about by the migration from the Pacific, alienation from traditional concepts of the village, family support, extended family relationships and in combination with the socio-economic stressors, for example scarce resources may be stretched between the demands of everyday living as well as customary obligations, such as those to the church and remittance to family members who have remained in the Pacific.

Victim Safety

- Maintaining safety of women and children is paramount, this includes only questioning women about abuse when they are alone or accompanied by children under 2 years.
- Affirm women and children's right to a safe, non-violent home
- Routinely screen Pacific women for violence
- Offer women options about possible plans of action they would like to take.

The Provision Of A Pacific-Friendly Environment

- Convey a genuine attitude that is gentle, welcoming, caring, non-judgemental and respectful
- Do not rush, leave time to think about and respond to questions
- Ask open-ended questions
- Offer resources and support that meets the ethnic specific needs of the victim
- Have Pacific staff available.

The Provision Of Culturally Safe And Competent Interactions

- Develop knowledge and understanding about the dynamics of family violence and victims who are from the Pacific culture.
- Identify and remove barriers for Pacific women and children accessing health care services
- All DHB staff are required to attend cultural training
- Pacific protocols are observed where possible
- Qualified interpreters are to be used where appropriate Refer Interpreter Service Policy (DHB/OPM/017).

A Collaborative Community Approach To Family Violence Should Be Taken

- Staff should be aware of the referral agencies appropriate for Pacific women and children who are victims of abuse
- 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).

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APPENDIX 4

RECOMMENDED PARTNER ABUSE SCREENING GUIDELINES FOR DIFFERENT SETTINGS

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

Health Care Setting

Routine screening for partner abuse is an important component of clinical care for all women 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 take place annually unless circumstances suggest more frequent questioning is warranted. Scope exists for individual units to establish the intervals dependent on their clinical sense of the situation.

Primary Care Settings

When should screening for abuse occur?

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

What should patients be screened for?

- At the first visit, female patients should be screened for any partner abuse, either physical or sexual, that occurred anytime in their lives.
- Annually, women should be screened for any physical or sexual abuse which has occurred during the previous 12 months
- Male patients and females aged 12-15 years 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 aged 16 years and over should be screened for both physical and sexual abuse during the previous 12 months
- Male patients should be questioned about partner abuse if they present with signs or symptoms indicative of abuse.
- Mothers of children reviewed in the Emergency Department or admitted to hospital should be screened for both physical and sexual abuse during the previous 12 months.

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Maternity and Sexual Health Settings

When should screening for abuse occur?

- At every prenatal and postpartum visit (maximise 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.
- Mothers of children reviewed in the Emergency Department or admitted to hospital
- When family violence is suspected, including when child abuse is identified.

What should patients be screened for?

- Women aged 16 years and over should be screened for either physical or sexual abuse over the past year.
- Male patients and women aged 12-15 years should be questioned about partner abuse if 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 each three month review.
- 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 and females 12-15 years should be questioned about partner abuse if 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.

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What should patients be screened for?

- Female patients should be screened for both physical and sexual partner abuse over the last year. Male patients and females 12-15 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

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APPENDIX 5

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 of 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 (e.g. extreme distress over minor injury).
- Explanation does not account for injury (e.g. "I walked into a door").

Illnesses

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

Serious Psychosocial Problems

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

History

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

1. The Oasis Protocol: Guidelines for identifying, treating and referring abused women. Auckland: Injury Prevention Research Centre, 1996. Cited in Fanslow, J. L. Family Violence Intervention Guidelines. Wellington: Ministry of health, 2002

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APPENDIX 6

GUIDELINES FOR IDENTIFYING VICTIMS OF ABUSE (STEP 1)

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

1.1 Asking Adults About Possible Abuse

Framing statements:

- “Because violence is so common in many peoples lives, I routinely ask patients about it”
- “Many women I see as patients are dealing with family violence, therefore I ask all women this question.”
- “I notice…I’m worried…” statements, E.g. “I notice you look sad/ have a bruise. I’m worried someone might be hurting you/ have caused this.”

Validated partner violence screening questions:

i. “Have you been hit, kicked, punched, forced to have sex or otherwise hurt by someone within the past year?
    - If so, by whom”.
    - A “Yes” response to this question is considered positive to partner abuse if the perpetrator was a current or former spouse or other intimate partner.

ii. “Do you feel safe in your current relationship?”

iii. “Is there anyone making you feel unsafe now?”

NB: An alternative set of questions can be found in the MOH Family Violence Intervention Guidelines found in your department, or contact the Co-ordinator of the Family Violence Intervention Programme, Extn 5886.

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APPENDIX 7

GUIDELINES TO SUPPORT AND EMPOWER VICTIMS OF ABUSE (STEP 2)

2.1 Identified Victims

2.1.1 Listen to the person's story

- Encourage them to go on. Example, "Tell me about that".
- Acknowledge what they have told you, be empathetic, non judgemental and non-blaming. Example "That must have been terrifying. You are a strong person to have survived that."

2.1.2 Validate

- "You are not alone, others experience abuse in their homes too"
- "You are not to blame for abuse. You did nothing to deserve or provoke this, abuse is never justified".

2.1.3 Inform

- "You have a right to feel safe, and live free of abuse"
- "I can provide some information, which may help/support you".

Do not pressure the person to leave. A person needs to feel well resourced and supported before they can leave safely.

2.2 Suspected Victims

2.2.1 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 a means of contacting appropriate support agencies, e.g. community resource card.

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APPENDIX 8

GUIDELINES FOR RISK ASSESSMENT (STEP 3)

3.1 Danger Assessment

Because of the associated risk of homicide in partner abuse an assessment of risk is necessary. However, there are no absolute indicators that can predict risk. Assessment of the following factors can assist in danger assessment, particularly if the woman is minimising or denying the extent of violence experienced. The greater the number of indicators, the greater the risk.

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, or severe/ life threatening assaults, e.g. choking, strangling, beatings
- 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 (upward trend)
- Perpetrator’s access to weapons, particularly firearms.

Other factors to consider
- Is alcohol or substance abuse involved?
- Other factors that increase risk of chaotic/ irrational behaviour, e.g. uncontrolled mental illness.

3.2 Risk Of Suicide Or Self-Harm

There is a strong association between victimisation from a partner 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:

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

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

3.3 If Partner Abuse Is Identified, Assess The Children’s Safety.

Partner abuse and child abuse frequently occur together. If partner abuse is identified or suspected it is essential that an assessment of risk to children is conducted. For example you could ask, “Are you ever worried about your children’s safety? Are they ever hurt?

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APPENDIX 9

GUIDELINES FOR SAFETY INTERVENTION (STEP 4)

4.1 For A Small Percentage Of The Women There May Be Immediate Safety Concerns

- Is the abuser here now?
- Does the abused person have a safe place to go to when leaving the consultation?
  Is emergency assistance required? (e.g. Police, Women's Refuge)

Any decision regarding contacting the police should be made in consultation with the patient. This is to ensure their safety, as reporting the incident may enrage the perpetrator and increase the risk to the women. In the cases where reporting is a requirement e.g. Crimes Act 1961 (See Appendix K page 72 of the Ministry of Health Family Violence Intervention Guidelines) inform the abused person of the requirement.

On the rare occasion that the healthcare provider believes a person's life is in immediate danger, or has good reason to believe that the person is unable to extricate themselves from 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.

The Health Information Privacy Code 1994 is not breached when the disclosure of 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

For any serious events involving staff or patients/clients, including any events where the police are required to be notified (refer to the Event Reporting Policy – DHB/OPM/002, and Police-Release of Health Information and Patient Property Policy, DHB/OPM/089), the Unit Manager or Duty manager (if after hours) and the Risk Manager should be **notified immediately.**

4.2 For Patients With Ongoing Safety Concerns

If possible, suggest the patient/ client makes contact with a specialist partner abuse service, such as DOVE HB or Women's Refuge, during the consultation. Ask the woman if she will talk to them on the phone. Identify an ongoing support system, for example family/whanau, friend or community agency.

Suggest the person considers legal options, e.g. Protection Orders.

Provide a copy of the community agency support card, with phone numbers and a brief safety plan.

4.3 For All Abused Patients

Provide information on the likelihood of the abuse becoming more severe and more frequent without intervention. The impact on children of witnessing abuse may also be relevant.

Getting "safer" is a process, not a single act. Unless there is a risk to a child or a clear and immediate risk to the adult victim, s/he has the right to choose a course of action. The role of the health professional is to support this decision. Supportive risk assessment and counselling can make it easier for that person to seek further assistance in the future when they are ready to act. Always leave the door open so they have a future point of contact.

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4.4 Raising Public Awareness

Routine questioning may be facilitated by creating an enabling environment with appropriate posters and pamphlets in waiting and clinical areas. From time to time DHB staff may also contribute to public campaigns aimed at reducing family violence.

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. For the assessment and management of children who may be at risk of abuse refer to the DHB Management of Child abuse and Neglect, Policy DHB/CPG/010. The emphasis should be on keeping the child(ren) safe and enabling the abused partner to get real and appropriate help.

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APPENDIX 10

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.

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. 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.

Preparation For Separation – Advance Arrangements And Flight Plans.

- Get support from 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 of 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 you family doctor to carefully note any evidence of injuries on your patient records.
  What to take

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- 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 that 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.

Living Safely After Separation

Children

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

Support

- Make contact with a Women's Refuge or a specialist family violence agency for support. These groups usually have 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.
- If relevant tell your employer that you are afraid of your ex-partner. Ask for your phone calls to be screened.

Protection Order

- Get a Protection Order from your local District Court. Make four copies –for your handbag, your home, your work and at your local Police Station. If you move, remember to give a copy to your new local Police Station. If relevant inform 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.

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- If the Police do not help, contact your advocate or lawyer for assistance.
- Keep a record of any breaches; noting time, date what occurred and what action you took.

Security

- Consider installing outside security lighting.
- 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 request an unlisted number that block 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 restriction on who can trace your car registration number.
- Contact the Electoral Enrolment Centre on 0800 637 656 and ask for your name and address to e excluded from the published electoral roll.
- Tell neighbours that your partner does not live with you and request they 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.

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APPENDIX 11

GUIDELINES FOR DOCUMENTATION OF FAMILY VIOLENCE (STEP 5)

5.1 Documentation Steps

Record the disclosure on the Family Violence Identification/Documentation Form (Pronto 46538465, available through Stores but a copy is also available on Nettie under Forms and Templates, also attached to policy on Nettie). If not available use a new sheet of clinical notepaper.

5.1.1 Note the stated or suspected cause of the injuries and when they allegedly occurred. "Assaulted by partner" is not sufficient. A vague history is readily challenged in court and therefore would not help keep a victim safe. Be specific, e.g. "Miss X alleges she was hit with a closed fist/ kicked by John Smith".
5.1.2 Record history obtained. Specify aspects you saw and heard, and which were reported or suspected. Use the patient's words as much as possible. Use quotation marks for specific disclosures where appropriate, e.g. "John punched me".
5.1.3 State the identified perpetrator's name and relationship to the patient
5.1.4 Mark site(s) of old and new injuries on the body injury map
5.1.5 Describe estimated age of injuries, coloration and measure size
5.1.6 For suspected cases of abuse, record your opinion as to whether the injury is consistent or inconsistent with the patient's explanation
5.1.7 Note the action taken by the clinician, referral information offered and follow-up arranged
5.1.8 Include the date, time, a legible signature and designation
5.1.9 Indicate in notes discreetly that family violence has been disclosed. For example, ticking the coded box in the notes
5.1.10 Forward the Family Violence Identification/Documentation Form to medical records as outlined in Point 5 (Page 6).

5.2 Collection of Physical Evidence

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

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

5.3 Photographs

The use of photographs to document injuries may be appropriate in some circumstances. If photographs with the potential to be used as evidence in legal proceedings are taken then the Photograph Policy (HCHB/OPM/020) must be adhered to.

NB: To ensure the photographs are appropriate, accurate and admissible as evidence it is recommended that the DHB photographer is called. The photographer is available during office hours on extension 6475 or cell phone. After-hours contact via the operator or access through the link directory.

If the DHB photographer is unavailable **and** the victim is proceeding with criminal charges contact the police photographer, Hastings Police Station.

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APPENDIX 12

SAFETY AND SECURITY GUIDELINES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.2. Complete the name suppression process as above if appropriate

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

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

3.4. The discharge plan may include the use of the following plans:

3.4.1. Leaving ED via X-ray and using the secure car park as a route for leaving the hospital
3.4.2. Leaving a ward or other department by a safe route, in consultation with security staff.

3.5. Document the discharge plan on the Family Violence Identification/Documentation Form (Pronto 46538465, available through Stores but a copy is also available on Nettie under Forms and Templates or attached to this policy). NB: Complete an Event Reporting Form if any unexpected outcomes occurred

3.6. Advise the Duty Manager of the discharge outcome.

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