TARANAKI DISTRICT HEALTH BOARD CODE OF CONDUCT

Title of Policy Manual:	People and Capability / Human Resources
Date Issued:	March 2020
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Responsibility:	General Manager People and Capability
Authorised By:	EMT
Version:	5

Introduction

The Taranaki District Health Board's (DHB) mission (Te Kaupapa) is improving, promoting, protecting and caring for the health and well-being of the people of Taranaki. Taranaki DHB's values define who we are as an organisation, the way we work with each other, our patients, whanau and external partners. Our Te Ahu Taranaki DHB values are:

Partnerships	WHANAUNGATANGA	We work together to achieve our goals
Courage	MANAWANUI	We have the courage to do what is right
Empowerment	MANA MOTUHAKE	We support each other to make the best decisions
People Matter	MAHAKITANGA	We value each other, our patients and whanau
Safety	MANAAKITANGA	We provide excellent care in a safe and trusted environment

Taranaki DHB is committed to ensuring the Treaty of Waitangi informs policy and practice across all service units. Development and implementation of this document has been undertaken in the spirit of partnership, participation and protection.

Purpose

1. The purpose of this Code is to establish the standards of conduct expected of all Taranaki District Health Board (TDHB) employees, contractors, volunteers and students, to ensure the efficient and successful operation of TDHB. It sets out accepted standards of behaviour that TDHB believes are essential for promoting harmony in relationships for all workers (employees, contractors and volunteers), protecting the interests of its clients, employees, contractors, volunteers, students, assets and information and ensuring all are treated in a fair and consistent manner.

Scope

2. The Code of Conduct applies to all Taranaki District Health Board employees, including permanent, temporary or casual employees. The Code also applies to persons engaged by TDHB including contractors, volunteers and students, and forms part of the contractual agreements between those persons and TDHB.

3. The Code of Conduct operates in conjunction with professional codes of conduct and does not replace the existing regulatory professional codes of conduct.

TDHB Values and Expected Behaviours - How we work together and with others (Nga Tikanga)

4. The actions and behaviours described below are how we aim to contribute to all our relationships including those with our patients, clients, whanau, funded agencies, staff and members of the public and form the core of this Code of Conduct. Therefore, we will work together by:

Partnerships	**WHANAUNGATANGA**	**We work together to achieve our goals**

All employees understand that their role and behaviours have a direct effect on others within the organisation, and the public. All employees are expected to respect and contribute to the rights of colleagues, patients and the diverse community they serve, by:

- Avoiding behaviour which might cause distress to or disrupt TDHB.
- Avoiding discriminating behaviour or language in accordance with the Human Rights Act.
- Respecting the privacy of individuals at all times and ensure personal and confidential information is used only for the purposes for which it was intended.
- Treating everyone fairly and with respect and dignity.
- Respecting the cultural background of colleagues, members of the public and patients in all dealings with them.
- Being supportive of work teams, and accepting responsibility as team members.
- Not influencing patients for personal gain or that of an associated person.
- Focussing on issues, rather than personalities.
- Not reproducing, photographing, filming or recording another employee, contractor, patient/client or visitor, or their records, without their permission or the permission of someone authorised on their behalf.
- Ensuring organisational and professional standards are maintained in any use of social media, particularly in respect of confidentiality.

Courage	MANAWANUI	We have the courage to do what is right

Employees are committed and loyal to the vision, values and goals of TDHB. They inspire trust and communicate openly, honestly and with integrity:

- All employment related matters are conducted in good faith, in an open and truthful manner.
- Employees take responsibility for their own actions and decisions, and challenge unethical or unprofessional behaviour.
- TDHB Employees are required to maintain open communication and share information where appropriate.
- Employees avoid oppressive, harassing or overbearing behaviour or language.
- Employees observe and protect the right of others to privacy and confidentiality.
- Employees shall behave with integrity; carry out assigned duties safely, faithfully and expeditiously.
- Employees will not withhold relevant information, or obstruct or delay a decision in dealings within the DHB or the community.
- All communications and dealings will be fair and transparent.
- Prior to any employee making a public disclosure, approval must be obtained from a member of the TDHB Executive Management Team. (Except for Whistle Blowers legislation).
- Employees will disclose events or proceedings that are relevant to their role and employment at TDHB in a timely manner.

Empowerment	MANA MOTUHAKE	We support each other to make the best decisions

Employees are encouraged to celebrate their professional achievements and publicise them in relevant internal communication channels.

- Employees are supported in taking the initiative and being creative in resolving problems, seeking improved productivity and responding to opportunities within their areas of responsibility.
- Employees are encouraged and supported, to the best of TDHBs ability with on-going learning relevant to their field of expertise and role. This is whether training is taken internally or externally, within disclosed financial parameters. Employees shall inform appropriate colleagues/managers of any relevant qualifications received.

Employees are aware that the expectations and culture of healthcare within New Zealand are constantly evolving. To ensure that TDHB meets the expectations of those in the community employees will support and encourage change.

- Employees actively seek innovative ways to improve efficiency, and embrace these changes as they occur.
- Employees work with Management and Unions to implement change.
- Employees support the DHB through the change management process.
- Employees actively encourage and embrace feedback, without blame, to inform understanding and continuous improvement.

People Matter	MAHAKITANGA	We value each other, our patients and whanau

Employees are committed to carrying out faithfully the duties and obligations of the role for which they are employed, in an efficient, competent and loyal manner, and avoid behaviour that might impair their effectiveness. Employees are proactive in protecting and enhancing TDHB's interests, rather than merely refraining from damaging them.

- Employees will comply with all reasonable and lawful instructions of TDHB.
- Employees ensure that all work is undertaken in accordance with the accepted standards of behaviour, code of ethics and competency requirements for their profession.
- Ensure professional boundaries are kept in dealings with patients and other employees, including appropriate distance from the personal affairs of patients.
- Employees perform their duties with all reasonable skill and diligence.
- Employees read, understand and comply with all policies and procedures implemented by TDHB.
- Employees avoid conduct which may, or does, impair work performance, including the use of alcohol and other drugs or substances.
- Care is taken with the handling of information, ensuring it is used only in accordance with the Privacy Act and applicable legislation and recognised standards, policies and directives.
- Private information is only to be accessed for a lawful purpose.
- All employees maintain a professional image and ensure their actions, do not bring TDHB into disrepute.

Safety	MANAAKITANGA	We provide excellent care in a safe and trusted environment

Each and every employee is committed to creating healthy and safe environments, both in the workplaces and in the community, for the benefit of employees and the public. All employees understand that their contribution makes a difference to the lives and experiences of others.

- Employees will consider the safety of themselves and others in the workplace at all time.
- Employees will comply with instructions given for workplace health and safety, including using any personal protective equipment supplied.

- Employees will support and promote actions and initiatives in the workplace which enable hazards and risks to be identified and isolated, eliminated or reduced.
- Employees follow all relevant policies and procedures regarding health and safety, including reporting near-misses, accidents and staff deficits.

All employees are also expected to work within the expectations of the State Services Commission Standards of Conduct and Integrity (see appendix 1).

Managers at Taranaki District Health Board are Responsible for:

5. Ensuring that each TDHB employee/contractor/volunteer/student under their direction reads, understands and meets the standards set out within the TDHB Code of Conduct, the Health and Safety at Work Act 2015 and the State Services Commission's Standards of Integrity and Conduct.

6. Taking appropriate action where the standards within these Codes are not met.

7. Acting as a good employer on behalf of TDHB, consistent with TDHB's aims, objectives and values.

TDHB Employee's, Contractors, Volunteers and students are responsible for:

8. Maintaining the trust and confidence of TDHB.

9. Adhering to this Code of Conduct and the State Services Commissions Standards of Integrity and Conduct and reporting any breaches of these Codes.

10. Adhering to the Health and Safety at Work Act 2015.

11. Conducting their duties in the best interests of TDHB and the employment relationship and ensuring their actions support TDHB's aims, objectives and values.

Use of TDHB Computer Systems, Network and Data

12. All users of the TDHB computer systems, networks, equipment and data must comply with the terms and conditions of use outlined in the **TDHB Information Technology Use Policy**.

Failure to comply with the Code of Conduct

13. Failure to comply with the code will result in appropriate action being taken, as set out in the **TDHB Disciplinary Policy & Procedures.**

14. The following definitions provide some examples of behaviours or performance that are not acceptable. This list is not exhaustive. The fact that a certain unsatisfactory behaviour or action is not listed does not mean it is condoned or acceptable. Depending on the context and the severity and impact of the conduct, any action or event could be **misconduct** or **serious misconduct**. These definitions are not restricted to the stated classifications.

Serious misconduct includes	• Wilful, or deliberate, behaviour that is inconsistent with the continuation of the employee's employment agreement; or • Conduct that causes imminent and/or serious risk, to: • The health, or safety, of a person; or • The reputation and/or, viability of TDHB; or • Theft, fraud, assault, and intoxication at work or refusing to carry out a lawful or reasonable instruction that is consistent with the employment agreement. • Accessing, using or disclosing information concerning patients, clients/employees or any other confidential information without proper authorisation. (This does not preclude the sharing of patient/client information among health professionals involved in the care/treatment of the individual on a 'need to know' basis.
Misconduct includes	• Any misconduct or misbehaviour that does not meet the above criteria to be considered serious misconduct; or • Continual or repetitive unacceptable behaviour; or • Negligence in the performance of role duties; or • Refusing to carry out a lawful and reasonable instruction that is consistent with the employee's employment agreement; or • Wilful or gross breach of TDHB' policies, regulations or procedures.

These are only example definitions and possible breaches of the code are not limited to the classifications outlined above. It is not possible to foresee every breach situation. Depending on the context and the severity and impact of the conduct, any action or event could be misconduct or serious misconduct.

An extensive list of **Examples of Breaches to the TDHB Code of Conduct** is included as Appendix 2.

(Please sign and return a copy to Human Resources, TDHB Base Hospital)

EMPLOYEE'S DECLARATION

I have received a personal copy of the Code of Conduct issued by Taranaki District Health Board.

I understand that it is my obligation to read and understand the Code of Conduct, and that I may be subject to the disciplinary procedures existing in Taranaki District Health Board for breaches of the Code.

I agree to abide by all reasonable written company policies, procedures and protocols and recognise the employer's right to vary or add to these and this Code of Conduct from time to time, following consultation.

Signature:……..

Name:…….Date……...

Appendix 1

State Services Commission Standards of Integrity & Conduct

The State Services is made up of many organisations with powers to carry out the work of New Zealand's democratically elected governments. As part of the public sector TDHB is required to act with a spirit of service to the community and comply with the standards of integrity and conduct set out in the State Services Commission Standards of Integrity & Conduct.

Incorporated into the TDHB Code of Conduct, all TDHB employees contractors, volunteers and students are required to be fair, impartial, responsible and trustworthy, as outlined in the following standards:

Fair	• Treat everyone fairly and with respect. • Be professional and responsive. • Work to make government services accessible and effective. • Strive to make a difference to the well-being of New Zealand and all its people.
Impartial	• Maintain the political neutrality required to enable us to work with current and future governments. • Carry out the functions of our organisation, unaffected by our personal beliefs. • Support our organisation to provide robust and unbiased advice. • Respect the authority of the government of the day.
Responsible	• Act lawfully and objectively. • Use our organisation's resources carefully and only for intended purposes. • Treat information with care and use it only for proper purposes. • Work to improve the performance and efficiency of our organisation.
Trustworthy	• be honest. • work to the best of our abilities. • ensure our actions are not affected by our personal interests or relationships. • never misuse our position for personal gain. • decline gifts or benefits that place us under any obligation or perceived influence. • avoid any activities, work or non-work, which may harm the reputation of our organisation or of the State Services.

For further information go to www.ssc.govt.nz/code

Appendix 2 - Examples Of how the TDHB Code of Conduct can be breached

Overview

To help illustrate those standards the following definitions provide some examples of behaviours or performance that are not acceptable. This list is not exhaustive. The fact that a certain unsatisfactory behaviour or action is not listed does not mean it is condoned or acceptable. Depending on the context and the severity and impact of the conduct, any action or event could be misconduct or serious misconduct. These definitions are not restricted to the stated classifications.

Misconduct

The following are some specific examples of the types of unsatisfactory behaviours which may constitute the misconduct and could lead to a formal warning, a final warning, or dismissal following due process:

1. Negligence or carelessness during employment.
2. Ongoing involvement in conflict with fellow employees that adversely impacts on other employees or service delivery.
3. Wilful misuse, mistreatment, or otherwise not taking reasonable care of TDHB property.
4. Absence from duty or place of work without proper reason or authorisation.
5. Repeated lateness for work, or repeated absenteeism without just cause.
6. Non-performance of assigned duties, including unauthorised sleeping whilst on duty.
7. Failure to comply with a lawful instruction, including a reasonable and lawfully given warning, unless there is good and sufficient cause to do otherwise.
8. Witnessing the signing of any personal patient/client documentation if requested to do so by patients/clients, which could result in any personal gain or cause a conflict of interest.
9. Breach of any professional protocols or standards, whether established by the DHB or the relevant professional body (including breach of professional boundaries).
10. Undertaking secondary employment which is in conflict with your engagement at TDHB, or which is likely to interfere with your ability to adequately perform the duties of your role.
11. Failure to declare a reasonably foreseeable conflict of interest.
12. Using abusive or offensive language.
13. Reporting to work in such a condition that you are unable to perform the required duties in a safe and/or proper manner.
14. Any act of non compliance with TDHB's policy on the use of the internet and email, systems, and any TDHB owned computer equipment or devices. This includes using Board computers to download or make unauthorised copies of any computer software, or the use of any unauthorised software.
15. Any other behaviour that TDHB considers is misconduct.

Serious Misconduct

The following are some of the specific examples of unsatisfactory behaviour that may be considered serious misconduct and which could justify dismissal without notice following due process:

16. Acts indicating gross incompetence.
17. Behaving in a manner that causes unreasonable distress to other employees or persons, including causing distress via indirect means (Inappropriate and/or disruptive behaviour including sexual, verbal, physical or personal harassment of any other person).
18. Deliberate or negligent behaviour adversely affecting the safety of a patient, client, visitor or another employee.
19. Failure to follow any health and safety related working practice, policy or instruction, including the failure to record and report any accident affecting patient/residents/staff.
20. Not being in possession of or eligible to hold a required Annual Practising Certificate or equivalent.
21. Any attempt to mislead the DHB, or any employee, or patient/client, or a member of the public in connection with the DHB's business; this includes falsification of any documentation.
22. Possession of or access to patient, client or TDHB property or information without proper authorisation lawful consent.
23. Possession of another person's property without that persons consent.
24. The unauthorised disclosure, use or access to confidential information.
25. Unauthorised possession of drugs or illegal intoxicating substances on TDHB property, or being under the influence of any of these substances while performing the duties of your role.
26. Assaulting (physically or verbally) or threatening anyone in the workplace.
27. Being in possession of offensive weapons in the workplace.
28. Unauthorised use of TDHB time, facilities, premises or equipment to undertake other employment.
29. Undertaking acts likely to bring TDHB into disrepute.
30. Conduct outside of work that impacts adversely on the organisation or raises concerns that your employer can no longer have the trust and confidence in you to perform the duties of the position in which you are employed.
31. Deliberately not maintaining yourself in a fit or capable state to undertake your duties, in so far as this has been identified as a contributing factor (for example, criminal conviction affecting employment, loss of drivers license, non-compliance with medical treatment or advice).
32. Deliberately undermining reasonable and lawful instructions from management
33. Accessing, transmitting, storing, downloading or displaying any form of pornographic, sexually explicit or inappropriate material or copyrighted material using DHB equipment, computers or resources, or other breach of the TDHB IT Use Policy.
34. Being absent for three consecutive days without reporting to your manager or without proper consent.
35. Misuse of position of trust and authority for the purpose of personal gain. This includes the failure to report to management any donations or monetary gifts received.

Incident Management Policy

Department:	Organisation-wide
Date Issued:	July 2019
Review By Date:	July 2022
Responsibility:	Clinical Board
Authorised By:	Chief Executive
Version:	3
Page:	1 of 3

Introduction

1. The Taranaki District Health Board (DHB) is committed to the following values:
   - **Partnership – Whanaungatanga** – *We work together to achieve our goals*
   - **Courage – Manawanui** – *We have the courage to speak up and advocate for each other*
   - **Empowerment – Mana Motuhake** – *We support each other to make the best decisions*
   - **People Matter – Mahakit*anga*** – *We value each other, our patients and whanau*
   - ***Safety – Manaakitanga*** – *We provide excellent service in a safe and trusted environment*

2. Taranaki DHB is committed to ensuring the Treaty of Waitangi informs policy and practice across all service units. Development and implementation of this document has been undertaken in the spirit of partnership, participation and protection.

3. Taranaki DHB is committed to providing and promoting a culture in which patients, family/whanau and workers are able and encouraged to recognise and report incidents, and participate in the review of events without fear of blame or retribution, to ensure improvements are made to prevent recurrence.

4. An incident is defined as an unplanned event that results in or has potential to result in injury, damage or loss. This applies to clinical and non clinical events.

Purpose

5. This purpose of this policy is to outline the requirements for reporting, investigating and managing the outcomes of incidents involving patients, workers or visitors that occur within all Taranaki District Health Board (Taranaki DHB) workplaces.

Objectives

6. To ensure that the appropriate framework/procedure is followed for the investigation of all incidents.

7. To ensure there is appropriate management of an incident and that every incident is investigated.

8. To ensure an approach that places the patient, worker or visitor central to the response. This includes the process of open communication with the patient/consumer, whanau, visitor, worker and their support person(s).

9. To create a culture where it is safe to report incidents and where a systems approach to incidents and investigation is used.

10. To identify opportunities to improve the quality and experience of care.

11. To minimise risk and prevent further incidents through appropriate review and recommendations.

12. To meet statutory and/or legislative requirements through informing workers of their responsibilities in relation to essential notification reporting and ensuring the correct authority is notified in an accurate and timely manner by the organisation.

Scope

13. This policy applies to:
    - any incident to any person, property or environment occurring in a Taranaki DHB place of work.
    - any patient or visitor within Taranaki DHB places of work.

Exclusions

This policy is not applicable to:

14. The management of complaints unless an incident is identified as part of the complaint. In which case the incident will be investigated before the complaint process is completed.

Policy

15. Incident management involves the following 10 steps:
    Step 1: Incident Identification
    Step 2: Immediate Action
    Step 3: Reporting
    Step 4: Notifications and Mandatory External Reporting
    Step 5: Initial Severity Assessment Code (SAC) Rating and Criteria
    Step 6: Review and Investigation
    Step 7: Open Communication
    Step 8: Feedback-Learning form the incident and from the consumer experience
    Step 9: Monitoring
    Step 10: Governance

Incident Reporting

16. All Taranaki DHB workers have a professional, moral and legal duty to report incidents. This includes clinical and non-clinical incidents involving or affecting (or where there is the potential to affect) patients, workers and visitors.
    i. The mode of reporting patient, workers and visitors incidents is via the electronic reporting system, Datix.
    ii. Incidents must be reported promptly and accurately in Datix by the end of the working day/shift and no later than 24 hours after the event.

Incidents involving patients

17. All patient incidents resulting in serious injury or death (SAC 1 & 2 ratings) are to be immediately notified to the Line Manager of the unit and reported in Datix. Taranaki DHB will report all such events to the Health Quality Safety Commission and/or Worksafe in accordance with legislative requirements.

18. All patient incidents resulting in moderate, minor or no injury (SAC 3 & 4 ratings) are to be reported in Datix.

Incidents involving workers and visitors

19. All worker and visitor incidents that result in a SAC 1 or 2 rating are to be immediately notified to the line manager of the unit and reported in Datix. Taranaki DHB will report all such events to Worksafe in accordance with legislative requirements.

20. All worker and visitor incidents resulting in moderate, minor or no injury (SAC 3 & 4 ratings) are to be reported in Datix.
21. Under the Health & Safety at Work Act 2015 businesses are expected to manage health and safety risk arising from their work as far as is reasonably practicable. Staff-to-staff incidents of workplace bullying and harassment are to be reported in Datix.

Organisational Incidents

22. All organisational incidents that result in a SAC 1 or 2 rating are to be immediately notified to the line manager of the unit and reported in Datix. Taranaki DHB will report applicable events to Worksafe in accordance with legislative requirements.

23. All organisational incidents resulting in moderate, minor or no injury (SAC 3 & 4 ratings) are to be reported in Datix.

Incident Investigation

24. All notified incidents require review at an appropriate level. The SAC applied in the prioritisation stage guides the level of investigation. If additional input is needed before an accurate SAC score can be applied, steps should be taken to address this immediately so that legislated requirements can be met without delay. It may be necessary to make a judgement call in relation to the SAC, based on the best evidence available, where the gathering of further evidence would amount to an unacceptable delay.

Responsibilities

25. **Managers** are responsible for ensuring workers report incidents via Datix and investigations are completed.

26. **Workers** are responsible for reporting all incidents. Workers are expected to participate in incident investigation that involves them or patients/consumers in their care.

27. The **Clinical and Governance Support Unit (CGSU**) and the **Health and Safety Team (H&S)** are responsible for supporting and advising workers and managers to identify and respond to incidents in a timely and appropriate manner.

28. The **Serious and Sentinel Events Coordinator** is responsible for coordinating the management and reporting of all serious and sentinel events (SAC 1 & 2 events).

29. **Workers assigned to specific security groups in Datix** are responsible for viewing, monitoring and utilising the information for the specific purpose for which access was approved eg improvement work and governance.

Compliance

30. An audit schedule is established against this policy, approved, implemented and monitored/evaluated by the Clinical Governance Support and Safety and Environment Units and reported to the appropriate governance groups.

Supporting Information

Legislation:

- Health and Disability Commissioner Act 1994 and Code of Rights 1996
- Health Information Privacy Code 1994
- Human Rights Act 1993
- Mental Health and (Compulsory Assessment and Treatment) Act 1992
- New Zealand Bill of Rights Act 1998
- Health Practitioners Competence Assurance Act 2003
- Accident Compensation Act 2001
- Health and Safety Work Act 2015

Key Standards and Guidelines:

- Health and Disability Commissioner – Guidance on Open Disclosure Policies
- Health Quality & Safety Commission – Guidance on Open Disclosure
- Health Quality & Safety Commission - National Adverse Events Reporting Policy 2017
- https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/National_Adverse_Events_Policy_2017/SAC-examples-table-2019-20.pdf
- Health Quality & Safety Commission - Maternity Severity Assessment examples May2019
- Root Cause Analysis for Clinical Incidents – A Practical Guide
- Systems Analysis of Clinical Incidents – The London Protocol
- Health Quality & Safety Commission – Quality Check for Adverse Events Reviews Template
- https://www.medsafe.govt.nz/regulatory/DevicesNew/9AdverseEvent.asp

Key Taranaki DHB Associated Documents:

- Taranaki DHB Open Disclosure/Communication Policy
- Taranaki DHB Coroner's Case : Inpatient Guidelines for Clinical Staff
- Taranaki DHB Protected Quality Assurance Activities Policy and Procedure
- Taranaki DHB Risk Management And Compliance Policy
- Taranaki DHB Health and Safety Policy
- Taranaki DHB Tikanga Recommended Best Practice Policy and Procedures

Appendix A: Definitions and Interpretations

1. **Accident**: An undesired event that results in harm to people, damage to property or loss to process.

2. **Adverse Event:** An event with negative or unfavourable reactions or results that is unintended, unexpected or unplanned. This includes events with clinical, service, financial or environmental consequences. (Also referred to as an 'incident' or 'reportable event').

3. **Datix:** The electronic integrated risk management system.

4. **Harm**: An illness, injury or both and includes physical or mental harm.

5. **Hazard:** Anything with the potential to cause harm or loss to any person, property or environment.

6. **Incident**: An unplanned event that results in or has potential to result in injury, damage or loss. This applies to clinical and non clinical events. (see adverse event, near miss).

7. **Incident Management:** A systematic process for identifying, notifying, prioritising, investigating and managing the outcomes of an incident and steps are taken to prevent similar occurrences.

8. **Injury:** Damage to the body caused by external force .

9. **Incident Investigation:** the management process by which underlying causes of undesirable events are uncovered.

10. **Just Culture:** recognizes that individual practitioners should not be held accountable for system failings over which they have no control. It also recognises many errors represent predictable interactions between human operators and the systems in which they work.

11. **Near Miss**: Any event that could have had adverse consequences but did not and where the incident was intercepted before causing harm.

12. **Open Communication:** or open disclosure, refers to the timely and transparent approach to communicating with engaging with and supporting patients and their whanau when adverse events occur.

13. **Patient**: For the purposes of this policy, when the word 'patient' is used, this will mean patient, client, consumer, service user or visitor.it is the person who uses/receives health and disability services, or their representative.

14. **Place of work**: A place (whether or not within or forming part of a building, structure or vehicle) where any person is to work, is working, for the time being works, or customarily works, for gain or reward; and in relation to an employee, includes a place under control of the employer.

15. **Recommendations:** A suggestion or proposal as to the best course of action following the completion of an incident review/investigation**.**

16. **Review**: Initial Datix Review/Review. For the purposes of this policy, 'review' is a broad term that means review, investigation and follow-up.

17. **Root Cause Analysis:** A method used to investigate and analyse incidents to identify the root causes and factors that contributed to the incident. The process yields recommenced actions directed at the prevention of a similar occurrence.

18. **Severity Assessment Code (SAC):** The Severity Assessment Code (SAC) is the method used to determine the appropriate action to take in relation to an event and applies to all events whether they are of a corporate or clinical nature. The score is ascertained by rating the **actual consequence** of the event (see Appendix B)
19. **Sensitive events**: Specific events or situations identified by managers as sensitive will be reported in Datix but managed through the TDHB HR process.

20. **Serious and Sentinel event**: An event which has resulted in permanent severe/major loss of function or temporary severe loss of function or death, not related to the natural course of the patient's illness or underlying condition.

21. **Treatment Injury**: A personal injury that has occurred within the context of treatment provided by, or at the direction of, one of more registered health professionals.

22. **Whanau:** The family or extended family/group of people who are important to the patient.

23. **Worker:** An individual who carries out work in any capacity for Taranaki DHB on any Taranaki DHB site. A worker may be an employee (full time, part-time, casual and temporary), or visiting health professionals, contractors or sub-contractor, students, a person gaining work experience or a volunteer.

TARANAKI
District Health Board

INFORMATION TECHNOLOGY SECURITY POLICY

Department:	ICT Services
Date Issued:	October 2019
Review By Date:	October 2022
Responsibility:	Chief Information Officer – ICT Services
Authorised By:	Chief Executive
Version:	2.1

Introduction

1. The Taranaki District Health Board (DHB) is committed to the strategic actions and behaviours of We Work Together By:
   - Treating people with trust respect and compassion
   - Communicating openly, honestly and acting with integrity
   - Enabling professional and organisation standards to be met
   - Supporting achievement and acknowledging successes
   - Creating healthy and safe environments
   - Welcoming new ideas

2. Taranaki DHB is committed to ensuring the Treaty of Waitangi informs policy and practice across all service units. Development and implementation of this document has been undertaken in the spirit of partnership, participation and protection.
3. Data and information can exist in many forms; for example, it may be written on paper or printed, spoken in conversation, stored or recorded electronically, transmitted by post or by electronic means, or shown on film.

Purpose

4. The Information Security Policy establishes Taranaki DHB's approach to managing information security risks in order to preserve confidentiality, integrity and availability of our "information resources". This will service to protect our patients, their personal information and their health outcomes, as well as our people, corporate image and reputation and to maintain legal, regulatory and contractual compliance.
5. This policy communicates management's commitment to protecting "information resources" and to promoting the consistent application of appropriate information security controls.

Scope

6. This policy applies to all employees, all ICT users and all suppliers of ICT Services, throughout Taranaki DHB.

Definitions

7. **Availability:** Protecting information from unauthorised deletion, and also ensuring that supporting Information Resources serve their purpose when needed and are protected from events on a scale running from disruption and interruption, all the way up to destruction and total loss.
8. **Confidentiality:** Maintaining possession and control of information, and also protecting it from unauthorised access or disclosure, both internally and externally
9. **Information Resource:** Data and information, and also the supporting infrastructure of information and communications technology services, applications, systems and networks (Information and Communications Technology (ICT))
10. **Integrity:** Protecting information from unauthorised modification or alteration, and also ensuring the authenticity of the information, of any changes, and of those making the changes Information Security Management System (ISMS)

Principles

The following Principles underpin this policy:

11. Information Resources will be protected in line with all applicable legislation and relevant TDHB policies, notably those relating to data protection, human rights, privacy and freedom of information.
12. Each information asset will have a nominated owner who will be assigned responsibility for defining the appropriate uses of the asset and ensuring that appropriate security measures are in place to protect the asset
13. Information will be made available solely to those that have a legitimate need for access.
14. All information will be classified according to an appropriate level of Security
15. The integrity of information will be maintained
16. It is the responsibility of all individuals who have been granted access to information to handle it appropriately in accordance with its classification
17. Information will be protected against unauthorised access
18. Breach of this Information Security Policy may be considered gross misconduct and compliance will be enforced accordingly.

Policy

Organisation of Information Security

19. An Information Security Management Framework (ISMF) is necessary to guide, monitor and control the implementation, operation and management of information security as a whole within Taranaki DHB. This would be carried out in accordance with its policies and other legal, regulatory and contractual requirements. Such a management framework is a business enabler, allowing information to be processed, managed and shared with the confidence that its security is assured and that information security risks have been identified, understood and treated appropriately.
20. Third party access to Taranaki DHB's facilities and information resource must be in accordance with the ISMF and must therefore be restricted to authorised hardware, software, organisations, people and purposes.
21. TDHB has the right and capability to monitor electronic information created and/or communicated by persons using TDHB computer systems and networks, including e-mail messages and usage of the Internet. It is not TDHB policy or intent to continuously monitor all computer usage by employees or other users of TDHB's computer systems and network. Users of the systems should be aware that TDHB may monitor usage, including, but not limited to, patterns of usage of the Internet (e.g. site accessed, on-line length, time of day access), and employees' electronic files and messages to the extent necessary to ensure that the Internet and other electronic communications are being used in compliance with the law and with TDHB policy.

Asset Management

22. Business Owners must be identified, reviewed and held accountable by management for the protection of all significant information resources.
23. Information resources must be risk assessed, classified and protected according to Taranaki DHB's information security requirements.

Human Resources Security

24. Information security responsibilities must be addressed during pre-employment screening, included in employment contracts and monitored by management during an individual's employment.
25. Users must be made aware of, and motivated to comply with, their obligations under the information security policy, its protocols, procedures and guidelines, plus the associated laws, regulations and contractual commitments.
26. A user's exit from, or change of status within, Taranaki DHB must be properly managed and controlled, such that ICT assets are retrieved and, where no longer justified, access rights to information resources are promptly revoked.

Physical and Environmental Security

27. Information resources must be housed and stored securely and adequately protected against identified risks.

28. ICT equipment and storage media must be correctly maintained and physically protected from security threats and environmental hazards to prevent loss, damage or compromise of information resources and interruption to business activities.

Communications and Operations Management

29. To ensure the correct and secure operation of all information resources, their operating procedures and management responsibilities must be documented, easily accessible and available to operations staff.
30. The contracts and service level agreements for any outsourced information resources must address:
    a. Information security risks, controls and procedures (including aspects such as notification and response to security incidents);
    b. Associated operating procedures (including aspects such as change management); and,
    c. Ownership.
31. Information resources must be managed to ensure the availability of adequate capacity and resources to satisfy legitimate business requirements for performance.
32. Information resources must be protected against the risks relating to malicious software: malware, such as computer viruses, network worms, Trojan horses, and logic bombs. A range of controls, including user awareness, is required to prevent the introduction of malware, detect its presence and remove it with minimal disruption.
33. Routine backups and related controls must maintain the integrity and availability of information resources, and must ensure the confidentiality of data on backup media
34. Taranaki DHB's networks must be protected from unauthorised access and other information security risks to confidentiality, integrity and availability. Additional controls may be required to protect sensitive information passing over public networks from interception, incorrect routing and loss.
35. Information exchanged with other organisations must be protected against unauthorised access or disclosure, and such exchanges must comply with applicable legislation, regulations and contractual obligations.
36. The particular information security requirements relating to electronic data interchange, electronic messaging and electronic commerce must be satisfied.
37. Information resources must be monitored routinely to detect and log security events and, where necessary, trigger suitable responses.

Access Control

38. Access must be controlled, restricted and logged for information resources, including the following:
    a. Operating systems;
    b. Application systems;
    c. Group shared areas and other file shares;
    d. Internal and external network services, both wired and wireless;
    e. Mobile devices and portable computer systems;
    f. Remote access facilities; and,
    g. Privileged access.
39. The rules for access, and the formal allocation of access rights, must balance legitimate business need against information security requirements, while applying the principles of "Need to Know", "Segregation of Duties" and "Least Privilege".
40. Users are responsible for the effectiveness of logical and physical access controls, regarding the choice and confidentiality of passwords and the physical security of equipment and media.
41. Operating system security facilities must be used to authenticate users and control logical access to information resources.
42. Logical security controls within application systems must restrict access to data, information and program functions to authorised users.
43. Information resources must be adequately protected when physically off-site and when accessed remotely.
44. User based access rights must be segregated from privileged or administrative access rights using separate accounts.

Information Systems Acquisition, Development and Maintenance

45. Information security must inform the entire Systems Development and Systems Implementation Life Cycle (i.e. from requirements gathering, through design and development, testing and evaluation, into operation and, ultimately, decommissioning the information resource).
46. Suitable controls must be designed into information resources to ensure the completeness, accuracy and integrity of data, satisfying information security and business requirements.
47. Access to information resources for support and maintenance, including access to system files and program source code, must be limited according to legitimate business needs.
48. All changes to information resources must be reviewed on a risk basis prior to implementation to verify that changes will not significantly compromise their confidentiality, integrity or availability.
49. Timely information about the technical vulnerabilities of information resources must be managed systematically.
50. System patching and maintenance must be done in a timely manner to mitigate risk associated with security vulnerabilities.

Information Security Incident Management

51. Information security incidents, events and weaknesses must be reported promptly through the correct management channels and resolved by suitable professionals.
52. When reported, information security incidents and improvement suggestions must be managed according to relevant procedures.

Business Continuity Management

53. Management must understand the risks and potential impacts Taranaki DHB faces as a result of a major failure across a number of critical information resources.
54. Information resources must be sufficiently resilient to ensure the continuity of critical business processes despite minor incidents.
55. Proven disaster recovery and contingency arrangements should be in place to minimise the business impacts of more serious incidents.

Compliance

56. Taranaki DHB must identify and comply with all applicable legal, regulatory and contractual obligations relating to information security, privacy and the protection of personally identifiable information.
57. The security of information resources must be regularly reviewed to ensure their technical compliance with Taranaki DHB's information security policies, protocols and guidelines.
58. ICT audits must be performed with minimal disruption by independent and competent auditors.
59. No adverse effects on Taranaki DHB patients or staff through non-compliance
60. No adverse effects on Taranaki DHB information resources through non-compliance
61. All users are aware of this policy
62. All users must undertake relevant information security training as part of on boarding and as part of the mandatory 2 yearly general refresher training
63. ICT Services may test organisational compliance with this policy utilising electronic tools and use the outcome of these tests to increase knowledge and education around the significance of information security.
64. All managers are to meet their responsibilities under this policy and the supporting protocols

Supporting Information

65. Legislation
    - The Code of Health and Disability Services Consumers' Rights Regulation 1996
    - Health Information Privacy Code 1994
    - Privacy Act 1993
    - Public Records Act 2005

66. Taranaki DHB Related Documents
    - Information Technology Use Policy
    - Privacy Policy and Privacy Standards

- Reportable Events Policy

67. Other Associated Documents
    - Health Information Security Framework (HISO 10029.2015)
    - ISO/IEC 27001:2005 (“Information technology – Security techniques – Information Security Management Systems – Requirements”)
    - ISO/IEC 27002:2005 (“Information Technology – Security Techniques – Code of Practice for Information Security Management”)
    - New Zealand Information Security Manual (v3.2)
    - Security in the Government Sector (2002)

TARANAKI DISTRICT HEALTH BOARD

RISK ASSESSMENT & MANAGEMENT POLICY

Department:	**Mental Health & Addiction Service (MHAS)**
Date Issued:	**June 2017**
Review By Date:	**June 2020**
Responsibility:	**Clinical Director MHAS**
Authorised By:	**Service Manager Mental Health & Addictions Service**

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1. Introduction

The Taranaki District Health Board (DHB) is committed to the strategic actions and behaviours of We Work Together By:

- Treating people with trust respect and compassion
- Communicating openly, honestly and acting with integrity
- Enabling professional and organisation standards to be met
- Supporting achievement and acknowledging successes
- Creating healthy and safe environments
- Welcoming new ideas

Taranaki DHB is committed to ensuring the Treaty of Waitangi informs policy and practice across all service units. Development and implementation of this document has been undertaken in the spirit of partnership, participation and protection.

2. Purpose

To provide direction within MHAS for assessment and management of risk/s, to minimise the likelihood of an adverse outcome.

3. Scope

3.1 MHAS wide

4. Definitions

4.1 Risk - is the likelihood of an adverse event or outcome.

4.2 Risk factors - the particular features of illness, behaviour or circumstances that alone or in combination lead to an increased risk.

4.3 Risk assessment - an estimation of the likelihood of particular adverse events, occurring under particular circumstances within a specified period of time.

4.4 Risk formulation - a process of summarising and organising risk data to identify risk factors and provide the information base for risk management.

4.5 Risk management - aims to minimise the likelihood of adverse events within the context of the overall management of an individual, to achieve the best possible outcome, and deliver safe, appropriate, effective care.

4.6 Positive or therapeutic risk – includes applying recovery principles by building and promoting a person's strengths, protective factors, autonomy and control

4.7 Suicide - The act of taking one's own life.

5. Policy

5.1 All Clinical Staff must ensure their knowledge and skills in risk assessment and managing risks is current and undertake risk assessment training.

5.2 All service users will be routinely assessed for suicidal ideas, self-harm, aggression and violence, Alcohol & other Drug issues, neglect and vulnerability and any other risks.

5.3 All service users must have a current management plan which addresses each risk and how this is to be managed in the ward and/or community.

5.4 Management Plans will be updated at every multidisciplinary review and at community reviews (minimum 90 days between reviews) and any change in risk (increase or decrease) will be documented and communicated in writing to other relevant staff involved with the service user, including those external to the organisation.

5.5 A current copy of the management plan will be filed in the service users file along with an electronic copy linked onto service users electronic file.

5.6 Maori service users and whanau will be informed of the cultural services available and how to access the services of this team.

5.7 Peer Support and Advocacy Information will be provided to the service user.

5.8 Disclosure of information to family / whanau or other third parties will be in accordance with The Health Information Privacy Code 1994 (HIPC)

NB: The HIPC, Rule 11:2 (d) - The responsible Clinician / or Lead senior clinician may choose to release information if the disclosure of the information is necessary to prevent or lessen a serious and imminent threat to;

- Public health or public safety; or
- The life or health of the individual concerned or another individual.

6. Compliance

Regular audits of compliance with this policy will be completed

7. Supporting Information

Legislation
Health & Disability Commissioner (Code of Health & Disability Consumer Rights) Regulation 1996
Protecting children and vulnerable adults – crimes act amendments: A summary of changes to the Crimes Act 1961 came in to force on 19 March 2012.
The Health Information Privacy Code (1994)
Health & Disability Services Standards 2008

8. Taranaki DHB Related Documents

Level of Observation of Service Users in TPW policy
Seclusion Policy –TPW
Sensory Modulation Policy
TDHB Partner Abuse Policy
TDHB Restraint Minimisation and Safe Practice Policy
TDHB Security Policy
TPW Model of Care
TDHB MHAS Risk Assessment Procedure

9. Other Associated Documents

Ministry of Health 1998: Guidelines for clinical risk assessment and management in mental health services.
Health & Disability Sector Standards 2008

PRIVACY AND CONFIDENTIALITY:

PROTECTING AND RESPECTING PERSONAL AND CONFIDENTIAL INFORMATION POLICY

Department:	Quality & Risk
Date Issued:	May 2019
Review By Date:	May 2022
Responsibility:	General Manager Safety & Environment
Authorised By:	Chief Executive
Version:	1
Page:	1 of 3

Introduction

1. The Taranaki District Health Board (DHB) is committed to the following values:
   - **Partnership – Whanaungatanga** – *We work together to achieve our goals*
   - **Courage – Manawanui** – *We have the courage to speak up and advocate for each other*
   - **Empowerment – Mana Motuhake** – *We support each other to make the best decisions*
   - **People Matter – Mahakitanga** – *We value each other, our patients and whanau*
   - **Safety – Manaakitanga** – *We provide excellent service in a safe and trusted environment*

2. Taranaki DHB is committed to ensuring the Treaty of Waitangi informs policy and practice across all service units. Development and implementation of this document has been undertaken in the spirit of partnership, participation and protection.

3. The right to privacy refers to having control over your personal information. It is the ability to limit who can collect this information, how this information is kept and what can be done with it.

4. The Privacy Act 1993 provides the foundation for managing all personal information while the Health Information Privacy Code 1994 specifically addresses the management of health information. The Act and the Code provide compliance guidance through 12 privacy principles.

Purpose

5. This Policy outlines the Taranaki DHB's expectations as to:
   - The management of personal information, including the collection, storage, use of, retention and destruction, and real or potential privacy breaches.
   - How we comply with the Privacy Principles as outlined in the Privacy Act 1993 and Health Information Privacy Code 1994.
   - Ensuring the confidentiality of Taranaki DHB's clinical and non-clinical information.

Scope

6. This policy applies to all Taranaki DHB employees that have access to personal and/or confidential information prior to, during and subsequent to their employment/engagement with Taranaki DHB.

Definitions

7. **Business Information:** means all information relating to Taranaki DHB business matters, including but not limited to: Trade secrets, contracts, confidential operations, processes or dealings, including any confidential event review reports or other reports; any information concerning the organisation, business, finances, transactions or affairs of the Taranaki DHB, its services or establishments; and any data that has been deemed commercial in confidence by the Chief Executive.
8. **Confidential Information:** Includes but is not limited to health information, employee information or business information.

9. **Confidentiality Breach:** is the result of unauthorised access to, or collection, use or disclosure of confidential information.
10. **Health Information:** information relating to the health and disability of a person, and for the avoidance of doubt, includes health information about persons who are also Taranaki DHB staff.
11. **Information:** To avoid doubt, 'information' means any information and may take the form of, among other things, conversations, records, photos, videos/DVDs, images associated with pathology reports or diagnostics, audio record notes, emails, personal details and statistics held by Taranaki DHB in hard copy or electronic format.
12. **Office of the Privacy Commissioner:** The Commissioner works to develop and promote a culture in which personal information is protected and respected. The Commissioner administers the Privacy Act 1993. The Commissioner's Office has a wide range of functions including investigating complaints about breaches of privacy, running education programmes and examining proposed legislation and how it may affect individual privacy.
13. **Patient:** For the purposes of this policy, when the word 'patient' is used, this will mean patient, client, consumer or service user.
14. **Personal Information:** Any piece of information that relates to a living, identifiable human being. People's names, contact detail, financial, health, purchase records: anything that you look at and say "this is about an identifiable person".
15. **Privacy:** The common understanding of privacy is that people need to be able to protect information about them and need to be able to restrict who they share their personal information with.
16. **Privacy Breach:** Is the result of unauthorised access to, or collection, use or disclosure of, personal information, including but not limited to health or employee information. In this context, 'unauthorised' means in contravention of the Privacy Act 1993.
17. **Staff:** For the purposes of this policy, when the word 'staff' is used, this will mean employee, visiting health professional, contractor, volunteer and student.

Policy

18. Ensure the Taranaki DHB has designated Privacy Officer(s) in place.
19. All Taranaki DHB staff, volunteers, students, visiting health professionals and contractors dealing with personal and/or confidential information will:
    a. Comply with this policy and related privacy and information management procedures, the Privacy Act Principles outlined in Appendix 1 and note the roles and responsibilities as outlined in Appendix 2.
    b. Observe legal and any relevant professional requirements concerning collection, access, disclosure, accuracy, storage, retention and destruction and correction of personal and/or confidential information.
    c. Only access personal and/or confidential information if this is required to undertake tasks related to their role.
    d. Uphold the patient's right to:
        I. Access their information about themselves.
        II. Seek correction of that information if they think it is inaccurate or misleading.
        III. Expect to be told the purpose for the collection of their information.
        IV. Expect their health information to be kept confidential, treated as sensitive and used for the purpose for which it was initially collected.
        V. Expect that their health information may have an ongoing use if a piece of clinical information becomes relevant to their care many years after it was first collected.
    e. Assess the sensitivity of information on a case by case basis in the context of the situation and ensure it is safeguarded appropriately.
    f. Assess whether, at a minimum, a Memorandum of Understanding (MOU) is required between collaborating agencies, in order to formalise a governance process for the protection of personal information where sharing is required.
    g. Treat a employee's personal information as private and confidential at all times, ensuring:
        I. Secure storage.
        II. Access by authorised employees only.
        III. Disclosure in accordance with the Privacy Act, other relevant legislation only.
        IV. Consent is obtained before taking an employee's image and/or audio recording.

V. The employee's right to access any information about, or regarding them, held by the Taranaki DHB in accordance with Principle 6 of the Privacy Act 1993.

h. Report all privacy/confidentiality or potential breaches via the Datix Incident module in accordance with the DHB's Reporting Privacy Breaches procedure.
i. Ensure or contribute, as appropriate, to the review into a breach following the DHB's Privacy/Confidentiality Breach Review process.
j. Attend Privacy/Confidentiality training as required.
k. When involved in a significant change to a workflow (e.g. to the design of a new process, the introduction of a new ICT system or making systemic changes), the project team/responsible person must:

I. Evaluate as to whether a Privacy Impact Assessment (determining the potential risk of new or changed privacy risks to the DHB, the mitigations proposed and how to manage any ongoing residual risk) is required.
II. If required, complete a Privacy Impact Assessment, following the DHB's process and have this signed off and approved before Go Live.

20. Utilise unique identifiers (National Health Index (NHI) number or employee number) to identify the individual in order to support the DHB to carry out its function of patient care and employee management, ensuring disclosure is aligned to the purpose of collection.
21. Ensure the completion of the Government Chief Privacy Officer's annual Privacy Self Assessment process.

Compliance

22. The following activities will be undertaken to assure policy compliance. These will be reported to the Taranaki DHB's Information, Security and Governance Group.
    - Event review to ensure appropriate and reasonable preventative actions are in place.
    - Proactive employee access checks to assure appropriate privacy and confidentiality.
    - Snap shot observational auditing.
    - Complete the Government Chief Privacy Officer's annual Privacy Self Assessment process to demonstrate improvement as agreed.

Supporting Information

23. Legislation:
    - Health Act 1956
    - Health and Disability Commissioner's Code of Consumer Rights
    - Health & Disability Services (Safety) Act 2001 and legislated Standards
    - Health Information Privacy Code1994
    - Human Rights Act 1993
    - Official Information Act 1982
    - Privacy Act 1993
    - Public Records Act
    - Vulnerable Children Act 2014

24. Taranaki DHB Related Documents
    - Clinical Records Policy
    - Code of Conduct Policy
    - Disciplinary Policy and Related Procedure
    - Information Technology Security Policy
    - Information Technology Use Policy
    - Making Protected Disclosures Policy and Procedure
    - Privacy/Confidentiality Breach Procedure (needs development)
    - Privacy Impact Assessment Procedure (needs development)
    - Taranaki DHB Privacy/Security Governance Group Terms of Reference
    - Protected Quality Assurance Activities Policy and Procedure
    - Release of Information (needs review)

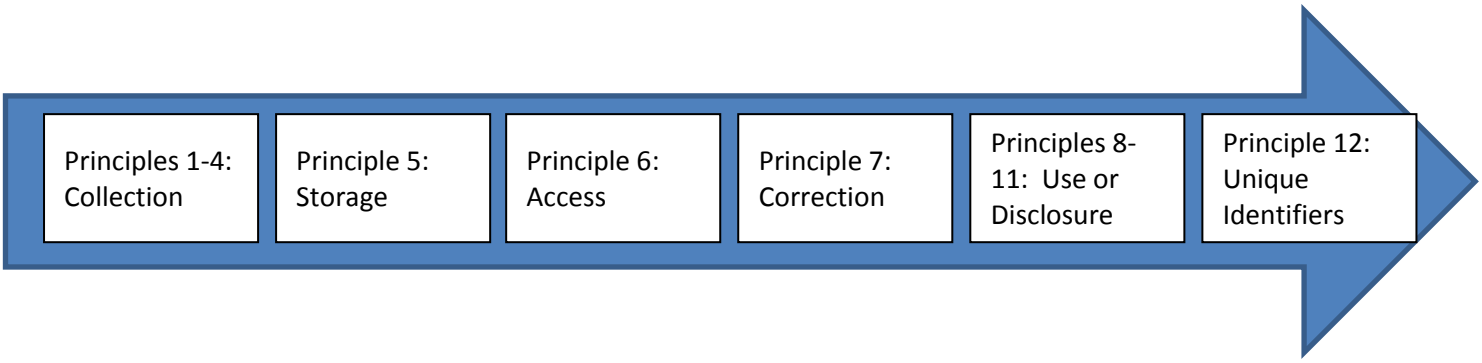
- Use of Mobile Phones and Other Communication Devices
- Visitors' and Partners in Care Policy
- What You Need to Know About the Privacy Act 1993 and Privacy Code 1994
- Your Rights and Responsibilities Pamphlet

25. Other Documents

- Privacy Impact Assessment Handbook
- A Guide to Health Information – the Privacy Act and the Health Information Code

Appendix 1
Privacy Act Principles

To protect and respect personal information, the following principles apply:
Note that the principles apply to personal information relating to staff, patients, visitors and contractors.



Principle 1: Only collect personal information if you really need it
Personal information must only be collected when:

- The collection is for a lawful purpose, connected with what the agency does, and
- It is necessary to collect the information for that purpose.

Principle 2: Get it straight from the people concerned where possible
Personal information is usually collected from the person the information is about. But sometimes it is appropriate to collect information from other people instead e.g. when:

- Getting it from the person concerned would undermine the purpose of the collection.
- The person is unable to provide the information at the time collection is necessary.
- The person authorises collection from someone else.

Principle 3: Tell them what you are going to do with it
When an agency collects personal information from the person the information is about, it has to take reasonable steps to make sure the person knows things like:

- Why it is being collected?
- Who will get the information?
- Whether the person has to give the information or whether this is voluntary?
- What will happen if the information is not provided?

Sometimes there are good reasons for not letting a person know about the collection, for example, if it would undermine the purpose of the collection, or it is just not possible to tell the person.

Principle 4: Collect it legally and fairly
Personal information must not be collected by unlawful means or by means that are unfair or unreasonably intrusive in the circumstances.

Principle 5: Take care of it once you have it
Agencies must ensure that there are reasonable safeguards in place to prevent loss, misuse or disclosure of information.

Principle 6: People can see their personal information if they want to
People usually have a right to ask for access to their personal information. However, sometimes agencies can decline to give access to information, for instance, because giving the information would:

- Endanger a person's safety.
- Prevent detection and investigation of criminal offences.
- Involve an unwarranted breach of someone else's privacy.

Principle 7: They can correct it if it is wrong
People have a right to ask the agency to correct information about them if they think it is wrong. If the agency does not want to correct the information, it does not usually have to, but people can ask the agency to add their views to the record about what the correct information is.

Principle 8: Make sure personal information is correct before you use it
Before it uses or discloses personal information, an agency must take reasonable steps to check that information is accurate, complete, relevant, current and not misleading.

Principle 9: Get rid of it when you are done with it
An agency that holds personal information must not keep that information for longer than is necessary for the purpose for which the information may be lawfully used.

Principle 10: Use it for the purpose you obtained it for
Agencies must use personal information for the same purpose for which it they collected if for. Other uses are occasionally permitted, for example, because this is necessary to enforce the law, or the use is directly related to the purpose for which the agency got the information.

Principle 11: Only disclose if you have a good reason to
Agencies can only disclose information in limited circumstances. An agency can disclose information if it reasonably believes, for example, that:

- Disclosure is one of the purposes for which the agency got the information.
- Disclosure is necessary to prevent or lessen a serious threat to the life or health of the individual concerned or another individual.
- Disclosure is necessary for court proceedings.
- The person concerned authorised the disclosure.
- The information is going to be used in a form that does not identify the person concerned.

Principle 12: Only assign unique identifiers where permitted
Some agencies give people a 'unique identifier' instead of their name. Examples are driver licence number, IRD number, Passport number, National Health Index (NHI) number. An agency can not use the unique identifier given to a person by another agency. People are not required to disclose their unique identifier unless this is one of the purposes for which the unique identifier was set up or is directly related to those purposes.

Appendix 2: Roles and Accountabilities

Protecting personal information across the Taranaki DHB requires the support and vigilance from all staff. Some roles and accountabilities are defined below:

Role	Accountabilities
All employee(includes students, contractors and volunteers)	• Understand and ensure compliance with privacy principle requirements, managing personal information safely and with integrity. • Respect others' information and be mindful when discussing personal information that this is appropriate and in the correct forum. • Be familiar with Taranaki DHB's Privacy: Protecting and Respecting Personal Information Policy and related policies and procedures.
Team Leaders & Managers	• Understand, ensure and be able to provide evidence of compliance with privacy principle requirements and managing personal information safely, with integrity, in the context of the area(s) they are responsible for. • Seek advice from the DHB's Privacy Officer(s) when process change is proposed to see whether a Privacy Impact Assessment is required. • Ensure all potential breaches are reported, investigated and any recommendations implemented in an effective and timely manner.
Human Resources	• Provide advice to managers when a potential privacy breach is identified to ensure Human Resources related policy and procedures are followed eg Code of Conduct and Disciplinary Policy and Related Procedure.
Privacy Officer(s)	• Provide advice on privacy related matters, including requests for access, release and correction of personal information, privacy impact assessments and where potential privacy breaches have been identified. • Provide organisation wide privacy training. • Act as a liaison person for the DHB with the Privacy Commissioner when required. • Undertake regular auditing of privacy against this policy and other and related procedures. • Assist the General Manager Safety and Environment to complete the Government Chief Privacy Officer's annual Privacy Self Assessment process.
Chief Executive	• Ensure the DHB has an effective Privacy/Security Governance group in place. • Ensure that the DHB has effective linkages regionally and nationally in regard to Privacy.

MANAGEMENT OF INFORMATION TECHNOLOGY USE IN TARANAKI DISTRICT HEALTH BOARD

Procedure and Guidelines for Monitoring IT Use

Compliance

These guidelines for management have been set out to outline the process that Taranaki District Health Board (TDHB) will use to monitor the use of information technology within the organisation. It must be read in conjunction with TDHB's Information Technology Use Policy. The monitoring of TDHB's computer system usage will apply to all individuals whether employed in, visiting or contracted to TDHB.

The reason for this monitoring process is to ensure that whilst internet and email is provided primarily for business purposes, occasional use other than for business purposes is permitted. This is on the understanding that any use, other than that for business purposes, utilises a trivial amount of resources, does not interfere with staff productivity or prevent any business activity and does not threaten the security and integrity of TDHB's computer system. As stated in the policy, any personal use of internet or email **should** be limited to meal and tea breaks **or** before and after duty hours.

Internet Usage – Monitoring Process (HR)

The monitoring of internet usage will be the responsibility of the Human Resources Department, who will review weekly reports on those individuals whose internet usage has exceeded the specified number of hits for each week. The guidance point has been initially set at 10,000 hits* and is subject to ongoing review. This report will list the names of the most active users, number of hits made that week, their departments and managers. *See below for definition of "hit".

HIQ will provide the reporting functionality and/or reports required as well as providing guidance and interpretation of the reports for HR and Managers.

The process to be followed in this regard is as follows:

1. HR receives notification in the form of a "Most Active Users" report, containing the names of all those individuals who have exceeded 10, 000 hits for that week.

2. HR notifies each employee's manager of their employee's excessive usage and requests written explanation from employee and/or manager on why usage is excessive. (For visitor/contractors/volunteers etc. HR will direct this request to the manager under whose responsibility these individuals fall).

3. HR expects to receive feedback from manager to verify reasons why the employee has high usage within 1 week of the notification being sent.

4. If the reason for the excessive internet use is valid, this will be noted by HR and only infrequent monitoring of that individual's usage may be undertaken thereafter, unless of course, the individual's internet usage "spikes" to unusually high levels.

5. If the individual/manager is unable to provide a satisfactory explanation as to the high usage of their internet, HR may choose to investigate further, using reports which may include: websites visited, dates and times when connected, size of data transmitted/received or time periods of internet activity. Similarly, HR may decide to escalate any matter of concern in this regard to the next level manager, GM or CE, as appropriate.

6. HR will also monitor organisational site visits and provide guidance or take action accordingly.

Follow up Action

7. Where there is no reason for the individual to be allowed excessive use of the internet and the employee has already been notified by their manager in this regard (in accordance with the above process), then the options open to TDHB could be either a follow up meeting in this regard and/or a letter of instruction to the individual concerned, directing that employee to discontinue with this behaviour. (Where it is discovered, as part of this investigation, that the material downloaded/sites visited by the employee are offensive and/or inappropriate, a disciplinary process may be undertaken at this point. This would be in accordance with TDHB's Disciplinary Policies and Procedures).

8. Should the employee's computer and internet usage continue to be excessive after step 7., then HR will notify the manager and GM. Where no plausible explanations are given, TDHB, may, at its discretion, prevent access to internet sites which are deemed inappropriate or have no direct business relevance, limit access to sites required for employee's work and/or instigate disciplinary action, due to an alleged breach of this Information Technology Policy and TDHB's Code of Conduct.

*Definition of a "hit" in terms of TDHB's Information Technology use policy :

A **hit** is a request to a web server for a file (web page, image, JavaScript, Cascading Style Sheet, etc.). When a web page is uploaded from a server the number of "hits" or "page hits" is equal to the number of files requested. Therefore, one page load does not always equal one hit because often pages are made up of other images and other files which stack up the number of hits counted.

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RESTRAINT MINIMISATION POLICY

Department:	Organisation Wide
Date Issued:	April 2019
Review By Date:	April 2022
Responsibility:	Restraint Minimisation Committee
Authorised By:	Clinical Board

Introduction

1. The Taranaki District Health Board (DHB) is committed to the following values:
   - **Partnership – Whanaungatanga** – *We work together to achieve our goals*
   - **Courage – Manawanui** – *We have the courage to speak up and advocate for each other*
   - **Empowerment – Mana Motuhake** – *We support each other to make the best decisions*
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   - **Safety – Manaakitanga** – *We provide excellent service in a safe and trusted environment*

2. Taranaki DHB is committed to ensuring the Treaty of Waitangi informs policy and practice across all service units. Development and implementation of this document has been undertaken in the spirit of partnership, participation and protection.

Purpose

1. This policy ensures that Taranaki District Health Board (TDHB) services meet the requirements of the Restraint Minimisation and Safe Practice Standards.

2. The objective is to minimise the use of restraint in all its forms, encourage the use of least restrictive practices and when it has to be practised, it occurs in a safe and respectful manner.

Scope

3. This policy applies to staff employed to provide services to patients of Taranaki DHB's Hospital and Specialist Services.
4. **NB**: This policy does not apply to:
   - Safe Holding/Technical Positioning – safe holding which may be part of usual clinical procedures or clinical interventions or to briefly manage clinical symptoms (refer definitions).
   - Specialling – occurs to safely manage and monitor patients who are assessed as being at risk of causing themselves injury and therefore is not considered a form of restraint.
   - Domestic Security – is the practice of locking external doors at night for general security.
   - Night Safety Orders – used to describe the practice of locking the entry to a patient's/client's bedroom overnight at the request of the patient/client or locking the entry to an inpatient unit or residential service at night for the general safety of all.
   - Locked Units – where a locked exit is a permanent aspect of service delivery to meet the safety needs of patients/clients who have been assessed as needing that level of containment.

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- Use of restraint recommended and applied by law enforcement officers eg police/prison officers, for reasons other than clinical treatment, is not covered by this policy as it does not fall under the standard. The police/prison officer has full responsibility for safe law enforcement restraint.

Definitions

5. Advanced Directive: A written or oral directive by which a patient/client makes a choice about a possible future health procedure; and that is intended to be effective only when not competent.
6. De-escalation: A complex interactive process in which the highly aroused patient/client is re-directed from an unsafe course of action towards a supported and calmer emotional state, This usually occurs through timely, appropriate, and effective interventions and is achieved by service providers using skills and practical alternatives.
7. Enablers: Equipment, devices or furniture, voluntarily used by a patient/client following appropriate assessment, that limits normal freedom of movement, with the intent of promoting independence, comfort and/or safety. Note: Both enablers and restraint limit the normal freedom of movement of the patient/client. Where the intent is to promote independence, comfort and safety and the intervention is voluntary, this constitutes an enabler. The use of enablers should be the least restrictive option to safely meet the needs of the patient/client.
8. Restraint: The use of any intervention by a service provider that limits a patient's/client's normal freedom of movement.
    a. Personal Restraint: Where a service provider uses their own body to intentionally limit the movement of a patient/client eg where a patient/client is held by a service provider.
    b. Physical Restraint: Where a service provider uses equipment, devices or furniture that limits the patient's/client's normal freedom of movement eg where a patient/client is unable to independently get out of a chair due to: the design of the chair, the use of a belt, or the position of a table or fixed tray.
    c. Environmental Restraint: Where a service provider intentionally restricts a patient's/client's normal access to their environment eg restricted by locking devices on doors or by having their normal means of independent mobility (such as a wheelchair) denied.
    d. Seclusion: Where a patient/client is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit
9. Safe Holding/Technical Positioning: which may be part of the usual clinical procedures or possible clinical interventions eg plaster casts, IV splints, paediatric limb splints, positioning and support during procedures or to briefly manage clinical symptoms. Safe holding, supporting and the positioning of a patient/client so that a procedure can be carried out in a safe and controlled manner with their consent, is not considered a form of restraint. Safe-holding when the patient/client is not competent/fully conscious short term, ie emerging from a general anaesthetic, is not considered a form of restraint when used for immediate patient/client safety and therapeutic purposes and is within accepted clinical practice

10. **NB**: Use of medications is not supported as a means of restraint. All medications should be prescribed and used for valid indications with appropriate health professional advice to ensure that the intervention is relevant and appropriate. This use does not equate to 'chemical restraint'.

Policy

11. Authorised restraint may be used in the context of ensuring, maintaining or enhancing the safety of the patient/client, service providers, others and the therapeutic environment.
12. All staff will follow Taranaki DHB protocols for appropriate use of restraint in the area they are employed.
13. De-escalation or distraction must be attempted prior to initiating the use of restraint.

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14. All restraint incidents are to be documented in the patient's/client's clinical record and documented on the Datix Incident Management System.
15. When equipment, devices or furniture are used as an enabler, it shall be voluntary and only be used following appropriate assessment. Enabler use shall be documented in the patient's clinical notes, monitored and evaluated.
16. Whenever possible family/whanau are to be involved in discussions regarding the use of restraint.
17. The Restraint Minimisation Committee shall:
    - Approve restraint mechanisms and publish on the appropriate inventory.
    - Ensure that the cultural requirements of the standard are met by seeking and implementing cultural advice during its approval activities.

Compliance

1. Evaluation of every restraint incident is recorded in the Datix Incident Management System.
2. Restraint practices in Taranaki District Health Board will be audited at least annually to ensure compliance to this policy.
3. Enabler use will be audited within the Prevalence Audit 6 monthly to ensure compliance
4. All protocols on restraint must comply with this policy.

Supporting Information

Legislation

- New Zealand Standard 8134.2:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Human Rights Act 1993
- Public Health and Disability Services Act 2000
- Health and Safety at Work Act 2015
- Health and Disability Services (Safety) Act 2001
- Code of Health and Disability Services Consumers' Rights 1996
- New Zealand Bill of Rights Act 1990
- Privacy Act 1993

TDHB Policies and Procedures

- Tikanga Recommended Best Practice Policy
- Midland e-Learning website Restraint Minimisation and Safe Practice module
- Taranaki DHB Security Policy
- Restraint Minimisation Protocol for Hospital Services
- Hospital Service Restraint Resources Inventory
- Mental Health: Seclusion
  Physical Restraint
  Restraint Inventory

TARANAKI DISTRICT HEALTH BOARD

Violence Intervention Programme

Taranaki DHB
Child Protection
Policy and Procedures

violence intervention programme

Funded by Ministry of Health & TDHB

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CHILD PROTECTION POLICY

Department:	Clinical Board
Date Issued:	December 2019
Review By Date:	December 2021
Responsibility:	Violence Intervention Coordinator
Authorised By:	Chief Executive
Version:	1
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Introduction

1. The Taranaki District Health Board (DHB) is committed to the strategic actions and behaviours of We Work Together By:
    - Treating people with trust respect and compassion
    - Communicating openly, honestly and acting with integrity
    - Enabling professional and organisation standards to be met
    - Supporting achievement and acknowledging successes
    - Creating healthy and safe environments
    - Welcoming new ideas

2. The Family Violence Act 2018 positions all DHBs as Family Violence Agencies. The Law emphasize safety, early intervention and requires health professionals having an understanding of the dynamics of family violence. It also mandates DHBs to share personal information to better respond to family violence and help protect wahine, tamariki, vulnerable adults and whānau from harm.

3. This Child Protection Policy has been developed in accordance with the principles of action including the Treaty of Waitangi principles, recognising Te Whare Tapa Wha and kaupapa principles. This is consistent with cultural training offered and mandated within the Taranaki DHB.

Purpose

4. The purpose of this policy is to provide Taranaki DHB community and hospital-based staff with a framework to identify and manage actual and/or suspected child abuse and neglect.

   It recognises the important role and responsibility staff have in the accurate detection of suspected child abuse and/or neglect, and the early recognition of children at risk of abuse and adults at risk of abusing children.

Scope

5. This policy applies to all Taranaki DHB staff, including volunteers, students, contractors and visiting clinical staff to the Taranaki DHB. In particular, it has significance for those working in clinical settings.

Terms and Definitions

6. **Child:** Unborn children and children aged 0-14 years old.
7. **Child Protection:** Activities carried out to ensure the safety of the child/ tamariki, young person/rangatahi in cases where there is abuse or risk abuse.
8. **Child Abuse:** Harming (whether physically, emotionally, or sexually), ill treatment, abuse, neglect or serious deprivation of any child/tamariki, young person/rangatahi (section 14b Children, Young Persons and their Families Act 1989). This includes actual, potential and suspected abuse.

9. **Physical Abuse:** Child physical abuse is any act or acts that may result in inflected injury to a child or young person.
10. **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.
11. **Emotional/Psychological Abuse:** Child emotional/psychological, social, intellectual and/or emotional functioning and development of a child or young person.
12. **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.
13. **Oranga Tamariki:** Government agency that carries out the legislative requirements of the Vulnerable Children's Act 2014, Oranga Tamariki Act 1989. Responsibilities are to:
    - Investigate causes of actual and suspected child abuse and/or neglect.
    - Completed diagnostic interviews.
    - Complete evidential interviews in cooperation with the New Zealand Police.
    - Provide care and protection for children found to be in need.
14. **Police:** Government agency responsible for:
    - Working collaboratively with Oranga Tamariki in child abuse and /or neglect protection work.
    - Investigating cases of abuse and/or neglect where an offence has or may have been committed.
    - Prosecuting offenders where an offence has been committed.
    - Accepting reports of suspected abuse and/or neglect and referring these to Oranga Tamariki.
15. **Young Person:** 14-18 years old.

Principles

16. The Ministry of Health's Family Violence Assessment and Intervention Guideline guides this policy.
17. The rights, welfare and safety of the child/tamariki, young person/rangatahi are our first and paramount consideration.
18. Health services for the care and protection of children are built on a bicultural partnership in accordance with the Treaty of Waitangi.
19. Maori children/tamariki, young persons/rangatahi are assessed and managed within a culturally safe environment. The Maori Health team is available for cultural support.
20. Wherever possible the family/whanau, hapu and iwi participate in the making of decisions affecting that child/tamariki young person/rangatahi.
21. Affirm with the child/tamariki, young person/rangatahi being abused of their right to be safe in their home.
22. All staff are able to recognise and be sensitive to other cultures.
23. In the case of mental health clients, support and advice is available from the Child, Adolescent and Mental Health Service (CAMHS).
24. Taranaki DHB provides an integrated service and works with external agencies to provide an effective and coordinated approach to child protection.
25. Staff are competent in the identification and management of actual or suspected abuse and/or neglect through the organisation's violence intervention programme infrastructure including policy and procedures, standardised documentation, education programme and access to consultation.
26. Taranaki DHB's physical environment and facilities are safe for children.

Organisational Responsibilities

27. The **Taranaki DHB** is responsible for ensuring:
    - An organisation-wide framework for the management of child abuse and neglect and associated policies and procedures.
    - Engagement with interagency processes such as the Memorandum of Understanding between the DHB, ORANGA TAMARIKI and the Polices that support effect collaboration.
    - Regular training for staff on the policy and related procedures.

- Regular monitoring of the policy to assess compliance.
- Adequate support (e.g. access to consultation) and supervision for staff.
- Activities are properly resourced and evaluated.

28. **Managers** of departments/services will support the implementation of this policy within their department/service as coordinated by the Violence Intervention Programme Coordinator.

29. All **Taranaki DHB staff** have a responsibility to be aware of this policy, follow appropriate procedures and attend appropriate training.

30. All **clinical staff** have a responsibility for the management of actual or suspected abuse and neglect. Responsibilities include:
    - Being conversant with the DHB's management of actual or suspected child abuse and neglect policy and procedures.
    - Understanding the referral and management of actual or suspected abuse and neglect.
    - Taking action when child abuse and or neglect is suspected or identified.
    - Attending initial training and regular updates appropriate to their area of work.
    - Providing or accessing Taranaki DHB specialist health services that may include:
        - Cultural assessments
        - Mental Health assessments
        - Diagnostic medical assessments
        - Social work services, counselling and therapy resources.
        - Paediatric assessment
    - Ensuring clinically and culturally safe practice, for example consulting a senior colleague during the intervention and seeking peer-support/supervision when child abuse is suspected or identified. This includes situations where child abuse is disclosed but the child may not be present (e.g. child of an adult patient).

31. **Human Resources** responsibilities include:
    - Ensuring recruitment, police vetting and worker safety checking policies and procedures reflect a commitment to child protection by including comprehensive pre-employment screening and ongoing checking procedures in accordance with the Vulnerable Children's Act 2014.
    - Ensuring that where suspicion exists of child abuse perpetrated by a Taranaki DHB staff member or volunteer the matter is dealt with in accordance with the Taranaki DHB's Code of Conduct Policy.

32. **Child Protection/Violence Intervention Programme Coordinator** responsibilities include:
    - Coordinating the Violence Intervention Programme implementation within services, working with service leaders to ensure system support is readily available.
    - Ensuring this policy remains current and aligned with national standards.
    - Providing cyclical workforce training in accordance with the Taranaki DHB Violence Intervention training plan.
    - Ensuring quality improvement activities in regard to policy compliance are undertaken and reported on at least biannually.
    - Being available to staff for consultation regarding any child protection concerns.
    - Facilitating communication with Oranga Tamariki and other key community agencies.

Supporting Information

33. Legislation:
    - Care of Children Act 2004
    - Oranga Tamariki Act 2017
    - Code of Health and Disability Services Consumers' Rights
    - Crimes Act
    - Family Violence Act 2018

- Health Act
- New Zealand Bill of Rights
- Privacy Act
- Summary of Offences Act
- **Vulnerable Children's Act 2014**

34. Taranaki DHB Policies and Procedures:
    - Recruitment Policy and Procedures
    - Worker Safety Checking Policy and Procedures
    - Elder Abuse and Neglect Policy
    - Intimate Partner Violence Management Policy

35. Associated Documents
    - Family Violence Assessment and Intervention Guideline, Ministry of Health, 2016

Maori and the Violence Intervention Programme

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

Family violence intervention for Maori is based on victim safety and protection being the paramount principle. Ensure practice is safe clinically and culturally. Affirm with the 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.

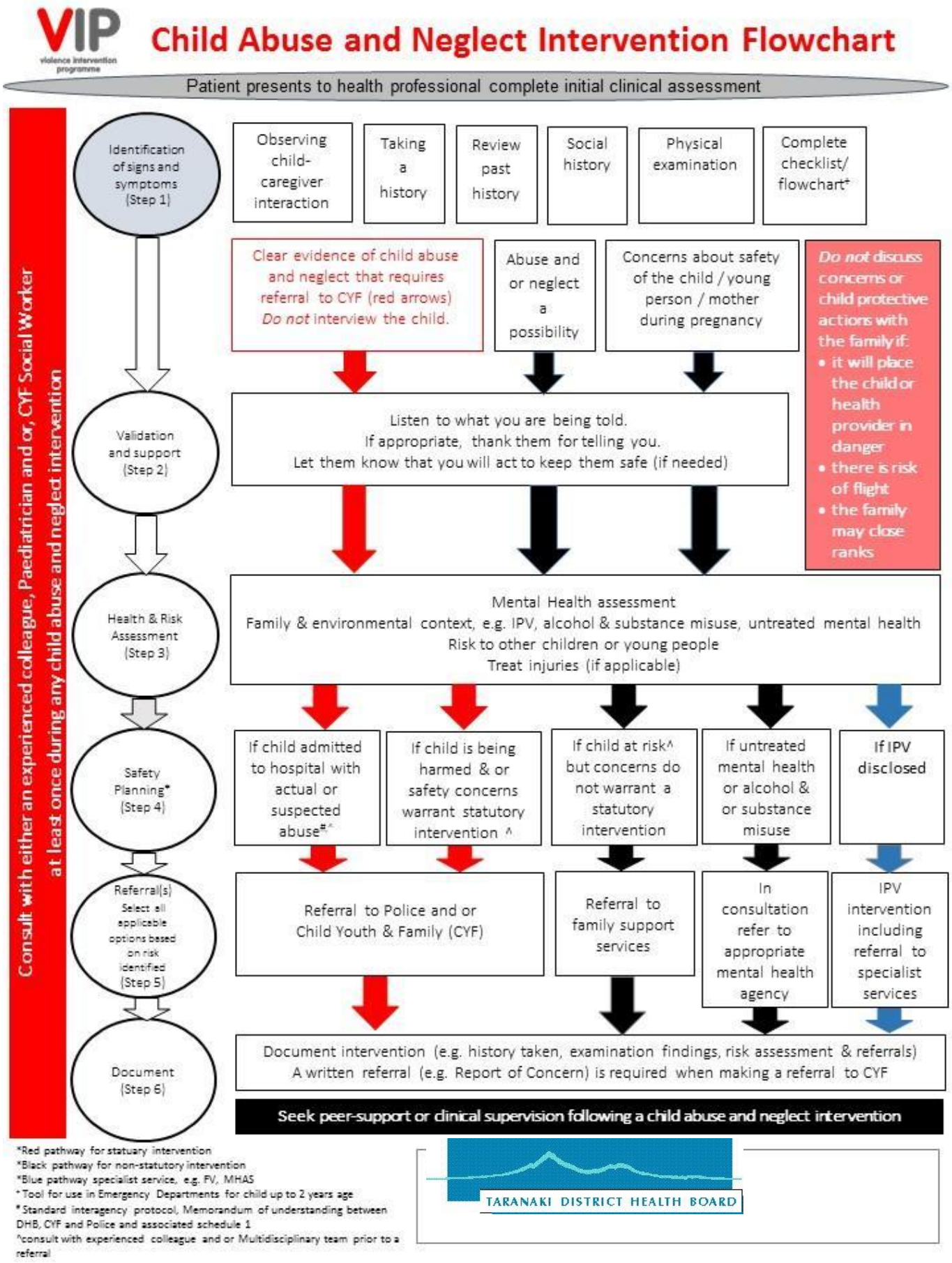
See Appendix 2 - Maori and Family violence

Pacific Peoples and the Violence Intervention Programme

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

See Appendix 3 - Pacific Peoples and Family Violence.

Flowchart for Responding to Actual or Suspected Child Abuse and/or Neglect



Six Step Child Protection Intervention

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

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

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

See Appendix 4 for the categories of abuse.

See Appendix 5 for signs and symptoms as per the categories.

Consultation should occur at <u>least</u> once. The following staff are available:
- An experienced colleague
- Paediatrician
- Child Protection Coordinator/Violence Intervention Programme Coordinator
- DHB Health Social Worker
- ORANGA TAMARIKI DHB Liaison Social Worker.

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

Step 1: Identify

There is no 'one-size-fits-all' approach for the identification of children or young people at risk. The healthcare provider should begin with their first point of concern. However, they should also be aware that, if they are concerned about a child or young person, all the aspects described in this first step need to be assessed.

The younger and more vulnerable the child (such as a pre-verbal infant), the more important this becomes. For example, a baby caught in the cross-fire of an episode of intimate partner violence (IPV) may need formal physical examination and other investigations for injury, even if they appear physically unharmed.

If there is clear evidence of child abuse or neglect, sufficient in your opinion to justify referral to ORANGA TAMARIKI in its own right, then do not interview the child. Record any information that the child volunteers. If you interrogate the child you may create more problems than you solve.

1.1 Observing child–caregiver interactions

- Observe the caregiver–child interactions at any clinical encounter; these observations are not 'diagnostic', but can provide additional information that may be helpful in determining future courses of action (e.g., by providing clues about who the child is comfortable with and seeks support from, or adults whose behaviour towards the child raises some concerns).
- All observations which raise concern should be documented objectively, prospectively and in detail in the clinical records, even if the health care provider is uncertain of their significance at the time. The presence of a documented pattern of concerning behaviours over time may at some stage become very important in enabling the health provider to take effective action on behalf of a child at risk.
- Possible cues/signs and symptoms in parent - child interaction
    - lack of emotional warmth, as opposed to strong attachment/bonding

- dismissive/unresponsive behaviours as opposed to sympathetic/comforting responses
- interaction between the child and parent or caregiver seems angry, threatening, aggressive or coercive
- indications that may raise concern are: a parent/caregiver calling the child names, using harsh verbal discipline, telling the child that they will harm something important to the child, threatening to seriously hurt or abandon the child, mocking the child or putting the child down in front of others.

1.2 Taking a history from parents and caregivers

- Your ability to interpret signs and symptoms in a child is reliant on the quality of the history taken from the family and (in some circumstances) the child about those signs and symptoms.
- If a child presents with an injury, it is important to understand how that injury occurred. Essential components of the history include the following:
  - Who is giving you the history (what is their name and relationship to the child)?
  - Who saw it happen (the history should be obtained from an eye-witness, if possible)?
  - When exactly did these events occur (time and date)?
  - How exactly did they occur? For example, if it was a fall, where did they fall; were they stationary or already moving; how did they fall (head first, feet first, arms out); what was the height of the fall (estimated on the eyewitness' own body); what surface did they fall onto; what was their position after the fall; were there any complicating factors, like use of a baby walker, or a fall in the arms of an adult?
  - When exactly did symptoms begin in relation to the accident? How were they noticed, and who noticed them?
- In a young child, it is important to know the developmental capacities of the child. (Can they crawl, pull to stand, climb, run or manage stairs?) It is also important, especially with babies, to know their usual pattern of feeding, sleeping and behaviour, and when that pattern changed.

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

- If a child has an injury, it is perfectly all right to ask open, non-leading questions e.g., 'how did this happen?' No harm is done by asking the kind of question you would ask of any child you see for treatment of an injury
- If you have concerns about possible abuse or neglect, but there are other possible explanations for the things causing you concern, then seek advice from the paediatrician, a social worker with experience in child protection or ORANGA TAMARIKI
- Privacy is just as important as with adults. Giving an adolescent a chance to talk to you alone should be part of your routine practice. With younger children, you should consider carefully whether or not it is appropriate. A hasty conversation in a gap is unlikely to create the time and space necessary for disclosure by an anxious child.
- Use age-appropriate language; children may not know what to say and use different words to express what is going on. You need to create an atmosphere where the child feels safe to talk to you.

What should be asked?

If you are going to have this kind of conversation, you need to frame it in a way that makes sense in terms of the signs and symptoms for which the child has come to see you, or in terms of your usual practice. For example: '*Sometimes when I see children with pain in their tummy like this, it's because they're worried or anxious about something. Is there anything that's*

making you worried or unhappy?' Or, '*One of the things I always do with children who come to see me, when they're old enough like you, is to check how things are at home.'*

It is reasonable to ask open and non-threatening questions, such as:

- *How are things at home?*
- *What happens when people disagree with each other in your house?*
- *What happens when things go wrong at your house?*
- *What happens when your parents/caregivers are angry with you?*
- *Who makes the rules? What happens if you break the rules?*

There are no evidence-based 'screening' questions for children about sexual abuse; if a presenting symptom has raised this concern for you, then open-ended questions (which do not suggest the answer) are always best.

1.4 Asking young people about possible abuse

- Ask in a place that is private, and confidentiality of information needs to be discussed
- Use a developmentally appropriate assessment if signs and symptoms of abuse are detected. Assessment of the causes of violence in this age group is best accomplished as part of a thorough psychosocial assessment for adolescents such as the HEEADSSS assessment
- If the young person is sexually active, it is important to consider the possibility of non-consenting sexual activity. This should be a part of routine HEEADSSS assessment in adolescents.

See Appendix 7 for the HEEADSSS assessment

1.5 Past history

- Review the child or young person's clinical record (previous presentations or admissions, particularly multiple presentations for illnesses and injuries, may indicate risk)
- Check for the presence of a Child Protection Alert; if an alert exists, follow the Taranaki DHB Child Protection Alert Policy to access the health information behind the alert, and take it into consideration when assessing the child

1.6 Social history

- Take a social history; a variety of factors may have an effect on the risk of child abuse and neglect, e.g. IPV, multiple changes of address; alcohol/drug abuse in the household, a family which actively avoids contact with health care providers or family support agencies, a caregiver with a past history of harming and/or neglecting children; severe social stress; social isolation and lack of support; untreated mental illness.
- While these factors are all relevant to the health and welfare of the child, they do not necessarily predict abuse or neglect in any individual case.

1.7 Physical examination

- A thorough physical examination is indicated in all cases of identified or suspected child abuse and/or neglect, to identify all current and past injuries.
- Further investigations may be necessary, but this will depend on the exact circumstances, including the age and developmental capacities of the child, and the type of abuse or neglect that is suspected. For example, a suspected head injury from child abuse in a child under one (even if they have no symptoms of concussion) will almost always require a CT scan of the head, and a skeletal survey will be required in most children under two years with suspected physical abuse and in some older children. Full blood count and coagulation studies may be required in the presence of bruising

- Cases of sexual abuse, or suspected sexual abuse, should always be discussed with a doctor specifically trained in this field. Always refer to the Paediatrician on call, before you decide whether or not to examine the child.

1.8 Using a child protection checklist in children under two years old

- All children under the age of two years presented to the emergency department should have the Child Protection Checklist as below completed; it is only possible to answer the questions it contains, if you have conducted a thorough assessment following the principles outlined above.
- The tool may be relevant for older children presenting to ED where any of the listed concerns exist
- The checklist is only a guide to assist safe process, not a diagnostic algorithm. Never jump to conclusions.

CHILD PROTECTION CHECKLIST to be completed for ALL children under the age of 2 presenting to ED

COMPLETE a)–d) FOR **ALL PATIENTS UNDER 2 YEARS OF AGE**

a)	Is there any concern about the child and/or family's BEHAVIOUR?	☐	Yes	☐	No
b)	Is there a past history of PREVIOUS INJURIES or does a CHILD PROTECTION ALERT exist?	☐	Yes	☐	No
c)	On examination, does the child have any UNEXPLAINED INJURIES?	☐	Yes	☐	No
d)	Any other concern?	☐	Yes	☐	No

ALSO COMPLETE e)–g) FOR **ALL PATIENTS UNDER 2 YEARS PRESENTING WITH AN INJURY**

e)	Has there been a DELAY between the injury and seeking medical advice, for which there is no satisfactory explanation?	☐	Yes	☐	No
f)	Is the HISTORY INCONSISTENT with the injury and/or with the child's developmental level?	☐	Yes	☐	No
g)	Is the child UNDER 12 MONTHS of age?	☐	Yes	☐	No

ANY SUSPICION OF NON-ACCIDENTAL INJURY (NAI)?

☐ Uncertain or possible ("Yes") to any answer above
→ **Discuss with ED Senior Doctor** and ensure **routine enquiry for intimate partner violence** is completed

☐ No suspicion of NAI

Name:..... Signature:..... Date:.....

1.9 Collection of physical evidence

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

Steps for collection and safe storage of evidence include:

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

Step 2: Validation and Support

- If you have concerns about the safety of a child or young person, then you will need to act on these. At some time, someone will need to have a frank conversation with the caregivers and (if old enough to understand) with the child
- While your actions are intended to support and validate the child or young person, they may not (depending on the circumstances) be seen as supporting or validating their caregiver(s)
- Do not assume that raising care and protection concerns with a family will necessarily result in a hostile reception. Some caregivers may appreciate your honesty and be willing to accept help
- Do not discuss concerns or child protective actions to be taken with a victim's parents or caregivers under the following conditions.
    - If it will place either the child or you, the health care provider, in danger
    - If the family may seek to avoid child protective agency staff
    - Where the family may close ranks and reduce the possibility of being able to help a child. If safe to do so, you should still be transparent about the actions you as a health care provider need to take, and the reasons for them, but do not divulge details of actions planned by the statutory authorities

2.1 Talking with the parents/caregivers of the child

- If you are unsure about how to talk with the parents/caregivers; consult with a paediatrician / senior colleague / ORANGA TAMARIKI
- Basic principles are:
    - create time and space for a private conversation
    - be professional (be calm, start with the facts before you, explain the reasons for your concern and the reasons for the actions you need to take)
    - don't accuse anyone. For example, if a child has an injury, you have reached the appropriate point in the consultation and have explained the features of the injury that are unusual, you might use phrasing such as *"I am concerned that someone may have injured your child"*
    - access cultural support, e.g. Maori Health Unit. It is important that contacting such support does not delay any referral to ORANGA TAMARIKI.
    - use interpreters (not family members) if there are language barriers
    - be transparent about what happens next.
- If circumstances permit discussing concerns with a victim's parents or caregivers, follow these principles:
    - broach the topic sensitively
    - help the parents/caregiver feel supported, able to share any concerns they have with you
    - help them understand that you want to help keep the child safe, and support them in their care of the child.

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

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

- Ensure the child's immediate safety. Try not to alert the alleged abuser

2.3 Health care provider response to parents/caregivers disclosure of abuse

- Listen to what the parent or caregiver is saying.
- Thank them for telling you.
- Let them know that you will act to keep the child safe, and them safe, if they need it.

Step 3: Assess Risk

3.1 Risk to the child or young person

- Thorough risk assessment needs to be conducted prior to the development of appropriate intervention plans
- Health care providers are responsible for conducting a preliminary risk assessment with victims of abuse and/or neglect, in order to identify appropriate referral options. Note that this is different from the role of conducting investigations to determine who is responsible for perpetrating the abuse and/or neglect, which is the role of ORANGA TAMARIKI or the Police.
- Immediate protection of a child is required if the child has suffered harm which in your view is a result of child abuse, and the environment to which the child is returning is unsafe. Obviously, the more serious the harm and the more vulnerable the child (for example, a baby or a preverbal child), the more critical the risk becomes.
- Safe process means:
  - never make decisions about risk in isolation
  - do not jump to conclusions
  - consult with senior staff e.g., a paediatrician, a health social worker or youth health service, or with the duty social worker at ORANGA TAMARIKI as you work to determine what level of risk the child might be facing
  - appreciate that other organisations (e.g., ORANGA TAMARIKI) may hold information that is crucial to determining the safety of the child.
- You do not need proof of abuse or neglect, and do not need to seek permission from a child's family, prior to talking with colleagues or a ORANGA TAMARIKI social worker about a child
- Early communication with ORANGA TAMARIKI can help identify if there have been other concerns raised about the safety of the child. It can be considered an additional component of reviewing the child's history. This early communication does not need to result in a report of concern to ORANGA TAMARIKI, which is a decision that ideally should only be made after a thorough assessment

3.2 Mental health assessment

- The health assessment should include an assessment for signs and symptoms of mental health concerns; risk of suicide or self-harm can themselves be symptoms of abuse
- Signs associated with risk of suicide include:
  - Previous suicide attempts.
  - Stated intent to die/attempt to kill oneself.
  - A well developed, concrete suicide plan.
  - Access to the method to implement their plan.
  - Planning for suicide (for example, putting affairs in order).
- If you are concerned that the child may be at risk of suicidal behaviour, it is appropriate to ask questions such as:

  "*Do you ever think about hurting yourself?"*

  "Do you ever feel sad enough that it makes you want to go away and not come back?"

  "Do you ever feel like crying a lot?"

- Do NOT ask questions using the words “suicide” or “killing oneself”. These can suggest behaviours that the child may not have thought of.

See Appendix 8 - Assessment and Referral for Children Under 12 at Risk of Suicide

- The level of assessed risk (based on the assessment) will inform the referrals required. A referral to the appropriate child or adolescent mental health service may be indicated, but if abuse or neglect issues are also present, referral to ORANGA TAMARIKI is also warranted, particularly if the child or young person cannot be cared for safely within their home. Remember that the most helpful intervention to reduce suicide risk may be to assist the person to obtain safety from the abuse.

3.3 Risk to other children or young people

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

3.4 Co-occurrence of intimate partner violence

- If child abuse is identified, assess the mother’s safety. Follow the procedure outlined in the VIP Intimate Partner Violence Management Policy.
- Victims of IPV are frequently threatened by the perpetrator that if they disclose the violence, s/he will tell ORANGA TAMARIKI that the non-abusive partner is a bad parent/abusive to the children, and that ORANGA TAMARIKI will take the children away. Careful assessment needs to be undertaken to ensure that children’s disclosure of violence, or the non-abusive partner’s disclosure of violence, leads to further safety for them both, rather than additional trauma through separation or other consequences.
- It is recognised that there are occasions when the only way to ensure the safety of a child in a situation of family violence may be to separate the child from the non-abusive parent, even if only temporarily. In these circumstances, best efforts should be made to mitigate the trauma of the separation to both.

3.5 Other risk factors

- If the social history identified other risk factors (see 1.6), then refer to other services e.g., serious untreated mental illness should be referred to the mental health crisis team, alcohol and drug addiction via referral to community alcohol and drug services.

Step 4: Plan Safety

- If child abuse and/or neglect is identified or suspected, then a plan is required for ensuring the safety of the child, or for providing help and support to the family

> **If there are concerns about immediate safety (including your own), contact the Police (Phone 111) and contact ORANGA TAMARIKI (phone 0508 326 459 followed by a Report of Concern template).**

- Information from the health and risk assessment process will help to ensure that acute needs are identified and can be included in the safety plan. Work with a multi-disciplinary team whenever possible or consult with a senior colleague
- All healthcare providers can undertake basic intervention and safety planning activities if they have received training, and have access to support
- Note that the purpose of risk assessment is to ascertain the likely level of immediate risk for a patient leaving the health care setting. Actual injuries or other evidence of abuse are not required for referral to ORANGA TAMARIKI, particularly if there is risk to children
- Assessing for positive/protective factors e.g., family’s efforts to actively pursue the safety and well-being of the child/young person, their willingness and capacity to respond or engage is

an important part of identifying resources that may help improve the situation during safety planning

- The identification of support needs within the family (e.g., health, education or disability) can be a strength if meeting these needs assists in establishing connections with other services
- The tasks at this stage are to:
  - Identify the support and safety procedures that are required e.g., what are the child's needs for; safety, physical and emotional needs, health and rehabilitation, access to caregivers?
  - Specify. What are the support or safety procedures that need to be put in place?
  - Allocate responsibilities for action (e.g., who are the key individuals and agencies that need to be engaged?).
- In non-critical situations, multiple referral and follow-up pathways are possible. The key issue is whether the child is 'at risk' or whether the child is actually already coming to harm.

4.1 Child being harmed

- A child who, in the opinion of the healthcare provider, is already coming to harm, should be notified to ORANGA TAMARIKI as a 'Report of Concern'. ORANGA TAMARIKI will form their own opinion on the level of risk for the child and triage accordingly.
- Children admitted to hospital with actual or suspected child abuse or neglect should be managed in accordance with the Memorandum of Understanding (2011) between DHBs, ORANGA TAMARIKI and the Police and the associated Schedule 1.

4.2 Child at Risk

- Identify the safety, care or behavioural issues that exist. Consider if the risk is likely to be mitigated by the family engaging further with your service, or another health or social agency. Will the family accept this referral? What positive or protective factors exist that could be enhanced?
- If you are unsure, discuss the situation and your concerns with ORANGA TAMARIKI to determine if a formal report of concern should be made
- If ORANGA TAMARIKI determines that the whānau is actively pursuing the safety and well-being of the child or young person, and has the willingness and capacity to respond then a report of concern to ORANGA TAMARIKI may not be indicated. Likewise if you consider that engagement by an agency with the family is likely to achieve positive outcomes and the family is willing to accept the referral(s), ORANGA TAMARIKI is also likely to suggest that a formal report of concern may not be necessary
- If there is a children's team in your area, this may provide another avenue for effective action.

4.3 Co-occurrence of child abuse and Intimate partner violence

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

- Any concerns about the safety of the children should be discussed with the abused partner, unless you believe that doing so will endanger the child, another person or yourself. If you or your colleagues decide to notify ORANGA TAMARIKI, the abused partner should be informed, unless the same concerns apply
- Be aware that actions taken to protect the child may place the non-abusive parent at risk. Always refer this parent to specialist family violence support services, and inform ORANGA TAMARIKI about the presence of IPV as well as child abuse
- Ask the abused partner how they think the abuser will respond (risk that the abuser will retaliate for disclosure of the family secret).

- Ask if a child protection report or report of concern has been made in the past, and what the abuser's reaction was.
- If the abuser is present in the health care facility, ask the abused partner whom they would like to inform the abuser about the report, e.g., would they like the health care provider to do it? Does the abused partner want to be present when the abuser is told? Do they want to do it?
- Make sure the abused partner has information on how to contact support agencies (e.g., Police, refuge, ORANGA TAMARIKI) if problems arise.

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

If it is safe to do so, discuss referral to ORANGA TAMARIKI with the child's parents or caregivers:

- Broach the topic sensitively and reasonably, in the light of the concerns you have
- Help the parents/caregiver feel supported, able to share any concerns they have with you
- Help them understand that you want to help keep the child safe, and support them in their care of the child
- Keep the parents informed at all stages of the process
- Where options exist, support the parents/caregivers to make their own decisions
- Involve extended family/whānau and other people who are important to them
- Be sensitive to, and discuss the patient or caregiver's fears about ORANGA TAMARIKI
- However, be clear that your role is to keep the child safe. Do *not* seek permission to consult with ORANGA TAMARIKI. You may do this at any time.

See Appendix 9 - Legal and Privacy Issues

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

Step 5: Referral Agencies

- Follow-up and referral plans need to be developed for all children and their families, based on the information obtained during the risk assessment and safety planning, and the collaborative planning undertaken
- The tasks at this stage are:
  - Make referrals as appropriate, and ensure that relevant information is appropriately and accurately transferred to receiving individuals/agencies

    > Oranga Tamariki should be notified of all cases of suspected child abuse and neglect.
    > Memorandum of Understanding between DHB, ORANGA TAMARIKI and Police (2011)

  - Ensure there is a plan for review and follow-up, e.g., what is the timeframe for the referral and follow-up plan? Who, when, and how, will the plan be reviewed?
  - A phone referral to ORANGA TAMARIKI should be made whenever possible. A copy of the written referral (e.g., Report of Concern) *must* be sent to ORANGA TAMARIKI and a copy placed in the clinical record of the child/young person (or mother when the concerns reported relate to the antenatal period). A copy must also be sent to the VIP/Child Protection Coordinator in accordance with the DHB's policy for the Child Protection Alert System.

5.1 Child being harmed

- To support follow-up, consider if and how the information should be transferred to the GP (e.g., written discharge summary, telephone call, other procedure)
- Continue to provide follow-up to children and families notified to ORANGA TAMARIKI; Taranaki DHB remains responsible for the follow-up of the health care needs of the child and family.

5.2 Child at risk

- If you have concerns about risk, but there has been no disclosure, and no definitive signs or symptoms, consult with an experienced colleague and/or ORANGA TAMARIKI
- There are opportunities for early intervention (even when a report of concern is not made) so:
  - Leave the door open for further contact with the child and the child's caregivers
  - Look for further indicators at the next consultation, or consider if you should raise your concerns with others within the health system (e.g., GP, Well-Child provider) so that additional follow-up and support can be offered, if required
  - Consider if there are other health, social, or community agencies where you can refer the family, to reduce stressors, and/or promote health, e.g. the Children's Teams, non-health agencies, such as educational or social support agencies (for the child or the parent/caregiver), or agencies that provide support that may alleviate other risks (e.g., budgeting advice, alcohol and drug addiction services, mental health services).

5.3 Co-occurrence of child abuse and intimate partner violence

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

Step 6: Document

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

6.1 History

- Document carefully and in detail the history you took, and who you took it from
- If you spoke to the child, write down what you asked, and the child's answers to your questions. If you spoke to the parent/caregiver, record what you asked, and how the caregiver responded. Use direct quotes.

6.2 Examination

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

6.3 Photographs

- Many healthcare organisations now regard photography as a routine supplement to the medical records (refer to Taranaki DHB policies and procedures regarding consent to photograph).
- The taking of photographs should be done by a suitably qualified person in accordance with Taranaki DHB's Digital Photography Procedure (Patient Clinical Images).
- Note that thorough documentation and body maps are always required, and cannot be replaced by photographs.

6.4 Document the results of your risk assessment

- Be sure to include suspected or confirmed risk to other family members (e.g., other children in the family, parents or caregivers who may be at risk).

6.5 Document the consultative process you undertook

- Who did you speak with? At what points?

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

- Record the actions taken, referral information offered, follow-up care arranged (e.g., report of concern to ORANGA TAMARIKI, discharge summary to GP, or referral information provided to family for other health and social service agencies)
- Note who will take responsibility for follow-up, and when this will occur.

6.7 Confidentiality of abuse documentation on the medical record

- Care must be taken to ensure the confidentiality of any information about abuse recorded in any records potentially available to family /whānau members.
- If the abuser finds out that the victim has disclosed the violence, the victim may be at increased risk of retribution for having revealed the "family secret"
- Children's health records are private to them. Parents can ask to access their children's notes until they are 16 years old, but they are not automatically entitled to them. All requests to access health records should be managed in accordance with Taranaki DHB's Policy Appropriate Access to Health Information Policy; there may be grounds for withholding information when the healthcare provider believes that it is not in the child's best interests to give the parents access
- The health notes for each individual should be stored in a separate file.

Staff Support and Safety

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

Death of a Child and Sibling Assessment

In the event that a child is brought into the DHB and is deceased on arrival or the child dies in the DHB and the cause of death is suspicious, then an assessment of the safety of any siblings should be urgently undertaken. The Paediatrician on-call should determine if there are other siblings and if so report to ORANGA TAMARIKI.

References

- Taranaki DHB VIP Intimate Partner Violence Management Policy
- Taranaki DHB Child Protection Alert Policy (contact Taranaki DHB Child Protection Coordinator)
- Reportable Events Policy
- Taranaki DHB Professional Supervision Policy
- Informed Consent Policy
- DHB Unit Specific procedures/policies
- Digital Photography Procedure (Patient Clinical Images)
- Appropriate Access to Health Information Policy
- Tikanga Recommended Best Practice Policy
- Security Policy

Legislation:

- Health Act (1956)
- Oranga Tamariki Act 2017
- Privacy Act (1993) and Health Information Privacy Code (1994)
- Code of Health and Disability Services Consumers Rights (1996)
- New Zealand Bill of Rights (1990)
- Crimes Act (1961)
- Family Violence Act (2018)
- Summary Offences Act (1981)
- Care of Children Act (2004)
- Vulnerable Children's Act (2014)

Other:

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

For further information contact the Taranaki DHB Child Protection Co-ordinator.

APPENDIX 1 - Terms and Definitions

Child	Unborn children and children aged 0–14 years old
Child Protection	Means the activities carried out to ensure the safety of the child/tamariki, young person/rangatahi in cases where there is abuse or risk of abuse.
Child Abuse	Refers to the harming (whether physically, emotionally, or sexually), ill treatment, abuse, neglect, or serious deprivation of any child/tamariki, young person/rangatahi (Section 14b Children, Young Persons and their Families Act 1989). This includes actual, potential and suspected abuse.
Physical Abuse	Child physical abuse is any act or acts that may result in inflicted injury to a child or young person.
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.
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.
DSAC	Doctors for Sexual Abuse Care. National organisation advancing knowledge and improving medical care for those affected by sexual abuse. Only DSAC trained practitioners should perform medical examinations for child sexual assault.
Oranga Tamariki	Government agency that carries out the legislative requirements of the Vulnerable Children's Act 2014 and Children, Young Persons, and their Families Act 1989. Responsibilities are: ▪ To investigate cases of actual and suspected child abuse and/or neglect ▪ To complete diagnostic interviews ▪ To complete evidential interviews in cooperation with NZ Police ▪ To provide care and protection for children found to be in need.
Police	Government agency responsible for: ▪ Working cooperatively with Oranga Tamariki in child abuse and/or neglect protection work ▪ Investigating cases of abuse and/or neglect where an offence has or may have been committed ▪ Prosecuting offenders where an offence has been committed ▪ Accepting reports of suspected abuse and or neglect and referring these to Oranga Tamariki.
Young person	14-18 years old

APPENDIX 2 - Maori and Family Violence

This section is drawn from the Family Violence Assessment and Intervention Guideline[1] was developed with leadership from the roopu, Te Korowai Atawhai. This appendix offers some background and context for family violence in relation to Maori, and identifies key principles and actions for effective screening and intervention. To strengthen the way health services respond to Māori individuals who are experiencing violence within their whānau, it is recommended that DHBs continue to implement He Korowai Oranga, the – Māori Health Strategy in their planning, governance, ethos, and staff development.

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

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

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

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

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

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

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

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

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

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

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

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

Principles for action
The Treaty of Waitangi principles of Partnership, Participation and Protection should underpin efforts to achieve equitable Māori Health outcomes.

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

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

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

2. **Whakapapa** – refers to the genealogical descent of all living things from Ranginui (the Sky Father), Papatuānuku (the Earth Mother), gods, ancestors, and through to the present. Reciting whakapapa enables individuals to identify their genealogical links to one another and to strengthen interpersonal relationships.

   Ways to put this into practice:
   - Note that whakapapa is a fundamental concept of the Māori world-view. Through whakapapa, people can identify and strengthen relationships between themselves and others, develop a healthy sense of belonging, and ground themselves in the world.
   - When building and strengthening relationships with Māori individuals, whānau, hapū, iwi or local Māori services, it is beneficial to share with each other information about your genealogical ties and where you and your ancestors come from.

3. **Atuatanga –** the qualities and wisdom of atua (gods, ancestors, guardians) are considered to endure through people living in the present.

   Ways to put this in to practice:
   - Acknowledge the rich whakapapa (genealogical heritage) of each individual.
   - Be aware that Māori support services in the community may be able to help individuals and whānau who are experiencing violence to reconnect with, and pass on to future generations, the mana (prestige and integrity) and wisdom of their ancestors. Rejecting violence is key to this approach.

4. **Ūkaipōtanga –** an Ūkaipō is a place of nurturing and belonging. Ūkaipōtanga is about nurturing and nourishing people and communities.

   Ways to put this into practice:
   - Encourage parents and whānau to provide a safe and nurturing environment for their children. For example, within maternity services, promote and support parent-infant bonding and talk to parents about how to respond safely to a crying baby.
   - Help parents connect with services in their community that can support them in their role as caregivers and protectors.
   - Ensure that your health service supports victims of violence within whānau.

5. **Whānaungatanga**- focuses on the importance of relationships. Individuals are seen as part of a wider collective, which has the potential to provide its members with guidance, direction and support.

   Ways to put this into practice:
   - Recognise the role of the whānau (family and extended family) in the life of each individual.
   - Engage and build relationships with whānau, identifying key people of influence and those who can provide strength and support to individual members (such as kaumatua and kuia).
   - Note that an individual who is experiencing family violence may wish to call on the support of someone outside their whānau.
   - Help whānau to participate in informed planning and decision making.
   - Work in partnership with whānau, hapū, iwi and Māori community organisations to provide support for individuals experiencing violence.

6. **Rangatiratanga** – is about demonstrating the qualities of a good leader (rangatira); altruism, generosity, diplomacy and the ability to lead by example. It can also refer to the concept of self determination, which respects the right of an individual or group of people to lead themselves. *He Korowai Oranga – Māori Health Strategy* acknowledges whānau, hapū, iwi and Māori aspirations for Rangatiratanga.

   Ways to put this into practice
   - Demonstrate integrity and respect when engaging with whānau.
   - Respect the right of individuals and whānau to determine their own solutions. Support them to make well-informed decisions. Allow them time to ask questions and explore options for action.
   - Ask open-ended questions about what plan of action individuals and/or whānau would like to take, and offer resources, support and guidance.
   - Ask the whānau (rather than assume) what tikanga and kawa (cultural protocols) they wish to follow. Honour their decisions wherever possible.

7. **Manaakitanga –** is about nurturing and looking after people and relationships. Here action is taken to enhance the mana (prestige and integrity) of each individual. Relationships are based on compassion, generosity, reciprocity and respect.

   Ways to put this into practice:
   - Build trust with Māori individuals and whānau from the first point of contact.
   - Convey a genuine, open, supportive, caring and respectful attitude.
   - Offer a comfortable and welcoming environment for Māori (including the physical environment and the behaviour and attitudes of health professionals).
   - Aim to pronounce Māori names and words correctly. This will convey a sense of care and respect. If you are not sure how to pronounce someone's name, ask.

8. **Kaitiakitanga –** refers to the guardianship or protection of people, taonga (cultural treasures), and the environment so that they continue to thrive from generation to generation.

   Ways to put this into practice:
   - Recognise that safety should always be the number one priority. Ensure processes are in place to keep all vulnerable people, and staff safe.
   - Be aware that the physical, emotional and spiritual safety/wellbeing of mothers is important for the safety of their children.
   - Respect and enable (wherever possible) the expression of Māori and other cultural practices and beliefs.

- In order to safeguard present and future generations, ensure that there is a sustained commitment within your practice to address violence within whānau.

9. **Oritetanga –** refers to equality.

Ways to put this into practice
- Deliver the same high quality service to everyone, no matter what their age, gender, ethnicity or social background.
- Understand that some whānau may have minimal information about the health sector and your role may be to empower and inform them of their rights and responsibilities.

10. **Kotahitanga –** exists when people work together in unity to support and achieve common goals.

Ways to put this into practice:
- Take a collaborative approach to keep victims of violence within whānau safe. This should involve information sharing and planning with other professionals, community providers and whānau members.
- Build a sense of partnership with whānau, hapū and iwi, and Māori organisations in your community.

11. **Pukengatanga** – involves the achievement of progressive milestones and skills, enabling individuals to reach their goals and their potential.

Ways to put this into practice:
- Work with the individual, whānau, and other professionals (where relevant) to identify achievable plans to ensure short, medium and longer term safety for victims of family violence. After short term safety is established, support them to take the next step.
- Ensure that individuals/whānau are aware of their options so that they have the opportunity to make informed choices and develop their own plans for the future.

12. **Te Reo** – refers to the Māori language, which is an official language of New Zealand. Its preservation is essential as it is through language that Māori beliefs and traditions are passed from generation to generation. Te Reo carries with it the 'life force' (mauri) of the culture.

> "Ko Te Reo te mauri o te mana Māori – The language is the life essence of Māori mana." - Sir James Henare (1979)

Ways to put this into practice:
- Aim to pronounce Māori names and words correctly. This will convey a sense of care and respect. If you are not sure how to pronounce someone's name, ask.
- Use Te Reo in signage and posters, and have key documents and resources available in Te Reo.
- Embrace opportunities to learn and use Te Reo and to understand the meanings of key Māori concepts (such as these 12 kaupapa).
- Be aware that Māori words often have multiple layers of meaning and convey perspectives and concepts that cannot always be directly translated into English.

The *Increasing Violence Intervention Programme (VIP) Programmes' Responsiveness to Māori* resource encourages health care providers to seek training to enhance their cultural competence when working with Māori. See www.health.govt.nz/publication/increasing-violence-intervention-programme-vip-programmes-responsiveness-maori

APPENDIX 3 - Pacific Peoples and Family Violence

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

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

What family violence means in a Pacific context

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

Risk factors for family violence amongst Pacific people

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

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

Protective factors for Pacific families

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

Transformation and restoration

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

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

Principles for action

1 Victim safety and protection must be paramount

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

Actions and behaviours to ensure victim safety and protection:

- routinely enquire about experience of IPV for women, and about intimate partner violence if there are signs and symptoms for men. Be alert for indication of abuse and neglect among children
- follow the health and risk assessment procedures outlined, and, wherever possible, involve the person in determining the plan of action they would like to take
- 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 or mainstream family violence advocates.

2 The provision of a Pacific-friendly environment

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

Actions and behaviours that contribute to Pacific people feeling comfortable:

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

3 The provision of culturally safe and competent interactions

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

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

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

4 A collaborative community approach to family violence should be taken

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

Actions and behaviours that contribute to a collaborative intersectoral approach:

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

APPENDIX 4 - Four Recognised Categories of Child Abuse

These frequently overlap in individual cases. Refer to the "Recognition of Child Abuse and Neglect" published by the Risk Management Project, Children, Young Persons and Their Families Agency 1997.

1. Physical Abuse

Child physical abuse is any act or acts that may result in inflicted injury to a child or young person. It may include, but is not restricted to:

- Bruises and welts
- Cuts and abrasions
- Fractures or sprains
- Abdominal injuries
- Head injuries
- Injuries to internal organs
- Strangulation or suffocation
- Poisoning
- Burns or scalds
- Non organic failure to thrive
- Fabricated Or Induced Illness By Carers (formerly Munchausen Syndrome by Proxy)

2. Sexual Abuse

Child sexual abuse is any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not. It may include, but is not restricted to:

Non-contact abuse

- Exhibitionism
- Voyeurism
- Suggestive behaviours or comments
- Exposure to pornographic material
- Inappropriate photography

Contact abuse

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

3. Emotional/Psychological Abuse

Child emotional/psychological abuse is any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person. It may include, but is not restricted to:

- Rejection, isolation or oppression.
- Deprivation of affection or cognitive stimulation.
- Inappropriate and continued - criticism, threats, humiliation, accusations, expectations of, or towards, the child or young person.
- Exposure to family violence.
- Corruption of the child or young person through exposure to, or involvement in, illegal or anti-social activities.
- The negative impact of the mental or emotional condition of the parent or caregiver.

- The negative impact of substance abuse by anyone living in the same residence as the child or young person.

4. 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. It may include, but is not restricted to:

- Physical neglect - failure to provide the necessities to sustain the life or health of the child or young person.
- Neglectful supervision - failure to provide developmentally appropriate and/or legally required supervision of the child or young person, leading to an increased risk of harm.
- Medical neglect - failure to seek, obtain or follow through with medical care for the child or young person resulting in their impaired functioning and/or development.
- Emotional neglect – not giving children the comfort, attention and love they need through play, talk, and everyday affection.
- Educational neglect – allowing chronic truancy, failure to enrol children in school, or inattention to special education needs.
- Abandonment - leaving a child or young person in any situation without arranging necessary care for them and with no intention of returning.
- Refusal to assume parental responsibility - unwillingness or inability to provide appropriate care or control for a child or young person.

APPENDIX 5 - Signs and Symptoms of Abuse and Neglect in Recognised Categories of Child Abuse

Physical abuse: Injuries that don't make sense

- **Unexplained head injuries** – even an apparently trivial bruise to the head of a baby or young infant with no evident signs of concussion may be reason for concern
- **Unexplained bruises, welts, cuts and abrasions** – particularly in unusual places (face, ears, neck, back, abdomen, buttocks, inner arms or thighs, back of the leg), clustered, patterned or in unusually large numbers
- **Any unexplained bruise or injury in a baby who is not yet independently mobile** – especially if they are not yet pulling to stand, crawling or walking. Fractures in babies are often not clinically obvious, and may present as reluctance to use one limb or to crawl, or with non-specific irritability.
- **Unexplained fractures** – many children get accidental fractures, but always consider whether the history is consistent with the fracture type. This depends entirely on the quality of the history you take.
- **Unexplained burns** anywhere on the body. Burns may be difficult to interpret, and if you are concerned they should be referred early to a doctor with expertise in burns or child protection.
- **The child or their parent** can't recall how the injuries occurred, or their explanations change or don't make sense. While there may be innocent explanations for this, 'no history of trauma' is a common feature of child abuse.

Sexual abuse

- In sexual abuse particularly, physical signs or symptoms are usually absent and behavioural changes may not be evident.
- If a child or young person tells you they have been abused (i.e., 'makes a disclosure'), this should always be taken seriously and referred to Oranga Tamariki.
- Anogenital symptoms in children (like redness or swelling, bruising or bleeding from the genital or anal area) do not necessarily indicate sexual abuse, but they do need to be evaluated by a doctor with the appropriate expertise. Most urinary tract infections in childhood are not related to sexual abuse. However, if you or the family have concerns about sexual abuse for these or other reasons, the child should be referred as soon as possible to a doctor trained in the area of child sexual abuse.
- Behaviour changes after sexual abuse may not be evident and if they do occur they may be highly variable. Concern may exist if there is:
    - **age-inappropriate sexual play or interest** and other unusual behaviour, like sexually explicit drawings, descriptions and talk about sex. However, this does not necessarily indicate sexual abuse, and should be discussed with clinicians experienced in child behaviour or child sexual abuse
    - **fear of a certain person or place.** Children might try to express their fear without saying exactly what they are frightened of, so listen carefully, and take what they say seriously. However, never jump to conclusions
    - other behavioural change suggesting emotional disturbance (see below).

Emotional abuse

- Most forms of abuse, exposure to violence or neglect are accompanied by emotional effects, which may or may not cause behavioural changes. The changes in behaviour noted below are not however specific for the emotional consequences of abuse or neglect.

- **sleep problems** like bed-wetting or soiling – with no medical cause, nightmares and poor sleeping patterns.
- **frequent physical complaints** – real or imagined, such as headaches, nausea and vomiting, and abdominal pains

- **signs of anxiety**
- **other altered behaviour**. Children who are abused may withdraw, present as sad and alone, or consider hurting themselves or ending their lives. Some children may develop conduct disorder, such as oppositional or aggressive behaviour, acting out or deteriorating school performance.

Neglect

- Neglect is one of the most common forms of child maltreatment, with serious long-term consequences for children, but can be very difficult to define. It is useful to consider:
  - do the conditions or circumstances indicate that a child's basic needs are unmet?
  - what harm or risk of harm may have resulted?
- These questions cannot be answered without sufficient information. This includes the pattern of caregiving over time, how the child's basic needs are met (or not met) and whether there have already been specific examples when an omission of care has led to harm or the risk of harm.
- Neglect can consist of:
  - **physical neglect** – not providing the necessities of life, like a warm place enough food and clothing. In babies or young children, this may present as poor growth ('failure to thrive')
  - **neglectful supervision** – leaving children home alone, or without someone safe looking after them during the day or night
  - **emotional neglect** – not giving children the comfort, attention and love they need through play, talk and everyday affection
  - **medical neglect** – the failure to take care of their health needs
  - **educational neglect** – allowing chronic truancy, failure to enrol children in school or inattention to special education needs.

See Appendix 6 for further information on assessing neglect

APPENDIX 6 - Child Neglect Assessment Guideline

Two primary questions should be asked in order to identify whether child neglect has occurred:

- Do the conditions or circumstances indicate that a child's basic needs are unmet?
- What harm or threat of harm may have resulted?

To answer these questions, sufficient information is required to assess the degree to which neglect can or may result in significant harm or risk of significant harm. The decision often requires considering patterns of caregiving over time. The analysis should focus on examining how the child's basic needs are met and on identifying situations that may indicate specific omissions in care that have resulted in harm or the risk of harm to the child. While information on all these domains will not be accessible to all health care providers, the list provides some indications of issues that may require consideration.

Further questions which may indicate that a child's physical or medical needs and supervision may be unmet include the following:

- Have the parents or caregivers failed to provide the child with needed care for a physical injury, acute illness, physical disability or chronic condition?
- Have the parents or caregivers failed to provide the child with regular and ample meals that meet basic nutritional requirements, or have the parents or caregivers failed to provide the necessary rehabilitative diet to a child with particular health problems?
- Have the parents or caregivers failed to attend to the cleanliness of the child's hair, skin, teeth and clothes? Note: It can be difficult to determine the difference between marginal hygiene and neglect. Health care providers should consider the chronicity, extent and nature of the condition, as well as the impact on the child.
- Does the child have inappropriate clothing for the weather? Health care providers should consider the nature and extent of the conditions and the potential consequences to the child. They also must take into account diverse cultural values regarding clothing.
- Does the home have obviously hazardous physical conditions (e.g., exposed wiring or easily accessible toxic substances) or unsanitary conditions (e.g., faeces- or trash-covered flooring or furniture)?
- Does the child experience unstable living conditions (e.g., frequent changes of residence or evictions due to the caretaker's mental illness, substance abuse or extreme poverty)?
- Do the parents or caregivers fail to arrange for a safe substitute caregiver for the child?
- Have the parents or caregivers abandoned the child without arranging for reasonable care and supervision?

The effects of neglect are as bad as, if not worse than, physical and sexual abuse. They include serious long-term disorders of attachment and behaviour, delays in cognitive and emotional development, mental health disorders, substance abuse, risk-taking sexual behaviour, violence and educational and employment failure.

APPENDIX 7 - HEEADSSS: Psychosocial Interview for Adolescents

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

Home	**Drugs**
Who lives with you? Where do you live? Do you have your own room?	Do any of your friends use tobacco? Alcohol? Other drugs?
What are relationships like at home?	Does anyone in your family use tobacco? Alcohol? Other drugs?
To whom are you closest at home?	Do you use tobacco? Alcohol? Other drugs?
To whom can you talk at home?	Is there any history of alcohol or drug problems in your family? Does anyone at home use tobacco?
Is there anyone new at home? Has someone left recently?	Do you ever drink or use drugs when you're alone?
Have you moved recently?	(Assess frequency, intensity, patterns of use or abuse, and how youth obtains or pays for drugs, alcohol, or tobacco)
Have you ever had to live away from home? (Why?)	(Ask the CRAFFT questions)
Have you ever run away? (Why?)	
Is there any physical violence at home?	
Education and employment	**Sexuality**
What are your favourite subjects at school? Your least favourite subjects?	Have you ever been in a romantic relationship?
How are your grades? Any recent changes? Any dramatic changes in the past?	Tell me about the people that you've dated. OR Tell me about your sex life.
Have you changed schools in the past few years?	Have any of your relationships ever been sexual relationships?
What are your future education/employment plans/goals?	Are your sexual activities enjoyable?
Are you working? Where? How much?	What does the term 'safe sex' mean to you?
Tell me about your friends at school.	Are you interested in boys? Girls? Both?
Is your school a safe place? (Why?)	Have you ever been forced or pressured into doing something sexual that you didn't want to do?
Have you ever had to repeat a class? Have you ever had to repeat a grade?	Have you ever been touched sexually in a way that you didn't want?
Have you ever been suspended? Expelled? Have you ever considered dropping out?	Have you ever been raped, on a date or any other time?
How well do you get along with the people at school? Work?	How many sexual partners have you had altogether?
Have your responsibilities at work increased?	Have you ever been pregnant or worried that you may be pregnant? (females)
Do you feel connected to your school? Do you feel as if you belong?	Have you ever gotten someone pregnant or worried that that might have happened? (males)
Are there adults at school you feel you could talk to about something important? (Who?)	What are you using for birth control? Are you satisfied with your method?
	Do you use condoms every time you have intercourse?
	Does anything ever get in the way of always using a condom?
	Have you ever had a sexually transmitted disease (STD) or worried that you had an STD?

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

Eating	**Suicide and depression**
What do you like and not like about your body?	Do you feel sad or down more than usual? Do you find yourself crying more than usual?
Have there been any recent changes in your weight?	Are you 'bored' all the time?
Have you dieted in the last year? How? How often?	Are you having trouble getting to sleep?
Have you done anything else to try to manage your weight?	Have you thought a lot about hurting yourself or someone else?
How much exercise do you get in an average day? Week?	Does it seem that you've lost interest in things that you used to really enjoy?
What do you think would be a healthy diet? How does that compare to your current eating patterns?	Do you find yourself spending less and less time with friends?
Do you worry about your weight? How often?	Would you rather just be by yourself most of the time?
Do you eat in front of the TV? Computer?	Have you ever tried to kill yourself?
Does it ever seem as though your eating is out of control?	Have you ever had to hurt yourself (by cutting yourself, for example) to calm down or feel better?
Have you ever made yourself throw up on purpose to control your weight?	Have you started using alcohol or drugs to help you relax, calm down or feel better?
Have you ever taken diet pills?	
What would it be like if you gained (lost) 10 pounds?	

Activities	**Safety**
What do you and your friends do for fun? (with whom, where, and when?)	Have you ever been seriously injured? (How?) How about anyone else you know?
What do you and your family do for fun? (with whom, where, and when?)	Do you always wear a seatbelt in the car?
Do you participate in any sports or other activities?	Have you ever ridden with a driver who was drunk or high? When? How often?
Do you regularly attend a church group, club, or other organized activity?	Do you use safety equipment for sports and or other physical activities (for example, helmets for biking or skateboarding)?
Do you have any hobbies?	Is there any violence in your home? Does the violence ever get physical?
Do you read for fun? (What?)	Is there a lot of violence at your school? In your neighbourhood? Among your friends?
How much TV do you watch in a week? How about video games?	Have you ever been physically or sexually abused? Have you ever been raped, on a date or at any other time? (If not asked previously)
What music do you like to listen to?	Have you ever been in a car or motorcycle accident? (What happened?)
	Have you ever been picked on or bullied? Is that still a problem?
	Have you gotten into physical fights in school or your neighbourhood? Are you still getting into fights?
	Have you ever felt that you had to carry a knife, gun, or other weapon to protect yourself? Do you still feel that way?

Source: Goldenring and Rosen 2004

APPENDIX 8 - Assessment and Referral for Children Under 12 at Risk of Suicide

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

Seriousness of injury

Suicidality History
History (Hx) of prior suicide attempts[1]
Child's Hx of prior suicide attempts[2]
Hx of suicidal ideation[1]
Child's Hx of suicidal ideation[2]

Medical History[2]
Hx of psychiatric diagnoses
Hx of mental health treatment and/or psychotrophic drug use
Hx of substance use or abuse
Number of previous ED visits for suspicious accidents
Chronic illness-frequency requiring compliance

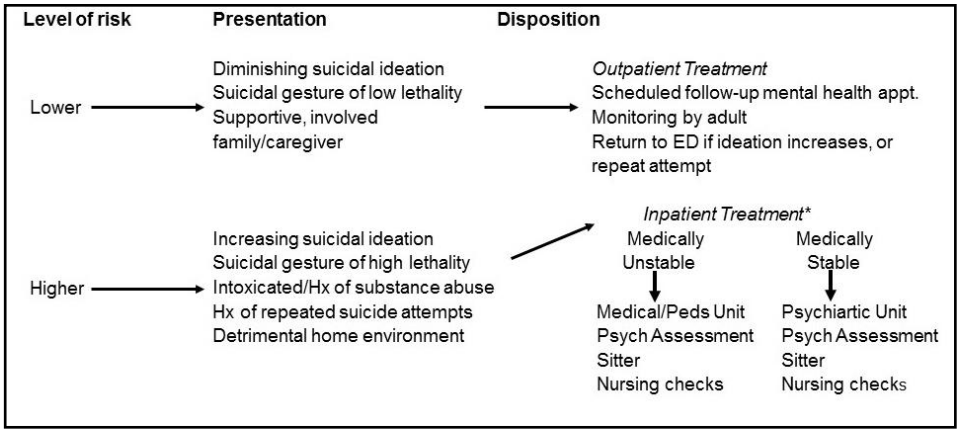
Current presentation
Intend to die[1]
Child's intent to die[2]
Suicide plan, method, access to method[1]
Current psychiatric symptoms (depression, psychosis, etc.)[1,2]
Child's reasons for living[1]
Current substance intoxication
Cognitive level of child

Environmental factors[1,2]
Family
Unsecured potential suicide methods (guns, medications, etc.)
Recent suicide, death, or loss in family
Suicidal ideation or suicidal attempts in family
Presence of child abuse or neglect
Supportiveness of parents or caregivers
Family turmoil
- Marital Problems
- Domestic Violence
- Financial Crisis
- Incarceration
- Alcohol and Substance Use

Child
Social isolation (ask about the effects)
Bullying or being bullied (ask about the effects)
Changes in school performance

Notes: 1 denotes questions addressed to the child, and 2 denotes questions addressed to the child's caregiver. The interviewer should also investigate with the child the impact of issues raised by the caregiver (eg, how does being bullied make you feel?)

ED disposition of suicidal children



*All children should be carefully monitored (with repeated checks) by health care staff in all inpatient settings to avoid suicide in these environments.

APPENDIX 9 - Legal and Privacy Issues

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

As well, all privacy restrictions are over-ridden by certain sections of the Children, Oranga Tamariki Act 2017 and the Family Violence Act 2018.These provide for the reporting of child abuse, protection of an individual from proceedings when disclosing child abuse to either a statutory social worker or police, and government agency obligations

Taranaki DHB encourages good communication between Taranaki DHB staff and ORANGA TAMARIKI or the police to keep children safe. Requests for information should be referred directly to unit managers, who are responsible for ensuring such requests are dealt with promptly and appropriately. Information must only be released to a ORANGA TAMARIKI social worker, police officer or care and protection coordinator (s66 ORANGA TAMARIKI Act: see below).

Health workers therefore, are able to give information to the Oranga Tamariki or Police.
Information can be given to both, by reporting abuse, or when requested by either agency.

ORANGA TAMARIKI ACT 2017

S6 Paramountcy principle

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

S15 Reporting of ill treatment or neglect of child or young person

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

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

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

S66 Government Departments may be required to supply information

(1) Every Government Department, agent, or instrument of the Crown and every statutory body shall, when required, supply to every Care and Protection Co-ordinator, ORANGA TAMARIKI social worker, or member of the police such information as it has in its possession relating to any child or young person where that information is required -

(a) For the purposes of determining whether that child or young person is in need of care or protection (other than on the ground specified in section 14 (1)(e) of this Act): or

(b) For the purposes of proceedings under this part of this Act.

Section 66 means that where a care and protection coordinator, ORANGA TAMARIKI social worker or police officer requires information about a child/young person for the purposes of

determining whether the child/young person is in need of care and protection, or for proceedings under the ORANGA TAMARIKI Act, DHB staff must provide that information. A staff member may be asked to provide this information in an affidavit. DHB recommends that the staff member seeks the support and advice of the unit manager, DHB's child protection coordinator and/or DHB's legal adviser.

PRIVACY ACT

Principle 11 (f) (ii)

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

PRACTICE NOTE: INTERAGENCY INFORMATION SHARING

Information is available regarding interagency information sharing from the Privacy Commission website, follow the following links to the *Sharing personal information of families and vulnerable children: A guide for inter-disciplinary groups* (www.privacy.org.nz/assets/InteractiveEscalationLadder/Escalation-Ladder-FINAL-HiRes.pdf) and the *Escalation ladder regarding 'Sharing information about vulnerable children'* (www.privacy.org.nz/how-to-comply/sharing-information-about-vulnerable-children).

HEALTH INFORMATION PRIVACY CODE

Rule 11 subsection 2 (d) (ii)

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

HEALTH ACT 1956

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

Any person being an agency, that provides health services or disability services…may disclose health information… to a Oranga Tamariki social worker or a Care and Protection Co-ordinator within the meaning of the Vulnerable Children's Act (2014) and Children Young Persons and their Families Act (1989), for the purposes of exercising or performing any of that person's powers under that Act.

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

VULNERABLE CHILDREN ACT 2014

The Vulnerable Children Act (VCA) forms a significant part of comprehensive measures to protect and improve the wellbeing of vulnerable children and strengthen New Zealand's child protection system.

The reforms within the VCA were proposed in the White Paper for Vulnerable Children, and confirmed in the Children's Action Plan, which was released in October 2012 after significant public consultation.

The Action Plan and the VCA are based on the premise that cross-sector collaboration and responsibility is essential to protecting vulnerable children. Chief executives from five government agencies are jointly accountable for implementing the Children's Action Plan.

Relevant provisions within the VCA include: requirements for government agencies and their funded providers to have child protections policies, and standard safety checking for paid staff in the government-funded children's workforce.

Part 2, covering child protection policies, states:

> The purpose of this Part is to require child protection policies (that must contain provisions on the identification and reporting of child abuse and neglect) to be –
>
> (a) adopted and reported on by prescribed State services and DHBs boards; and
>
> (b) adopted by school boards; and
>
> (c) adopted by certain people with whom those services or boards enter into contracts or funding arrangements.

It is appreciated that DHBs already have child protection policies in place, as part of the VIP and their wider commitment to identifying and responding to child abuse and neglect.

Part 3, covers children's worker safety checking, and provides:

> The purpose of this Part is to reduce the risk of harm to children by requiring people employed or engaged in work that involves regular or overnight contact with children to be safety checked.

The VCA contributes to the Government's Better Public Services result to reduce the number of physical assaults on children.

Legislative changes are being phased in over several years, together with other Children's Action Plan initiatives, including the roll-out of further children's teams and common competencies for all children's workers.

The requirements of the VCA should complement and strengthen the implementation of the VIP within the public health setting.

APPENDIX 10 - Safety and Security Guidelines

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

- Ensure persons making public enquiries about the victim are given no details by suppressing all details on the hospital computer

- Use a safe process to discharge the family to an advocacy agency, e.g. women's refuge. This may include informing an inquirer that the patient has left the hospital before this is so and/or denying knowledge of where the patient has gone.

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

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

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

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

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

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

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

1.5. The following staff are informed of this name suppression being actioned:
- 1.5.1. Duty Manager
- 1.5.2. Switchboard staff
- 1.5.3. Security
- 1.5.4. All relevant staff within the department. This information transfers if the patient is admitted to a ward

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

1.7. Complete the name suppression documentation form)

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

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

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

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

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

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

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

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

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

3.2. Complete the name suppression process as above if appropriate.

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

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

3.4. The discharge plan may include the leaving the ED / ward or other department by a safe route, in consultation with security staff.

3.5. Document the discharge plan. N.B. Complete an Event Reporting Form if any unexpected outcomes occurred.

3.6. Advise the Duty Manager of the discharge outcome.

TARANAKI DISTRICT HEALTH BOARD

Violence Intervention Programme

Intimate Partner Violence Assessment and Intervention Policy and Procedures

VIP violence intervention programme

Funded by Ministry of Health & TDHB

TABLE OF CONTENTS

INTIMATE PARTNER VIOLENCE MANAGEMENT POLICY

Department:	Clinical Board
Date Issued:	December 2019
Review By Date:	December 2021
Responsibility:	Violence Intervention Coordinator
Authorised By:	Chief Executive
Version:	1
Page:	1 of 3

Introduction

1. The Taranaki District Health Board (DHB) is committed to the strategic actions and behaviours of We Work Together By:
    - Treating people with trust respect and compassion
    - Communicating openly, honestly and acting with integrity
    - Enabling professional and organisation standards to be met
    - Supporting achievement and acknowledging successes
    - Creating healthy and safe environments
    - Welcoming new ideas

2. The Family Violence Act 2018 positions all DHBs as Family Violence Agencies. The Law emphasize safety, early intervention and requires health professionals having an understanding of the dynamics of family violence. It also mandates DHBs to share personal information to better respond to family violence and help protect wahine tamariki, vulnerable adults and whānau from harm.

3. This Intimate Partner Violence Management Policy has been developed in accordance with the principles of action including the Treaty of Waitangi principles, recognising Te Whare Tapa Wha and kaupapa principles. This is consistent with cultural training offered and mandated within the Taranaki DHB.

Purpose

4. The purpose of this policy is to provide Taranaki DHB community and hospital-based staff with a framework to identify, assess and manage family violence; intimate partner violence.
5. It recognises the important role and responsibility staff have in the accurate detection of intimate partner violence.

Scope

6. This policy applies to all Taranaki DHB staff, including volunteers, students, contractors and visiting clinical staff to the Taranaki DHB. In particular, it has significance for those working in clinical settings.

Terms and Definitions

7. **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.

8. **Physical Abuse:** Includes all 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.
9. **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 posers (in relation to adults) and (in relation to 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.
10. **Sexual Abuse:** Includes any forced, coerced or exploitive sexual behaviour or threats imposed on an individual, including sexual acts imposed on a person unable to give consent, or sexual activity when an adult with mental incapacity is unable to understand.
11. **Intimate Partner Violence – also called Partner Violence:** Physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners. Intimate partners include current spouses (including de facto spouses), current non-marital partners (including dating partners, heterosexual or same sex), former marital partners and former non-marital partners.
12. **Routine Enquiry:** Routine enquiry, either written or verbal, by the 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.
13. **Young Person:** 14-18 years old.

Principles

14. The Ministry of Health's Family Violence Assessment and Intervention Guideline guides this policy.
15. Health services should identify, assess, offer referral and advocate for victims of family violence.
16. Health services that care and protect victims of family violence are build on a bicultural partnership in accordance with the Treaty of Waitangi.
17. All people using the services of the Taranaki DHB are assessed and managed in a culturally safe environment. The Maori Health team is available for cultural support. All staff are able to recognise and be sensitive to other cultures.
18. Staff are competent in the identification and management of actual or suspected family violence through the organisation's violence intervention programme infrastructure including policy and procedures, standardised documentation, education programme and access to consultation.
19. Requirement to integrate care through a coordinated approach with community providers.

Organisational Responsibilities

20. The **Taranaki DHB** is responsible for ensuring:
    - An organisation-wide framework for the management of intimate partner violence and associated policies and procedures.
    - Regular training for staff on the policy and related procedures.
    - Regular monitoring of the policy to assess compliance.
    - Adequate support (e.g. access to consultation) and supervision for staff.
    - Activities are properly resourced and evaluated.

21. **Managers** of departments/services will support the implementation of this policy within their department/service as coordinated by the Violence Intervention Programme Coordinator.

22. All **Taranaki DHB staff** have a responsibility to be aware of this policy, follow appropriate procedures and attend appropriate training.
23. All **clinical staff** have a responsibility for the assessment and intervention of family violence. Responsibilities include:
    - Being conversant with the DHB's family violence intervention policy and procedures.
    - Understanding the referral and management of suspected or disclosed intimate partner violence.
    - Attending initial training and regular updates appropriate to their area of work.
    - Providing or accessing Taranaki DHB specialist health services that may include:
        - Cultural assessments
        - Mental Health assessments
        - Diagnostic medical assessments
        - Social work services, counselling and therapy resources.
    - Ensuring clinically and culturally safe practice, for example consulting a senior colleague during the intervention and seeking peer-support/supervision when intimate partner violence is suspected or disclosed.

Violence Intervention Programme Coordinator

Responsibilities include:

- Coordinating the Violence Intervention Programme implementation within services, working with service leaders to ensure system support is readily available.
- Ensuring this policy remains current and aligned with national standards.
- Providing cyclical workforce training in accordance with the Taranaki DHB Violence Intervention training plan.
- Ensuring quality improvement activities in regard to policy compliance are undertaken and reported on at least biannually.

Supporting Information

24. Legislation:
    - Code of Health and Disability Services Consumers' Rights
    - Crimes Act
    - Family Violence Act 2018
    - Oranga Tamariki Act 2017
    - Health Act
    - New Zealand Bill of Rights
    - Privacy Act
    - Summary of Offences Act

25. Taranaki DHB Polices and Procedures:
    - VIP Child Protection Policy
    - Older Adults and Vulnerable Adults Abuse and Neglect Policy

26. Associated Documents
    - Family Violence Assessment and Intervention Guideline, Ministry of Health, 2016

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 Taranaki DHB Intimate Partner Violence Policy has been developed in accordance 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 Taranaki DHB.

Family violence intervention for Maori is based on victim safety and protection being the paramount principle. Ensure practice is safe clinically and culturally. Affirm with the 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.

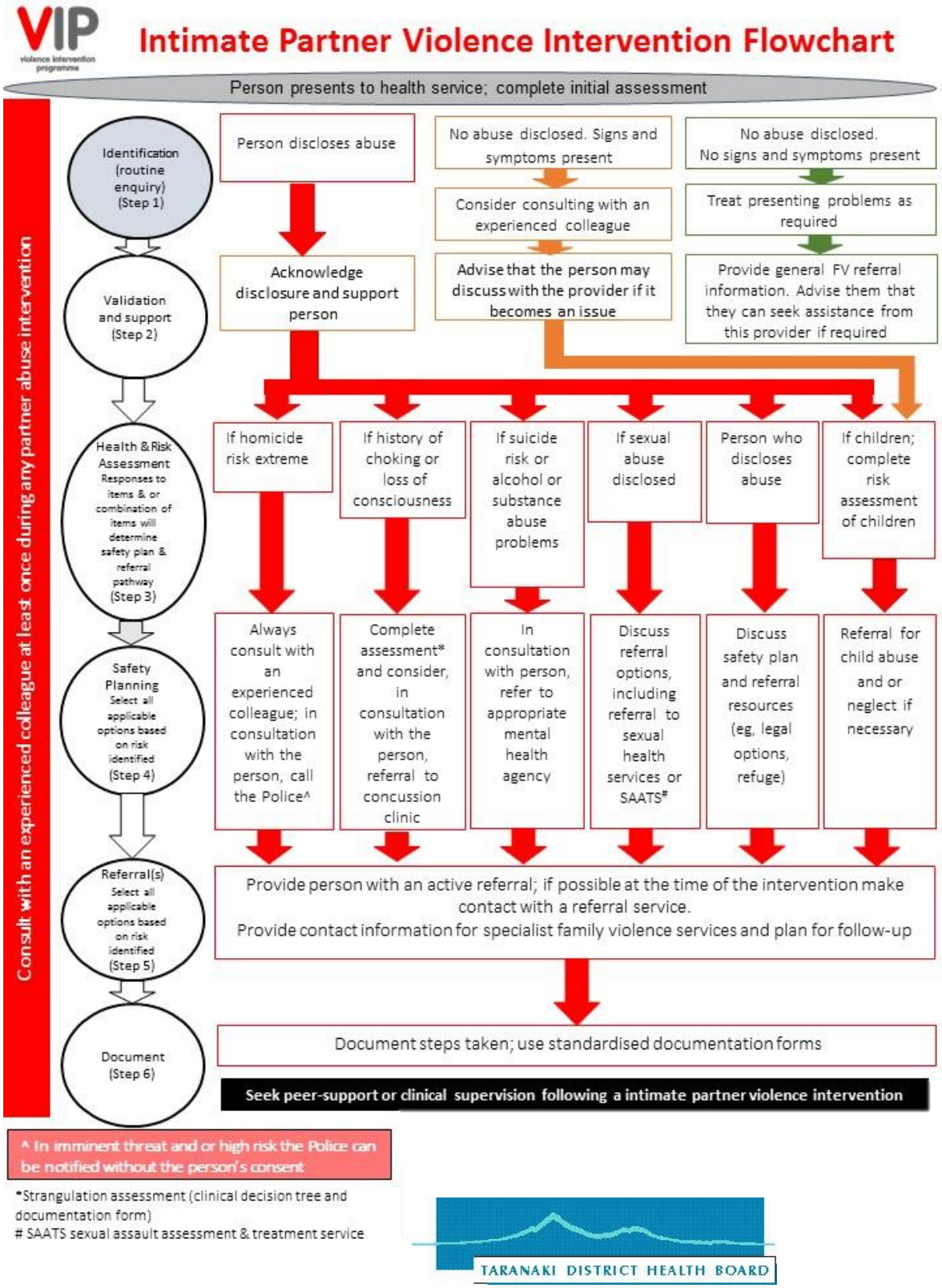
See Appendix 2 - Maori and family violence

Pacific peoples and the Violence Intervention Programme

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

See Appendix 3 - Pacific peoples and family violence.

Intimate Partner Violence Intervention Flowchart



Brief Intervention Model: A Six-Step Process

Consultation should occur at <u>least</u> once when intimate partner violence is disclosed or suspected.

The following staff are available:

- Violence Intervention Programme and or Child Protection Coordinator
- Health Social Workers
- VIP Clinical Champions
- An experienced colleague
- Domestic violence advocate

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

Step 1: Identify

Partner abuse occurs in heterosexual and in lesbian, gay, bisexual and transgender relationships. Routine enquiry should only occur when the adult is alone or accompanied by non-verbal age children.

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

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

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*.*

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

See Appendix 4 - Recommended Intimate Partner Violence Routine Enquiry Guidelines for Different Clinical Settings.

See Appendix 5 - Signs and Symptoms of Intimate Partner Violence.

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

Step 2: Validation and Support of Persons Experiencing Abuse

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 Maori Health Unit.

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

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

Step 3: Assess Risk

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.

See Appendix 8 - 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 partner abuse 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 the VIP Child Protection Policy.

Step 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 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, to determine safety options for the future. A multidisciplinary team approach is the preferred option.

See Appendix 9 - Guidelines on Identifying and Responding to Safety Needs.

See Appendix 10 - Safety Plan Resource.

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

Step 5: Referral agencies

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.

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. Early referral to support agencies is the preferred intervention.

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

If the person is at moderate/ongoing risk, 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 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 12 - Guidelines on Referral and Follow Up.

TDHB has established interagency processes with a range of organisations and agencies (refer to the directory of family violence community services).

Step 6: Document

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

Health professionals should record the outcome of the routine enquiry, the findings of the health and risk assessment, the safety planning and referrals made. This documentation process is standard practice in regard to recording the health intervention and it is important part of keeping victims safe because the clinical record may help in future legal action. For example the documentation can be used when securing a Protection Order or prosecuting assault. An objective, systematic history and health and risk assessment is therefore essential. Standard professional requirements also apply (e.g. a legible signature and designation).

See Appendix 13 - Guidelines for Documentation of Family Violence.

To ensure the safety and confidentiality of the information, intimate partner violence disclosures are managed in the following way. The VIP Intimate Partner Violence Documentation Form is stored as accessory file and an electronic record.

This ensures that:

1. The information is kept confidential (minimise the risk that the perpetrator of the abuse can access/see the information),

2. the right information is stored in the right file, and

3. the information is available to clinical staff who provide care in the future.

Safety and Security

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

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

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

Staff Resources

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)
- A full day (8 hour) training session.

Access to the Violence Intervention Programme training can be obtained through:
- Intranet
- Taranaki DHB Learning and Development Administrator Extn 7649
- Taranaki DHB Co-ordinator of Violence Intervention Programme Extn 8973
- Taranaki DHB Child Protection Co-ordinator Extn 7891

Staff are also required to undertake in-service training as indicated and refresher training biannually.
Advanced training will be offered to designated staff.

Supervision and/or peer support

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

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

The Employee Assistance Programme is also available should further counselling be required. Contracted professional staff provide this confidential offsite support and

employees are encouraged to self-refer to this programme. To access the service please call EAP Services Ltd on 0800 7872867 (STRATOS)

Taranaki DHB Employees and Family Violence

The Taranaki DHB Employee Assistance Programme (EAP) is available to support employees experiencing or perpetrating family violence. Contracted professional staff provide confidential offsite services and employees are encouraged to self-refer to this programme. To access the service please call EAP Services Ltd on 0800 7872867.

MoH Family Violence Assessment and Intervention Guidelines (2016)

This resource is available here and on the Ministry of Health website.

Other resources

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

Reference Documents

Type	Document Title(s)
Organisational Policies	• VIP Child Protection Policy • Taranaki DHB Reportable Events Policy • Taranaki DHB Interpreter Policy • Taranaki DHB Digital Photography Procedure (Patient Clinical Images) • Taranaki DHB Appropriate Access to Health Information Policy
Legislation	• Privacy Act (1993) • Crimes Act (1961) • Crimes Amendment Act (No. 3) 2011 • Family Violence Act 2018 • Vulnerable Children's Act 2014 • Oranga Tamariki Act 2017
Associated Documents	• Ministry of Health. Family Violence Assessment and Intervention Guidelines; Child Abuse and Intimate Partner Violence. Wellington: Ministry of Health, 2016. • Ministry of Health He Korowai Oranga, the – Māori Health Strategy

For further information contact the Taranaki DHB Violence Intervention Programme Co-ordinator

APPENDIX 1 - Terms and Definitions[a]

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

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.

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

Psychological/Emotional Abuse	Includes any behaviour that causes anguish or fear. Intimidation, harassment, damage to property, threats of physical or sexual abuse, removal of decision-making powers (in relation to adults) and (in relation to a child) exposing the child to physical, psychological or sexual abuse of another person. Concerted attacks on an individual's self-esteem and social competence results in increased social isolation.
Sexual Abuse	Includes any forced, coerced or exploitive sexual behaviour or threats imposed on an individual, including sexual acts imposed on a person unable to give consent, or sexual activity when an adult with mental incapacity is unable to understand.
Intimate Partner Violence *(also* called partner abuse*)*	Physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners. Intimate partners include current spouses (including de facto spouses), current non-marital partners (including dating partners, heterosexual or same-sex), former marital partners and former non-marital partners.
Routine Enquiry	Routine enquiry, either written or verbal, by health care providers to individuals about personal history of 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.
Young Person	14-18 years old.

APPENDIX 2 - Maori and Family Violence

This section is drawn from the Family Violence Intervention Guidelines[1] was developed with leadership from the roopu, Te Korowai Atawhai. This appendix offers some background and context for family violence in relation to Maori, and identifies key principles and actions for effective screening and intervention. To strengthen the way health services respond to Māori individuals who are experiencing violence within their whānau, it is recommended that DHBs continue to implement He Korowai Oranga, the – Māori Health Strategy in their planning, governance, ethos, and staff development.

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

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

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

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

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

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

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

Safety first

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

Equity of Health Care for Māori

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

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

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

Principles for action

The Treaty of Waitangi principles of Partnership, Participation and Protection should underpin efforts to achieve equitable Māori Health outcomes.

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

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

   Ways to put this into practice:

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

2. **Whakapapa** – refers to the genealogical descent of all living things from Ranginui (the Sky Father), Papatuānuku (the Earth Mother), gods, ancestors, and through to the present. Reciting whakapapa enables individuals to identify their genealogical links to one another and to strengthen interpersonal relationships.

   Ways to put this into practice:

   - Note that whakapapa is a fundamental concept of the Māori world-view. Through whakapapa, people can identify and strengthen relationships between themselves and others, develop a healthy sense of belonging, and ground themselves in the world.
   - When building and strengthening relationships with Māori individuals, whānau, hapū, iwi or local Māori services, it is beneficial to share with each other information about your genealogical ties and where you and your ancestors come from.

3. **Atuatanga –** the qualities and wisdom of atua (gods, ancestors, guardians) are considered to endure through people living in the present.

   Ways to put this into practice:

   - Acknowledge the rich whakapapa (genealogical heritage) of each individual.
   - Be aware that Māori support services in the community may be able to help individuals and whānau who are experiencing violence to reconnect with, and pass on to future generations, the mana (prestige and integrity) and wisdom of their ancestors. Rejecting violence is key to this approach.

4. **Ūkaipōtanga –** an Ūkaipō is a place of nurturing and belonging. Ūkaipōtanga is about nurturing and nourishing people and communities.

   Ways to put this into practice

- Encourage parents and whānau to provide a safe and nurturing environment for their children. For example, within maternity services, promote and support parent-infant bonding and talk to parents about how to respond safely to a crying baby.
- Help parents connect with services in their community that can support them in their role as caregivers and protectors.
- Ensure that your health service supports victims of violence within whānau.

5. **Whānaungatanga**- focuses on the importance of relationships. Individuals are seen as part of a wider collective, which has the potential to provide its members with guidance, direction and support.

Ways to put this into practice

- Recognise the role of the whānau (family and extended family) in the life of each individual.
- Engage and build relationships with whānau, identifying key people of influence and those who can provide strength and support to individual members (such as kaumatua and kuia).
- Note that an individual who is experiencing family violence may wish to call on the support of someone outside their whānau.
- Help whānau to participate in informed planning and decision making.
- Work in partnership with whānau, hapū, iwi and Māori community organisations to provide support for individuals experiencing violence.

6. **Rangatiratanga** – is about demonstrating the qualities of a good leader (rangatira); altruism, generosity, diplomacy and the ability to lead by example. It can also refer to the concept of self determination, which respects the right of an individual or group of people to lead themselves. *He Korowai Oranga – Māori Health Strategy* acknowledges whānau, hapū, iwi and Māori aspirations for Rangatiratanga.

Ways to put this into practice

- Demonstrate integrity and respect when engaging with whānau.
- Respect the right of individuals and whānau to determine their own solutions. Support them to make well-informed decisions. Allow them time to ask questions and explore options for action.
- Ask open-ended questions about what plan of action individuals and/or whānau would like to take, and offer resources, support and guidance.
- Ask the whānau (rather than assume) what tikanga and kawa (cultural protocols) they wish to follow. Honour their decisions wherever possible.

7. **Manaakitanga –** is about nurturing and looking after people and relationships. Here action is taken to enhance the mana (prestige and integrity) of each individual. Relationships are based on compassion, generosity, reciprocity and respect.

Ways to put this into practice

- Build trust with Māori individuals and whānau from the first point of contact.
- Convey a genuine, open, supportive, caring and respectful attitude.
- Offer a comfortable and welcoming environment for Māori (including the physical environment and the behaviour and attitudes of health professionals).
- Aim to pronounce Māori names and words correctly. This will convey a sense of care and respect. If you are not sure how to pronounce someone's name, ask.

8. **Kaitiakitanga –** refers to the guardianship or protection of people, taonga (cultural treasures), and the environment so that they continue to thrive from generation to generation.

   Ways to put this into practice

   - Recognise that safety should always be the number one priority. Ensure processes are in place to keep all vulnerable people, and staff safe.
   - Be aware that the physical, emotional and spiritual safety/wellbeing of mothers is important for the safety of their children.
   - Respect and enable (wherever possible) the expression of Māori and other cultural practices and beliefs.
   - In order to safeguard present and future generations, ensure that there is a sustained commitment within your practice to address violence within whānau.

9. **Oritetanga –** refers to equality.

   Ways to put this into practice

   - Deliver the same high quality service to everyone, no matter what their age, gender, ethnicity or social background.
   - Understand that some whānau may have minimal information about the health sector and your role may be to empower and inform them of their rights and responsibilities.

10. **Kotahitanga –** exists when people work together in unity to support and achieve common goals.

    Ways to put this into practice

    - Take a collaborative approach to keep victims of violence within whānau safe. This should involve information sharing and planning with other professionals, community providers and whānau members.
    - Build a sense of partnership with whānau, hapū and iwi, and Māori organisations in your community.

11. **Pukengatanga** – involves the achievement of progressive milestones and skills, enabling individuals to reach their goals and their potential.

    Ways to put this into practice

    - Work with the individual, whānau, and other professionals (where relevant) to identify achievable plans to ensure short, medium and longer term safety for victims of family violence. After short term safety is established, support them to take the next step.
    - Ensure that individuals/whānau are aware of their options so that they have the opportunity to make informed choices and develop their own plans for the future.

12. **Te Reo** – refers to the Māori language, which is an official language of New Zealand. Its preservation is essential as it is through language that Māori beliefs and traditions are passed from generation to generation. Te Reo carries with it the 'life force' (mauri) of the culture.

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

    Ways to put this into practice

    - Aim to pronounce Māori names and words correctly. This will convey a sense of care and respect. If you are not sure how to pronounce someone's name, ask.

- Use Te Reo in signage and posters, and have key documents and resources available in Te Reo.
- Embrace opportunities to learn and use Te Reo and to understand the meanings of key Māori concepts (such as these 12 kaupapa).
- Be aware that Māori words often have multiple layers of meaning and convey perspectives and concepts that cannot always be directly translated into English.

The *Increasing Violence Intervention Programme (VIP) Programmes' Responsiveness to Māori* resource encourages health care providers to seek training to enhance their cultural competence when working with Māori. See www.health.govt.nz/publication/increasing-violence-intervention-programme-vip-programmes-responsiveness-maori

APPENDIX 3 - Pacific Peoples and Family Violence

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

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

What family violence means in a Pacific context

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

Risk factors for family violence amongst Pacific people

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

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

Protective factors for Pacific families

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

Transformation and restoration

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

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

Principles for action

1 Victim safety and protection must be paramount

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

Actions and behaviours to ensure victim safety and protection:

- routinely enquire about experience of IPV for women, and about intimate partner violence if there are signs and symptoms for men. Be alert for indication of abuse and neglect among children
- follow the health and risk assessment procedures outlined, and, wherever possible, involve the person in determining the plan of action they would like to take
- 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 or mainstream family violence advocates.

2 The provision of a Pacific-friendly environment

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

Actions and behaviours that contribute to Pacific people feeling comfortable:

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

3 The provision of culturally safe and competent interactions

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

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

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

4 A collaborative community approach to family violence should be taken

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

Actions and behaviours that contribute to a collaborative intersectoral approach:

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

APPENDIX 4 - Recommended Intimate Partner Violence Routine Enquiry for Different Clinical Settings

The Family Violence Assessment and Intervention Guidelines offer a range of recommended routine enquiry guidelines for various services, which are repeated here. Each service and unit may develop a unit-level procedure, specifying where, when, how often and by whom screening 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.

What should women be questioned about?

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

When should screening for abuse occur?

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

What should patients be questioned about?

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

APPENDIX 5 - Signs and Symptoms Associated with Intimate Partner Violence (IPV)

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

Physical injuries	**Illnesses**
Injuries to the head, face, neck, chest, breast, abdomen or genitals	Headaches, migraines
Bilateral distribution of injuries, or injuries to multiple sites	Musculoskeletal complaints
Contusions, lacerations, abrasions, ecchymosis, stab wounds, burns, human bites, fractures (particularly of the nose and orbits) and spiral wrist fractures	Gynaecological problems
Complaints of acute or chronic pain, without evidence of tissue injury	Sexually transmitted infections.
Sexual assault (including unwanted sexual contact by a partner)	Chronic pain/undiagnosed causes for pain
Injuries or vaginal bleeding during pregnancy, spontaneous or threatened miscarriage, low birth weight babies	Malaise, fatigue
Multiple injuries, such as bruises, burns, scars, in different stages of healing	Depression
Substantial delay between time of injury and presentation for treatment	Insomnia
Tufts of hair pulled out	Anxiety
Strangulation/choking	Chest pain, palpitations
	Gastrointestinal disorders
Patient's manner	Hyperventilation
Hesitant or evasive when describing injuries	Eating disorders
Distress disproportionate to injuries (e.g., extreme distress over minor injury, or apparent lack of concern about a serious injury)	**Serious psychosocial problems**
Explanation does not account for injury (e.g., 'I walked into a door')	Alcohol abuse or addiction
Different explanation for same injury at different presentations	Severe depression
	Drug abuse or addiction
	Suicidal ideation or attempts
	Continued alcohol, tobacco or substance abuse during pregnancy
	Inappropriate attempts to lose weight, development of eating disorder during pregnancy
	History
	Record or concerns about previous abuse (e.g., injuries inconsistent with explanation)
	Substantial delay between time of injury and presentation for treatment
	Multiple presentations for unrelated injuries

Source: Injury Prevention Research Centre 1996

APPENDIX 6 - Guidelines for Identifying Victims of Abuse (Step 1)

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

Asking Adults About Possible Abuse

Framing statements:

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

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

'I notice…I'm worried…" statements, e.g. "I notice you look sad/have a bruise. I'm worried someone might be hurting you/have caused this.'

Recommended intimate partner violence routine questions:

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

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

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

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

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

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

Confidentiality
In many health care settings, confidentiality may have been explained or be understood already, as part of the provider–patient relationship (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').

APPENDIX 7 - 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 five good principles to follow:

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

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

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

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

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

*Inform***:** let them know that their experiences of violence may be relevant to their health, that help is available, and that you will support them and help them to consider their options.
'Family violence happens in all kinds of relationships.'
'This sort of behaviour (abuse) can affect your health in many ways.'
'Without getting help, this behaviour (violence) can keep happening, and it can get more frequent, and more serious.'
'You are not to blame, but exposure to violence in the family can emotionally and physically hurt your children or others in the family who are dependent on you.'

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

Signs and symptoms indicative of IPV, no disclosure (see Appendix 5)
If 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
- 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 (egg, 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.

APPENDIX 8 - Guidelines for Health and Risk Assessment (Step 3)

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

Thorough risk assessment needs to be conducted prior to the development of appropriate intervention plans. Health care providers 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

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 threated you with a weapon?
8. Do you believe your partner is capable of killing you?
9. Is your partner constantly jealous of you? If yes, has the jealousy resulted in violence?
10. Have you recently left your partner, or are you considering leaving?
11. Has your partner ever threatened to commit suicide?
12. Have you ever considered hurting yourself/suicide?
13. Is alcohol or substance misuse a problem for you or your partner?
14. Have the children seen or heard the violence?
15. Has anyone physically abused the children?

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

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

Sexual and reproductive health assessment

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

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

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 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 VIP 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 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?

APPENDIX 9 - 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 DHB’s Emergency Procedures Flipchart. This may include calling the operator on 777 to summon assistance from on-site security or the Police.

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

High Risk

Indicators of high risk

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

- Life threatening injuries.
- Children, elders or 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?

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?

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 1993 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 11).

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 partner abuse is presented in Appendix 10.
- Make sure the person has information about, and contact details for, other legal and support options that may assist them.

Further information is available regarding interagency information sharing from the Privacy Commission website, follow the following links to the *Sharing personal information of families and vulnerable children: A guide for inter-disciplinary groups* (www.privacy.org.nz/assets/InteractiveEscalationLadder/Escalation-Ladder-FINAL-HiRes.pdf) and the *Escalation ladder* regarding 'Sharing information about vulnerable children' (www.privacy.org.nz/how-to-comply/sharing-information-about-vulnerable-children).

Moderate risk

If you do not think the person is in imminent danger or at high risk, but there is evidence of violence within their relationship (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.
- 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 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.

APPENDIX 10 - Safety Plan – Resource

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

1. Avoiding injury, escaping violence

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

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

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

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

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

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

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

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

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

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

2. Preparation for separation – advance arrangements and flight plans

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

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

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

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

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

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

What to take

- documents for yourself and children
- keys to house, garage, car, office
- clothing and other personal needs
- a phone or phone card and list of important addresses and phone numbers
- for children, take 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.

Security

Consider installing outside lighting that lights up when a person comes near your house at night. If possible, use different shops and banks to those you used when you lived with your ex-partner.

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

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

Contact the Electoral Enrolment Centre on 0800 367656 or contact online and ask for your name and address to be excluded from the published electoral roll. Tell neighbours that your partner does not live with you, and ask them to call the Police if s/he is seen near your house.

From: Auckland Domestic Violence Centre. Safety Plan.

APPENDIX 11 - Guideline for Notification 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 DHB staff to contact the police without consent under Rule 11 of the Privacy Code 1994.

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

Disclosure must only be to the extent necessary for the particular purpose. The purpose of disclosure should be made clear so the person receiving the information (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 DHB 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 Charge Nurse.

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;

1. Advise the person of the need to notify the police and that an ongoing safety plan will be discussed
2. Inform security and Duty Manager (if after-hours) of the concerns regarding safety
3. Ring the Police (111) and advise them of the current situation with information disclosed
4. Refer to the Appropriate Access to Health Information Policy" which is available on intranet under Forms and Templates or attached to this policy
5. On the arrival of the Police to the department, the Police should complete the Consent for the Collection and Release of Information form.
6. Once this form is completed, staff can provide the appropriate and relevant information without concerns regarding breach of privacy. Information shared should be related to the referral to the Police and should include:
    a. The disclosure of abuse, including all relevant history and verbatim statements
    b. The injuries sustained pertinent to their inquires
7. 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:

1. Advise the individual (abused person) of the need to notify the police and that an ongoing safety plan will be discussed
2. Inform security and Duty Manager (if after-hours) of the concerns regarding safety within department
3. 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
4. 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.
5. If the report/information provided to the Police includes information disclosed by a person then complete a Consent for the Collection and Release of Information form.
6. Once this form is completed, staff can provide the appropriate and relevant information without concerns regarding breach of privacy. Information shared should be related to the referral to the Police and can include:
    a. The disclosure of abuse
    a. The injuries sustained as pertinent to their inquires
7. Facilitate the introduction of the Police to the abused person and ensure privacy for their ongoing discussions.

APPENDIX 12 - Guideline for Referral and Follow Up

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

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

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

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

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

a) 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 (see APPENDIX 16).

b) Follow-up

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

Moderate risk, or persons with ongoing safety concerns

a) Referral

- If possible in your area, make contact *during* the consultation with a refuge or other 24-hour family violence service.
- Suggest the person consider obtaining a protection order through the Family Court. Refuge and other family violence prevention advocates can provide assistance with obtaining such orders.
- Identify an ongoing support system (for example, family, friends who may help).

- Ensure that the person has a list of contact numbers for specialist family violence agencies, and a means of contacting them.
- Provide abused person with information that will help them plan for safely leaving an abusive situation.
- Ensure the person is aware of the legal support available to them, and how to access it.
- If the person feels that it is safe, give them a copy of the safety plan in APPENDIX 11 - . If they don't want to take a copy, talk through the contents of the plan.

b) Follow-up

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

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

Sharing of information between clinicians

Developing and implementing safe and appropriate systems for sharing information about IPV between clinicians (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.'

After disclosure of current or past IPV

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

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

Responding to abused persons at follow-up

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

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

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

  'I am concerned about you, and your health and safety.'
- Repeat the routine enquiry questions.
- 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.

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

1. <u>Provide the adult with referral information for a specialist family violence support agency</u>
   The intervention selected may be to provide the disclosing adult with information only. The material provided needs to include information about the impact that witnessing IPV can have on children.

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

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

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

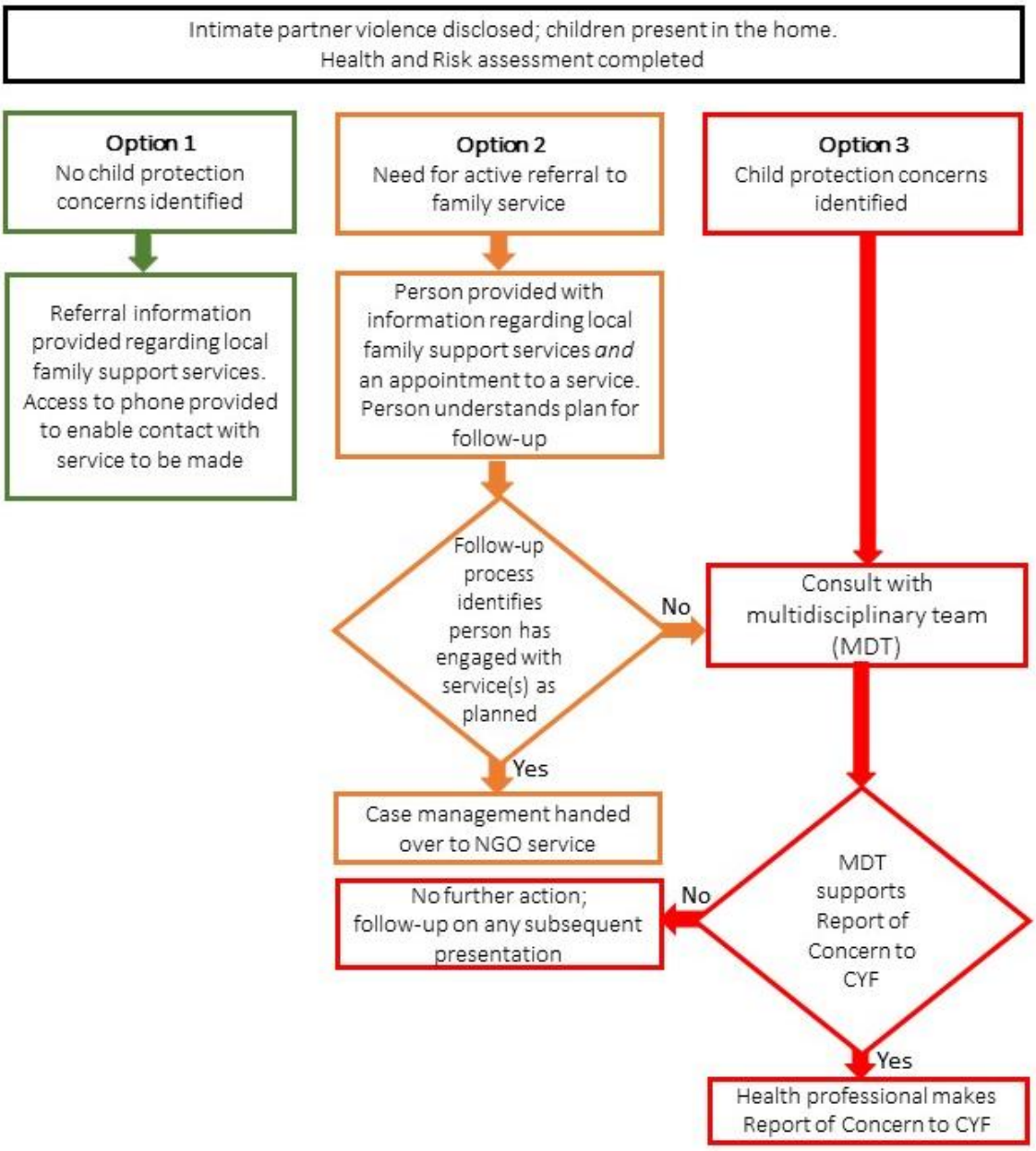
   This intervention requires the health professional to contact an appropriate local family support agency during the episode of care and set a mutually agreed appointment time between the

person and a worker at the family support service. This intervention allows for the adult to take responsibility for engaging with the family support service.

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

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



APPENDIX 13 - Guidelines for Documentation of Intimate Partner Violence (Step 6)

6.1 Documentation Steps

Record the disclosure on the Intimate Partner Violence Documentation Form. 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".

6.1.1 Record history obtained. Specify aspects you saw and heard, and which were reported or suspected. Use the individual's words as much as possible. Use quotation marks for specific disclosures where appropriate, e.g. "John punched me".
6.1.2 State the identified perpetrator's name and relationship to the person
6.1.3 Mark site(s) of old and new injuries on the body injury map
6.1.4 Describe estimated age of injuries, coloration and measure size
6.1.5 For suspected cases of abuse, record your opinion as to whether the injury is consistent or inconsistent with the person's explanation
6.1.6 Note the action taken by the clinician, referral information offered and follow-up arranged
6.1.7 Include the date, time, a legible signature and designation
6.1.8 Indicate in notes discreetly that IPV has been disclosed. For example, ticking the coded box in the notes
6.1.9 Forward the IPV Identification/Documentation Form to medical records as outlined in Point 6 (Page 11).

6.2 Collection of Physical Evidence

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

- 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.

6.3 Photographs

The use of photographs to document injuries may be appropriate in some circumstances. If photographs with the potential to be used as evidence in legal proceedings are taken then the Digital Photography Procedure (Patient Clinical Images) must be adhered to.

APPENDIX 14 - Safety and Security Guidelines

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.2. Complete the name suppression process as above if appropriate

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

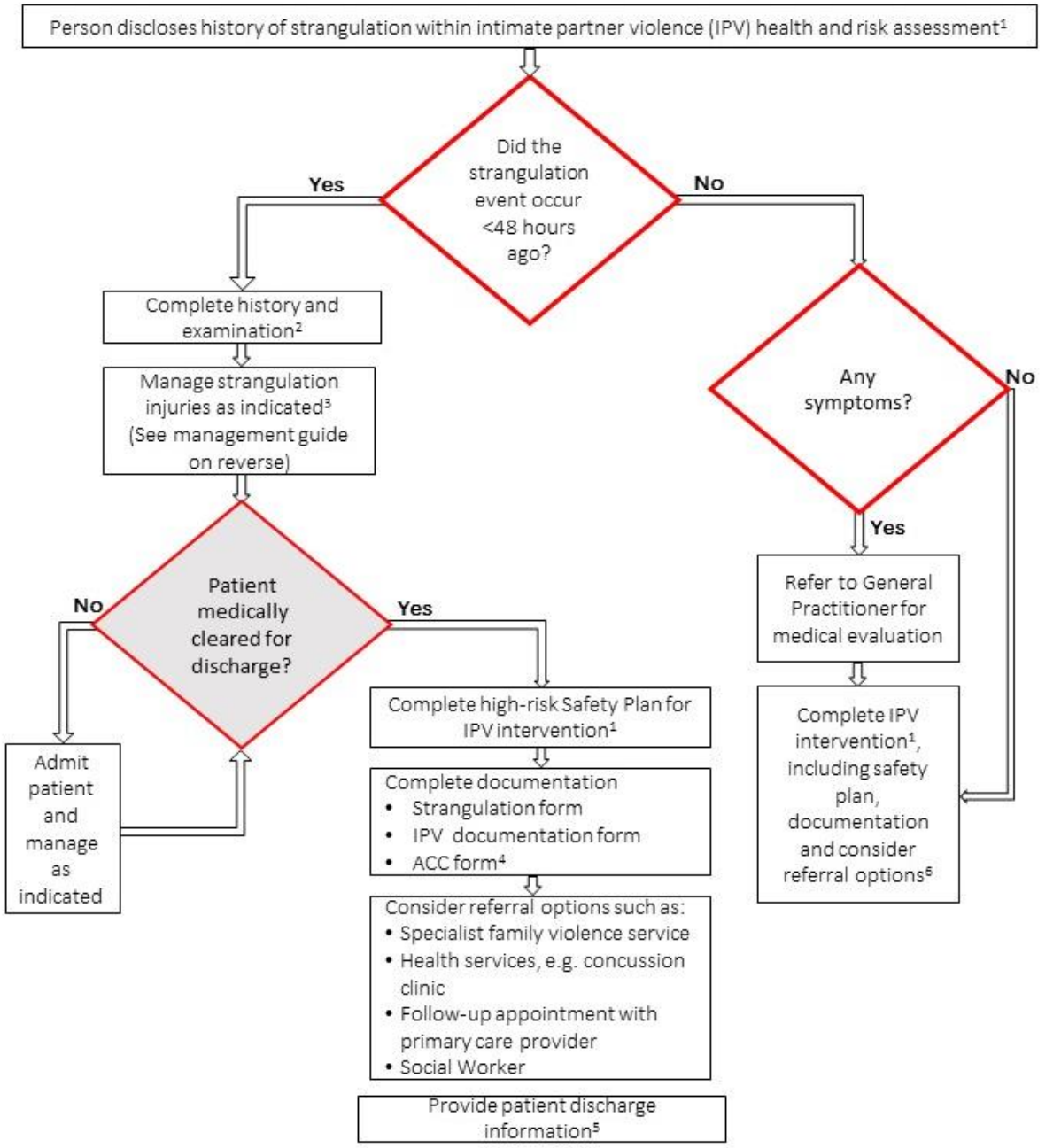
3.3.1. Duty Manager
3.3.2. Security +/- the Police (if risk is considered high by department staff and security)

3.4. The discharge plan may include the leaving the ED / ward or other department by a safe route, in consultation with security staff.

3.5. Document the discharge plan on the Intimate Partner Violence Documentation Form.

3.6. Advise the Duty Manager of the discharge outcome.

APPENDIX 15 - Clinical Guideline: Assessment and Management of Strangulation



Notes

1. Family Violence Assessment and Intervention Guideline (2016) details the intimate partner violence intervention
2. Standardised strangulation documentation form includes items that should be included within assessment and examination
3. Management may be guided by head injury tools such as the Westmead Head injury assessment and management tool
4. Complete ACC form including mechanism of injury/assault and associated health effects. READ code TL32.
5. Discharge information can include strangulation advice sheet, head injury 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)

Strangulation (choking) management

Management of strangulation depends upon the mechanism of injury, clinical picture of the patient and time since the strangulation event. The post-strangulation documentation (see Appendix M) form guides clinicians through the processes of care. Be aware that many victims of strangulation have minimal symptoms and signs following the event.

- If patient is alert, orientated, no loss of consciousness, no signs of compromised airways +/- superficial injuries to neck:
  - ensure home support
  - provide post-strangulation information sheet to patients
  - consider referral to primary care for re-evaluation of signs and symptoms that may emerge within 48 hours of the event.

- History of loss of consciousness more than a few hours ago, but is currently clinically stable -
  assess and treat as for any other head injury:
  - ensure home support
  - provide post-strangulation information sheet to patient
  - consider referral to primary care for re-evaluation of signs and symptoms that may emerge within subsequent days.

- Significant neck pain, dysphagia or dysarthria – discuss/manage with emergency department support

- Reduced level of consciousness, confusion or compromised airway – usual emergency care provided and refer to the emergency department for urgent assessment/management

APPENDIX 16 - Strangulation Discharge Information: Discharge Advice to Patients and Their Families and Friends

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

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

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

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

Milder problems

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

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

What you can do to help yourself

Medication and drugs:

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

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

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

Driving: DO NOT drive for at least 24 hours.

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

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

<u>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</u>

TARANAKI DISTRICT HEALTH BOARD

Violence Intervention Programme

Taranaki DHB

Older Adults and Vulnerable Adults Abuse and Neglect Policy

VIP
violence intervention programme

Funded by Ministry of Health & TDHB

TARANAKI DISTRICT HEALTH BOARD

Contents

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Older Adults and Vulnerable Adults Abuse and Neglect

1. Overview

This document covers topics relating to the definition, identification and management of abuse and neglect of vulnerable adults and older adults within Taranaki District Health Board (Taranaki DHB).

The Family Violence Act 2018 positions all DHBs as Family Violence Agencies. The Law emphasize safety, early intervention and requires health professionals having an understanding of the dynamics of family violence. It also mandates DHBs to share personal information to better respond to family violence and help protect older adults, vulnerable adults, tamariki and whānau from harm.

1.1 Purpose

The purpose of this document is to:

- Promote the rights and well-being of older adults and vulnerable adults.
- Provide guidelines for the identification of abuse and/ or neglect of older adults and vulnerable adults.
- Provide guidelines for the resolution of identified (or suspected) situations of older adult and vulnerable adult abuse.
- Acknowledge that this is a community and social health issue.

1.2 Scope

All Taranaki DHB health professionals working with older adults and/ or vulnerable adults are required to follow the policy outlined herein for all cases of alleged or suspected abuse or neglect of patients/ clients that they become aware of, whether or not that person is under their direct care. Abuse and neglect of an older and / vulnerable adult is not acceptable. (MoH, Elder Abuse Guidelines, 2007)

Note:

a) This policy applies only to persons aged 18 and over. A TDHB Child Protection Policy exists for children under this age.

b) This policy applies in situations that are outside the scope of the TDHB Intimate Partner Violence Management Policy.

1.3 Terms & definitions

Term	Definition
Age Concern Taranaki (Elder Abuse Response Service - EARS)	An autonomous local NGO concerned with all welfare aspects of the older person and is affiliated to a National Body "Age Concern New Zealand" which maintains various service contracts (e.g. Elder Abuse Response Contract) with the Ministry of Health.
Client/Patient	Individual suspected/identified as being the subject of abuse or neglect.
Elder Abuse	See page 3.
EPOA (Property)	Enduring Power of Attorney for Property matters.
EPOA (Personal Care & Welfare	Enduring Power of Attorney for Personal Care & Welfare (special conditions attached).
HCP	Health Care Professional.
PPPR Act	Protection of Personal and Property Rights Act (1988).
MDT	Multi-disciplinary Team - consisting of medical, nursing and allied health professionals involved in the patient's care.
Carer	A family member, relative, friend or paid helper who regularly looks after the older adult or vulnerable adult

Terms & definitions continued

Term	Definition
OAVAAP	Older Adult and Vulnerable Adult Abuse Prevention.
Taranaki DHB VIP Governance Group	Taranaki District Health Board VIP Governance Group – with membership including senior managers from the Medicine and Health of Older People Service and Allied Health Management - provide guidance and support to the OAVAAP Response.
Safeguarding Vulnerable Adults Taranaki Advisory Panel (SVAT)	Safeguarding Vulnerable Adults Taranaki Advisory Panel – with membership including Taranaki DHB, NZ Police, Age Concern, Disability representatives - a confidential forum where complex situations of abuse are presented by Taranaki SVAT members for consideration and guidance.
Vulnerable Adult	A person who is unable to withdraw himself or herself from the care of another for reasons specified in section 2.
Taranaki DHB/EARS Advisory Panel	Taranaki DHB Resource Team for Elder Abuse

2. Legal Obligations - Crimes Act

- Under the Crimes Amendment Act 2011 and Family Violence Act 2018 Taranaki DHB staff may be under a legal duty to take steps to protect vulnerable adults from ill treatment and neglect.
- A vulnerable adult is a person who is:
  'unable to withdraw him or herself from the care of another, by reason of:
  - detention
  - age
  - sickness
  - mental impairment
  - any other cause.'

    (Crimes Amendment Act (No 3) 2011 Part 1 4 (1) retrieved from http://www.legislation.govt.nz/act/public/2011/0079/50.0/whole.html#DLM3650006)
- Section 151 provides that anyone who has actual care or charge of a vulnerable adult is under a duty to 'provide that person with necessaries' *and* to 'take reasonable steps to protect them from injury', (Crimes Amendment Act (No 3) 2011).
- Under Section 195 anyone who has 'care or charge' of a vulnerable adult or is a 'staff member of a hospital, institution or residence' where a vulnerable adult resides may be criminally liable if their conduct 'is likely to cause suffering, injury, adverse effect to health or any mental disorder or disability' to the vulnerable adult, (Crimes Amendment Act (No 3) 2011).
- Health care professionals have a duty of care to ensure vulnerable adults and older adults are discharged to a safe environment.
- Section 195A specifies that a person 'who is a member of the same household' as a vulnerable adult or 'a staff member of a hospital, institution or residence' where a vulnerable adult resides *and*
  - has frequent contact with the vulnerable adult *and*
  - knows the vulnerable adult is at risk of death, grievous bodily harm or sexual assault as the result of an unlawful act by another person or an omission by that person to perform a legal duty *and* fails to take reasonable steps to protect the vulnerable adult from that risk may be criminally liable, (Crimes Amendment Act (No 3) 2011).

- Criminal liability will only arise if the failure to protect is a 'major departure from the standard of care expected of a reasonable person', (Crimes Amendment Act (No 3) 2011 retrieved from http://www.legislation.govt.nz/act/public/2011/0079/50.0/whole.html#DLM3650006)

3. What is 'Older Adult & Vulnerable Adult Abuse & Neglect'?

3.1 Definitions

- *"Older Adult Abuse and Vulnerable Adult Abuse", f*or the purposes of this document are defined in accordance with the Ministry of Health Elder Abuse – Family Violence Intervention Guidelines (FVIG), December 2007.

For the purposes of this document "*Older Adult and/or Vulnerable Adult Abuse"* is defined as:

"A single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to the older or vulnerable person".

- Adult abuse occurs when an older person aged 65 years plus, or vulnerable person (18 and over) experiences harmful physical, psychological, sexual, material or social effects caused by the behaviour of another with whom they have a relationship implying trust.
- A person of any age experiencing any form of abuse is vulnerable. They may or may not fit the Crimes Amendment Act (2011) criteria of '*a vulnerable adult.'*

3.2 Older Adult Abuse and Vulnerable Adult Abuse

It is noted that there is a clinical impression of abuse being linked to "carer stress" and "burden of care". Awareness of "carer burnout" is required in context of abuse and/or neglect and attention should also be given to assessment of carer relief and carer support.

Type of Abuse	Definition
Physical	Infliction of physical pain, injury or force. Includes medication abuse and inappropriate restraint or confinement.
Psychological/ emotional	Behaviour which causes anguish, stress or fear (including verbal abuse, intimidation, discrimination, harassment, damage to property, threats of physical or sexual abuse and the removal of decision making powers).
Sexual	Sexually abusive behaviours including forced, coerced or exploitive sexual behaviour or threats, including sexual acts imposed on a person unable to give consent or to understand.
Material/ financial	The illegal or improper exploitation and/or use of funds or other resources which are the property of the older or vulnerable person and include financial abuse by a person holding Enduring Powers of Attorney (EPOA).
Institutional	Institutional abuse occurs when an institution actively or passively allows, or accepts, any form of abuse or neglect to occur. This may arise from the action or inaction of an individual as an employee, or it may be embodied in organisational systems, which fail to provide adequately for the safety and well-being of the individual person.

3.3 Definition: Older Adult & Vulnerable Adult Neglect

Older adult or vulnerable adult neglect occurs when an older (aged 65 years plus) or vulnerable adult (aged 18 years plus) experiences harmful physical, psychological, material and/ or social effects as a result of another person failing to perform functions or tasks which are a reasonable obligation of their relationship to the older or vulnerable person and are warranted by the older or vulnerable person's unmet needs.

The table below explains the forms this neglect may take:

Type of Neglect	Description
Active	Conscious and intentional actions by a carer denying/failing to provide basic necessities consequently resulting in harmful physical, psychological, material and/or social effects.
Passive	Refusal or failure by carer, because of inadequate knowledge, infirmity or disputing the value of the prescribed services, to provide basic necessities consequently resulting in harmful physical, psychological, material and/or social effects.

3.4 Definition: Older Adult & Vulnerable Adult self-neglect

- Older Adult and Vulnerable Adult self-neglect occurs when an older (aged 65 years plus) or vulnerable person (aged 18 years plus) experiences harmful physical, psychological, material and/ or social effects as a result of failing to provide him/ herself with the basic necessities for physical and/ or mental well-being.
- It is necessary to assess whether a situation is one of neglect by others, self-neglect or a combination.
- Self-neglect that is solely the result of an informed choice freely made by a competent person does not fall within the bounds of this policy.

4. Competency

Competent adults are entitled to make choices that have a negative impact on their health and wellbeing, or that may seem to be the 'wrong' choice when measured against the standards and values of others. Where there is any doubt as to a person's capacity to understand the situation they are in or foresee the consequences of their choices, then a competency assessment is recommended.

5. Enduring Power of Attorney

When the alleged abuser also holds EPOA or Welfare Guardianship for the older or vulnerable person advice will need to be sought from appropriate Taranaki legal services.

6. Principles

6.1 Principles which guide prevention of & response to older adult and vulnerable adult abuse & neglect

- The safety of the older or vulnerable person is paramount.
- Any action should not cause more harm than the abuse or neglect, nor should it undermine the rights of the older person/ vulnerable person or their carer.
- The safety of those working with abuse should be protected. Do not work in isolation.

- Actions that are supportive and empowering assist older people and vulnerable people experiencing abuse to take control over their lives.
- Each adult has distinctive family/ whānau, cultural and other values that should be respected and addressed appropriately.
- A collaborative and inter-sectorial approach enables solutions to be found that are meaningful to the person and provides support for those working with older adult and vulnerable adult abuse and neglect.
- Consult, consult, consult. Do not work in isolation.

(*Ministry of Health - Family Violence Intervention Guidelines – Elder Abuse and Neglect 2007)*

7. Assessing & Reporting Abuse

7.1 Cultural perspective

Appropriate cultural consultative processes will be followed, so that the most skilled and appropriate cultural person is involved in care and proceedings. Patient's consent will be obtained if patient has competency. Appropriate literacy assessment will be conducted to assess English proficiency and also assessment of any hearing impairment. Where required a qualified interpreter will be used when interviewing older people/ vulnerable people with hearing impairment or for those who have limited or no English language skills.

7.2 Sharing Information

Patients are provided with an explanation from staff of how health information is shared with other members of multidisciplinary health teams and General Practitioners (GPs). (FV Act 2018)

7.3 Documentation

- Concerns regarding possible abuse or neglect should be clearly documented in the patient's clinical record. This could include:
  - Unsolicited statements made by the patient, or others, explaining injuries which are at odds with physical observations of injuries.
  - Behaviours and reactions to treatment.
  - Assessments showing inconsistencies in statements or condition of patient.
  - Statements of others who have observed the patient at or just prior to admission.
  - Direct observation by Taranaki DHB clinical staff of a possible abusive situation between a patient and another person.

Note: All information must be recorded objectively.
Incorrect or unsubstantiated records can potentially lead to legal action.

8. Social Work Intervention

8.1 Responsibility

All Taranaki DHB social workers according to their service specifications.

8.2 When to refer to Health Social Workers or EARS Social Workers

In cases where there are indicators of older adult or vulnerable adult abuse or neglect.

8.3 Process

Each case is considered individually, taking into account the specific context in which it is occurring.

- The social worker will act on the premise of 'do no more harm'.
- The social worker will consult with a VIP member/ TDHB EAR Panel/ SVAT Advisory Panel and with the MDT in all cases where abuse is alleged.
- The social worker and nominated TDHB EAR Panel member/VIP Coordinator will draw together an appropriate SVAT Advisory Panel to review the situation as soon as possible after a situation has been highlighted in order to develop a well-informed safety net/plan for the person
- The social worker may also bring any complex case of alleged abuse to the SVAT Advisory Panel's monthly meeting for consideration and guidance where there is uncertainty about the most appropriate process to follow.

8.4 Safety

- In the community setting do only visit a home with the Police where you believe there may be violence occurring or where you understand a dangerous person may be present.
- Make sure you always have a safety plan when preparing to visit. Tell your team leader of your visiting plan, park your car on the road where you will be able to drive away, lock your car and keep the keys under your control. Be aware of exits and having clear access to exits when a situation escalates and you need to you need to leave the property.
- Do not discuss concerns or actions with a carer or family/ whānau member if you are uncomfortable or concerned that doing so will place you or others in danger.
- Be aware of warning signs of aggression, including threatening comments to you or others, attempts to block your exit and increasing agitation or irritation.
- Remove yourself and other support staff who are with you, i.e. cultural staff or interpreter promptly if you feel at risk.
- If you feel you or another person is in immediate danger, phone 111.
- Document concerns and notify incidents.

8.5 Procedure

Step	Action
1	If there are indicators of abuse - See Flowchart p.6
2	If the person does not agree to referral, the health care professional consults with their MDT and engages with social work regarding the vulnerable adult and duty of care.
3	If there is doubt as to legal responsibility the health care professional and/or social worker consults with Taranaki legal service.
4	If the person meets the criteria of vulnerable adult the health care professional follows legal advice to report concern to the Police.
5	If the person does not meet the criteria of vulnerable adult, the health care professional is to provide the client with the Age Concern brochure or the Health and Disability Advocate contact information or other as appropriate.
6	If the person consents to referral, the social worker consults with the relevant community Older Adult (EARS) or SVAT Advisory Panel or cultural services and
7	Complete the TDHB *Older Adult or Vulnerable Adult Risk Assessment and Documentation Form* and post it in the internal mail to the VIP Co-ordinator, TDHB.

Older Adults and Vulnerable Adults Abuse and Neglect

8.5 Procedure continued

Step	Action
8	Where the assessment is to occur in the community setting the social worker may co-work with a social work colleague and/ or other health care professional including their GP and/ or appropriate community agencies for example Age Concern , IDEA Services, the Health and Disability Commission or the Police in order to ensure the safety of the worker as well as the safety of the client.
9	Consider whether direct action to remove a client from a high risk situation needs to occur.
10	Appropriate to their Service, the social worker conducts an initial risk assessment with the person and whanau/care-giver as indicated. The risk assessment will inform the process.
IF ABUSE AND NEGLECT IS HAPPENING	
11	Where indicated notification to the Police regarding ill-treatment or neglect of an older/ vulnerable adult is to occur.
12	If the person is competent, the social worker works with the client and family/ caregiver/ multi-disciplinary team Taranaki DHB VIP/ EARS Advisory Panel and/or Safeguarding Vulnerable Adults Taranaki (SVAT) Advisory Panel including appropriate community agencies to develop a well-informed safety plan. The situation is then reviewed at intervals until closure.
13	If the person is not competent the social worker engages with the EPOA, family/whanau, and/or Taranaki Community legal services to follow the legal processes (EPOA, PPPR Act 1988) in conjunction with MDT/ VIP/EARS/SVAT Advisory panels including appropriate community agencies to ensure client safety.
IF ABUSE AND NEGLECT IS NOT HAPPENING	
14	Report back to referrer, document findings objectively and discharge client.
15	Documentation is objective clear accurate and timely throughout this process reflecting Taranaki DHB *Clinical Documentation* policy. No unsubstantiated statements.

The social worker may bring the client's situation to the Safeguarding Vulnerable Adults Taranaki (SVAT) Advisory Panel at any time through their intervention for guidance and assistance.

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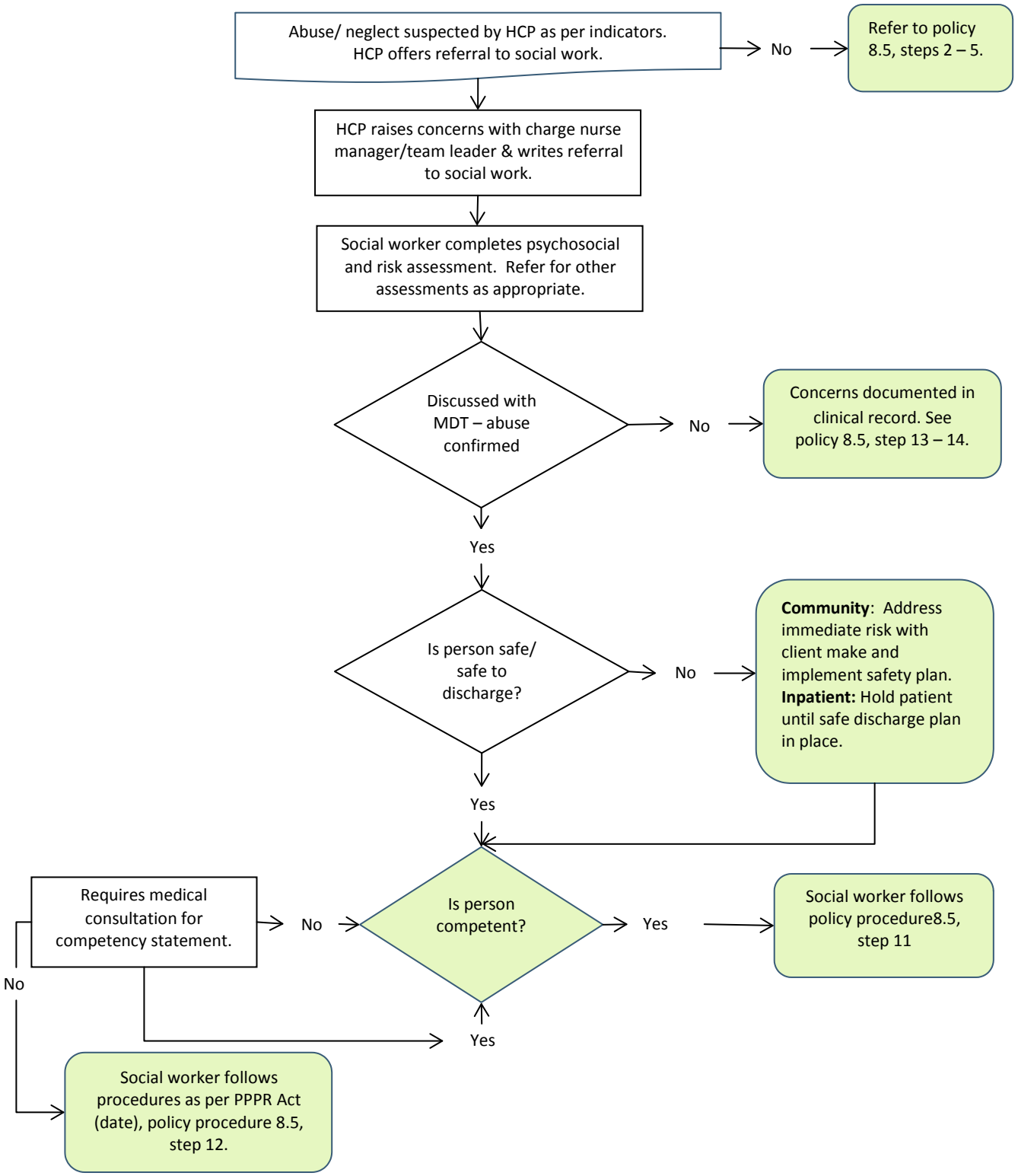
9. Assessing & Reporting Abuse - Flow Chart



Accurate documentation is paramount during this process

10. Staff Training to Manage Older Adult & Vulnerable Adult Abuse & Neglect

10.1 Training and education

- **All clinical staff working with older and vulnerable adults** are required to demonstrate competence in responding to people at risk of experiencing abuse.
- Each service will require their staff to complete the e-learning module regarding working with older and vulnerable adults and recognising the indicators of abuse. The 30 minute on-line Ko Awatea course: Vulnerable Adults is available to all staff.
- Each service will provide adequate training opportunities to enable and support their staff to achieve competence in following procedure regarding older adult and vulnerable adult abuse.
- Social workers working with adults and older adults are required to demonstrate competence in working with patients/clients who are vulnerable and who display indicators of abuse. They are required to be proficient in older adult and vulnerable adult abuse assessment and intervention.
- Clinical leaders or senior clinicians will audit the competency of staff members annually as a part of their clinical practice audit, and provide evidence of education achieved and audits undertaken to the VIP Coordinator for reporting purposes.

10.2 Staff understanding and awareness

Taranaki DHB FVIP Governance Group The governance group has leaders of adult services including the oversight of the Operational Manager Older Persons Health, Allied and Community Services. This group meets quarterly to support the role of the VIP co-ordinator and to ensure that the Ministry of Health Family Violence Intervention Guidelines – Elder Abuse and Neglect (2007) and the Crimes Amendment (No. 3) Act (2011) in relation to the protection of older adults and vulnerable adults are woven in to policy and practice within the Taranaki DHB.

Safeguarding Vulnerable Adults Taranaki (SVAT) Advisory Panel

The Safeguarding Vulnerable Adults Taranaki Advisory Panel (SVAT) will meet monthly and have senior practitioners proficient in working with older adult abuse from each service that work with older adults and vulnerable adults across the Taranaki Community, and would invite elder abuse coordinators and/or social workers from Age Concern, community workers from appropriate disability services, funding bodies and members of the Police and legal profession for consultative purposes. The group membership will vary to ensure it can ably discuss the issues scheduled.

SVAT, TDHB VIP and EARS advisory panel members, the social worker and appropriate community and funding contacts will meet informally as necessary to support workers managing situations of alleged older adult and vulnerable adult abuse.

The role of the group is to:

- **To** advocate for non-discriminatory practices and policy within the Taranaki DHB and in the wider community.

- Provide a forum for up-to-date information sharing and be a reference point for working with older and vulnerable adults and situations of abuse, and the prevention of abuse for Taranaki DHB services.
- Promote a consistent across-services approach to attending to prevention of abuse and addressing older and vulnerable adult abuse issues.
- Provide advice in the development and review of policy relating to older adults and vulnerable adults and the prevention of older adult and vulnerable adult abuse at a service and organisational level.
- Provide guidance in educating staff to be able to:
  1. Identify vulnerable adults and to know their responsibilities to vulnerable adults.
  2. To identify situations which may be older adult abuse or vulnerable adult abuse and know their part in the processes to attend to situations of alleged abuse.
  3. To recognise ageist and discriminatory behaviour –their own or others.
  4. To act to prevent abuse.
  5. To be able to document occurrences and action taken competently.
- Provide guidance on the assessment and audit of staff and service competency in this area.
- Receive, monitor and report to family violence coordinator on the audits of service competency in attending to older adult's abuse and neglect.
- Develop staff awareness and expertise in vulnerable adult response through publishing committee findings, reports, and minutes.

10.3 Link with representation

All services working with adults (18 years and over) and older adults (65 years and over) will follow consistent procedures for referral of suspected older adult and vulnerable adult abuse and neglect to social workers. Social workers will consult with the Safeguarding Vulnerable Adults Taranaki (SVAT) or TDHB EARS Advisory Panel as required.

11.Emergency Situations

In emergencies where the patient/client is at risk of serious harm (physical, psychological, sexual, financial, consequences of self-neglect, etc), urgent assessment and management is required, potentially involving Police intervention and an immediate safety plan. Any action of this type must be discussed with Taranaki Police, Legal Services and the manager of the DHB service.

12.Consent

- Decisions around the management of the patient/ client, where possible and appropriate, will happen with the consent of the patient/ client.
- Where the patient/ client lacks capacity and the patient/ client has appointed person/s as EPOA Health and Welfare and EPOA Property, the EPOA must be sighted and verified and a copy of this document placed on the patient/client's clinical record along with proof of activation of the EPOA before the person appointed as EPOA can act in that capacity. Please refer to the Informed Consent Policy.
- Where engagement of services outside Taranaki DHB is to take place, this will not be at a legal risk to Taranaki DHB.

13.Confidentiality/ Information Sharing

An assurance of confidentiality cannot be given to patients/ clients. There are many instances where the organisation is required, or authorised, to disclose confidential information (eg in legal proceedings). Guaranteeing confidentiality, and subsequently breaking that promise, can lead to a breakdown in trust.

It is recommended to state:

*"Where your safety is considered to be at risk we are **legally required, and permitted, to disclose information**."*

All information sharing will be undertaken with due regard to the Privacy Act 1993.

14.Institutional Abuse

14.1 Expectations

- All older adults and vulnerable adults will be treated with respect and dignity.
- All staff providing services are aware of the particular needs of older adults and vulnerable adults and ensure that the care provided is tailored to minimise stress and anxiety.

15.Associated Documents

Type	Description
Legislation	• Protection of Personal and Property Rights Act, 1988 • Family Violence Act 2018 • Crimes Act (No. 3) Amendment, 2011 • Health Information Privacy Code, 1994 • Health and Disability Sector Standards Regulations 2001 • Privacy Act, 1993 • Mental Health (Compulsory Assessment and Treatment) Act 1992
Taranaki DHB Resources	• Taranaki DHB Values
Taranaki DHB Policies	• Health Information – privacy – general • Intimate Partner Violence Management • Clinical Documentation • Informed Consent • Safety – Clinical Practice • Discharge of Vulnerable Patients from ED/ADU • PPP&R Competence Assessment Applications • Violence Management and Code Orange Teams • Vulnerable Adults Response Group ToR • Vulnerable Adults Response Steering Group ToR
Taranaki DHB Forms	1.VIP Older Adults and Vulnerable Adults Risk Assessment and Documentation Form 2.VIP Taranaki FV Community Specialist Services Referral Form 3.Safeguarding Vulnerable Older and Vulnerable Adults Integrated Safety Plan Documentation Form (in development)

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Associated Documents continued

Type	Description
Articles & Reports	• Promoting the Rights & Well-being of Older People & Those who Care for Them – Age Concern, 1992 • Elder Abuse – Its Detection and Management – E.A. Bowie • Living Standards of Older New Zealanders by The Ministry of Social Policy • The New Zealand Positive Ageing Strategy Action Plan, 1 July 2001 to 30 June 2002 by the Senior Citizens • *Patient Management*, Sept. 1996 • Statement of Government Policy on Adult Safeguarding, Department of Health, United Kingdom 16th May 2011 • International Year of Older Persons 1999 Final Report by the Senior Citizens Unit of the Ministry of Social Policy • Factors Affecting the Ability of Older People to Live Independently. A report for the International Year of Older Persons by Maire Dwyer, Alison Gray and Margery Renwick. • The Social Report Indicators of Social Wellbeing in New Zealand by The Ministry for Social Policy (2001) • "Dementia in New Zealand: improving quality in residential care": Disability Issues Directorate 2002. • "How should we care for the Carers", National Health Committee Report, June 1998. • Elder Abuse – Family Violence Intervention Guidelines, Ministry of Health 2007 • Health of Older People Strategy 2002