

Te Whatu Ora Health New Zealand Hauora a Toi Bay of Plenty	INTIMATE PARTNER VIOLENCE (IPV) - INTERVENTION STANDARDS	Policy 1.6.3 Protocol 2
FAMILY VIOLENCE INTERVENTION PROTOCOL		

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PURPOSE

This document outlines Te Whatu Ora – Health New Zealand Hauora a Toi Bay of Plenty commitment to the identification and appropriate referral of Intimate Partner Violence. The Ministry of Health: *Family Violence Assessment and Intervention guideline: Child abuse and intimate partner violence (2016)* underpins this document

Te Whatu Ora Hauora a Toi Bay of Plenty is committed to the prevention of Family Violence. This includes child abuse, intimate partner violence and elder abuse and abuse of vulnerable adults.

This document provides all Te Whatu Ora staff and those contracted by Te Whatu Ora Hauora a Toi Bay of Plenty, particularly those on front-line clinical roles, in specified inpatient, outpatient and community services, with a framework to identify, assess and manage Intimate Partner Violence (IPV).

PRINCIPLES

When managing issues of family violence the rights, welfare and safety of the children/Tamariki and young people/rangatahi are the first and paramount consideration.

Staff will be supported in the identification and management of actual or suspected family violence through the Te Whatu Ora Hauora a Toi Bay of Plenty Violence Intervention Programme infrastructure, e.g. policies, procedures, standardized documentation and education programme.

At the heart of Te Whatu Ora Hauora a Toi Bay of Plenty Core Values is the need to respect the dignity of every single person and the fact that in health we are entrusted with the care of people. All staff are to recognise and be sensitive to the diverse needs of our population group and where appropriate, involve the services of Maori Health and Pacific Health and/or relevant community agencies.

It is expected that the principles of informed consent, consultation and collaboration will be incorporated throughout the Brief Intervention for Intimate Partner Violence. A key element of protection is the requirement to integrate a coordinated approach with internal and external service providers.

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 Te Whatu Ora Hauora a Toi Bay of Plenty are assessed and managed in a culturally safe environment through active involvement of Te Pare ō Toi. All staff are to recognise and be sensitive to other cultures.

SCOPE

The policy applies to all cases of actual and/or suspected family violence encountered by employees, students and people working at Te Whatu Ora Hauora a Toi Bay of Plenty or under contract for service.

The policy specifically relates to the identification, assessment, management and referral of victims of intimate partner violence. See also [1.6.3 P1 Child Protection, Abuse and Neglect - Management and Reporting](#).

TERMS AND DEFINITIONS

All terms and definitions related to this document have been defined. See [Appendix 1](#) and [Te Whatu Ora Hauora a Toi Bay of Plenty Glossary of Terms / Definitions](#).

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ORGANISATIONAL RESPONSIBILITIES

Executive Responsibilities

Te Whatu Ora Hauora a Toi Bay of Plenty is responsible for:

- Ensuring there is an organisation-wide policy for the management of intimate partner violence
- Regular training for staff on the policy
- Processes to ensure the policy is adhered to, such as quality improvement activities
- Providing adequate support and supervision for staff.

These activities need to be properly resourced and evaluated.

Service Responsibilities

All services/departments will support the implementation of the policy within services as coordinated by the Violence Intervention Programme (VIP) Co-ordinator(s).

Employee Responsibilities

All Te Whatu Ora employees have a responsibility for the assessment and intervention of family violence.

Responsibilities include:

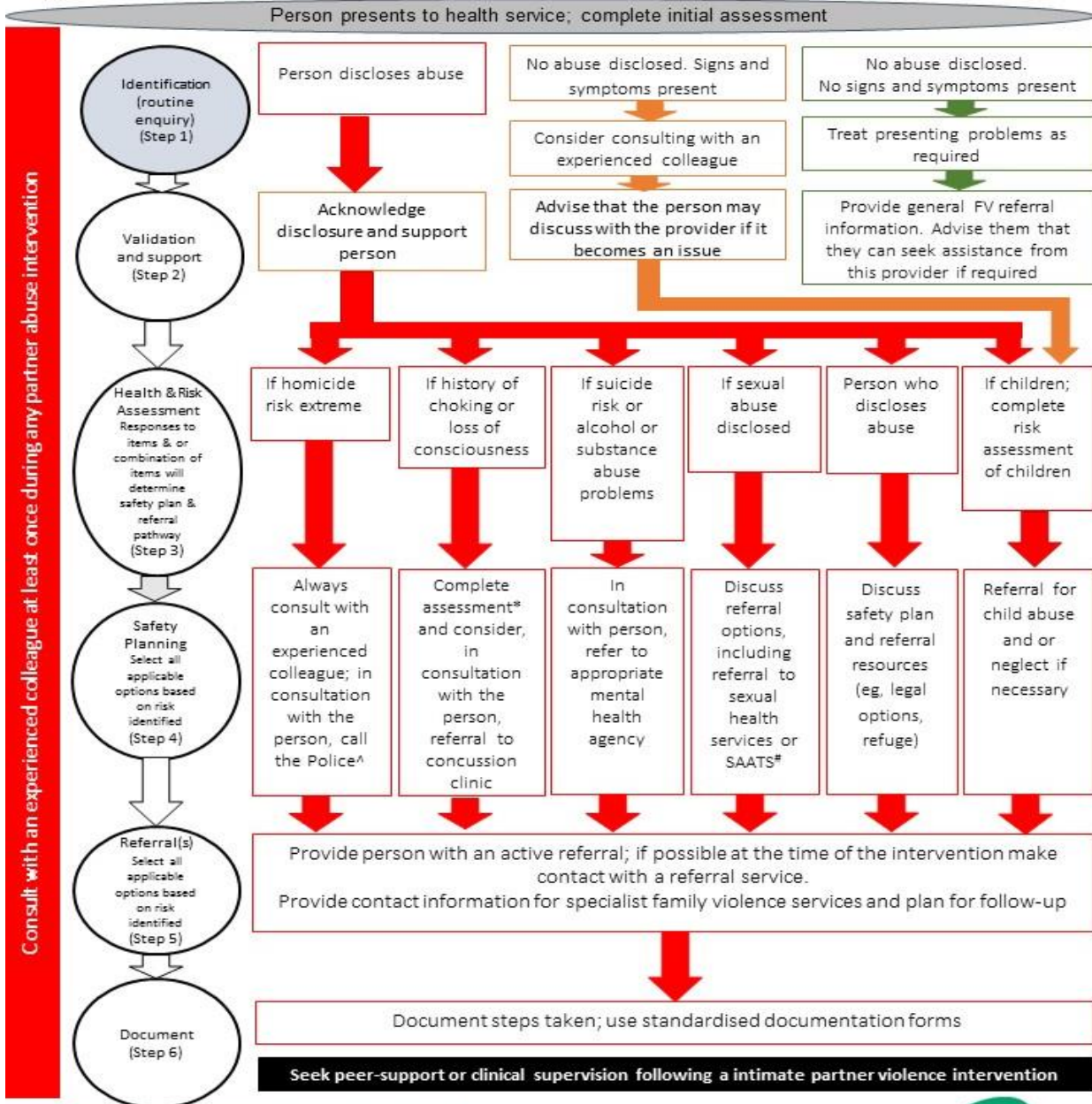
- To be conversant with Te Whatu Ora Hauora a Toi Bay of Plenty intimate partner violence and related policies
- To understand how to identify, manage and refer victims of suspected or disclosed intimate partner violence
- To attend initial training and regular updates appropriate to their area of work
- To provide or access Te Whatu Ora Hauora a Toi Bay of Plenty 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
- To practice safely, for example consulting with a senior colleague during the intervention and seeking peer-support/supervision after each disclosure of intimate partner violence.
- Core training is booked through Te Whatu Ora Hauora a Toi Bay of Plenty Education Centre / Clinical School and requires service manager approval. Biennial updates are recommended and will be arranged by the VIP Team in collaboration with individual service managers. Training attendance records should be kept by the individual and service manager.
- **NOTE:** Where staff have previously attended the MOH VIP core training at a previous Te Whatu Ora district, they are required to contact the Te Whatu Ora Hauora a Toi Bay of Plenty VIP Team to arrange orientation in lieu of further core training.

Violence Intervention Programme Co-ordinator Responsibilities

- Co-ordinate programme implementation within services, working with service leaders to ensure the system supports are available
- Ensure the Te Whatu Ora Hauora a Toi Bay of Plenty-wide policy is current and aligned with national standards
- Ensure provision of training in accordance with the Te Whatu Ora Hauora a Toi Bay of Plenty VIP training plan; this will include ensuring that the VIP training is available cyclically
- To be available to staff for consultation regarding family violence concerns
- Ensure quality improvement activities in regard to policy compliance are undertaken and reported on at least biannually.

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INTIMATE PARTNER VIOLENCE INTERVENTION FLOWCHART



[^] In imminent threat and/or high risk the Police can be notified without the person's consent

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



MAORI AND THE 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 Te Whatu Ora Hauora a Toi Bay of Plenty Intimate Partner Violence Policy has been developed in accordance

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with the principles of action including the Treaty of Waitangi principles, recognising The Whare Tapa Wha and tikanga principles. This is consistent with cultural training offered and mandated within the Te Whatu Ora Hauora a Toi Bay of Plenty.

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 person(s) being abused of their right to be safe in their home. Have Maori staff available to offer support to the family whenever possible.

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

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

Key Kaupapa to be considered when working with Maori Whanau are described in [Appendix 2](#) and should be used in conjunction with active consultation with Regional Maori Health services.

See [Appendix 2](#) for Maori and family violence

PACIFIC PEOPLES AND THE VIOLENCE INTERVENTION PROGRAMME

What family violence means in a Pacific context

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

Key principles to be considered when working with Pacific Peoples are described in [Appendix 3](#) and should be used in conjunction with Pacific Support / Services- **Pacific Island Trust**

Asian, Middle Eastern, African

A resource has been developed by CALD, this provides a general guide, culture specific knowledge and tools around family violence intervention for health professionals working with clients from Asia, Middle Eastern and African background. It can be located through www.eCALD.com.

- Shakti - Shakti is the specialist provider of culturally competent support services for women, children and families of Asian, African and Middle Eastern origin. Contact details should be accessed through www.shakti-international.org or **0800SHAKTI**

Key principles to be considered when working with Asian, Middle Eastern and African Families are described in [Appendix 4](#).

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Interpreters

Professional interpreters should always be used - **do not** use a family member. Interpreters are booked through the [Te Whaut Ora Hauora a Toi Bay of Plenty Interpreters List](#) – refer to policy [1.5.1 Interpreter Services](#).

The preferences of the client should also be checked wherever possible. When requesting an interpreter for a woman, a female interpreter should be requested where possible. The interpreter should be briefed before starting and debriefed following the interview, by the person completing the Routine Enquiry questions.

Providing a female interpreter may not always be possible for women from some of the smaller and/or newly arrived language groups. In these instances, and if there is a male interpreter available, the woman for whom the interpreter is needed should be asked, if possible, if she will agree to assistance being provided by a male interpreter.

Confidentiality becomes an issue in smaller communities or recently arrived groups. The woman may be reluctant to use an interpreter because she knows the interpreter and/or fears that details of the matter will be made public. At the beginning of the interview, reassure the woman that you and the interpreter will respect her rights to confidentiality (unless there are serious safety concerns for the woman and/or her children).

Once an interpreter has been arranged, health professionals should brief the interpreter on the situation and the areas to be covered before the interview begins. The interpreter may offer information to the health professional about relevant cultural factors relating to concerns identified. This information should be noted but should not be regarded as definitive. It must be noted that not all interpreters are familiar with family violence/ child protection perspectives within their own community and some may not be able to offer any views. Following the interview, the health professional should debrief the interpreter to ensure that the interpreter has an opportunity to share their concerns about any aspects of the case and to have these answered. It is important to thank the interpreter for their services.

It should always be remembered that the interpreter is not an advocate or a counsellor and should not be asked to provide advice, or an opinion on clinical matters (or any other assistance), beyond an interpretation of the interview between the patient/client and the health professional. Full details on working with interpreters can be found in the eCALD® Services **CALD 4: Working with Interpreters** course, which can be accessed on www.ecald.com

BRIEF INTERVENTION MODEL; A SIX-STEP PROCESS

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

- The following staff are available: Violence Intervention Programme and or Child Protection Co-ordinator
- Social Worker
- VIP Clinical Champions
- An experienced colleague
- Family violence advocate

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

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1. Routine Enquiry

Who will be ROUTINELY ASKED?

- All females aged 16 years and older should be questioned *routinely*.
- Males aged 16 years and older who present with *signs and symptoms* indicative of intimate partner violence should be questioned.
- Young people aged 12 to 15 years who present with *signs and symptoms* indicative of abuse should be questioned preferably in the context of a general psychosocial assessment, such as the HEEADSSS.

- Intimate partner violence occurs in heterosexual and in lesbian, gay, bisexual and transgender relationships.
- The routine enquiry should take place in private with no children over the age of two years present and/or no friends or relatives present during the routine enquiry
- Use a trained professional interpreter if translation is required. Do not use children, or other family members. If the person is deaf and a sign-language interpreter is not available, use written communication.
- Physical and sexual abuse commonly co-exist, therefore assessment for both, needs to occur.

See [Appendix 5](#) for Recommended Intimate Partner Violence Routine Enquiry Guidelines for Different Settings.

See [Appendix 6](#) for Signs and Symptoms of Intimate Partner Violence.

See [Appendix 7](#) for Guidelines on Identifying Abuse including recommended framing statements and the questions that should be asked routinely.

2. Validation and Support

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

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

Involve Pacific staff for support as appropriate, for example the Pacific Island Trust.

See [Appendix 8](#) for Guidelines on Validating and Supporting Victims of Intimate Partner Violence.

3. Health and Risk Assessment

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

The health and risk assessment for intimate partner violence (IPV) includes assessment of risk to the person being abused and others in the family.

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

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For any disclosures of intimate partner violence(IPV) received outside of the routine enquiry process the [FM.F4.1 Family Violence - Intimate Partner Violence \(IPV\) Assessment and Intervention Documentation \(for all disclosures of FV\)](#) should be completed as a means to document the assessment of risk and referrals made.

See [Appendix 9](#) for Guidelines on Health and Risk Assessment.

- Health care professionals are responsible for conducting a preliminary health and risk assessment with victims about the abuse in order to identify appropriate safety planning and referral options.
- A detailed risk assessment may be undertaken by agencies that specialise in responding to intimate partner violence, e.g. a social worker or community agency, such as refuge. A multi-disciplinary team approach is the preferred option for assessment.
- When intimate partner violence is identified and there are children in the person’s care, it is imperative that an assessment of risk to children is conducted. In all cases, the emphasis should be on keeping the child safe and enabling the abused person to get real and appropriate assistance.
- For the assessment and management of children who may be at risk of abuse refer to Te Whatu Ora Hauora a Toi Bay of Plenty Child Protection Policy.

4. Safety Planning

The experience of any violence within relationships is damaging to health and wellbeing, so some level of safety planning is always required. Without intervention, violence within relationships may increase in frequency and severity over time. Safety planning needs to be guided by consideration of a number of factors including degree of risk (high versus moderate), immediacy of the risk (acute, chronic or historic), as well as consideration of protective factors that already exist, or those that can be engaged to support the victim.

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

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

Remember, safe practice involves consulting with the person, and senior colleagues and or community agency advocates, to determine safety options for the future.
A multidisciplinary team approach is the preferred option.

See [Appendix 10](#) for Guideline for Safety Planning.

See [Appendix 11](#) for Safety Plan Resource.

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When it is identified children/ren were present during Intimate partner Violence (IPV) episode or who are living in an environment where Intimate Partner Violence(IPV) is occurring/or has occurred:

Consultation with Senior clinician and/or Oranga Tamariki – Ministry for Children (Oranga Tamariki)^a Liaison Social Worker and/or Oranga Tamariki Call Centre to determine response pathway **is critical.**

Note: If there are **child protection concerns** during work hours, contact Oranga Tamariki Liaison at 029 6501390 or contact

Oranga Tamariki @ (0508-326459), ask for an intake social worker and discuss appropriate action. **Refer to Te Whatu Ora Hauora a Toi Bay of Plenty: Child Protection Policy**

• **Note: Care And Protection Of The Unborn Child**

In all matters where there is imminent harm towards the life of an unborn child or it is assessed that there are significant risk factors where the unborn child is at risk during pregnancy and/or following the birth a notification to Oranga Tamariki may be made following assessment Refer: Child Protection Policy Te Whatu Ora Hauora a Toi Bay of Plenty

A referral to Vulnerable Unborn Forum would also be required.

Once clinician determines indicative risk, **consultation** must take place with a colleague or senior staff member. Professional judgement will always be required.

See [Appendix 9](#) for Guidelines on Identifying and Responding to Safety Needs (Step 3).

See [Appendix 10](#) for Guideline for Safety Planning.

See [Appendix 11](#) for Safety Planning resource.

On occasions staff may identify imminent danger or high risk for the individuals including staff secondary to family violence that requires an immediate referral to the Police without consent. See Appendix 11 for Guidelines for notifying the Police.

5. Referral and follow-up

- Referral agencies are a vital service for the support of victims of intimate partner violence.
- All identified victims of IPV need to have appropriate referrals made and follow-up planned.
- Early referral to support agencies is the preferred intervention.
- The presence or absence of injuries or other evidence of intimate partner violence are not prerequisites for making a referral, particularly if there is a risk to children.
- If the person is at moderate/ongoing risk, or might benefit from early intervention, the health care provider needs to make sure that the person has the information necessary to contact appropriate health, social support or community services.
- All victims of IPV should be provided with assistance to contact support services and access legal options for protection.
- Appropriate follow-up is also needed; IPV is a health issue that merits appropriate follow-up in its own right. Additionally, the presence/history of IPV may affect the way in which

¹ a Formerly known as Ministry for Vulnerable Children (Oranga Tamariki) and Child Youth and Family (CYF)

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follow-up is delivered when responding to other health issues. If IPV is currently an issue, safety procedures for re-contacting the person need to be considered.

- While follow-up will vary depending on the needs of the individual, the resources and training of the health care provider, and the point at which the person has entered the health system (eg, well-health services, primary or secondary care), at least one follow-up appointment (or referral) with a health care provider, social worker, or IPV advocate should be offered after disclosure.

See [Appendix 13](#) for guidelines on referral and follow-up.

5.1 Referral Agencies

Police Family Violence Teams		
Tauranga Police Family Harm Team	07 213 0478	
Whakatane Police Family Harm Team	07 3084872	
Oranga Tamariki /Child, Youth and Family		
Oranga Tamariki /CYF	0508 326459	
Other services		
BOPSASS Tau Tokomai (Bay Of Plenty Sexual Assault Support Service)	0800- 227 233	
Women's Refuge		
Women's Refuge Tauranga		0800 8673384
Women's Refuge Whakatane		07-3085531
Shakti (Migrant Services)		0800 742584
Victim Support (back up for all areas)		0800 842 846 (24 hours support)
Men's Services		
Kids need Dadz	Dad's refuge	07 5710379
Living without Violence		07 5779297
Family Works	Whakatane	07 3071133
	Tauranga	07 5759709
LGBTI Community		
National	Kahukura	www.kahukura.co.nz
National	Outline	0800 688 5463
Te Whatu Ora Hauora a Toi Bay of Plenty Family Violence Prevention and Child Protection Co-ordinator		
Office	Whakatane: 07 306 3182 ext.: 4682 Tauranga: 07 577 3340 ext.: 6840	
Mobile	Whakatane: 0212456338 Tauranga: 0278863012	

6. Documentation

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

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- Health professionals should record the outcome of the routine enquiry, the findings of the health and risk assessment, the safety planning and referrals made. This documentation process is standard practice in regard to recording the health intervention and it is important part of keeping victims safe because the clinical record may help in future legal action.
- Record the disclosure on form [FM.F4.1 Family Violence - Intimate Partner Violence \(IPV\) Assessment and Intervention Documentation \(for all disclosures of FV\)](#).
- **Record Disclosure.** [See Appendix 14](#) for Guidelines for Documentation of Family Violence.

6.1 Storage/Filing of the Intimate Partner Violence Assessment and Intervention Documentation Form

- For caregivers of child clients, the information should be stored/saved/entered against the individual's NHI.
- If the woman caregiver's NHI cannot be located in local iPM then the "nominated person in the Service" will need to locate the relevant NHI on the national database, bring it into local iPM, and then place the assessment form into the health record.

This ensures that:

- the information is kept confidential (minimise the risk that the perpetrator of the abuse can access/see the information).
- The right information is stored in the right file.
- The information is available to clinical staff who provide care in the future

STAFF SUPPORT FOLLOWING DISCLOSURE

Staff must report a disclosure of family violence to their Team Leader / Clinical Nurse Manager / Clinical Midwife Manager (or senior staff member).

Clinical supervision and or peer support for staff is recognised as an important requirement to ensure the practice of routinely questioning women for intimate partner violence remains safe for the individual and staff.

Clinical supervision and or peer support is available for staff to whom a disclosure has been made and is available within the service/department.

Intimate Partner Violence intervention within families / whanau is a sensitive area of work and it is acknowledged that staff may require additional support. Staffs are to be provided with information on EAP provision at all family violence training sessions.

Staff can contact the Violence Intervention Programme Coordinators for support and/or advice
Ext: 4682 or Ext: 6840

EAP provides a confidential counseling service for all Te Whatu Ora staff. Staff can self-refer.

EAP in Whakatane: 07 306 0711 EAP in Tauranga: 07 557 5597/5596 (Management approval is not required for the first 3 sessions)

SAFETY AND SECURITY

Immediate Security

- When there are security concerns for staff, clients or visitors, **Security** should be called to assist as required for management of both victims and perpetrators. This may include the use of trespass orders.

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If there are concerns about immediate safety (including your own), call 777 and state security alert and your location. The Duty Nurse Manager will then manage the situation and contact appropriate emergency services if required e.g. Police / Oranga Tamariki (by telephone followed by emailed referral).

- Access to the inpatient units (Maternity, Paediatrics, Neonatal) is limited at all times, except during visiting hours when doors are unlocked. If there are specific concerns for safety, access can be limited throughout the visiting period if required.
- Trespass orders can be issued if high concerns exist. These can be instigated by contacting Security / Duty Nurse Manager.

Family Safety and Security Process

- At times it may be necessary to optimise the safety for victims of family violence when the risk to the victim's safety is assessed to be a imminent / high risk. If a client who is a victim of family violence expresses fear of the perpetrator or others, s/he is likely to be correct. Under such circumstances it may be necessary to suppress patient details and or provide secure processes at the time of discharge. Security processes and name suppression must be in consultation with service management.
- See [Appendix 15](#) for Guidelines for Safety and Security Procedure.

Refer to Child Protection Policy – for procedures regarding known or suspected child abuse

INFORMATION AND RESOURCES

Appropriate information is highlighted and available in all client and staff areas about family violence prevention and appropriate support agencies e.g. posters, brochures, contact cards

Information should be culturally appropriate and easy to read

EVALUATION

Regular audits of Intimate Partner Violence Routine Enquiry, documentation and referral processes will be undertaken in each of the services where routine enquiry is implemented.

Feedback will be provided to managers and staff who are involved in intimate partner violence intervention and the Family Violence Steering Group.

Analysis of results will be undertaken within each service and reported on at the service Quality Improvement Committee (QIC) and annually to the Executive Leadership Team (ELT).

Results of analysis will also be reported to the Violence Intervention Programme Co-ordinator who will collate an organisational summary.

Results will be audited and reported on as required by the Ministry of Health.

In addition, there will be, at least annually

- Assessments of staff knowledge and attitudes to intimate partner violence intervention
- Feedback from clients (including feedback from Maori clients on effectiveness of services)
- Feedback from referral agencies

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TRAINING

Family Violence training is mandatory for all staff working with children and women. The training includes:

- Pre-training information (pre-reading document/online training package)
- 2 day (16 hours) training session.
- Access to the Violence Intervention Programme training can be obtained through:
 - Intranet
 - Te Whatu Ora Hauora a Toi Bay of Plenty Education Centre / Clinical school
- Staff are also required to undertake in-service training as indicated and refresher training biennially. Advanced training will be offered to designated staff.

REFERENCES

Legislation & Other

- [Children's Act \(2014\)](#)
- Family Violence Act 2018
- Health Information Privacy Code (1994)
- Oranga Tamariki Act, 1989. Previously-(Children, Young Persons and their Families Act (1989)
- Health & Disability Services (Safety) Act (2001) Health Act (1956)
- [Privacy Act 2020](#). The amendment to the Privacy Act can be viewed on Rule 11 <http://www.legislation.govt.nz/act/public/1993/0028/latest/DLM297038.html>
- Ministry of Social Development Taskforce for Action on Violence within Families. 2012
- Nga Vaka o Kāiga Tapu: A Pacific Conceptual Framework to address family violence in New Zealand. Wellington: Ministry of Social Development³. Ministry of Health. 2002. He Korowai Oranga: Māori Health Strategy. Wellington: Ministry of Health.
- Ministry of Health. 2008. *The Whānau Ora Tool*. Wellington: Ministry of Health.
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- Ministry of Health. 2014a. *Equity of Health Care for Māori: A framework*. Wellington: Ministry of Health.
- Ministry of Social Development. 2002. *Te Rito: New Zealand Family Violence Prevention Strategy*. Wellington: Ministry of Social Development.
- [Ministry of Health: Family Violence Assessment and Intervention Guideline – Child abuse and intimate partner violence \(2016\)](#)
- 10.Elder Abuse and Neglect Guidelines (2007)
- Health & Disability Sector Standards NZS 8134:2001
- MOU with NZ Police, Oranga Tamariki (Child Youth and Family) and Te Whatu Ora Hauora a Toi Bay of Plenty (August 2011)
- [Te Aorerekura National Strategy to eliminate family violence and sexual violence](#)

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ASSOCIATED DOCUMENTS

- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.6.3 Family Violence Intervention – Identification and Intervention
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.6.3 protocol 1 Child Abuse and Neglect (CAN) – Intervention Standards
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.6.3 protocol 3 Older Person Violence, Abuse, Neglect Standards (Interim)
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.6.2 Child Protection Alerts
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.6.2 protocol 1 Child Protection Alerts Standards
- Te Whatu Ora Hauora a Toi Bay of Plenty Glossary of Terms / Definitions – Vulnerable Children Act
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.1.1 Informed Consent
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.4.4 Cultural Safety - Māori
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 1.5.1 Interpreter Services
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 2.5.1 Health Information Privacy
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 2.5.1 protocol 1 Health Information Privacy Standards
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 2.5.2 Health Records Management
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 2.6.1 protocol 1 Management of Information
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 3.50.01 protocol 1 Recruitment Standards
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 3.50.02 protocol 7 Supporting Staff
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 3.50.05 Protected Disclosures
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 3.50.13 Investigation and Disciplinary
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 5.5.1 Security
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 5.5.1 protocol 1 Abduction of Baby / Child Receiving Treatment - Responsibilities & Management of Risk
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 5.5.1 protocol 2 Abduction - Post Abduction of Baby / Child From Hospital - Management of
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 5.5.3 Trespass
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 6.1.5 Alerts
- Te Whatu Ora Hauora a Toi Bay of Plenty policy 6.9.4 Visitors and Nominated Support Persons
- Te Whatu Ora Hauora a Toi Bay of Plenty Summary of Injuries Form (618C) – *viewable only. Order through Design & Print Centre*
- Te Whatu Ora Hauora a Toi Bay of Plenty Form FM.F4.1 Family Violence – Intimate Partner Violence (IPV) Assessment and Intervention Documentation (for all disclosures of FV)
- Te Whatu Ora Hauora a Toi Bay of Plenty Form FM.R6.1 Report of Concern – Oranga Tamariki
- Te Whatu Ora Hauora a Toi Bay of Plenty Strangulation Assessment (Post Acute) 8400 – *viewable only. Order through Design & Print Centre*
- Te Whatu Ora Hauora a Toi Bay of Plenty Paediatric Acute Medicine Admission Proforma – 0 – 11 months (8382) – *viewable only. Order through Design & Print Centre*
- Te Whatu Ora Hauora a Toi Bay of Plenty Paediatric Acute Medicine Admission Proforma – 1 – 4 years (8383) – *viewable only. Order through Design & Print Centre*
- Te Whatu Ora Hauora a Toi Bay of Plenty Paediatric Acute Medicine Admission Proforma – 5 years + (8384) – *viewable only. Order through Design & Print Centre*

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- Te Whatu Ora Hauora a Toi Bay of Plenty Paediatric Admission to Discharge (8243) – *viewable only. Order through Design & Print Centre*
- Te Whatu Ora Hauora a Toi Bay of Plenty Emergency Department Paediatric Assessment (140502)
- Te Whatu Ora Hauora a Toi Bay of Plenty Emergency Department Child Injury Assessment for all children 10 years and under (7441) – *viewable only. Order through Design & Print Centre*
- Te Whatu Ora Hauora a Toi Bay of Plenty Emergency Department Adult Assessment (11531)
- Te Whatu Ora Hauora a Toi Bay of Plenty Adult Admission Assessment and Plan of Care (8341) – *viewable only. Order through Design & Print Centre*
- Te Whatu Ora Hauora a Toi Bay of Plenty. A Guide to Safe Recruitment of Children’s Worker Roles. November 2016
- Te Whatu Ora Hauora a Toi Bay of Plenty Form FM.S21.1 Security Plan – High Risk of Family Violence Patient

FAMILY VIOLENCE ROUTINE ENQUIRY PROCESS - MATERNITY

Overview

Te Whatu Ora Hauora a Toi Bay of Plenty Policy

This associated document must be read in conjunction with the Te Whatu Ora Hauora a Toi Bay of Plenty Family Violence/Intimate Partner Violence Intervention Policy. This appendix gives specific guidance to clinicians working in Maternity Services.

Training requirements

All midwives must be familiar with the Te Whatu Ora Hauora a Toi Bay of Plenty Family Violence/Intimate Partner Violence Intervention Policy. All employed midwives should complete a minimum of four hours of family violence training as part of the 12 hour Core Training provided by either NZCOM or Te Whatu Ora Hauora a Toi Bay of Plenty.

Routine Enquiry Protocol

All women should be asked the Routine Enquiry Questions twice in pregnancy (at booking and at 36 weeks) and once prior to discharge from hospital.

Antenatal

All women should be asked the Routine Enquiry Questions **twice** in pregnancy (at booking and at 36 weeks), and **once** prior to discharge from hospital.

The Lead Maternity Carer (LMC) should complete the Routine Enquiry questions at the first opportunity, usually at the first antenatal (booking) appointment.

The Routine Enquiry questions must be repeated at around 36 weeks. In addition if a woman is admitted antenatally, for any reason, the Routine Enquiry questions should be repeated. Admissions for hyperemesis, abdominal pain, antepartum hemorrhage, abruption or accidental injury should alert carers to the possibility of family violence.

Routine Enquiries that are undertaken by Te Whatu Ora Hauora a Toi Bay of Plenty midwives that occur after the registration Routine Enquiry should be recorded in the patient’s health record using the sticker provided.

Postnatal

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Prior to discharge the midwife discharging the mother should again complete the Routine Enquiry questions to ensure that the mother is safe to return home with her baby. It is not safe to discharge a woman without establishing that she and her infant are going into a safe environment.

Postnatal results are then recorded in the postnatal assessment.

Outcome of Routine Enquiry

No Violence Disclosed

Thank the woman for her response. Remind her that it is likely that she will be asked about this again during her pregnancy. Give her the Ministry of Health “*Partner Abuse: This is not love*” brochure (HP4096) and point out the pop-out 24 hour help numbers on the back should she ever need them for herself or her friends or family, explain how this information can be kept safe. Brochures are available from the Te Whatu Ora Hauora a Toi Bay of Plenty Violence Intervention Programme (VIP)

Violence Disclosed

If the woman discloses abuse, or is admitted at any time in her pregnancy with signs of physical or emotional abuse follow the intervention as detailed in this policy. Inform the Maternity Health social worker for additional support

Vulnerable Women

Some very vulnerable women may change LMC or chosen place of birth in order to avoid contact with Oranga Tamariki (CYF). Consider completing a Report of Concern to Oranga Tamariki and /or referral to **Vulnerable Unborn Forum (MCW&CP MAG)**

Multi-Disciplinary Meeting

For vulnerable families, where family violence has been disclosed or suspected, a multi-disciplinary meeting should be arranged by the Women’s Health social worker to ensure that a plan of care is made prior to birth or discharge.

Referral to Oranga Tamariki

The impact of family violence on children is well documented. Even in situations where the children are not being victimized the experience of witnessing violence is extremely damaging. It is therefore recommended that in all confirmed incidences of family violence, where children are resident in the home, the Maternity social worker is involved and a full psycho-social and risk assessment of the children is completed and appropriate notification to Oranga Tamariki service is made.

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Appendix 1: Terms And Definitions^b

The following terms and definitions will be used through-out this document and [Te Whatu Ora Hauora A Toi Bay Of Plenty Vulnerable Children Act Glossary Of Terms / Definitions](#)

Child	Unborn children and children aged 0–14 years old.
Child Protection	Activities carried out to ensure the safety of the child in cases where there is abuse or risk of abuse.
Child Abuse	The harming (whether physically, emotionally, or sexually), ill treatment, abuse, neglect or deprivation of any child/tamaiti, or young person.
Child Physical Abuse	Child physical abuse is any act or acts that may result in inflicted injury to a child or young person.
Child Sexual Abuse	Child sexual abuse is any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not.
Child Emotional/ Psychological Abuse	Child emotional/psychological abuse is any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person.
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, perpetrated by one family member against another family member. It includes child abuse, intimate partner violence 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.
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.

^a Ministry of Health. Family Violence Assessment and Intervention Guideline; child abuse and intimate partner violence. Wellington: Ministry of Health, 2016.

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<p>Sexual Abuse</p>	<p>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.</p>
<p>Intimate Partner Violence (<i>also called partner abuse</i>)</p>	<p>Physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners.</p> <p>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.</p>
<p>Routine Enquiry</p>	<p>Routine enquiry, either written or verbal, by health care providers to individuals about personal history of partner abuse. Unlike indicator-based questioning, routine enquiry means routinely questioning all women aged 16 years and over about abuse. The enquiry is usually made within the social history.</p>
<p>Young Person</p>	<p>14-18 years old.</p>

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Appendix 2: Maori Kaupapa in Practice – Responding to Family Violence

<p>Te Whatu Ora Hauora a Toi Bay of Plenty BOPDHB Maori Kaupapa In Practice</p>	
<p>Kaitiakitanga Refers to the guardianship or protection of <i>family/whānau</i> and the environment so that they continue to thrive from generation to generation.</p>	<p><i>Recognise that safety should always be paramount. Ensure processes are in place to keep all vulnerable people, and staff safe.</i> <i>Be aware that the physical, emotional and spiritual safety/wellbeing of mothers is important for the safety of their children</i></p>
<p>Oritetanga Refers to equality</p>	<p><i>Deliver the same high quality service to everyone, no matter what their age, gender, ethnicity or social background.</i> <i>Understand that some whānau may need more information about the health sector and your role may be to empower and inform them of their rights and responsibilities.</i></p>
<p>Manaakitanga Is about nurturing an looking after people and relationships. Here action is taken to enhance the mana (prestige and integrity) of each individual. Relationships are based on compassion, generosity, reciprocity and respect.</p>	<p><i>“The capacity to care (Manaakitanga) is a critical role for whanau in respect of children and older members” (Mason Durie Measuring Maori Wellbeing 01/08/2006).</i> <i>Convey a genuine, open, supportive, caring and respectful attitude from first point of contact.</i> <i>Offer a comfortable and welcoming environment for Māori (including the physical environment and the behaviour and attitudes of health professionals).</i> <i>Aim to pronounce Māori names and words correctly. This will convey a sense of care and respect. If you are not sure how to pronounce someone’s name, ask.</i></p>
<p>Pukengatanga Involves the achievement of progressive milestones and skills, enabling individuals to reach their goals and their potential ie: Mana Wellbeing.</p>	<p><i>Work with the individual, whānau, and other professionals</i> <i>(where relevant) to identify achievable plans to ensure short, medium and longer term safety for victims of family violence. After short term safety is established, support them to take the next step.</i> <i>Ensure that individuals/whānau are informed of their options so that they have the opportunity to restore and enhance their Mana.</i></p>
<p>Kotahitanga Exists when people work together in unity to support and achieve common goals.</p>	<p><i>Application of a collaborative approach to enable family / whānau to be safe. This should involve information sharing and planning with whanau, other professionals, and community providers.</i> <i>Build partnerships with whānau, and Māori organisations in your community.</i></p>

“The best outcome is one where whanau members have a strong sense of identity, feel well cared for, are able to enjoy quality lifestyles with a sense of independence, yet remain

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concerned about the wellbeing of other whanau members” Mason Durie (Measuring Maori Wellbeing 1/08/2006)

Safety first

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

Equity of Health Care for Māori

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

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

Health organisations can champion, consider and apply these actions across their practice to facilitate responsive, appropriate and effective care for Māori. This can contribute to improved patient care pathways for Māori patients, and effective identification and response processes to family violence.

information about your genealogical ties and where you and your ancestors come from.
 Note that an individual who is experiencing family violence may wish to call on the support of someone outside their whānau.
 Help whānau to participate in informed planning and decision making.
 Work in partnership with whānau, hapū, iwi and Māori community organisations to provide support for individuals experiencing violence.

**“Ko Te Reo te mauri o te mana Māori – The language is the life essence of Māori mana.”
Sir James Henare (1979)**

Ways to put this into practice

Aim to pronounce Māori names and words correctly. This will convey a sense of care and respect. If you are not sure how to pronounce someone’s name, ask.
 Use Te Reo in signage and posters, and have key documents and resources available in Te Reo.
 Embrace opportunities to learn and use Te Reo and to understand the meanings of key Māori concepts (such as these kaupapa).
 Be aware that Māori words often have multiple layers of meaning and convey perspectives and concepts that cannot always be directly translated into English.

The [Increasing Violence Intervention Programme \(VIP\) Programmes’ Responsiveness to Māori resource](#) encourages health care providers to seek training to enhance their cultural competence when working with Māori.

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Appendix 3: Working With Pacific Peoples

What family violence means in a Pacific context

PACIFIC PEOPLES AND FAMILY VIOLENCE

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

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

What family violence means in a Pacific context

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

Risk factors for family violence amongst Pacific people

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

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

Protective factors for Pacific families

- reciprocity
- respect
- genealogy
- observance of tapu relationships
- language and belonging are concepts that are shared across the seven ethnic specific communities as elements that protect and strengthen family and individual wellbeing.

Transformation and restoration

Education is identified as a critical process for transforming violent behaviour and restoring wellbeing to families. It is the responsibility of both practitioners and the communities. The following are 4 important features that must be practiced together when delivering an education programme aimed at building and restoring relationships within families:

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

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Principles for action

1. *Victim safety and protection must be paramount*

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

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

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

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

- introduce yourself and acknowledge who you’re speaking with
 - start with some general conversation; do not be too clinical and business-like
- convey a genuine attitude that is gentle, welcoming, caring, non-judgemental and respectful – first contact is vital
- do not rush – leave time to think about and respond to questions
- ask open-ended questions
- offer resources and support that meets the ethnic-specific needs of the victim.

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

Health care providers are encouraged to seek training to develop their cultural safety and competence in working with Pacific peoples. Actions and behaviours that contribute to the development of culturally safe and competent interactions:

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

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

The implementation of interventions for Pacific victims of FV should occur in collaboration with other agencies or sectors to ensure that the needs of Pacific victims of violence are adequately addressed. Actions and behaviours that contribute to a collaborative intersectoral approach:

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

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Appendix 4: Working With Asian, Middle Eastern And African Peoples

This section is taken from the *CALD Family Violence Resource for Health Practitioners: Working with Asian, Middle Eastern and African Women and Families resource (WDHB eCALD® Services, 2016)*. The CALD Family Violence Resource complements eCALD® Services, CALD Cultural Competency Training Programme which can be accessed on www.ecald.com.

Family Violence Context

Culture influences how people view abuse, whether they seek help and how they communicate their experience and from whom they are likely to seek assistance (Weber & Levin, 2003). For migrant women in situations of intimate partner violence, cultural factors such as ostracism from family and community may serve to prevent disclosure. As well, perceptions of what constitutes violence differ culturally. In some communities verbal and physical violence are not considered abuse. Accordingly, women may not consider themselves the victims of crime, or that they have rights as victims (Lay, 2006).

Risks and vulnerability factors for Migrant Women

Ethnic community perceptions that family violence is a private matter and; women’s desire to keep their marriage intact are significant barriers to reporting partner abuse. It is also important to remember that divorced women, even when there is known abuse, lose all their social status in their community and are often ostracised.

There are a number of factors which contribute to the migrant women’s vulnerability. These include the following:

- Family, face saving, faith, custom and fate
- Social Isolation and lack of family networks
- Family values
- Conflict with in-laws
- Dependency through low or no English language and literacy skills
- Uncertainty around accessing help
- Forced Marriage
- A woman’s immigration status plays a significant role in her susceptibility to abuse.
- Women from culturally and linguistically diverse backgrounds may face cultural and language barriers to using health services and may be under-served as health populations.
- Migrant women in situations of family violence are particularly at-risk during pregnancy.
- Asian, Middle Eastern and African women and children have the poorest access to women’s refuge services in New Zealand compared to other groups in New Zealand society (Ministry of Social Development, 2011).
- Family violence in Asian, refugee and other CALD migrant communities is heavily stigmatised and is under-reported (Boutros et al., 2011; Family Violence Prevention Fund, 2009; Mehta, 2012; Rees & Pease, 2007).

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Areas for consideration

How to reduce fear of authorities - (Adapted from Weber and Levine, 2003)

Fear of the Police	Fear of Immigration Authorities
<i>Factors to consider</i>	<i>Factors to consider</i>
<p>The victim may believe that her immigration status prevents her from seeking police protection and assistance.</p>	<p>If a woman is not a New Zealand resident, her abusive partner may threaten to contact immigration officials to have her deported. Women should be informed that as a victim of partner abuse, they can seek protection from such deportation (<i>Immigration New Zealand, 2015</i>).</p>
<p>A refugee or migrant woman's negative experience with Police in her country of origin or asylum may affect her expectations of police in New Zealand.</p>	<p>Women need to be reassured that it is safe to report family violence to Police and or Oranga Tamariki in New Zealand. Further, as above women need to be informed that they can seek protection from deportation, as a victim of family violence.</p> <p>Inform the victim of the <i>Residence Category for victims of domestic violence</i> (<i>Immigration New Zealand, 2015</i>).</p> <p>Refer to S4.5 Residence Category for victims of domestic violence on the Immigration NZ website: http://onlineservices.immigration.govt.nz/opsmanual/42635.htm</p>
<i>Critical information for the patient</i>	
<p>Disclosing abuse to a health professional does not imply that the police will be contacted</p>	<p>The victim does not jeopardise her immigration status by seeking medical treatment for her injuries or her child's injuries</p>
<p>Health professionals can help establish a plan of safety and support for the victim and her children.</p>	<p>Counselling and other legal and social services ie: 0800SHAKTI may be available in the victim's language and may be offered by health professionals / services who understand her culture / religious background.</p>
<p>What you can do</p> <ul style="list-style-type: none"> • Emphasise that the health professional and the interpreter are bound by patient confidentiality- unless there is threat of serious harm to the patient, children or others. • Confidentiality of disclosures – advise and reassure the patient/client that any details will be kept secure and not given out without authority – unless people are in danger. In the case of serious harm to the patient or others the Police and/or Child, Youth and Family will be informed. Consult with experienced staff first if possible. • Where relevant, inform the victim of the <i>Residence Category S4.5 in Immigration NZ Legislation</i> • Inform the patient that there is expert legal assistance available to her. • Refer the victim to trustworthy and confidential cultural support (if available). 	

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Appendix 5: Recommended Intimate partner violence routine enquiry for different clinical settings

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

Health care settings

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

Males and females over 14 years need to be questioned about IPV when presenting with acute injuries, given the common occurrence of early peer dating and sexual relationships, as well as vulnerability to grooming and abuse by adults.

Primary care settings

When should routine enquiry for IPV occur?

- as part of routine health history
- during visits for a new problem
- during any new patient consultation
- any new intimate relationship
- during any preventive care consultation (e.g., cervical screening, mammography)
- as part of Well Child assessments
- at other times that may suggest high risk (e.g., alcohol/drug abuse consultations, sexual health consultations (e.g., for emergency contraception), mental health consultations, presentation for undiagnosed/chronic pain).

What should individuals be questioned about?

- At the first visit, females should be questioned about IPV, physical, sexual, and/or psychological abuse that occurred anytime in their lives.
- Annually, women should be questioned about physical, sexual and/or psychological abuse over the past year.
- Males should be questioned about IPV when they present with signs or symptoms indicative of abuse.

Emergency department/urgent care

When should routine enquiry for IPV occur?

At every emergency department visit.

What should individuals be questioned about?

- Females should be questioned about physical, sexual and/or psychological abuse over the last year.
- Male and females, aged over 14 should be questioned about IPV when they present with signs or symptoms indicative of abuse.

Maternity and sexual health

When should routine enquiry for IPV occur?

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

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What should individuals be questioned about?

- Routine enquiry should be about current (past year) and lifetime experience of physical, sexual and/or psychological abuse.

Paediatric settings

When should routine enquiry for IPV occur?

- as part of Well Child assessments
- when family violence is suspected.

What should individuals be questioned about?

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

Mental health settings

When should routine enquiry for IPV occur?

- as part of every initial assessment
- at every new intimate relationship
- annually, if receiving ongoing or periodic treatment.

What should individuals be questioned about?

- At the first visit, females should be questioned about any IPV, physical, sexual, and psychological abuse that occurred anytime in their lifetime.
- Annually, females should be questioned about physical, sexual and/or psychological abuse over the past year.
- Males should be questioned about IPV when they present with signs or symptoms indicative of abuse.

Inpatient Setting

When should routine enquiry for abuse occur?

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

What should patients be questioned about?

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

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Appendix 6: Signs And Symptoms Associated With Intimate Partner Violence (IPV).

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

<p>Physical injuries</p> <ul style="list-style-type: none"> - Injuries to the head, face, neck, chest, breast, abdomen or genitals - Bilateral distribution of injuries, or injuries to multiple sites - Contusions, lacerations, abrasions, ecchymosis, stab wounds, burns, human bites, fractures (particularly of the nose and orbits) and spiral wrist fractures - Complaints of acute or chronic pain, without evidence of tissue injury - Sexual assault (including unwanted sexual contact by a partner) - Injuries or vaginal bleeding during pregnancy, spontaneous or threatened miscarriage, low birth weight babies - Multiple injuries, such as bruises, burns, scars, in different stages of healing - Substantial delay between time of injury and presentation for treatment - Tufts of hair pulled out - Strangulation/choking <p>7. <u><i>Patient's manner</i></u></p> <ul style="list-style-type: none"> - Hesitant or evasive when describing injuries - Distress disproportionate to injuries (e.g., extreme distress over minor injury, or apparent lack of concern about a serious injury) - Explanation does not account for injury (e.g., 'I walked into a door') - Different explanation for same injury at different presentations 	<p>Illnesses</p> <ul style="list-style-type: none"> - Headaches, migraines - Musculoskeletal complaints - Gynaecological problems - Sexually transmitted infections. - Chronic pain/undiagnosed causes for pain - Malaise, fatigue - Depression - Insomnia - Anxiety - Chest pain, palpitations - Gastrointestinal disorders - Hyperventilation - Eating disorders <p>Serious psychosocial problems</p> <ul style="list-style-type: none"> - Alcohol abuse or addiction - Severe depression - Drug abuse or addiction - Suicidal ideation or attempts - Continued alcohol, tobacco or substance abuse during pregnancy - Inappropriate attempts to lose weight, development of eating disorder during pregnancy <p>History</p> <ul style="list-style-type: none"> - Record or concerns about previous abuse (e.g., injuries inconsistent with explanation) - Substantial delay between time of injury and presentation for treatment - Multiple presentations for unrelated injuries
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Source: Injury Prevention Research Centre 1996

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Appendix 7: Guidelines For Identifying Victims Of Abuse (Step 1)

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

Who will be ROUTINELY ASKED?

- All females aged 16 years and older should be questioned routinely.
- Males aged 16 years and older who present with signs and symptoms indicative of intimate partner violence should be questioned.
- Young people aged 12 to 15 years who present with signs and symptoms indicative of abuse should be questioned preferably in the context of a general psychosocial assessment, such as the HEEADSSS.
- Intimate partner violence occurs in heterosexual and in lesbian, gay, bisexual and transgender relationships.

Where should the Routine Enquiry about IPV take place?

- At a time when the individual is feeling reasonably at ease, for example, while taking routine history.
- The routine enquiry should take place in private with no children over the age of two years present and or no friends or relatives present during the routine enquiry

8. Asking Adults About Possible Abuse

The Framing Statement- some examples

- *‘Because we know partner violence affects a lot of women’s health we are asking all our female patients about it.’*
- *‘Because violence affects people’s health, I routinely ask all my patients about any violence they may have experienced.’*
- *‘We know that family violence is common and affects women’s and children’s health, so we are asking routinely about violence in the home.’*

The FOUR (IPV) Routine Enquiry Questions

- 1) Within the past year, did anyone scare or threaten you, or someone you care about? (If so, who did this to you?)**
- 2) Within the past year, did anyone ever try to control you, or make you feel bad about yourself?**
- 3) Within the past year have you been hit, pushed, shoved, slapped, kicked, choked or otherwise physically hurt? (If so, who did this to you?)**
- 4) Within the last year has anyone forced you to have sex, or do anything sexual, in a way you did not want to? (If so, who did this to you? When did this happen (the last time?).**

ALL FOUR QUESTIONS MUST BE ASKED

OR, IF SYMPTOMS ARE PRESENT

- *It can be framed as “ I am concerned that someone hurting you may have caused all your symptoms”*
- *Followed by the Four Routine Enquiry Questions*

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

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

If the person declines to answer, thank them and offer them a brochure "Partner Abuse This is Not Love This is Control", with an explanation that IPV is really common and therefore they may know someone, e.g. family member or friend, who may find it useful.

Confidentiality

In many health care settings, confidentiality may have been explained or be understood already, as part of the provider–patient relationship (e.g., in primary care). In other situations, there may be a need to re-state this briefly, 'this is a subject that is confidential (as are all health discussions); however, if there is any situation discussed that suggest someone might be in danger, then we would need to seek other help'.

Making a statement about the limited nature of confidentiality immediately before routine inquiry about IPV is not recommended. Doing so has the potential to raise the anxiety of both individual and health care provider, and is inconsistent with screening practices for other health issues, where confidentiality of the information disclosed is not explicitly stated at the outset.

If information disclosed by the person during routine enquiry, history taking and careful assessment indicates that there is sufficient risk to warrant further action, there is scope to point out the limits of confidentiality of information during the course of the consultation (e.g., 'what you have told me is concerning. I think it is important that we talk to some other people to help make sure you (your child) can stay safe').

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Appendix 8: Guidelines For Validating And Supporting Victims Of Abuse (Step 2)

Health care provider response to disclosure about experience of violence is important in terms of maintaining rapport with the person, encouraging further disclosure and setting the foundation for further assessment.

How should providers respond?

Listen and express empathy. Be prepared to listen to the experiences of violence and abuse if the person wants to describe these. Do not express shock, horror, or disbelief.

If appropriate, there are 5 good principles to follow:

- Let them know you believe them.
- Let them know you're glad they told you.
- Let them know you're sorry it happened.
- Let them know it's not their fault.
- Let them know you'll help.

Do not overreact. A first disclosure is a critical moment. The person will monitor every reaction, and may be frightened if the abuser has threatened them not to disclose the violence, or has told them that no-one will believe them.

Do not panic. Good listening with supportive, minimal encouragers allows the person space to say all they need.

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

Acknowledge: You are glad the person told you:

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

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

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

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

Signs and symptoms indicative of IPV, no disclosure (see Appendix 6)

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

- respect her/his response
- let the person know that should the situation change you are available to discuss it with them if they would like to

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- provide them with the means of contacting appropriate support agencies, and/or give information that can be read at the time of the consultation, pass on to a 'safe' friend, dispose of or take away
- make a note in the medical record to assess for violence again at future presentations

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

- 'I'm glad, that's good to hear. But if you do encounter any problems, please know that I am here to offer help and support if you need it.'
- 'That's good; you are part of the majority. But it is important to know that if anything changes, this is a good place to come for help. If we are doing our job well we should be asking you about this again in about a year.'

It may also be helpful to provide them with contact details for family violence support agencies. You can introduce this by saying

- 'It is really common, and therefore you may know someone who may find this information useful. You are very welcome to take this information away to a friend or family member who may find this useful.'

Early intervention (health promotion approach)

There may be circumstances where intimate partner violence is not occurring, but where there still may be opportunities for early intervention. For example, cases where there are high-risk indicators such as alcohol or drug abuse; frequent, low levels of emotional abuse (e.g., insults); or other stress points, such as extreme financial stress.

Health care providers can still play an important role in responding to these cases. They can:

- educate about the potential for these risks to escalate into violence and about the importance of good relationships for good health
- offer referrals to community or other agencies that can assist with the problems identified (e.g., relationship services, alcohol and drug services, budgeting services, etc.)
- leave the door open for the person to raise concerns about violence or other issues with them in future if needed.

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Appendix 9: Guidelines for Health and Risk Assessment (Step 3)

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

Thorough risk assessment needs to be conducted prior to the development of appropriate intervention plans. Health care providers should conduct the preliminary risk assessment to identify appropriate referral options. Note that this is different from the role of conducting investigations to determine who is responsible for perpetrating the abuse and/or neglect, which is the role of the Police.

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

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

Health and Risk Assessment

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

Introducing the Health and Risk Assessment [FM.F4.1 Family Violence - Intimate Partner Violence \(IPV\) Assessment and Intervention Documentation \(for all disclosures of FV\)](#)

a) Health and Risk Assessment Questions

1. Is your partner here now?
2. Are you afraid to go/stay home?
3. Has the physical violence increased in frequency or severity over the past year?
4. Has your partner ever choked you (one or more times?)
5. Have you ever been knocked out by your partner?
6. (If applicable) Have you ever been beaten by your partner while pregnant?
7. Has your partner ever used a weapon against you, or threatened you with a weapon?
8. Do you believe your partner is capable of killing you?
9. Is your partner constantly jealous of you? If yes, has the jealousy resulted in violence?
10. Have you recently left your partner, or are you considering leaving?
11. Has your partner ever threatened to commit suicide?
12. Have you ever considered hurting yourself/suicide?
13. Is alcohol or substance misuse a problem for you or your partner?
14. Have the children seen or heard the violence?
15. Has anyone physically abused the children?

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

Question	Further assessment may include
3: Has the violence increased in frequency and severity?	Can you tell me more about that? 'Do you have any injuries that you would like me to look at?'

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Question	Further assessment may include
4: Has your partner ever choked you?	If yes, follow the procedures in the Strangulation Guideline and complete the post-strangulation documentation form
5: Have you ever been knocked out by your partner?	Carry out further assessment for traumatic brain injury.
7: Has your partner ever used a weapon against you, or threatened you with a weapon?	Assess to determine if any injuries were sustained as a result of this assault.

However, the disclosure must still come from the person directly to the health practitioner. *The (IPV) Assessment and Intervention Documentation form IS NOT* for 3rd party purposes [FM.F4.1](#)

Sexual and reproductive health assessment

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

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

Mental health assessment

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

Risk of suicide or self-harm

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

- Suicidal thoughts
- Previous suicide attempts
- Stated intent to die/attempt to kill oneself
- A well-developed concrete suicide plan
- Access to the method to implement their plan
- Planning for suicide (for example, putting affairs in order).

Make direct enquiries to assess if the abused person is thinking about committing suicide, or has attempted suicide in the past.

'You sound really depressed. Are you thinking about hurting yourself?'

'Have you hurt yourself before?'

'What were you thinking about doing to hurt/kill yourself?'

'Do you have access to (a gun, poison, etc.)?'

In extreme cases, referral to the appropriate adult or adolescent mental health service is required. Because of the abuse issues however, joint referral to a specialist family violence agency is also

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warranted in these cases. The most helpful intervention to reduce suicide risk may be to assist the person to be safe from the abuse.

Physical health assessment

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

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

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

If intimate partner violence exists, and action is needed to protect the children, follow the procedures outlined in the Te Whatu Ora Hauora a Toi Bay of Plenty Child Protection Policy.

Remember, if possible, any concerns about the safety of the children should be discussed with the abused person. If you have any doubts about discussing concerns about child abuse and/or neglect with the suspected victim’s parents or caregivers, you should *first* consult with senior colleagues within your practice setting.

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

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

Be aware that actions taken to protect the child may place the abused partner at risk. Always refer the abused person to specialist family violence support services, and inform the Oranga Tamariki about the presence of IPV as well as child abuse.

- Ask the abused partner how they think the abuser will respond.
- Ask if a child protection report has been made in the past, and what the abuser’s reaction was.
- If the perpetrator is present in the health care facility, ask the abused partner whom they would like to inform the abuser about the report. For example, would they like the health care provider to do it? Does the abused partner want to be present when the abuser is told? Do they want to do it?

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Appendix 10: Guidelines for Safety Planning (Step 4)

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

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

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

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

Remember, safe practice involves consulting with the person, and senior colleagues and or community agency advocates, to determine safety options for the future. A multidisciplinary team approach is the preferred option.

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

Imminent threat/extremely high-risk situations

In situations of imminent threat, or extremely high risk (i.e., the abuser is present, and threatening either the victim or the health care provider), the focus needs to be on securing immediate safety.

Immediate safety risk: things to consider:

- Where is the abuser now?
- Where are the children now?
- Is there a threat to staff safety?
- Is emergency assistance required (for example, Police, onsite security (if available))?

Actions to take:

If the focus is on securing immediate safety for the person, follow the procedures outlined in the Te Whatu Ora [Threatening Behaviour, Bullying & Violence Management Standards](#). This may include calling on-site security or the Police (call 111).

Once the immediate situation is contained, it is important to ensure that the abused adult and any children receive the appropriate onward referral and follow-up, as per the high risk situation below.

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Co-occurrence of child abuse and IPV

Joint safety planning and referral processes need to be implemented when both IPV and child abuse are identified. It is also important to establish the whereabouts and safety of other child/ren.

When it is identified children/ren were present during Intimate partner Violence (IPV) incident or who are living in an environment where Intimate Partner Violence(IPV) is occurring/or has occurred:
 Consultation with Senior clinician and/or Oranga Tamariki Te Whatu Ora Liaison SW and/or Oranga Tamariki Call Centre to determine response pathway **is critical.**

Note: If there are **child protection concerns** during work hours, contact Oranga Tamariki Liaison at 029 6501390 or contact Oranga Tamariki @ (0508-326459), ask for an intake social worker and discuss appropriate action.
Refer to Te Whatu Ora Hauora a Toi Bay of Plenty: Child Protection Policy

High Risk

Indicators of high risk

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

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

Other Factors to Consider

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

*Refer: [Te Whatu Ora Hauora a Toi Bay of Plenty Assessment and Management of Strangulation Guidelines \(2016\)](#) where there have been indicators or disclosures of non-fatal strangulation

Actions to take (high risk)

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

Any decision about reporting a suspected episode of abuse to the Police should be made in consultation with the person.

If there are indicators of high risk, the health care provider needs to make assertive efforts to mitigate these risks. A primary consideration is:

- Does the abused person have a safe place to go when leaving the consultation?
- Does the abused person understand their true level of risk?

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If assessment indicates a serious/high risk situation, then you can discuss the need for additional support with the person, e.g. ‘Ms X, what you are telling me sounds serious, and perhaps dangerous. I think we may need to involve more specialist support for everyone’s safety.’ Wherever possible, implement an active referral to a specialist family violence support agency (i.e., make contact with a specialist agency as part of the health visit and have the person speak with someone from the agency directly).

On the rare occasion that a health care provider believes a person’s life is in immediate danger, or has good reason to believe that the person is unable to extricate themselves from an ongoing, life-threatening situation, the Police may be notified without the person’s permission. The Privacy Act 2020 is not breached if the health care provider has acted in good faith to protect the person from serious harm. Make sure that you inform the person after the Police have been notified. In cases where it is standard procedure to notify the Police, this should be explained to the person (see [Appendix 12: Guideline for Notification of Police for Family Violence](#))

Health care provider options include

- Express your concern for the person’s safety (and that of their children, if relevant).
- If possible, initiate a multidisciplinary response
- Depending on the person’s health needs, and the resources available, consider arranging inpatient care, which can allow the person both temporary respite and further opportunity to connect with in-house support services (e.g., social workers) or external support agencies (e.g., refuge). If inpatient care cannot be arranged, help the person access emergency shelter/refuge.
- Active referral to a community agency that specialises in responding to family violence is required.
- Encourage the person to seek help from family or friends (or other safe housing).
- If they insist on going home, make sure they have information on safe exit planning if they need to leave a violent situation in a hurry. A detailed safety plan designed as a handout for victims of intimate partner violence is presented in [Appendix 11: Safety plan – Resource](#)
- Make sure the person has information about, and contact details for, other legal and support options that may assist them.

Further information is available regarding interagency information sharing from the Privacy Commission website, follow the following links to the [Sharing personal information of families and vulnerable children: A guide for inter-disciplinary groups](#) and the *Escalation ladder* regarding ‘[Sharing information about vulnerable children](#)’).

Moderate risk

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

- Let them know that you are concerned about their safety, and that without help violence can increase in frequency and severity.
- Talk to them about what help and support they might get from family and friends.
- Let them know about options for help and support from the community (e.g., refuge, other advocacy groups). Make sure they have contact details for these organisations, and that they have a safe place to keep the information.
- Let the person know about legal options (police safety orders and protection orders), or other supports that might be available if they need help (e.g., Work and Income supports). Make sure they have contact details for these organisations.

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- If they have children, let them know about the impact of violence within the family on children, and that children are seldom unaware of what is going on within families. If there are children who are old enough to talk, but the person is adamant that they are not, or have not, been affected by the violence, consider strongly encouraging them to have a private conversation with each child, asking them what they know/how they feel about what is happening.

For all abused individuals

- Educate the person about the likely increase in frequency and severity of abuse, without outside help.
- Support the person, irrespective of their choices. Understand that it is important for each person to make their own choices.
- Let the person know that they can come to you for help with violence, if they need to in the future.
- Help the person work through options for increasing safety. These can include:
 - Actions that s/he can take (e.g., moving house, installing deadbolts and security lights). Note that they are almost certainly already working to keep safe and may have well-developed strategies of their own.
 - Help and support from family members or friends.
 - Help from community agencies (e.g., refuge, or other advocacy groups).
 - Help from police (e.g., police safety orders), courts (e.g., protection orders), and other government agencies (e.g., Work and Income and Housing New Zealand).
 - Help from you, and or from others in the health or social services.

Historic abuse

In some cases, individuals may tell you about violence that they have experienced in the past, but say that it does not pose a current risk for them. This can be important information that is relevant to current health issues they are experiencing, and requires appropriate acknowledgement.

Disclosure of past abuse

- Listen to their story.
- Acknowledge what they have to tell you.
- Validate their experience ‘this is not your fault’, ‘no one deserves to be treated like this.’
- It may be relevant to explore if this past violence has current implications in their lives.

‘Do you feel you are still at risk?’

‘Are you still in contact with your (ex-partner)? Do you have children together? Do you share custody?’

Consider if further support may be required.

- ‘How do you think the abuse has affected you emotionally and physically?’
- ‘Would you like to talk to someone else for support about this experience?’
- Discuss referral options (e.g., counselling, information sources).
- Follow up as appropriate.

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Appendix 11: Safety Plan – Resource

This safety plan has 3 parts: safety to avoid serious injury and to escape an episode of violence, preparation for separation, and long-term safety after separation.

1. Avoiding injury, escaping violence

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

Leave if you can. Know the easiest escape routes – doors, windows, etc. What’s in the way? Are there obstacles to a speedy exit?

Know where you are running to and have a safe place arranged. You may want to organise this with a neighbour in advance of trouble. You may want to leave a spare set of clothes there.

Always keep your purse, cash cards, keys, essential medications and important papers together in a place where you can get them quickly or have someone else fetch them.

If you can’t leave the house, try to move to a place of low risk. Try to keep out of the bathroom, kitchen and garage, away from weapons, upstairs or rooms without access to outside.

Talk to your children about getting help. Think of a code word you could say to your children or friends so they can call for help. Depending on age and ability they could:

- run to a neighbour and ask them to call the Police
- call 111. Teach them the words to use to get help (‘This is Jimmy, 99 East Street. Mum’s getting hurt. She needs help now’)
- go to a safe place outside the house to hide. Arrange this in advance.

Try to leave quietly. Don’t give your attacker clues about the direction you’ve taken or where you’ve gone to. Lock doors behind you if you can – it will slow down any attempt to follow you.

Have refuge or safe house numbers memorised or easy to find.

If you have to leave to save your life – leave fast. Take nothing and go to the nearest safe place and call for help.

2. Preparation for separation – advance arrangements and flight plans

Get support from a refuge or a specialist family violence agency to discuss your options and plans. Make sure you have all the information and support that is available for you.

Arrange transport in advance. Know where you’ll go. Make arrangements with the refuge or safe house.

Tell only one or two trusted friends or a refuge worker about your plans. Go through the details together.

Start a savings account. A small amount of money saved weekly can build up and be useful later.

Gather documents. Start collecting the papers and information you need. Make your own list: birth certificates, marriage certificate, copies of protection orders, custody papers, passports, any identification papers, driver’s licence, insurance policies, Work and Income documents, IRD number, bank account details and statements, cheque book, cash cards, immigration documentation, adoption papers, medical and legal records, etc.

Ask your family doctor to carefully note any evidence of injuries on your patient records.

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What to take

- documents for yourself and children
- keys to house, garage, car, office
- clothing and other personal needs
- a phone or phone card and list of important addresses and phone numbers
- for children, take essential school needs, favourite toy or comforter
- a photograph of your partner so that people protecting you know what s/he looks like.

Playing it safe

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

3. Living safely after separation

Children

Teach your children what to do if your ex-partner makes contact with them unexpectedly, breaching access arrangements; that is, rules about checking first before opening the door, coming inside or going to neighbours if s/he comes to the house, telling a teacher if they are approached at school.

Teach your children what to do if your ex-partner takes them; for example, calling the Police on 111.

Tell other adults who take care of your children (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 refuge or a specialist family violence agency for support. As well as understanding abuse, these groups usually keep lists of sympathetic lawyers, and can assist in dealing with Work and Income, Housing New Zealand or other government departments you may need to deal with.

Attend a woman's education programme to help strengthen your confidence, independence and freedom, make connections with other women, and deal with your ex-partner.

Think about how to deal with potential abuse, feelings of fear and safety issues when you have to communicate with your ex-partner by telephone, or in person.

Tell your employer that you are afraid of your ex-partner. Ask for your phone calls to be screened.

Get a protection order from your local District Court. Make four copies – one for your handbag, one kept at home, and one at work. Make sure your local Police Station has a copy. If you move, remember to give a copy to your new local Police Station. Tell your employer that you have a protection order, or that you are afraid of your ex-partner.

If your ex-partner breaches the protection order, phone the Police and report it, contact your lawyer and your advocate.

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

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

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Security

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

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

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

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

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

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

From: Auckland Domestic Violence Centre. Safety Plan.

- [Security Plan - High Risk of Family Violence Patient FM.S21.1](#)

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Appendix 12: Guideline for Notification of Police for Family Violence

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

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

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

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

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

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

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

1. Safety for the person, public and staff should be the paramount consideration. This also includes risk to children living in the home, recognising the significant co-occurrence of intimate partner violence (IPV) and child physical abuse. The greater the severity and frequency of IPV, the more likely the children are to be victims of physical abuse.
2. If police become involved this may result in further violent acts towards the victim (note victim's fear of retaliation)
3. The individual's relationship with the clinician may be affected if the rights of their rights are felt to be compromised (disclosing the information without consent)
4. Intimate partner violence intervention recognises the following:
 - a. The victim is an expert in their own environment and surroundings, s/he may know the reaction a referral to the police would create
 - b. The victim is encouraged to take control of the decisions around keeping safe, unless there are immediate issues of safety for either the victim or their children
5. There are no legal requirements to report crimes (e.g. assaults) to the police. However ethically Te Whatu Ora staff have a responsibility to notify police if we suspect any of the following;
 - a. Ongoing safety issues, such as further violence to this victim or others if perpetrator remains at large
 - b. Injuries that may be life-threatening
6. If there is uncertainty amongst the team about the actions required, team discussion should follow with a consensus being reached on the outcome. Please consult the Clinical Nurse Manager / Clinical Midwife Manager.

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ACTIONS

1. Notification to Police due to an individuals safety

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

- a) Advise the person of the need to notify the police and that an ongoing safety plan will be discussed
- b) Inform Security and Duty Nurse Manager (if after-hours) of the concerns regarding safety
- c) Ring the Police (111) and advise them of the current situation with information disclosed
- d) Staff can provide the appropriate and relevant information without concerns regarding breach of privacy. Information shared should be related to the referral to the Police and should include:
 - i) The disclosure of abuse, including all relevant history and verbatim statements
 - ii) The injuries sustained pertinent to their inquires
- e) Staff should facilitate the introduction of the Police to the individual and ensure privacy for their ongoing discussions.

2. Notification to Police for staff safety reasons:

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

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Appendix 13: Guideline for referral and follow-up (Step 5)

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

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

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

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

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

While follow-up will vary depending on the needs of the individual, the resources and training of the health care provider, and the point at which the person has entered the health system (eg, well-health services, primary or secondary care), at least one follow-up appointment (or referral) with a health care provider, social worker, or IPV advocate should be offered after disclosure.

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

Imminent danger/high risk

1. Referral

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

2. Follow-up

Plan to follow-up with the person at a later date, and/or pass on relevant information for other health care providers to follow-up about their safety later (e.g., if discharged from hospital, ensure their primary care provider knows about and can follow-up on safety issues).

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Moderate risk, or persons with ongoing safety concerns

1. Referral

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

2. Follow-up

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

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

Sharing of information between clinicians

Developing and implementing safe and appropriate systems for sharing information about IPV between clinicians (e.g., between hospital-based and primary care and community providers) is important because:

- the information usually has a big impact on health, and healthcare information needs to be shared appropriately
- often the clinician to whom the person has disclosed the sensitive information is not the long-term health care provider, and thus cannot provide ongoing care or support
- failure to share information appropriately has been linked with adverse outcomes (including death).
- individuals need to have a role in determining who information should be shared with. They can best be supported to make these decisions if the health care provider explains to them why the information should be shared and how this might take place.

Examples:

- *'Is it OK if we let your GP, Dr X, know that you have been to see us and what we talked about in relation to your partner's behaviour? That way, your GP will be informed about what is going on for you, and can help you with your health needs better (help you plan for your safety).'*
- *'It would be helpful for your midwife to know what you have been going through so she can help support you. I can write her a separate note with the referral.'*

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After disclosure of current or past IPV

At least 1 follow-up appointment (or referral) with a health care provider, social worker or IPV advocate should be offered after disclosure.

- *‘If you like, we can set up a follow-up appointment (or referral) to discuss this further.’*
- *‘Is there a number or address where it is safe to contact you?’*
- *‘Are there days/hours when we can reach you alone?’*
- *‘Is it safe for us to make an appointment reminder call?’*

Responding to abused persons at follow-up

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

- Review the medical record and ask about current and past episodes of IPV.
- Communicate concern and assess both safety and coping or survival strategies
 - *‘I see from reviewing your notes that previously you talked to us about what was happening in your relationship at home. How have things been for you since you were here last?’*
 - *‘I am concerned about you, and your health and safety.’*
- Repeat the routine enquiry questions.
- Repeat the health and risk assessment questions.
- Provide intervention again, based on findings of current health and risk assessment.
- Review the person’s options for increasing safety (individual safety planning, talking with friends or family, seeking support from advocacy services and support groups, legal options, transitional/temporary housing, seeking support from Work and Income, etc.).

For current and previous victims of IPV:

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

Co-occurrence of child abuse and IPV

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

Remember: when the IPV risk assessment identifies child protection concerns, consultation should occur with a child protection multidisciplinary team.

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

Note that:

- a) All adults who disclose IPV should be offered referral to specialist family violence support services.
- b) Receiving a positive response to IPV routine enquiry does not necessarily require a referral to Oranga Tamariki.

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

1. Provide the adult with referral information for a specialist family violence support agency

The intervention selected may be to provide the disclosing adult with information only. The material provided needs to include information about the impact that seeing and hearing IPV can have on children.

This intervention focuses on empowering the person to contact the services. This can include offering the use of a phone to make contact while the person is in the department/service.

Follow-up on the outcomes of this intervention can be carried out if and when the person re-presents to the same service, or at another service (e.g. when obtaining follow-up health care in the transition from secondary to primary care).

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

This intervention requires the health professional to contact an appropriate local family support agency during the episode of care and set a mutually agreed appointment time between the person and a worker at the family support service, e.g. Childrens Team, where available. This intervention allows for the adult to take responsibility for engaging with the family support service.

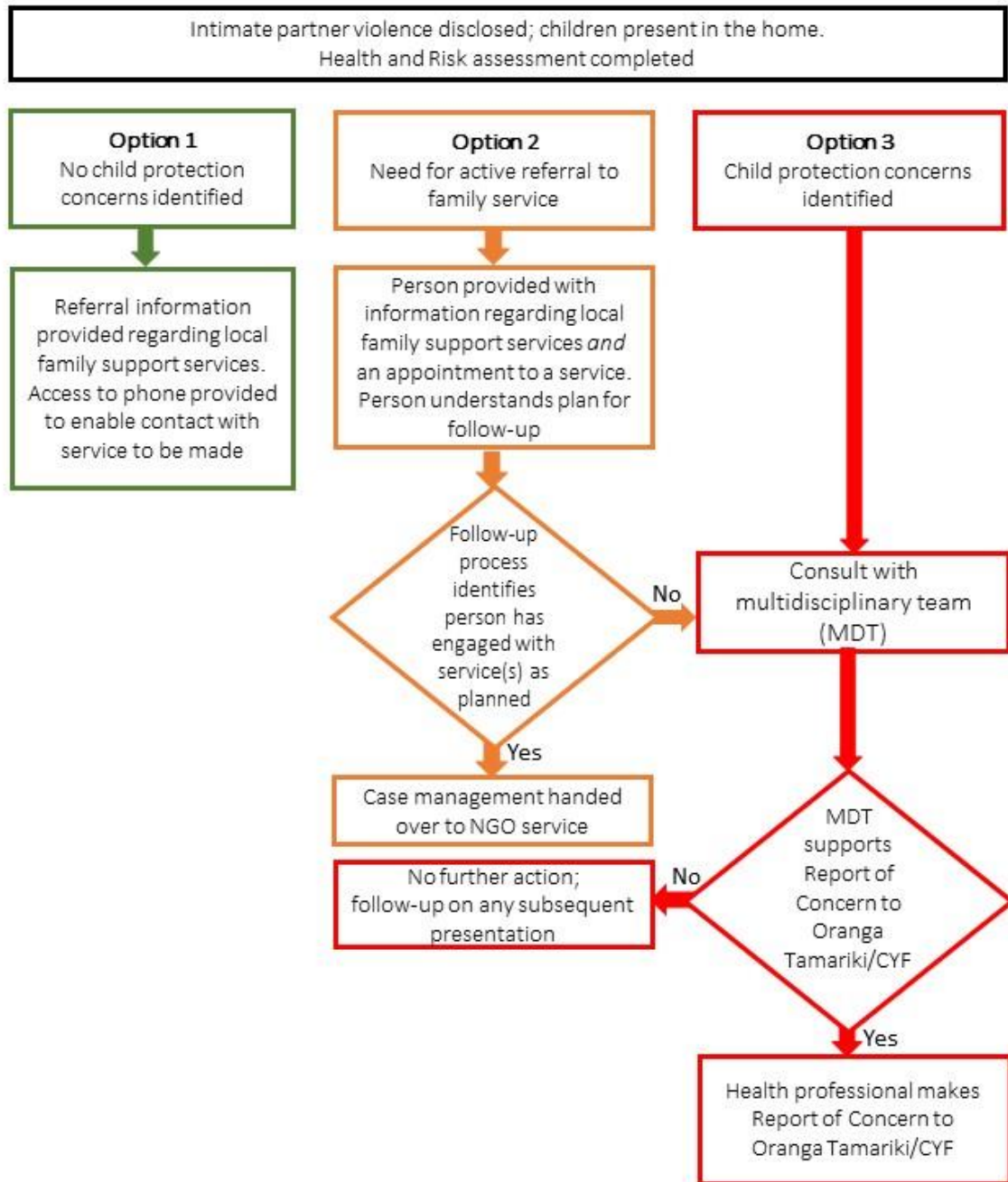
The health professional needs to note the agreed meeting time, and subsequently contact the family support service to confirm that the appointment was attended. In the follow-up process, if it is identified that the person did not engage with services (and no alternative appointment has been made or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

3. Statutory intervention

Based on the information disclosed to health care providers and/or members of a child protection multi-disciplinary team, and/or other information they have obtained relevant to the child(ren), the level of risk to children may be such that a report of concern to Oranga Tamariki is indicated. If this is the case, the child protection MDT team will advise on the best process for making this report.

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Flowchart: Referral Options When Intimate Partner Violence is Disclosed, and Child(ren) are present in the Home



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Appendix 14: Guidelines for Documentation of Intimate Partner Violence (Step 6)


6.1 Recording Routine Enquiry

INPATIENT and MATERNITY SERVICES

Place and complete Intimate Partner Violence sticker on client's notes

FVQ asked	Yes	No
FV disclosed	Yes	No
Referral / resources given	Yes	No
FV Risk assessment Complete	Yes	No

Date _____
Signature _____



COMMUNITY CHILD HEALTH

Routine Enquiry Recordings are completed on the 5 to 18 Health Referral (626CY)

6.2 Recording IPV Disclosure

Record the disclosure on the Intimate Partner Violence Documentation Form [FM.F4.1](#)

- 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".
- Record history obtained (past and current abuse). Specify aspects you saw and heard, and which were reported or suspected. Use the individual's words as much as possible. Use quotation marks for specific disclosures where appropriate, e.g. "John punched me".
- State the identified perpetrator's name and relationship to the person
- Mark site(s) of old and new injuries on the body injury map
- Describe type of injury, shape, coloration and measure size. Do not attempt to age bruises.
- Examination findings
- Assessment findings; if risk assessment identified a history of choking / strangulation, document the findings on the Post-Strangulation documentation form [assessment & Management of strangulation](#)
- For suspected cases of abuse, record your opinion as to whether the injury is consistent or inconsistent with the person's explanation
- Note the action taken by the clinician, referral information offered and follow-up arranged
- Include the date, time, a legible signature and designation
- Indicate in notes discreetly that IPV has been disclosed. For example, ticking the coded box in the notes
- Upload Intimate Partner Violence Assessment and Intervention Form into CHIP under clients NHI.
- The document will be located into CIDA and coded Family Violence

6.3 Collection of Physical Evidence

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

- Place torn or blood-stained clothing and/or weapons in a sealed envelope or bag (these can be provided by the Police).
- Mark the envelope with the date and time, the person's name, and the name of the person who collected the items. Sign across the seal.
- Keep the envelope in a secure place (e.g., a locked drawer or cupboard) until turned over to the Police. Document in your clinical record the time and date that you handed it over, and to whom the envelope was given.

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6.4 Photographs

Photography of injuries (Emergency Department / Assessment and Diagnostic Unit)

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 required, contact **the Police** to carry out the photography (as per forensic requirements.)

Appendix 15: Guidelines for Safety and Security Processes

- It is important to ensure that anyone making public enquiries about the victim is given no details. Do not confirm that the client has been admitted / discharged or has had contact with Te Whatu Ora Hauora a Toi Bay of Plenty. State clearly that under the Privacy Act you cannot provide information. Name suppression should be advised to the Duty Nurse Manager, Telephony, Security and all relevant service staff including volunteers
- If a notification has been made to the Police or Oranga Tamariki, discharge plans should be arranged in consultation with the agency / case worker concerned and the parent / guardian (if appropriate) e.g. ensure the guardian speaks to the agency concerned and that all parties are in agreement with the plan. If discharge is being made to a woman's refuge or other place of safety, the discharge plan needs to also be in consultation with the discharge agency
- The discharge plan may include leaving ED / hospital ward / other department by a safe route, in consultation with security staff.
- Document the discharge plan.
- Complete **an Incident Management Form (Datix)** if any unexpected outcomes occurred.
- Advise the Duty Nurse Manager / Team Leader / Manager of the discharge outcome.
- Each service implementing intimate partner violence intervention must also have (in the unlikely situation of the referral agency not being immediately available) provision for both safe emergency shelter (<24 hours) and safe transport.
- When a woman has a protection order, advise the Duty Nurse Manager / Team Leader / Manager as well as relevant agencies as appropriate, e.g. the refuge and/ or police in consultation with the woman.

Staff Safety, Clinical/Community Settings

- Staff safety is a priority at all times (Refer to [policy 5.4.7 protocol 0 Threatening Behavior, Bullying, Harassment & Violence Management - Standards](#))
- All services will have clear guidelines for safe practice, especially when undertaking home visits.

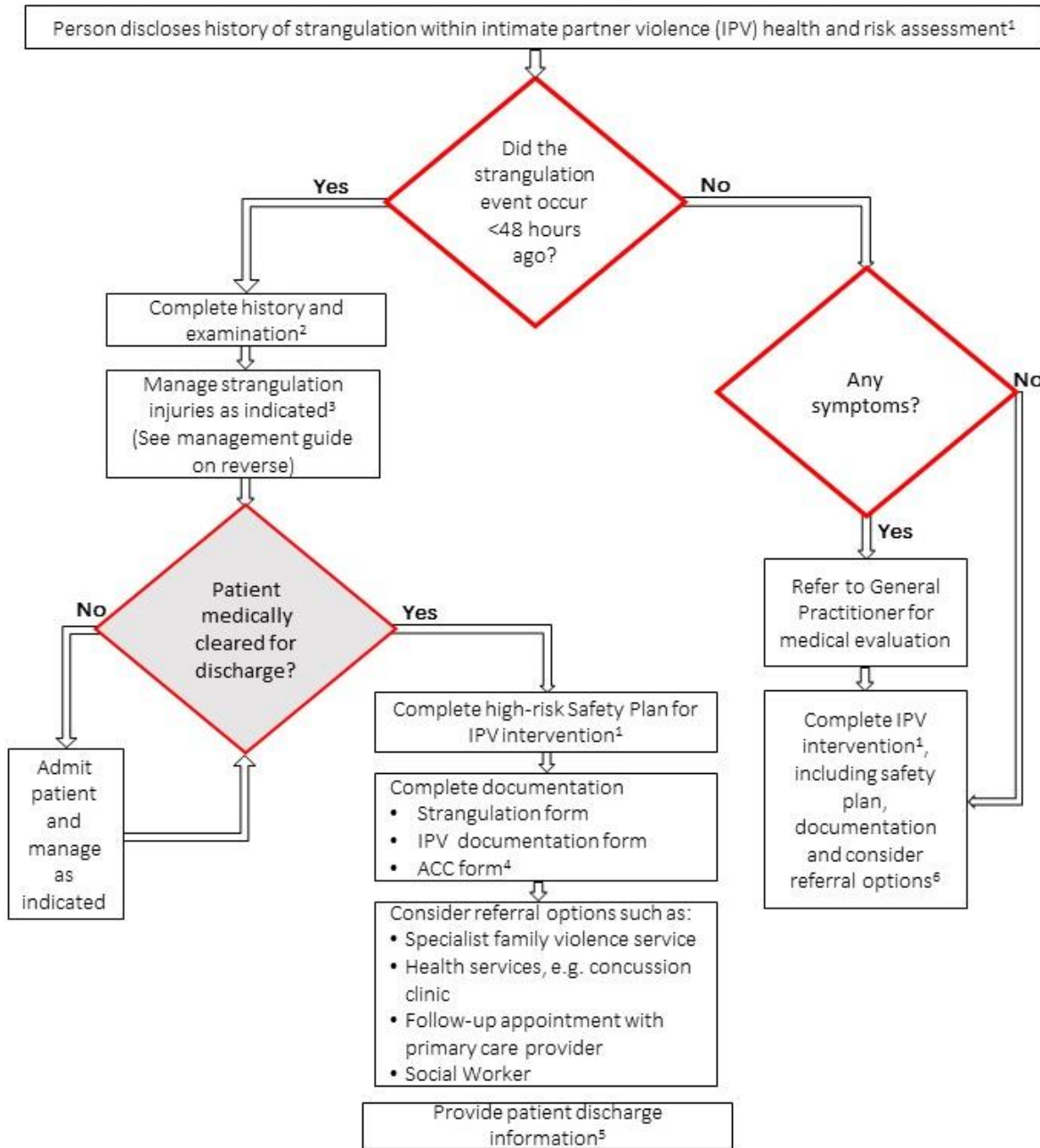
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Appendix 16: Clinical guideline: assessment and management of strangulation

<p>Strangulation (choking) management</p> <p>Management of strangulation depends upon the mechanism of injury, clinical picture of the patient and time since the strangulation event. The post-strangulation documentation Assessment & Management of strangulation form guides clinicians through the processes of care. Be aware that many victims of strangulation have minimal symptoms and signs following the event.</p> <ul style="list-style-type: none"> • If patient is alert, orientated, no loss of consciousness, no signs of compromised airways +/- superficial injuries to neck: <ul style="list-style-type: none"> - ensure home support - provide post-strangulation information sheet to patients - consider referral to primary care for re-evaluation of signs and symptoms that may emerge within 48 hours of the event. • History of loss of consciousness more than a few hours ago, but is currently clinically stable - assess and treat as for any other head injury: <ul style="list-style-type: none"> - ensure home support - provide post-strangulation information sheet to patient - consider referral to primary care for re-evaluation of signs and symptoms that may emerge within subsequent days. • Significant neck pain, dysphagia or dysarthria – discuss/manage with emergency department support • Reduced level of consciousness, confusion or compromised airway – usual emergency care provided and refer to the emergency department for urgent assessment/management
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Notes

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

Acknowledge Canterbury Health Pathways tool: Physical and sexual assault resource (Healy, C)

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Appendix 17: Strangulation discharge information: discharge advice to patients and their families and friends

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

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

Serious problems

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

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

Milder problems

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

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

What you can do to help yourself

Medication and drugs:

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

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

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

Driving: DO NOT drive for at least 24 hours.

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

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

Your doctor or nurse today will tell you when to see your family doctor (GP) for a check. Take this sheet and your discharge letter with you to the appointment

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