

New Zealand Standard

**Screening, Risk assessment
and Intervention for
Family Violence including
Child abuse and neglect**

NZS 8006:2006

NZS 8006:2006

COMMITTEE REPRESENTATION

Committee P 8006 was responsible for preparation of this Standard and consisted of representatives of the following:

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Barnardos New Zealand
Department of Child, Youth and Family Services
Department of Corrections
District Health Boards New Zealand
Ministry of Health
Ministry of Justice
Ministry of Social Development
National Collective of Independent Women's Refuges
New Zealand Police
New Zealand Principals' Federation
Office of the Health and Disability Commissioner (Committee Chair)
Paediatric Society of New Zealand
Preventing Violence in the Home
Relationship Services
Royal New Zealand Plunket Society (Inc.)
Victim Support
WAVES (Waitakere Anti Violence Essential Services)

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We would also like to acknowledge the contributions of Child Abuse Prevention Services, Mental Health Commission, Family and Community Services of Ministry of Social Development, Shakti Community Council Inc. and a wide range of Māori and Pacific groups during the consultation phase for this Standard.

AMENDMENTS

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New Zealand Standard

**SCREENING,
RISK ASSESSMENT AND
INTERVENTION FOR FAMILY
VIOLENCE INCLUDING
CHILD ABUSE AND NEGLECT**

NOTES

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PREFACE

The purpose of this document is to provide an appropriate Standard, which establishes the minimum requirements that should be met by individuals and agencies/services involved in working with families living with family violence, child abuse or neglect. It provides a common language for these agencies/services to screen for this behaviour, assess risk relating to these situations, and provide for safety planning interventions.

A family is a place where everyone should be safe, yet violence, abuse and neglect within the family are major problems in New Zealand. In 2005, New Zealand Police recorded over 60,000 offences and non-offence incidents involving family violence, at which over 62,000 children and young people under 17 were present or involved in some capacity. Family violence, child abuse and neglect directly affect the well-being of families and their ability to participate in society. They create high personal costs for the people involved, and significant social and economic costs to society as a whole. Research has shown, for example, that the costs from family violence in New Zealand could go as high as five billion dollars in a year.

In the face of this challenge, it is vital to support and co-ordinate the efforts of those agencies and services working to help people affected by family violence, abuse and neglect within the family. This Standard aims to provide a consistent set of guidelines for those at the forefront of dealing with the results of family violence, abuse and neglect including teachers, police, medical personnel, midwives, nurses, social workers and others. It is hoped that this will help to enable a coherent response to incidents and symptoms of family violence, abuse and neglect.

I commend the work of the Committee and the inter-sectoral approach taken to developing this Standard. As tragedies have shown us, it is critical that systems around families are integrated and working towards a common goal. I am confident that the development of this Standard will go some way towards these agencies working smarter and more collaboratively which will make a difference for families exposed to or experiencing violence, child abuse and neglect.



Howard Broad

Commissioner of Police

May 2006

REFERENCED DOCUMENTS

Reference is made in this document to the following:

Publications

Age Concern New Zealand. Promoting the Rights and Well-being of Older People and Those who Care for Them. 1992

Age Concern New Zealand. Elder Abuse and Neglect: A Handbook for those working with older people. Auckland. 1999

Age Concern New Zealand. Age Concern Elder Abuse and Neglect Services – An analysis of referrals 1998 - 2001. Wellington. 2002

Anderson, J., Martin, J., Mullen, P. et al. Prevalence of childhood sexual abuse experiences in a community sample of women. *J Amer Acad Child and Adol Psychiatry* 1993:32 pp. 911-919

Asiasiga, L. and Gray, A. Intervening to Prevent Family Violence in Pacific Communities: A literature review for the Offending by Pacific Peoples Project. Ministry of Justice. Wellington. 1998

Australian Government's Office of the Status of Women. The Cost of Domestic Violence to the Australian Economy: Part 1. Report prepared for the Commonwealth of Australia. 2004

Balzer, R., Haimona, D., Henare, M., Matchitt, V. Māori Family Violence in Aotearoa. Te Puni Kokiri. Wellington. 1997

Barnes, H.M. Kaupapa Māori: Explaining the ordinary. *Pacific Health Dialog* 2000:7(1) pp. 13-16

Blackburn, R. The psychology of criminal conduct. Wiley. Chichester. 2002

Bonner, M., Campillo, L. and Cosier, G. I Have Learnt How to Ask Questions – Implementing Screening for Domestic Violence Paper. Expanding Our Horizons. Sydney. 2002

Bonta, J., Law, M. and Hanson, K. The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin* 1998:122 pp. 123-142

Carter, Y.H., Davidson, L.L., Feder, G., Ramsay, J., Richardson, J. Should health professionals screen women for domestic violence? *Systematic Review. BMJ* 289:5, pp. 601-605

Cyr, M., Wright, J., McDuff, P. et al. Intrafamilial sexual abuse: brother-sister incest does not differ from father-daughter and stepfather-stepdaughter incest. *Child Abuse and Neglect* 2002:26 pp. 957-973

Department of Child, Youth and Family Services Annual Report. Wellington. 2004

Department of Child, Youth and Family Services Annual Statistical Report. Wellington. 2002

Department of Corrections. National Study of Psychiatric Morbidity in New Zealand Prisons. Wellington. 1999

Department of Social Welfare. Good Practice Guidelines for Co-ordination of Family Violence Services. Wellington. 1996

Durie, M. Whaiora Māori Health Development. Oxford University Press. Melbourne. 1994

- Edleson, J. The Overlap Between Child Maltreatment and Women Battering, Violence Against Women. 1999:5(2) pp. 134-154 as cited in University of Auckland Injury Prevention Research Centre Fact Sheet #34. Partner Abuse and Child Abuse in New Zealand. 2001
- Fanslow, J. and Robinson E. Violence against women in New Zealand: prevalence and health consequences. New Zealand Medical Journal 26 November 2004:117 (1206)
- Fanslow, J., Kotch, J. and Chalmers, D. Partner homicide in New Zealand 1978-1987. Unpublished manuscript
- Fergusson, D.M. and Lynskey, M.T. Physical punishment / maltreatment during childhood and adjustment in young adulthood. Child Abuse and Neglect 1997:21 pp. 617-630
- Fergusson, D.M., Lynskey, M.T. and Horwood, L.J. Childhood sexual abuse and psychiatric order in young adulthood. Prevalence of sexual abuse and factors associated with sexual abuse. J Am Academy Child Adolescent Psychiatry 1996:35 pp. 1355-1364
- Fergusson, D.M. and Horwood, L.J. Exposure to interparental violence in childhood and psychological adjustment in young adulthood. Child Abuse and Neglect 1998:22 pp.339-357
- Fergusson, D.M., Horwood, L.J. and Woodward, L.J. The stability of child abuse reports: a longitudinal study of the reporting behaviour of young adults. Psychological Medicine 2000:30 pp. 529-544
- Goldenring, J.M. and Cohen, E. Getting into Adolescent's Heads. Contemporary Paediatrics 1988 pp. 75-90
- Hegarty, K. and Taft A. Australian and New Zealand Journal of Public Health 2001. 26:5 pp. 437-442 in Laing, L. Routine screening for domestic violence in health services. Australian Domestic and Family Violence Clearinghouse Topic Paper. Sydney
- Heise, L., Ellsberg, M., Gottemoeller, M. 1999. Ending violence against women. In: Population Reports Series L (11). Baltimore. Johns Hopkins University School of Public Health, Population Information Program
- International Covenant on Civil and Political Rights
- International Convention on the Elimination of All Forms of Racial Discrimination
- Irwin, J. and Waugh, F. Unless they're asked: routine screening for domestic violence in NSW Health: an evaluation report of the pilot project. NSW Health Department, Sydney. 2003
- Kellogg, N. and Menard, S. Violence among family members of children and adolescents evaluated for sexual abuse. Child Abuse and Neglect 2003:27 pp. 1367-1376
- Kōrero with Roma Balzer, Acting CEO National Collective of Independent Women's Refuges Friday 14 June 2002
- Koziol-McLain, J., Gardiner, J., Batty, P. et al. Prevalence of intimate partner violence among women presenting to an urban adult and paediatric emergency department. New Zealand Medical Journal 26 November 2004:117 (1206)
- Langley, J., Martin, J. and Nada-Raja, S. Physical assault among 21-year-olds by partners. J Interpers Viol 1997:12 pp. 675-684
- Laviola, M. Effects of older brother-younger sister incest: a study of the dynamics of 17 cases. Child Abuse Negl 1992:16 pp. 409-21
- Leibrich, J., Paulin, J. and Ransom, R. Hitting Home: Men speak about abuse of women partners. Wellington. Department of Justice. 1995

- Leahy, H. Te Puni Kokiri response to Māori Family Violence. Presentation to 'Children and Family Violence Effective Interventions Now' Conference 4-5 July 1999
- Lipsky, S., Holt, V., Easterling, T.R. et al. Impact of Police-related intimate partner violence during pregnancy on birth outcomes. *Obstet Gynecol* 2003:102 pp. 557-564
- McGuigan, W. and Pratt, C. The predictive impact of domestic violence on three types of child maltreatment. *Child Abuse and Neglect* 2001:25 pp. 869-883
- Magdol, L., Moffitt, T., Caspi, A. et al. Gender differences in partner violence in a birth cohort of 21 year olds: Bridging the gap between clinical and epidemiological approaches. *J Consul Clin Psychol* 1997:65 pp. 68-78
- Mikaere, A. Māori Women: Caught in the Contradictions of a Colonised Reality. *Waikato Law Review* 1994:2 pp. 125-149
- Miller, D., Thow, N., Hall, J. et al. Documentation of family/whānau violence in New Zealand. *NZ Med J* 2005:118
- Ministry of Health. Child and Youth Mortality Committee Annual Report. Wellington. 2004
- Ministry of Health. Family Violence Intervention Guidelines – Child and Partner Abuse. Wellington. 2002
- Ministry of Health. Family Violence Intervention Guidelines – Elder Abuse. (Final draft) Wellington 2004
- Ministry of Health. He Taura Tieke: Measuring effective health services for Māori. Wellington. 1995
- Ministry of Health. Our children's health: Key findings on the Health of New Zealand Children. Wellington. 1998
- Ministry of Justice. National Survey of Crime Victims 2001. Wellington. 2003
- Ministry of Social Development. Te Rito: New Zealand Family Violence Prevention Strategy. Wellington. 2002
- Morris, A., Reilly, J., Berry, S. et al. New Zealand National Survey of Crime Victims 2001. Ministry of Justice. Wellington. 2003 pp 137-158. Web site address: www.justice.govt.nz/pubs/reports/2003/victims-survey. For Family Court Statistics for 2004 refer: www.justice.govt.nz/2006/family-court-statistics-2004.
- National Collective of Independent Women's Refuges Annual Statistics for 1999 to 2004
- National Collective of Independent Women's Refuge Fact Sheets and Resources
- National Health Committee. Screening to improve health in New Zealand. National Health Committee. Wellington. 2003
- New Zealand Children and Young Persons Service. Breaking the cycle – Interagency protocols for child abuse management. Wellington. 1996
- New Zealand Children and Young Persons Service. Breaking the cycle – An interagency guide to child abuse. Wellington. 1995
- New Zealand Guidelines Group (NZGG) and Ministry of Health. The Assessment and Management of People at Risk of Suicide for Emergency Departments and Mental Health Service Acute Assessment Settings. Ministry of Health. Wellington. 2003
- New Zealand Guidelines Group (NZGG) and Ministry of Health. Guidelines on Assessment Processes for Older People. Ministry of Health. Wellington. 2003.

- New Zealand Health Information Service (NZHIS). Morbidity and Mortality Data from the National Minimum Data Set. 1993-1998
- New Zealand Police. Identifying Red Flags – Risk Factors
- New Zealand Police. Apprehension data for “Male assaults Female” offence category, 2003. Source: www.statistics.govt.nz-Tablebuilder, and Conviction rate for “Male assaults Female” offence category 2003. Justice data Warehouse, Ministry of Justice
- Noland, V., Liller, K., McDermott, R. et al. Is adolescent sibling violence a precursor to college dating violence? *Am J Health Behav* 2004;28(suppl1) pp. S13-S23
- Preventing Violence in the Home – Safety Plan and Family Violence Intervention – Risk and Lethality Assessment. 2003
- Public Health Commission. He Mataariki: A strategic plan for Māori public health – He kaupapa whaingā roa mo te hauora tumatanui Māori. Wellington. 1995
- Ribe, J., Tegatz, J., Harvey, C. Blows to the maternal abdomen causing fetal demise: report of three cases and a review of the literature. *J Forensic Sci* 1993;38 pp. 1092-1096
- Rorie, J.L., Paine L.L., Barger, M.K. Primary care for women: Cultural competence in primary care services. *Journal of Nurse-Midwifery* 1996;41(2) pp. 92-100
- Ross, S. Risk of physical abuse to children of spouse abusing parents. *Child Abuse and Neglect* 1996;20 pp. 589-598
- Royal New Zealand Plunket Society Inc. Family Violence Policy and Protocol. 2003
- Rumm, P., Cummings P., Krauss, M. et al. Identified spouse abuse as a risk factor for child abuse. *Child Abuse and Neglect* 2000;24 pp. 1375-1381
- Ryan, G. Childhood sexuality: A decade of study. Part I – Research and curriculum development. *Child Abuse and Neglect* 2000;24 pp. 33-48
- Siegal, R.E.M., Hill, T.D., Henderson, V.A. et al. Screening for Domestic Violence in Community Paediatric Setting. *Paediatrics* 1999;104 pp. 874-877
- Simonelli, C., Mullis, T., Elliott, A. et al. Abuse by siblings and subsequent experiences of violence within the dating relationship. *J Interpers Viol* 2002;17 pp. 103-121
- United Kingdom Domestic Violence Good Practice Indicators. London. 2002
- United Nations Convention on the Rights of the Child
- UN General Assembly – General Assembly Resolution. Convention on the Elimination of all Forms of Discrimination Against Women. 1976-66.36.242.93
- University of Auckland Injury Prevention Research Centre. Fact Sheet #34. Partner Abuse and Child Abuse in New Zealand. 2001
- University of Canterbury, Te Awatea Violence Research Centre. Te Awatea Review Dec 2005
- University of Otago. Injury Prevention Research Unit. Fact Sheet 29. Injury causes by age. 2003
- Wainohu, R. Correcting the Stories – Te Whakamarama. *The Māori Law Bulletin* 1991;10 pp. 5-6
- Walker, Lenore. *The Battered Woman*. Harper and Row. New York. 1979

Williams. 1992. In Gray, A. Intervention programmes for domestic violence abusers: A literature review. Family Violence Prevention Co-ordinating Committee, Department of Social Welfare. Wellington. 1994

Windham, A., Rosenberg, L., Fuddy, L. et al. Risk of mother-reported child abuse in the first 3 years of life. Child Abuse and Neglect 2004:28 pp. 645-667

World Health Organization. World report on violence and health, E. Krug, et al., Editors. Geneva. 2002

Young, W., Morris, A., Cameron, N. and Haslett, S. New Zealand National Survey of Crime Victims 1996. Wellington. Victimization Survey Committee. 1997

New Zealand Legislation

Care of Children Act 2004

Children, Young Persons and Their Families Act 1989

Domestic Violence Act 1995

Domestic Violence (Programmes) Regulations 1996 and Amendments 2002

Related Documents

When interpreting this Standard, it may be helpful for information purposes to refer to the following.

Child Abuse Prevention – The Health Sector’s Contribution to the Strengthening Families Initiative – The Public Health Issues 1995 – 1996. This paper is one of a new series of papers on public health issues developed by the Public Health Group of the Ministry of Health. This document should be read in conjunction with A Strategic Direction to Improve and Protect the Public Health which provides an overall framework for improving the health of New Zealanders.

Family Violence Guidelines for Health Sector Providers to Develop Practice Protocols 1998. These Guidelines have been developed in consultation with providers and in partnership with the Health Funding Authority (HFA). Their purpose is to help those involved in the delivery of health and disability support services develop family violence protocols for their own practice settings.

Recommended Referral Process for General Practitioners – Suspected Child Abuse and Neglect 2001. The guidelines were produced in consultation with health professional leaders and Māori and Pacific peoples. These groups were concerned that health workers ensure the safety and well being of both women and children when abuse occurs in the same family. The integration of child and partner abuse intervention strategies is a major achievement of the guidelines.

Useful Websites and Email Addresses

Age Concern New Zealand Inc.	www.ageconcern.org.nz
Barnardos New Zealand	www.barnardos.org.nz
Child Abuse Prevention Services New Zealand Inc.	Email: caps.nz@xtra.co.nz
Department of Child, Youth and Family Services	www.cyf.govt.nz
Department of Corrections	www.corrections.govt.nz
District Health Boards New Zealand	www.dhbnz.org.nz
Family Court	www.justice.govt.nz/family
Ministry of Health	www.moh.govt.nz
Ministry of Justice	www.justice.govt.nz
Ministry of Social Development	www.msd.govt.nz
National Collective of Independent Women's Refuges	www.refuge.org.nz
New Zealand Guidelines Group	www.nzgg.org.nz
New Zealand Police	www.police.govt.nz
New Zealand Principals' Federation	www.nzpf.ac.nz
Office of the Health and Disability Commissioner	www.hdc.org.nz
Paediatric Society of New Zealand	www.paediatrics.org.nz
Relationship Services	www.relate.org.nz
Royal New Zealand Plunket Society (Inc.)	www.plunket.org.nz
Preventing Violence in the Home	www.preventingviolence.org.nz
Shakti Community Council Inc.	www.shakti.org.nz
Statistics New Zealand	www.statistics.govt.nz
Victim Support	www.victimsupport.org.nz
WAVES – Waitakere Anti-Violence Essential Services	Email: wavesnetwork@xtra.co.nz

List of references

The cited numbered references used in sections 1 to 4 of this Standard are listed in Appendix A. Other references are also given where relevant in each Appendix.

FOREWORD

This Standard was prepared by the Standards New Zealand Committee for Screening, Risk Assessment and Intervention for Family Violence including Child Abuse and Neglect.

Family/whānau violence in New Zealand is a significant social issue. It directly affects the well-being of families/whānau, their physical and mental health and the extent to which they actively participate in society.

Te Rito, the New Zealand Family Violence Prevention Strategy released by Hon. Steve Maharey, then Minister of Social Services and Employment in February 2002, and published by the Ministry of Social Development, was developed by the Family Violence Focus Group as an implementation strategy for the government's key goals and objectives. Te Rito also sets out guiding principles and a five-year implementation plan to maximise progress toward the vision of families/whānau living free of violence.

Te Rito relates a set of nine principles, five key goals, and a number of objectives for achieving those goals to 18 specific interrelated areas of action. Te Rito promotes the positive working relationship between government and non-government agencies and represents a collaborative effort toward preventing violence in families/whānau.

Te Rito's area of action point 10 aims to enhance screening, risk assessment and early intervention.

It is the aim of this Standard to support an organised and systematic approach to selective or targeted screening for exposure to family/whānau violence in New Zealand.

To this end the Standard provides a framework whereby those working in the community with families will have the confidence and knowledge to carry out a systematic approach to screening for families and their individual members with whom they interact on a day-to-day basis. This Standard also addresses the issue of risk assessment, how it can inform the need for intervention, and the practice of intervention in the form of safety planning.

REVIEW PERIOD

It is intended that the NZS 8006 *Screening, risk assessment and intervention for family violence including child abuse and neglect* remains a dynamic document reflecting the challenges and changes experienced by New Zealand society as it moves towards reducing and eliminating family violence.

In order to achieve this, regular review of the Standard is required to ensure it remains appropriate and applicable. The initial review will occur in two years from publication of this Standard and will be overseen by the Expert Committee.

NEW ZEALAND STANDARD

SCREENING, RISK ASSESSMENT AND INTERVENTION FOR FAMILY VIOLENCE INCLUDING CHILD ABUSE AND NEGLECT

1 GENERAL

1.1 Scope

Definition of family violence

Family/whānau violence covers a broad range of controlling and harmful behaviours commonly of a physical, sexual, and/or psychological nature which typically involve fear, intimidation and emotional deprivation. Violence includes spouse/partner violence, dating violence, child abuse and neglect, abuse of parents by teenagers, elder abuse and neglect, sibling abuse, and abuse committed by another family member or person with whom there is a close personal or domestic relationship.

Family/whānau violence is a deliberate act, used by perpetrators as a means of asserting domination, power and control over others. The perpetrators of the most severe and lethal cases of family/whānau violence are predominantly male, while the victims of the most severe and lethal cases are predominantly women and children. There are significant overlaps between male violence against female partners and child abuse and neglect. Appendix B describes the prevalence of family violence with particular reference to data from New Zealand where local data is available.

This Standard provides best practice guidelines to individuals and agencies/services involved in screening, risk assessment and/or safety planning for those living with family/whānau violence.

As a voluntary Standard, this document is not designed as an instant solution. It is intended to set out best practice in screening, risk assessment and safety planning for family/whānau violence. While it provides a user-friendly framework for screening, managing risk, and intervening in the area of family/whānau violence, including child abuse and neglect, the Standard will still require ongoing consideration and review on the part of all involved.

The main focus for this Standard is on processes for dealing with victims of such abuse. Working directly with perpetrators is considered to be a separate specialist area. Some general guidelines relevant to interactions with perpetrators are provided in the document.

This Standard covers a range of elements within the continuum of family/whānau violence, recognising that different agencies respond at different points. Coverage includes:

- (a) Principles and guidelines for the screening of family/whānau violence, child abuse and neglect;
- (b) Aspects of risk assessment i.e. identification; analysis; evaluation; treatment of risks; monitoring and review; communication and consultation; and documentation; and
- (c) Intervention and safety planning. 

In addition, the Standard takes into account:

- (d) The needs of specific communities, including Māori, Pacific and recent immigrant communities;
- (e) The different dynamics involved in identifying family/whānau violence, including partner violence (between partners), abuse (between partners and including elderly people and children) and neglect;
- (f) Areas of compliance, and/or areas requiring additional improvement to manage risks and provide consistency and quality of service; and
- (g) All legislative requirements, including the Children, Young Persons and Their Families Act 1989.

This Standard is structured with sections 1 to 3 addressing the overview, cultural awareness and documentation for family/whānau violence and section 4 documenting the specific risk tools for individuals and agencies/services involved in screening, risk assessment and /or safety planning for those living with family/whānau violence.

Before undertaking risk screening, risk assessment and safety planning for family/whānau violence, personnel need to have received specific training in these areas and the Standard recommends where practical also having qualified Māori personnel as part of the workforce.

Appendix C provides a glossary of terms used in this Standard.

1.1.1 Screening

Screening is the systematic application of enquiry, either written or verbal, to clients about their personal history with family/whānau violence, to identify at-risk individuals in order to determine if they should be offered the opportunity of intervention.¹

Screening should be followed by risk assessment and safety planning if it is to be an effective tool in preventing harm and breaking the cycle of the family/whānau violence.

An immediate safety plan is necessary whenever family/whānau violence is identified.

1.1.2 Risk assessment

Risk assessment is a process allowing for a full examination of circumstances and interactions to begin to form an opinion about a person's risk of harm either to themselves or to others.

Risk assessment is a dynamic process, as situations of domestic violence, child abuse and neglect may change rapidly. There is an implicit assumption in any assessment process that a decision will be made during or after assessment about what form any intervention will take. Assessment is never static and requires ongoing review.

1.1.3 Safety planning and intervention

Safety planning is a process for identifying and planning to minimise harm and maximise safety. This may be through the preparation of an immediate safety plan or through short or longer term plans. Safety planning is central to the provision of support for victims. Safety plans work best when developed together by the victim and a trained support person.

Safety plans need to be developed immediately whenever violence is identified.

1.2 Overview

Family/whānau violence are significant public health, social and justice impacts, directly affecting the safety and well-being of adults and children, and the extent to which they can participate in society. Violence creates high ongoing personal costs for those affected and significant social and economic costs to society.

Violence in families/whānau is the most prevalent form of violence in New Zealand and affects people of all ages from all cultures, backgrounds and socio-economic circumstances.

Violence in families/whānau contributes to the continuation of violence across different generations as well as within families/whānau and within society in general.²

The prevalence of family/whānau violence in New Zealand is indicated by research that shows:

- (1) 15 – 35 % of New Zealand women have been hit or forced to have sex by their partner at least once in their lifetime. 21 % of men report having physically abused their partner in the past year (average 11 deaths/year);^{3, 4, 5}
- (2) 4 – 10 % of New Zealand children experience harsh or severe physical punishment (average 9 deaths/year);^{6, 7, 8}
- (3) 18 % of New Zealand children experience sexual abuse. Estimates are higher for girls: 25 – 30 %;^{9, 10}
- (4) 2 – 5 % of people over 65 in New Zealand are victims of elder abuse.

Recent research¹¹ shows that 33 % of the studied participants in Auckland and 39 % in North Waikato reported that they had experienced at least one act of physical and/or sexual violence by an intimate partner in their lifetime. Experience of physical and/or sexual violence by an intimate partner within the previous 12 months was reported by approximately 5 % of respondents. Of those who had experienced moderate or severe physical violence, 42.4 % had also experienced sexual violence.¹²

Edleson's research shows that, in 30 – 60 % of families where either child abuse or partner abuse is found, the other type of abuse also occurs.¹³

In 2005, New Zealand Police recorded 62,470 offences and non-offence incidents involving family/whānau violence, at which 62,615 children and young people under the age 17 were present or involved in some capacity. In 2005, 29 murders in New Zealand were family/whānau violence related.¹⁴

While no population-based studies of elder abuse have been conducted in New Zealand, the most recent research estimates 2 % to 5 % of the older population are victims of elder abuse¹⁵. Of the 1546 cases of abuse or neglect seen by Age Concern New Zealand's elder abuse and neglect services between 1 July 1998 – 30 June 2001¹⁶, 1249 cases involved one or more individual abusers, accounting for 81 % of all cases. A further 127 cases of institutional abuse, accounted for 8 % of all cases. 170 cases of self-neglect, which did not occur in conjunction with an other type of abuse or neglect, accounted for the remaining 11 %. Almost half of all older clients experienced more than one type of abuse or neglect.

1.3 Principles

This Standard adopts the nine principles set out in Te Rito to reduce family/whānau violence in New Zealand. These guiding principles are:

- Principle 1** All people have a fundamental right to be safe and to live a life free from violence.
- Principle 2** The unique customary and contemporary structures and practices of whānau, hapū and iwi must be recognised, provided for and fully engaged.
- Principle 3** Family violence prevention is to be viewed and approached in a broad and holistic manner.
- Principle 4** Perpetrators of violence in families/whānau must be held accountable for their violent behaviour.
- Principle 5** There must be a strong emphasis on prevention and early intervention with a specific focus on the needs of children and young people.
- Principle 6** Approaches to family violence prevention must be integrated, co-ordinated and collaborative.
- Principle 7** The community has a right and responsibility to be involved in preventing violence in families/whānau.
- Principle 8** The diverse needs of specific populations must be recognised and provided for when developing and implementing family violence prevention initiatives.
- Principle 9** Family violence prevention initiatives should be continually enhanced as information and better ways of working are identified.¹⁷

Further guidance is provided in the 1996 “Good Practice Guidelines”.¹⁸ These focus on:

- (a) Prevention – prevention of family/whānau violence is a key concern for government agencies;
- (b) Breaking the cycle – breaking the cycle of violence is a necessary component in preventing ongoing family/whānau violence (see Appendix D for a graphical representation of this cycle);
- (c) Safety – safety of victims should be the paramount concern of all policies and programmes where family/whānau violence is a focus;
- (d) Access to services – victims in crisis require appropriate and timely intervention, ongoing support and have a right to adequate legal protection;
- (e) Support of victims – the response of agencies should support survivors of family/whānau violence to make informed choices, enhance their rate of recovery and maintain their ongoing safety;
- (f) Protection of children – children have a right to live in families free from violence;
- (g) Accountability – abusers will be held accountable and encouraged to accept responsibility for their use of violence, and for changing their behaviour;
- (h) Consistent response – the response of government agencies should be co-ordinated. A multi-agency approach is required to avoid duplication and gaps in services and to provide a clear and consistent message that violence will not be tolerated;
- (i) Cultural relevance – different cultural backgrounds must be recognised in the development and delivery of all government policies and programmes. Māori designed and managed services are a priority;

- (j) Equality – the response of government agencies should contribute to a reduction in gender inequality and improvement in the status of women;
- (k) Community responsibility – the whole community has a responsibility to be involved in preventing and eliminating family/whānau violence. Although the principles are inclusive of people with disabilities, it is specifically recognised that those with significant disabilities may be particularly vulnerable to abuse or neglect.

1.4 The role of the Treaty of Waitangi

The Treaty of Waitangi is the founding document of New Zealand and provides for a unique relationship between Māori and the Crown. In recognition of this and the status of Māori as tangata whenua, it is important that approaches to family/whānau violence prevention are constructed and implemented with the particular interests and needs of whānau, hapū and iwi in mind, and that measures taken strengthen the ability of whānau, hapū and iwi to control their own development and achieve their own aspirations.¹⁹

The government acknowledges that Māori are significantly over-represented as both victims and perpetrators of violence in families/whānau. In recognising this within the Te Rito framework, Goal 4 recognises that approaches to family/whānau violence prevention must be culturally relevant and effective for whānau, hapū and iwi.

1.5 The role of human rights

New Zealand has a legal obligation to comply with international human rights instruments which advocate the right to security of the person and the right to freedom from discrimination. This Standard is underpinned by international human rights contained in the International Covenant on Civil and Political Rights, the United Nations Convention on the Rights of the Child, the International Convention on the Elimination of all Forms of Discrimination Against Women and the International Convention on the Elimination of All Forms of Racial Discrimination.

The principle that all people have a fundamental right to be safe and to live a life free from violence has been adopted as a guiding principle to the Standard. Regardless of the possible causes of domestic violence, it is not acceptable in any culture. Implementation of this Standard will enhance New Zealand's commitment to and compliance with international human rights obligations.

1.6 Who should use this Standard?

The users of this Standard will be agencies, services and individuals working with families and particularly those who have first contact with families/whānau and children. While the information in this Standard is important for general public and agency awareness, agencies and individual practitioners need to be very clear about their specific expertise, roles and responsibilities and training needs. While safety will be a priority for all, some individuals and agencies will be involved in, or will develop risk screening, while others will be involved in specific risk assessment and targeted interventions.

Implementation of this Standard will enable government agencies, non-governmental organisations (NGOs), community groups and individuals including, but not necessarily confined to community service providers, educators, SPCA and territorial authority animal

protection officers, local authority personnel/practitioners, police, lawyers, youth justice workers, victim support workers, physical and mental health workers, medical practitioners, midwives, family/whānau violence programme providers, work and income staff, cultural workers, child protection workers, Plunket nurses, district nurses, probation officers, early childhood programme providers, church leaders, counsellors, psychologists (including private practitioners), Department of Corrections staff and social workers involved in screening and risk assessment of family/whānau violence, child abuse and neglect, to identify agreed processes for sharing clear and comprehensive risk assessment information to facilitate consistent and accessible services that meet the needs of clients.

All personnel, staff and volunteers need to be trained and supported in the effective and consistent use of this Standard.

1.7 Purpose and application

This Standard is generic and independent of any specific government department or NGOs, and is intended to support and enhance the policies and procedures already in place within different agencies/services. The design and implementation of the screening, risk assessment and intervention systems will be influenced by the varying functions and purpose of an organisation, its particular objectives, its services and processes and specific practices employed.

The particular needs of Māori, Pacific and other ethnic groups shall be addressed. People involved in the sector range from the very knowledgeable and experienced in relation to risk assessment, to those for whom this is a new responsibility, and this Standard allows for that range.

Safety, protection and accountability is more likely to be achieved if shared expectations of quality screening, risk assessment and intervention practices are established, clarified and resourced. Screening, risk assessment and intervention tools for family/whānau violence, including child abuse and neglect can differ according to the purpose and function of each organisation providing services, but the underlying principles remain the same. Not only should personnel/practitioners and volunteers be trained and supported in the effective and consistent use of these tools, they must also be able to either implement any intervention safely, or to refer on to more appropriate personnel/practitioners or agencies. However to be most effective screening, risk assessment and safety planning should become part of an organisation's culture, embedded into its philosophy, practices and business processes rather than viewed or practised as a separate activity.

Protocols and memoranda of understanding have been used between various government agencies to promote consistency and collaboration and set out mutual responsibilities and underpin the relationships between each agency. An example of this is the interagency protocols guide for child abuse management (CYF).²⁰

1.8 Benefits of this Standard

The main benefits of drawing together validated best practice screening, risk assessment and safety planning are to reduce further harm, enhance the safety of victims, increase offender accountability as well as organisational service provision and accountability. The aim is to increase co-operation between government and non-government agencies/services working together to identify and address family/whānau violence, child abuse and neglect as well as to provide for a consistent approach based on the best available evidence.

This Standard is intended to be suitable for individuals and small agencies/services as well as large agencies/services and institutions. It is recognised that some will only be involved in one aspect of the pathway, such as screening.

1.9 Interpretation

The broad diversity and specific nature of family/whānau violence work has necessitated the use of a number of generic phrases and terminology throughout this document. See Appendix C.

The aim is to assist agencies interpret the Standard into their everyday language without standardising as such the terminology used in different parts of the sector. For example, the expression “safety plan” could be interpreted to mean a safety plan for a service, for a victim or a perpetrator etc., depending on the service setting.

The terms “Informative” and “Normative” have been used in this Standard to define the application of the Appendix to which they apply. An “Informative” Appendix is only for information and guidance. A “Normative” appendix is an integral part of the Standard.

Since this Standard is voluntary the words “should” or “may” refer to practices that are advised or recommended. The word “shall” refers to requirements that need to be met for the Standard to be complied with.

2 Cultural awareness

2.1 Māori whānau violence

This section has been adapted from the Ministry of Health *Family Violence Intervention Guidelines – Child and Partner Abuse*²¹. It provides some context and background on family violence for Māori, and suggests some principles and actions for effective screening and intervention with Māori experiencing family violence. The aim is to improve understanding of the issues that underpin family violence for Māori, and of strategies to improve responsiveness to Māori.

Violence within the whānau was not the norm for traditional Māori society.^{22, 23} The effects of colonisation resulting in loss of land and urbanisation distanced Māori whānau from their whakapapa, and the support of their extended family. Traditional roles within whānau have changed; family violence is no longer always constrained by the whānau and traditional sanctions are no longer in place.

2.1.1 Māori and whānau violence

The experience of family violence by Māori is complex. It occurs within the historical context that reshaped the foundations of Māori society through the process of colonisation. It also occurs within a contemporary context of socio-economic disadvantage, which can be linked to a health status that is poorer than most other groups within the New Zealand population.²⁴ The development of tools and training programmes to improve the ability to respond effectively is vital in improving the effectiveness of identification and the appropriate referral of Māori who are victims of family violence.

Violence has been consistently identified as negatively impacting on health and well-being, by whānau, hapū and iwi.²⁵ The occurrence of violence in Māori whānau has both historical and contemporary causes, and can be attributed to the complex interaction of many factors. For Māori these factors may include:

- (a) The breakdown of the traditional Māori way of life through the process of colonisation, including social structures and systems of discipline and justice;
- (b) Loss of Te Reo Māori, traditional beliefs, values and philosophy, the breakdown of traditional social structures, and the loss of identity for many Māori;
- (c) Movement of concern with family violence from a public iwi and hapū concern to a private whānau issue, mirroring Pakeha attitudes;
- (d) Urbanisation and associated isolation of Māori throughout city suburbs, resulting in social isolation and dislocation from vital support networks for some Māori;
- (e) Hardship experienced by many Māori associated with low educational achievement, low income, restricted employment opportunities and drug and alcohol abuse.

Māori are significantly over-represented as both victims and perpetrators of whānau violence. In the National Survey of Crime Victims 2001, Māori women reported experiencing violence victimisation at a higher rate than non-Māori.²⁶

It is important that those working with Māori gain an understanding about the dynamics of family violence, and the historical socio-cultural influences and context for contemporary Māori in relation to family violence. This understanding can assist them to demonstrate attitudes and behaviour toward Māori that are supportive and encourage Māori victims to seek help.

2.1.2 Treaty of Waitangi

The government is working to address the needs of Māori, including the reduction of inequalities experienced by Māori. Services need to:

- (a) Take account of Māori needs and perspectives;
- (b) Develop culturally appropriate practices and procedures;
- (c) Engage with whānau, hapū and iwi;
- (d) Develop partnerships with Māori providers;
- (e) Recruit and support Māori personnel.

2.1.3 Māori health holistic model and quality framework

There are several Māori models and frameworks that illustrate Māori holistic approaches to health and well-being. The most well-known of these is Te Whare Tapa Whā which represents the aspects of health and well-being for Māori. The strong and solid walls of the house reflect the four dimensions of health and well-being: taha wairua (spiritual), taha hinengaro (mind), taha tinana (physical), and taha whānau (extended family). A person's wellness relies on these foundations being secure. See Appendix E for a model of health that is widely accepted by Māori.²⁷

2.1.4 Forms of whānau abuse

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

2.1.4.1 Partner abuse

Approximately 27 % of battered women using Women's Refuge services are Māori.²⁸ Where women are at risk, their children may also be at risk.

2.1.4.2 Child abuse

Approximately 40 % of children who come into contact with Women's Refuge are Māori.²⁹ Children being raised within violent family environments may not understand the negative consequences of the use of violence.³⁰ It is a concern that as they mature they may adopt the learned behaviour of violence and abuse within their own families.

2.1.5 Principles for action

Agencies/services and individuals shall ensure the service they provide is safe and respectful of Māori beliefs and practices. The following whakatauki highlights the importance of respectful practice in optimising the effectiveness of services and their actions:

E tau hikoi i runga i oku whariki

E tau noho i toku whare

E hau kina ai toku tatau toku matapihi

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

Opens my doors and windows.³¹

The delivery of a culturally safe and competent intervention that responds to Māori victims of family violence should be underpinned by the following principles:^{32, 33}

- (a) Victim safety and protection shall be paramount;
- (b) Māori-friendly environment;
- (c) Culturally safe and competent interactions (guided by kaumātua support, *Te Whare Tapa Wha*³⁴ and *He Taura Tieke*³⁵);
- (d) Engagement with local iwi, hapū and Māori;
- (e) Knowledge of community;
- (f) Intersectorial collaboration;
- (g) Monitoring and evaluation of family violence interventions with Māori.

These principles are the foundation for the following guidelines:

- (1) *Victim safety and protection shall be paramount* – while cultural safety is desirable, maintaining the safety of victims shall be paramount.^{36, 37} Any practices or interventions should not further endanger or disadvantage Māori victims.
- (2) *The provision of a Māori-friendly environment* – agencies/services shall ensure that they provide a Māori-friendly environment, including both the physical environment and the behaviour and attitudes of the personnel/practitioners. Māori images, signage and designs (such as kowhaiwhai) are important in putting Māori at ease. These could also include images that promote a violence-free home, such as:

*Ko te tapu, o te whare tangata, me te āhua ātua, o nga tamariki*³⁸

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

- (3) *The provision of culturally safe and competent interactions* – services and individuals responding to Māori who are victims of family violence should have an understanding of the application of the Treaty of Waitangi and its principles in relation to their service. There is a need to ensure provision for training to develop cultural safety and competence in working with Māori.
- (4) *A collaborative community approach to family violence should be taken* – the implementation of interventions for Māori should occur in collaboration with other agencies or sectors to ensure that the needs of Māori who are victims of violence are adequately addressed. It should not be assumed that the whānau should be involved in supporting Māori victims – a victim should be consulted on the plan of action and whether they may want to include the whānau.

2.2 Pacific peoples and family/fanau violence

This section has been adapted from the Ministry of Health *Family Violence Intervention Guidelines – Child and Partner Abuse*. It provides some context and background on family violence for Pacific peoples. The aim is to improve understanding of the complex issues that underpin family violence for Pacific peoples.

2.2.1 Pacific peoples and family violence

Pacific peoples make up 6 % of the total population in New Zealand, with about two-thirds living in Auckland. There are seven main Pacific communities in New Zealand representing Tuvalu, Tokelau, Fiji, Tonga, Niue, the Cook Islands and Samoa. The New Zealand Women's Refuge, and Department of Child, Youth and Family Services data confirm that family violence is prevalent among Pacific communities in New Zealand.^{39,40}

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

“Research points to the breakdown of family structure when people migrate. People moving to a new country often attempt to hold on to their familiar ways of being and doing but those ways are not always successful in the new environment. Perhaps one of the most significant points about migration for Pacific families is the break in kinship ties and the loss of collective support.”⁴¹

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

- (a) Lack of communication between parents and children;
- (b) Change in the status of women and children;
- (c) Urbanisation of Pacific peoples and the impact of alcohol and drugs;
- (d) Low income.

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

Ministry of Justice data indicate that Pacific peoples have been over-represented in violence offence apprehensions and convictions throughout 2003. In this year, 13 % of the total apprehensions for offences classified as ‘male assaults female’, most of which were family violence cases, involved Pacific peoples. The conviction rate for Pacific peoples in this offence category mirrored the apprehension rate, at 13 %.⁴² The 2001 census reported 5 % of those aged 15 and over were identified as belonging to the Pacific peoples ethnic group, suggesting that Pacific peoples are very much over-represented in the criminal statistics for family/whānau violence.

2.2.2 Forms of family/fanau violence

2.2.2.1 Partner abuse

There is some anecdotal evidence that Pacific women are reluctant to report abuse or injury and when they do, their injuries or situation is usually more severe or urgent.

Traditional protocols that once protected women from abuse were eroded by the influence of Western social and religious values and beliefs in the Pacific. The newcomers brought attitudes about the appropriate role of women (and the place of children) within the family and society. The growing authority of the new religion also altered the traditional exercise of authority and decision-making in which women had been significant participants. In some Pacific societies these historical events resulted in profound changes in the position of women. Cross-cultural studies have found a consistent correlation between the status of women and the prevalence and severity of partner abuse.⁴³

2.2.2.2 Child abuse

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

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

2.2.3 Principles for action

Services shall be safe and respectful of Pacific victims. The delivery of a culturally safe and competent service that responds to Pacific victims of family violence should be underpinned by the following principles:⁴⁴

- (1) *Victim safety and protection must be paramount* – the safety of women and children shall be paramount. Any practices or interventions that are used should not further endanger or disadvantage Pacific victims.
- (2) *The provision of a Pacific-friendly environment* – non-Pacific organisations and services shall ensure that they provide a Pacific-friendly environment, including attention to the physical environment and the behaviour and attitudes of the personnel/practitioners. An appropriately trained person with the same ethnicity as the victim may be the best person to interview, assess or follow up Pacific victims. Some Pacific victims will have English as a second language, so communication should be simple and clear; or assistance should be provided from an appropriately trained (non-family) interpreter who speaks the same language.
- (3) *The provision of culturally safe and competent interactions* – services are encouraged to seek training for their personnel/practitioners to develop their cultural safety and competence in working with Pacific peoples.
- (4) *A collaborative community approach to family violence should be taken* – the implementation of actions may need to occur in collaboration with other agencies or sectors to ensure that the needs of Pacific victims of violence are adequately addressed. The development of local community knowledge when responding to Pacific victims of family violence can be vital to identifying appropriate agencies and to be able to offer referral to Pacific advocates with expertise in family violence. It should not be assumed that the family or church should be involved in supporting the victims. A victim should be consulted on the plan of action and whether it may or may not include the family and church.

2.3 Immigrant and ethnic communities

Family/whānau violence in New Zealand affects many immigrant, refugee and ethnic communities in New Zealand. Approximately 2% of battered women using Women's Refuge services are Asian/Indian. Shakti Community Council which is a refuge dedicated to working with ethnic and refugee women in Auckland receives on average 200 calls a month, directly or indirectly related to family/whānau violence.

While some domestic violence may be culturally sanctioned within some immigrant ethnic communities, it is nevertheless unlawful in New Zealand. There are significant barriers for women accessing services addressing such violence. Lack of English language skills, the stigma associated with leaving a violent marriage, social ostracism, isolation and anxiety about losing children and residency are factors to be considered when affected individuals seek help.

In spite of the different cultural values at work, it is important to make safety a priority for all concerned in addressing violence in immigrant, ethnic and refugee communities.

With the increased number of refugee, ethnic and immigrant families coming to New Zealand the delivery of a culturally safe and competent intervention that responds to immigrant and ethnic victims of family/whānau violence is critical. Services and individuals responding to victims from immigrant and ethnic communities should involve relevant specialists' services already working in their community.

3 Documentation and confidentiality

3.1 Policies and procedures

Agencies/services shall have specific and clear policies on obtaining, sharing and recording information. Codes of practice relating to particular sectors and areas of practice need to be followed. Where appropriate it may be prudent to alert victims to situations where information could be discoverable e.g. through legal action. Information must be safeguarded from the abuser and unauthorised others gaining access to it. However, approved and authorised personnel/practitioners need to be able to access the information when required.

Policies and procedures shall identify if the information is to be kept confidential, electronically or in a non-integrated file, and how this will be flagged to personnel/practitioners. If the information is held in a personal file, policies shall cover the need to include what happens if the file is accessible to the client. Will the abuser be able to access and read the file? What is the alert system if the client presents to the Emergency Department (e.g. after an assault), and previous information including screening or risk assessment results can be accessed immediately?

Written documentation provides an audit trail and may also become important for future planning or later review, including for legal action. Relevant data to assess the quality and outcomes of the service for guiding future practice can also be gathered.

3.2 Information sharing

The potential benefits and risks of sharing information with other agencies or individuals shall be taken into account in relation to maximising safety and minimising risk. Where possible, any exchange or sharing of information needs to include the victim and/or relevant others. Policies and procedures should reflect this approach by outlining how information can be safely shared with other agencies/individuals that may form part of a co-ordinated approach to an ongoing safety plan or intervention.

4 Application

4.1 Policy

4.1.1 Policy and procedures

Agencies or individuals undertaking screening and/or risk assessment shall have clear written policy and practice guidelines based on the principles in 1.3. These guidelines should be developed in consultation with professional groups including employer and employee groups and should:

- (a) Outline the agency's agreed understanding of, or definition of, family/whānau violence;
- (b) Outline the understanding of the client's rights to safety and to confidentiality, including the limits to this confidentiality/mandatory reporting requirements (e.g. if risk to a child is identified, it will be reported to CYF but the client will be informed – **where this does not increase risk to the child or young person**);
- (c) Define the legal obligations of the agency's personnel/practitioners;
- (d) Outline who will conduct screening and/or risk assessment and safety planning;
- (e) Outline who will be screened or assessed (e.g. screening for all female clients 16 years of age and older);
- (f) Outline when and where screening and/or risk assessment and safety planning will occur;
- (g) Clarify exactly how screening and/or risk assessment and safety planning are to be approached/undertaken (e.g. the policy could specify the particular tools to be used and include the list of questions to be asked of clients);
- (h) Outline the measures to ensure personnel/practitioners safety;
- (i) Outline how and where screening and/or risk assessment and safety planning is to be documented or recorded, how that information will be held in confidence and what should happen when an alternative form of record is indicated;
- (j) Include actions for dealing with inadvertent disclosure of client information;
- (k) Include guidelines for cultural safety;
- (l) Clarify the expected actions to be taken by personnel/practitioners when screening has identified family/whānau violence, and/or for various levels of risk identified by a risk assessment;
- (m) Outline how personnel/practitioners should refer the client or family/whānau to other personnel/practitioners or to outside agencies, including specifically in what situations the personnel/practitioner should refer children to CYF;
- (n) Outline how personnel/practitioners should deal with perpetrators and referral policies for them, including specifically what the personnel/practitioner should do in situations of imminent threat;
- (o) Outline the actions and behaviours that contribute to the development and delivery of a culturally safe and competent service; and
- (p) Outline how screening and/or risk assessment and safety planning will be monitored and reviewed within the agency.

NOTE – It may not always be appropriate to notify people that CYF has been involved, and this should not occur if it raises risks for the safety and well-being of the children involved.

In addition the guidelines need to define how the agency will deal with personnel/practitioners that are currently, or have been, victims or perpetrators of violence. As family/whānau violence affects a large number of families in New Zealand it must be expected that some personnel/practitioners, who may be asked to conduct screening and/or risk assessment and safety planning, may be victims or perpetrators of family/whānau violence themselves. The guidelines should outline how to respond to personnel/practitioners who disclose being a victim or are found to be a perpetrator of family/whānau violence (e.g. through police vetting). Immediate consideration needs to be given to whether they should be supported to continue their task or removed from situations where they would be expected to conduct screening and/or risk assessment and safety planning.

4.1.2 Training

All personnel/practitioners expected to conduct screening and/or risk assessment and safety planning shall have adequate training to ensure safety for themselves and their clients. They also need to be using an effective process, and applying an appropriate response.

Training for personnel/practitioners should include an understanding of:

- (a) The power and control dynamics of all forms of family/whānau violence including child abuse and neglect and elder abuse. Section 5 of the Domestic Violence Act states “domestic violence in all its forms, is unacceptable behaviour”;
- (b) Why violence happens and common misconceptions about family/whānau violence;
- (c) Reasons why victims may stay with, or defend, perpetrators;
- (d) Reasons why victims may be reluctant to disclose the violence and abuse;
- (e) The effects of violence and neglect on victims including the effects of adult violence on child witnesses, and the effects of abuse and neglect on older persons;
- (f) The agency’s established policies and procedures including documentation and confidentiality;
- (g) The roles of different personnel/practitioners, including their responsibilities;
- (h) How to conduct the screening and/or risk assessment and being able to practise doing this;
- (i) The principles, identification, process and implementation of safety planning;
- (j) The processes and their importance for personnel/practitioner safety, supervision, mentoring and personnel/practitioner self-care;
- (k) Protocols for reporting and referring to other agencies;
- (l) The importance of working collaboratively to maximise safety and accountability;
- (m) The work and role of other agencies in the community which provide support for victims or work with perpetrators;
- (n) Hallmarks of a culturally competent system (e.g. partnerships with iwi, hapū and Māori that are sustained; accessibility of the service by a range of cultures including immigrant ethnic communities (Asian, African and Middle Eastern) and other migrant and refugee communities where appropriate); and
- (o) The conditions of protection orders.

Training should be provided by a competent trainer with proven skills and experience in addressing family/whānau violence and a demonstrated knowledge of the sector. In selecting trainers, agencies/services should consider involving relevant specialist family/whānau violence services already working in their community including engaging with kaumātua to provide cultural guidance and applying the quality framework He Taura Tieke to ensure that the services are effective for Māori. Training using local providers enables opportunities for developing vital networking and building rapport between agencies/services and their community.

Training in screening and/or risk assessment and safety planning should form an integral part of every agency's initial personnel/practitioners' orientation and on-going training. Training should be reviewed and updated on a regular basis.

Every effort should be made to attract suitably qualified Māori staff to services addressing family/whānau violence and to provide ongoing training on cultural safety where non-Māori staff are involved in the provision of services to Māori service users.

NOTE – It would be useful for individuals and agencies/services to consult with the Ministry of Social Development, Work and Income, and District Health Boards which are currently developing relevant resources. This material should be linked in with local training plans and opportunities.

4.1.3 Personnel/practitioners' safety, monitoring, support and supervision

4.1.3.1 Safety

The agency/service shall identify areas of potential risk and harm that could compromise the safety of personnel/practitioners undertaking screening, risk assessment, safety planning and other interventions. Personnel/practitioners shall be informed about risks and appropriate systems established to minimise harm.

4.1.3.2 Monitoring

Monitoring should be a continuous activity and may be included as part of supervision. A systematic approach to monitoring will ensure that personnel/practitioners are consistently conducting screening and/or risk assessment and safety planning according to agency/service policy or identify where additional support or training is required.

4.1.3.3 Support/mentoring

Support and/or mentoring of personnel/practitioners is important for client safety, as well as for the safety and accountability of the personnel/practitioners and the agency/service. The need for support and mentoring may vary depending on the situation that personnel/practitioners are working in and their level of experience.

Support and mentoring should help personnel/practitioners to overcome personal barriers to conducting effective screening and/or risk assessment and safety planning. Mentors who are more experienced in the field of family/whānau violence and particularly with conducting screening and/or risk assessment can also offer support in group settings such as discussion groups or meetings, as well as one-on-one and informally. It is helpful for personnel/practitioners to observe someone more experienced at screening and/or risk assessment in order to gain confidence in doing it themselves.

4.1.3.4 Debriefing

Debriefing is an opportunity for personnel/practitioners to vent feelings and/or tell a story of distress, trauma and their reactions to a stressful event within a work environment, in order to assist with closure and moving forward and to reframe thinking to enable solutions.

4.1.3.5 Formal supervision

Best practice principles support the provision of clinical supervision to all personnel/practitioners (paid and unpaid) involved in screening and/or risk assessment and safety planning. As a minimum, supervision in organisations/agencies should be available to the personnel/practitioners to access themselves or if directed by a supervisor or manager. Supervision needs to be provided by an experienced practitioner/supervisor, who should ensure that actions are not carried out in isolation, and that the person is working as part of a team approach.

4.1.3.6 Review of processes

Processes for screening and risk assessment of family/whānau violence, child abuse and neglect should be subject to formal monitoring and review on a regular basis. Organisations/services should facilitate regular monitoring and review of such processes in a number of ways including:

- (a) Annual review of the risk assessment mechanisms by the clinical manager, or other appropriate personnel;
- (b) Conducting an extensive client accountability survey to ascertain levels of client satisfaction;
- (c) Reviewing processes on a two-year cycle and in addition, when service manuals are developed, updated or reviewed, or when legislative change requires it;
- (d) Monitoring new protocols that have been developed on the management of services, and reviewing them after a period of implementation; and
- (e) By creating an overview of the service through process and outcome evaluations undertaken by external evaluators.

4.1.4 Organisational activities

4.1.4.1 Auditing

An audit is a formal process to determine if established procedures and policies are being followed at an organisational level. A formal audit can be carried out both internally or externally. Audits or reviews can be carried out by other agencies or services and the findings of the monitoring process referred to in 4.1.3.2, which focuses on individual preferences, will also be taken into account.

4.1.4.2 Evaluation

Evaluation is the process of checking whether the desired outcomes have been achieved, and if the service is acting effectively. If not, the policy, or practice may need to be changed. Evaluations can include client questionnaires, community partner feedback, formal external evaluation, or internal assessment.

4.1.5 Violence-free environment and culture

Agencies involved in screening and/or risk assessment and safety planning should demonstrate an organisational commitment to the prevention and elimination of family/whānau violence. This should be reflected in their policies, practices and physical environment.

Some examples include:

- (a) Development of a human resource policy on supporting personnel/practitioners who are victims of family/whānau violence;
- (b) Development of policy on the accountability and supervision of personnel/practitioners who are family/whānau violence offenders;
- (c) Information on family/whānau violence and available resources is displayed in the workplace;
- (d) A safe private place for consultation with victims and personnel/practitioners is provided;
- (e) Initial and ongoing family/whānau violence training is provided for all personnel/practitioners and linked to performance and promotion criteria; and/or
- (f) Relationships/memoranda of understanding are developed with specialist family/whānau violence agencies; and
- (g) Leadership and support for the prevention of family/whānau violence is exhibited by senior management.

4.1.6 Interagency collaboration

No one agency has sole possession of all the information required to determine risk and suitable interventions. In many communities around New Zealand there are already established collaborative initiatives providing examples of best practice and integrated responses to families/whānau experiencing violence. Where such collaborative projects or networks exist in a community, agencies/services undertaking screening and/or risk assessment and safety planning should participate at a level appropriate to their expertise.

In most situations it will be useful to collaborate with other agencies/services to maximise partnerships, and understanding of each other's work, in sharing policies and procedures, undertaking shared training, and a joint approach to the evaluation of screening, risk assessment and safety planning. The specialist family/whānau violence agencies, (e.g. National Network of Stopping Violence Services, the National Collective of Independent Women's Refuges and the Department of Child, Youth and Family Services), should at least be consulted on the development of policies or procedures for referring clients to them.

4.2 Risk screening

Screening is the systematic application of enquiry, either written or verbal, by agencies/services to clients about their personal history with family/whānau violence to identify individuals who would benefit from further investigation/assessment and some form of intervention. The World Health Organization (WHO) defines screening as "the process of identifying those individuals who are at sufficiently high risk of a specific disorder or harm to warrant further investigations or direct action"⁴⁵.

Enquiry can move from general framing statements such as ‘Because violence is so common I’ve begun to ask all my clients about it’ to direct questions like ‘Are you in a relationship with a person who physically hurts or threatens you?’ Screening may be conducted routinely with all individuals, specified categories of individuals, or can be indicator-based.

It is important to be aware that risk is increased when risk factors accumulate. For example alcohol and drug abuse combined with such factors as poor housing, low socio-economic status, social stress, lack of social support and a past history of violence may considerably increase the risk of family/whānau violence.

4.2.1 Approaches

There are three main sorts of screening:

- (a) Population screening – when everyone in a specific population group is asked either verbally or in writing about a specific issue;
- (b) Selective or targeted screening – performed in a subgroup of individuals who have already been identified as relatively high risk or who present to a specific service (e.g. Emergency Department, or Maternity);
- (c) Opportunistic screening – carried out at a time when professionals/practitioners see individuals for other purposes (e.g. teachers of a school).

Opportunistic and selective or targeted screening are the most common approaches to screening for family/whānau violence, including child abuse and neglect in New Zealand. Police, CYF and some health professionals use the selective approach to screening. Selective screening for suspected child abuse and neglect normally occurs in high risk groups and in the presence of signs and symptoms. Health professionals such as Plunket nurses, midwives and Emergency Department personnel/practitioners use the population and opportunistic screening approach.

4.2.2 Purpose

Screening tools for possible family/whānau violence, including child abuse and neglect are used to determine if individuals would benefit from some form of risk assessment, investigation or intervention.

The signs of abuse are not always visible and therefore opportunities to identify a problem are missed without a screening process.

Evidence exists that women are unlikely to disclose unless specifically asked⁴⁶, and high numbers of women support the use of routine screening for family/whānau violence^{47, 48}.

4.2.3 Risk screening principles

Risk screening shall:

- (1) Recognise that family/whānau violence, in all its forms, is unacceptable behaviour;
- (2) Must not compromise the safety of people affected by any risk of family/whānau violence.

4.2.4 Organisational/practice responsibilities

Before an organisation/service can expect staff/personnel to screen for family/whānau violence, they shall receive both appropriate training and support.

The training shall cover:

- (a) The staff member/practitioner's role in family/whānau violence intervention;
- (b) The role of screening and effective use of the screening tool;
- (c) The difference between screening, risk assessment and the provision of support;
- (d) An understanding of the prevalence and dynamics of family/whānau violence;
- (e) Cultural issues and cultural competence;
- (f) The principle of respecting the autonomy of the victim;
- (g) The barriers to screening and how to address them;
- (h) Documentation and confidentiality issues;
- (i) Risk assessment and safety planning for victims;
- (j) Support services available in the community; and
- (k) The impact of the power dynamic between screener and client.

Organisations/services shall ensure that they have a support system in place for all personnel/practitioners, which could include supervision (external, peer and/or line)/mentoring/debriefing processes, where personnel/practitioners receive support and are able to reflect on their practice. For further details see 4.1.3.

Agencies need to be aware that there may be staff members/personnel who are undertaking screening who may be perpetrators.

The task of screening may make some personnel/practitioners uncomfortable, especially if they themselves have a history of family/whānau violence. If required, an external supervisor should be provided, or personnel/practitioners (with their permission) may be referred to an outside agency – (e.g. an Employee Assistance Programme, or another local family/whānau violence agency).

4.2.5 When to screen

The introduction of routine screening of any individual in contact with an organisation/service which is using this Standard, must be handled with care. Without the necessary policy and protocols and without proper management, routine screening can be potentially harmful.

Each agency/service should develop a policy which identifies when screening should take place. Issues to consider are potential opportunities for safe screening, identified high risk groups and identifying the appropriate tool.

This Standard endorses the following best practice approach based on the Ministry of Health guidelines for screening for partner abuse:⁴⁹

- (a) Using validated screening tools all females aged 16 years and older should be screened routinely, about physical and sexual partner abuse, or to ascertain if they are afraid of a current or past partner;

NOTE – An additional screening question on psychological abuse can add value to a partner abuse screening. ➤

- (b) All females aged 12 to 15 years who present with signs and symptoms indicative of abuse should be questioned, preferably in the context of a general psychosocial assessment;
- (c) Males aged 16 years and older who present with signs and symptoms indicative of partner abuse should be questioned;
- (d) Questioning about suspected child abuse and neglect in high risk groups and questioning about abuse based on the presence of signs and symptoms is recommended. Routine screening for child abuse using direct questions such as those outlined for partner abuse is **not** recommended;
- (e) Caregivers of children using health services should also be screened;
- (f) Questions about abuse and/or neglect should be integrated into the clinical assessment undertaken by appropriately trained personnel/practitioners;
- (g) Agencies are expected to be systematic in determining the appropriate approach to screening and the specific population to screen; and
- (h) Elder abuse – screening is only recommended when high risk factors (see 4.2.9), or signs and symptoms of abuse are present.

4.2.6 Tools for screening

Questions always need a framing or introductory statement. This statement should cover such points as:

- (a) This service is asking the questions of all women, because family/whānau violence is quite common;
- (b) Family/whānau violence affects victims' health and their well-being;
- (c) Who will have access to the screening documentation;
- (d) How the person disclosing will be protected from the abuser;
- (e) There is help and assistance available; and
- (f) The limits of confidentiality on what is disclosed.

4.2.6.1 Question criteria

There is a variety of questions to ask when screening for family/whānau violence. The following criteria should be considered before the types of questions can be established:

- (a) The number of questions to be asked – this is based on how to uncover the abuse, what else is covered, the time available, the context of the visit;
- (b) Set or prescribed questions versus a range of suggested questions;
- (c) Close-ended questions (requiring a tick in the box) versus open-ended questions (requiring note-taking);
- (d) Need to build rapport with client;
- (e) Whether questions include one or more on sexual abuse;
- (f) Use of terms (abuse, violence, etc);
- (g) The possibility of whakamā (shame/embarrassment) for Māori, especially if interviewed alone;
- (h) Looking at time periods – 'ever' – 'in the last year';
- (i) Considering current, and/or previous relationships; and

- (j) Consideration of cultural beliefs and practices.

Research outcomes have identified the following influences on devising and conducting routine questioning. These may provide guidance in deciding the questions to use:

- (k) People do not respond to the same types of questions and so the questions about abuse must be asked in different ways;
- (l) The percentage of those who admit to a history of abuse will increase with the number of questions asked;
- (m) People often do not respond immediately to questions but if the questioning continues in a non-judgemental manner then some degree of trust can be established and the victim is more likely to answer; and
- (n) If a possible victim is asked a general question such as “have you ever been physically or sexually abused” she is likely to answer “no”. She is more likely to accurately answer specific detailed questions such as “have you ever been hit, punched, or shoved?”

Although it is highly recommended that family violence screening questions are asked verbally, and for some cultures that should be in their first language, some agencies/services use a written question (e.g. one of several questions on an intake questionnaire clients are asked to complete prior to their appointment).

4.2.6.2 Some questions in use

In USA Emergency Department settings⁵⁰ the following set of questions have been validated for sensitivity and specificity:

- (a) “Have you been hit, kicked, punched or otherwise hurt by someone within the past year?”
- (b) “Do you feel safe in your current relationship?”
- (c) “Is there a partner from a previous relationship who is making you feel unsafe now?”

In New Zealand variations of such questions are being asked. The Royal New Zealand Plunket Society uses the following:⁵¹

- (d) Framing statement – “We at Plunket are concerned about violence, and how it affects the health of women and children. We know it is quite common, so we routinely ask everyone a confidential question”;
- (e) Example question – “Have you ever been hit, kicked, or otherwise hurt or mistreated by any member of your family or extended family?”

Screening staff should be aware of the situation of any children involved and whether they have witnessed violence, or are the target of violence themselves.

4.2.7 Screening for partner abuse

Assumptions should not be made about partner abuse as it is not limited to any particular type of relationship, gender, religious, cultural, ethnic or income group. Studies indicate that less than 5 % of partner abuse and family violence is reported to the police or other official bodies.⁵²

Screening for partner abuse is recommended when high risk factors (see 4.3.7) or signs and symptoms of abuse or neglect are present. A list of signs and symptoms indicative of abuse is presented in Appendix F adapted from Ministry of Health Family Violence Intervention Guidelines for Child and Partner Abuse. These signs and symptoms described in Appendix F are not diagnostic of abuse. However in certain situations, contexts and combinations they will raise the practitioner’s suspicion of abuse. ➤

The following are useful examples of opportunities for selective, targeted or opportunistic screening. This list is not intended for mandatory use in each consultation to screen for abuse; rather it illustrates a range of events and situations to be alert to, when screening is valuable:

- (a) At the time of a healthcare consultation such as regular cervical screening, admission into hospital (e.g. in all cases of an injury presenting to Emergency Department), ante-/post-natal care, as pregnancy has been identified as a time of increased risk of partner violence;
- (b) When a client applies for financial assistance, (e.g. ACC, Work and Income);
- (c) When entering the justice system – Family Court applications, Youth Justice and Criminal Court for assault/abuse as perpetrator/victim/witness;
- (d) When indicators such as multiple injuries, especially of different ages: bruises, welts, cuts or abrasions, are present;
- (e) When child abuse is suspected;
- (f) When a client has a new relationship or partner or is in the process of separating from a partner;
- (g) When the client presents with depression or anxiety;
- (h) When the partner presents in an agitated state suggestive of the potential for violence or unpredictable behaviour of a worrying nature, or the client describes their partner in this way;
- (i) When the client presents with sexual or reproductive health issues which could include injuries or vaginal bleeding during pregnancy, spontaneous or threatened miscarriage;
- (j) When young people seek assistance from or are referred to youth services, for example for drug and alcohol addiction, mental or sexual health issues.

The health sector currently has the most robust and well-defined family violence screening practices in New Zealand.

In general, in order to screen routinely, the professional with the most contact with clients in any service shall carry out the screening (i.e. front-line workers). Screening should take place as close as possible to the first contact with the service to allow adequate time for intervention. Rapport with the client should be established prior to screening if at all possible. Screening should be repeated at regular intervals if signs and symptoms persist.

However, no screening is perfect and the potential impact of screening failures can result in harm. It is important for there to be a process for reviewing screening failures, both when the screening process fails to identify high risk situations and when risk is identified that is later found to be unjustified. This process of review will provide information that will help refine and improve the way screening tools are applied and interpreted.

4.2.7.1 The screening setting

Screening should take place only after the following circumstances have been met:

- (a) Privacy – arrange a separate interview space where the interview cannot be overheard;
- (b) Alone – request that other people (family/friends) leave the room, or put a strategy in place to allow the client to be seen alone;
- (c) Confidentiality of disclosures – explain the agency’s provision for, and limitations of confidentiality;

- (d) No children aged over two are present – arrange childcare if possible or postpone screening;
- (e) An interpreter is present and briefed – if language barriers exist. Family/friends should not be used for this purpose and the assessor needs to be aware of any gender issues with interpreters; and
- (f) Culturally safe environment – the provision of a culturally friendly environment including the physical environment and the behaviour and attitudes of the personnel/practitioner. The first point of contact is important in building trust, together with an atmosphere that conveys openness and caring without judgement.

4.2.7.2 Asking the screening questions

Screening is most effective when a trained and confident person is able to introduce the procedure and ask the questions verbally in an open, friendly, non-judgemental manner.

Research shows that women victims react positively to screening questions on family/whānau violence – (e.g. Department of Health, New South Wales, surveyed 586 women who were screened, of whom 97 % said they felt ‘OK’ or ‘relieved’ about being asked). Personnel/practitioners may benefit from being shown the procedure by an experienced practitioner prior to carrying it out alone. Memory prompters such as diary cards are also useful.⁵³

4.2.7.3 Responding to disclosures

If a person discloses family/whānau violence, including child abuse and neglect, it is important to provide support and validation. Abused people often feel ashamed, humiliated, frightened and may blame themselves. In particular, it is important to:

- (a) Convey a non-judgemental attitude to the client;
- (b) Allow the person to talk about some of the ways in which the abuse has affected them;
- (c) Accept any ambivalence the client has towards staying/leaving the situation;
- (d) Always tell the person that help is available and they do not deserve to be abused;
- (e) Advise the person, except in extraordinary circumstances what will happen to the information.

Other effective responses are:

- (f) “You are not alone – this happens to many people”;
- (g) “It’s not your fault”;
- (h) “You have a right to be safe”;
- (i) “I am concerned for your safety – I’m glad you told me.”

4.2.7.4 Responding to “yes”

Successfully intervening in family/whānau violence usually involves several individuals, team/departments and/or agencies. For example, a GP may screen and respond and then refer to CYF or a social service agency. It is important for staff/practitioners to realise they are part of a process; they are not required to address the situation on their own. However the success of their part of the intervention will be enhanced by a smooth referral process which empowers the client to increase their safety and that of any children involved.

In order to screen effectively, personnel/practitioners need to have:

- (a) A non-directive manner;
- (b) An awareness of the risk to the client after disclosure;
- (c) The ability to explain appropriate options;
- (d) An awareness of community resources;
- (e) An ability to convey to the client that effective help is available;
- (f) An understanding of informed consent;
- (g) An understanding of confidentiality and mandatory reporting requirements;
- (h) The ability to ensure that an effective referral is made and to follow it up.

4.2.7.5 Responding to “no”

If a client responds with “no” answers, it is important to respect their response. The client may be in a violent situation but does not feel safe enough yet to let the staff member/practitioner know. The client may disclose later to another personnel/practitioner, or he/she may simply feel supported because someone is taking the issue seriously and is interested in his/her welfare. A “no” response can also mean that the client is not being abused currently, or may never have been abused.

An appropriate reply is to thank the client for answering the questions, inform the client how and when help (including follow-up help) can be accessed at any time and provide details. Offering a brochure/card in case any friends or family might benefit from reading it at some time may be appropriate.

4.2.8 Screening for child abuse and neglect

Child abuse and neglect may be perpetrated by parents or other relatives, and by males or females. Neglect is defined as any act or omission that results in impaired physical functioning, injury, and/or development of a child of young person. Routine screening for child abuse and neglect using direct questions such as those outlined for partner abuse in 4.2.6.2 is not recommended. Screening should be conducted where signs and symptoms of abuse or neglect are present, which could include physical signs such as multiple injuries, (especially of different ages), or behavioural and development signs (e.g. fear, aggressions, anxiety and regression) or a history of past abuse, exposure to family violence, alcohol or drug abuse.

4.2.8.1 Asking children about possible abuse and/or neglect⁵⁴

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

Older children may be asked:

- (a) Where do you live?
- (b) Who lives in your house?
- (c) Who are your extended family?
- (d) What happens when people disagree with each other in your house?
- (e) What happens when things go wrong at your house?
- (f) What happens when your parents/caregivers are angry with you?
- (g) Who makes the rules? What happens if you break the rules?

4.2.8.2 Questions for the caregiver

Staff should use non-judgemental questions about parenting and discipline, for example:

- (a) How do you think it is for your children living in the home at the moment? How do you think they see things?
- (b) What happens when you are unhappy with your child's behaviour?
- (c) What concerns have you had/do you have about your child's safety? Can you tell me about these worries?
- (d) Who else is involved in looking after your children when you are not at home?

4.2.8.3 If you suspect the caregiver may be the abuser

- (a) How do you react with the children when you're really stressed, tired or angry? Do you worry about how you deal with it?
- (b) What happens when you get angry?
- (c) What do you do when the child misbehaves?
- (d) Are you ever afraid that you might hurt a child in your care?
- (e) Have you ever hurt a child in your care?
- (f) Do you know what practical help is available to assist you with parenting/childcare?

4.2.8.4 Asking adolescents/young people about possible abuse

The different profile of abuse that young people may experience requires a developmentally appropriate assessment to be undertaken if signs and symptoms of abuse are detected. Assessment of the causes of violence in this age group might be best accomplished as part of a thorough psychosocial assessment for adolescents such as the HEADSS⁵⁵ assessment (see Appendix C for HEADSS definition). This needs to be referenced and outlines a review of home environment, education and employment, peer activities, drugs, sexuality and suicide or depression factors.

4.2.8.5 Children with disabilities

It is specifically recognised that children with significant mental or physical disabilities may be particularly vulnerable to abuse and neglect because of their dependency upon adult care and their limited ability to self-defend. They may be unable to talk about what has happened to them or to even comprehend it. Caregivers of disabled children are more likely to exhibit abusive or neglectful behaviour towards the child because of the greater stresses placed on them caring for a child who is totally physically dependent or has significant behavioural problems. Screening in this situation must be done in a supportive manner using non-judgemental questions. The questions listed in 4.2.8.3 can be used but should be prefaced by acknowledgement of the difficulties that are experienced by the caregiver. For example:

- (a) "It must be very hard for you caring for Mary when she takes up so much of your day. How do you manage when you are really tired, or frustrated with her?"
- (b) "John's behaviour must be very hard for you to manage. What do you do when you get to the end of your tether with him?"
- (c) "I have known many parents in your situation who have found it really hard to keep their cool with a child who is as difficult to manage as Kathy. Have you ever experienced that? What happens when you find yourself in that situation?"

4.2.8.6 Take action

If there are concerns that a child may be being abused or neglected, then a referral to CYF shall be made. The service has a statutory responsibility to complete an assessment that covers screening and risk assessment within the practice requirements and guidelines of CYF using its approved tools.

4.2.9 Screening for elder abuse

Elder abuse and neglect happens amongst older people living in the community and among those in short- and long-term residential care, private homes and hospitals. It is not limited to any particular sex, religious, cultural, ethnic or income group. Financial and emotional/psychological abuse of older people is more common than physical or sexual abuse.⁵⁶

Questioning for elder abuse is recommended when high risk factors or signs and symptoms of abuse or neglect are present. Routine screening of all older people in the absence of signs and symptoms is currently not recommended. The following risk factors described are not diagnostic of abuse. However certain situations, contexts and combinations may raise the practitioner's suspicion of abuse.⁵⁶

Elder abuse or neglect is more likely to occur when:

- (a) The abused lives together with the abuser;
- (b) There is a history of family violence or partner abuse;
- (c) There is a history of, or unresolved previous sexual abuse;
- (d) The level of dependency is increasing;
- (e) There is a lack of adequate support and relief for the caregiver; or
- (f) There has been a recent change in living arrangements.

When working with older people from another culture, advice and assistance shall be sought from that culture. Wherever possible, it is preferable that services be provided by people from the same culture as the older person. People from other cultures are likely to have ways of addressing elder abuse and neglect which are consistent with their own culture.⁵⁷

The responsibility to protect older people against abuse does not rest with any one group. It does not recognise any professional boundaries but rather calls on a wide network of community and government services to alleviate elder abuse. Establishing networks of people who can assist with cases of elder abuse and neglect is crucial. The networks used by the Age Concern Elder Abuse and Neglect Services include, but are not limited to:

- (1) Police Family Co-ordinators and Community Constables;
- (2) Health services which specialise in the health of older people (geriatricians, assessment, treatment and rehabilitation units);
- (3) Community groups such as the Alzheimers New Zealand, the Stroke Foundation of New Zealand, Parkinsons New Zealand, Victim Support and Citizen Advice Bureaux;
- (4) Mental Health Services;
- (5) Iwi/Māori services.

4.2.9.1 Asking the older person about possible abuse and/or neglect

Asking the older person to describe their situation in a general way may be an effective way to open discussion. The abused person may feel ashamed, frightened or intimidated. They may be resigned to, or accepting of, long-standing abuse. A sense of duty or a desire to protect a carer, who may be their only source of social contact or care, can deter the person from speaking out. Cultural differences in communication style should also be considered.

Older people may initially be asked:⁵⁸

- (a) “How are things going at home/in residential care?”
- (b) “How are you spending your days?”
- (c) “How are you feeling about the amount of help you are getting?”
- (d) “How do you feel your (husband/wife/son/daughter/other caregiver) is managing?”
- (e) “Do you have everything you need to take care of yourself?”

Where there are high risk factors, (see 4.2.9) or signs and symptoms indicate possible abuse, older people can be asked:

- (f) “Has anyone at home ever hurt you?”
- (g) “Has anyone ever taken anything that was yours without your consent?”
- (h) “Has anyone ever made you do things you didn’t want to do?”
- (i) “Has anyone ever touched you without your consent?”
- (j) “Has anyone ever scolded or threatened you?”
- (k) “Have you ever signed documents that you didn’t understand?”
- (l) “Are you afraid of anyone at home?”
- (m) “Are you alone a lot?”
- (n) “Has anyone ever refused to help you to take care of yourself when you needed help?”

4.2.9.2 Questions for the caregiver

Open-ended, non-judgemental questions work best:

- (a) “How is (older person receiving care) getting on?”
- (b) “How has life changed for you since becoming a caregiver?”
- (c) “Have you been able to talk to someone about these changes?”
- (d) “How has having (older person receiving care) dependent on you affected your relationship?”
- (e) “Do you know what practical help is available to assist you?”

4.2.9.3 If you suspect the caregiver may be the abuser

- (a) “What kinds of things do you have to do now as part of you caring for (older person receiving care)?”
- (b) “Are you able to get a break or have enough time for yourself?”
- (c) “Do you ever worry that (older person receiving care) is not safe?”
- (d) “Are you ever worried that you might hurt (older person receiving care)?”

4.2.10 Documentation

Documentation shall record the standard screening questions that were asked and the response given, followed by any actions that occurred, including recommendations that the person screening identifies as being appropriate. All screening episodes and routine screening shall be documented. A clear and up-to-date record of the screening means that possible victims will not be screened more often than necessary and appropriate, timely, monitoring can occur. All reasonable steps should be taken to avoid inadvertent disclosure of confidential information.

Documentation requirements include:

- (a) Clear accurate notes;
- (b) Copies of any standard forms used;
- (c) Secure storage;
- (d) Policy covering who can access information and information sharing;
- (e) Processes to protect client from inadvertent disclosure to the perpetrator;
- (f) Adherence to agency/organisation policies.

4.2.11 Flow chart for screening

Figure 1 sets out a summary of the options and steps in the screening process, depending on disclosures made.

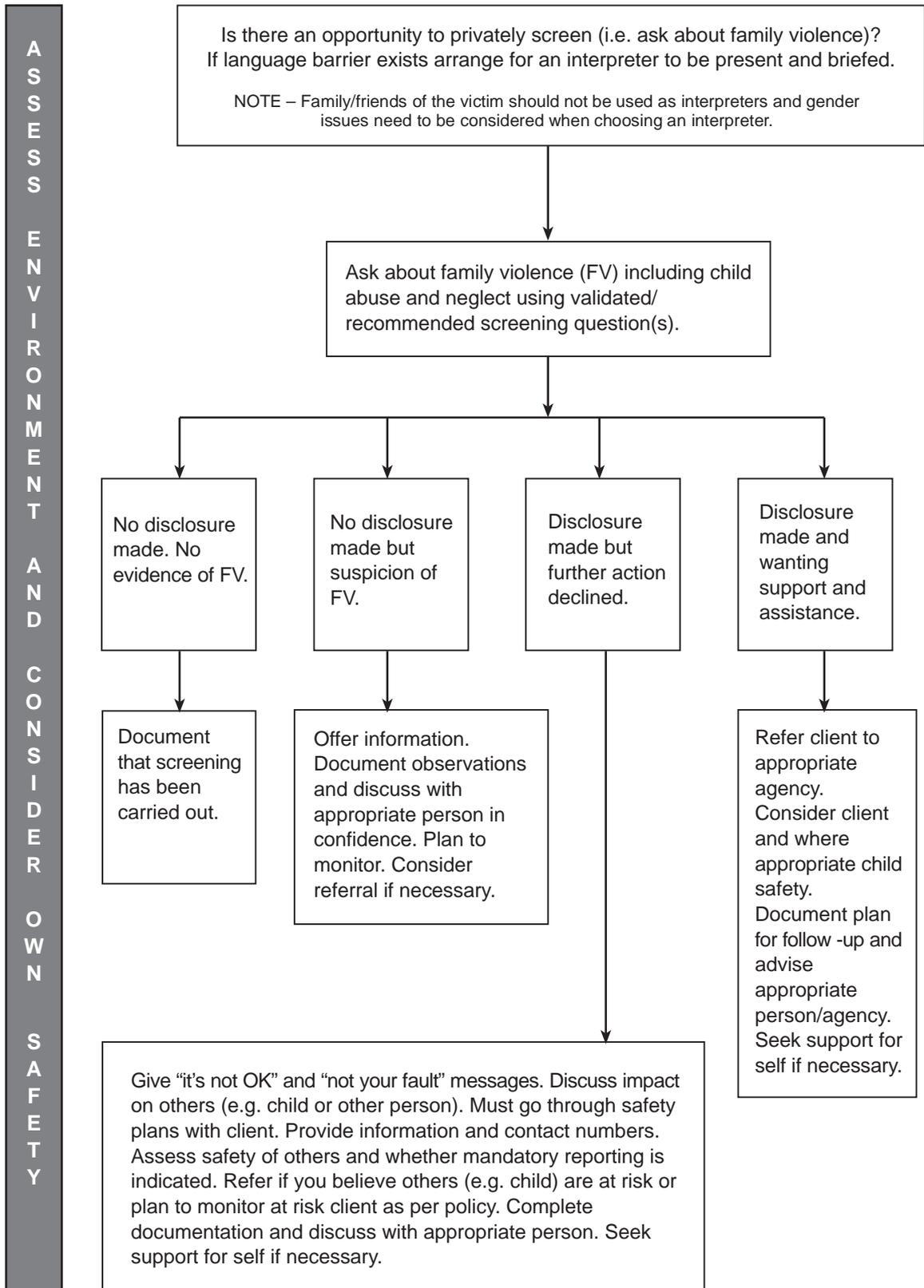


Figure 1 – Flow chart for screening for family/whānau violence, including child abuse and neglect⁵⁹

4.2.12 Examples of risk screening resources

All risk screening tools require appropriate training and support before use. See Appendix G for examples of risk screening resources provided by the Royal New Zealand Plunket Society Inc. and Ministry of Health.

In essence, these are:

- (1) 'Family Violence Policy and Protocol' from the Royal New Zealand Plunket Society Inc.⁶⁰ Plunket Nurses use a socio-ecological framework which enables them to identify health determinants that are known to influence a child's/tamariki's well-being and provides a context for prioritising healthcare and interventions. Family violence is a health determinant that significantly affects the well-being of children. The Family Violence Policy and Protocol provides guidance to staff for screening, response to disclosure, continuing support and referral regarding family violence for their client base.
- (2) 'Family Violence Intervention Guidelines – Elder Abuse'⁶¹ (final draft, Ministry of Health), provide a series of scenarios and list healthcare settings in which screening for elder abuse should occur as either signs and symptoms of abuse are identified and/or as a result of apparent alert features.

4.3 Risk assessment

This section provides information to raise public awareness about risk assessment for those interested in learning about family/whānau violence. It highlights many high risk factors and provides guidance for those agencies/individuals undertaking family/whānau violence risk assessment and associated safety planning. Section 4.1 provides an overview of policies and procedures needed to support safe, effective practice.

4.3.1 General

Risk assessment is a process (defined in Appendix C) that takes into account a full examination of the circumstances and interactions to enable a trained person to form an opinion about another person's risk of harm either to themselves or to others. Assessment aims to evaluate the risk of future abuse to any person. It also evaluates the likelihood of violence and the level of danger posed by any potential offender in order to provide adequate protection to known and potential victims.

The victim's knowledge and perceptions during the risk assessment process should be taken seriously.

Risk is never static and requires ongoing assessment and review as situations of family/whānau violence, child abuse and neglect may change rapidly.

There is an implicit assumption in any assessment process that a decision will be made during or after assessment about what form any intervention will take. Best practice would suggest that any level of disclosure or risk requires a safety plan.

It is generally most helpful to assess risk in terms of various categories, with the highest level of risk (most severe and acute) requiring the most immediate and intensive response. Risk assessment may cover short, medium and long term safety considerations and will involve some form of safety planning.

Risk assessment is based on structured professional judgement, but is only ever a guide and does not provide an absolute measure of risk. Risk assessment is not an exact science, and should never be used to exclude anybody from access to family violence services.

4.3.2 Purpose

A risk assessment framework for potential family/whānau violence, including child abuse and neglect is used to:

- (a) Identify those persons at any risk of family/whānau violence;
- (b) Identify situations of potential risk;
- (c) Provide the basis for safety planning, interventions and referrals.

4.3.3 Risk assessment principles/guidelines

Risk assessment should:

- (a) Recognise that family/whānau violence, in all its forms, is unacceptable behaviour;
- (b) Not compromise the safety of people affected by any risk of family/whānau violence;
- (c) Guide ongoing safety planning, intervention and referral;
- (d) Recognise the best predictor of future behaviour is past behaviour when assessing ongoing family/whānau violence;
- (e) Recognise specific factors likely to lead to any form of abuse including serious harm or death;
- (f) Recognise that risk is never static and should be subject to ongoing assessment and review;
- (g) Be undertaken at each new referral source or stage of intervention;
- (h) Include information from a number of sources including relevant individuals and agencies;
- (i) Take seriously the fears, concerns and perceptions of any client;
- (j) Aim to educate clients and raise their awareness of risk;
- (k) Always consider the needs of any children or other dependants;
- (l) Recognise that some clients may be both a perpetrator and a victim of family/whānau violence;
- (m) Also note any protective factors including cultural factors.

4.3.4 What does a risk assessment procedure contain?

A robust risk assessment procedure has the following generic features:

- (a) Clarity about the type of risk being assessed, whether it is:
 - (i) Risk to victim's well-being and safety
 - (ii) Risk of death for victim and/or perpetrator
 - (iii) Risk of further violence by the perpetrator
 - (iv) Risk to safety and well-being of children and other witnesses
 - (v) Risk to the assessor.
- (b) Policy, with aims, goals and principles;
- (c) Guidelines, including cultural considerations;

- (d) Procedures for:
 - (i) Identifying when and where it is safe to complete the assessment
 - (ii) Identifying possible abuse
 - (iii) Supporting and empowering victims of abuse
 - (iv) Assessing risk to the client and others
 - (v) Assessing immediate, short and long term risk
 - (vi) Engagement and empowerment of clients in change process
 - (vii) Safety planning and referral
 - (viii) Documenting evidence
 - (ix) Working with referral agencies, and
 - (x) Interagency collaboration and information sharing.

4.3.5 How to develop a risk assessment tool/procedure?

The first task is for each agency to identify their specific field of practice and expertise. This will determine both the most appropriate tool and the associated processes to ensure effective risk assessment, safety planning, intervention and referrals can be achieved.

Agencies shall use risk assessment tools which are:

- (a) Validated by robust evidence-based research; and/or
- (b) Based on cultural values and competencies, or
- (c) Founded in practical knowledge and experience where the above are not available.

Any model/tool used should be informed by an assessment of the following:

- (d) Age, sex and family factors;
- (e) Individual lifestyle factors (e.g. drug or substance abuse or misuse);
- (f) Intellectual capability;
- (g) History of violence;
- (h) Social and community factors, (e.g. gang affiliations);
- (i) Living and working conditions; and
- (j) Socio-economic, cultural, and environmental conditions.

4.3.6 When to complete a risk assessment?

Opportunities for risk assessment arise whenever family/whānau violence has been identified, with any new family/whānau violence referral, with any new situation, and on an ongoing regular basis for each referral. A full assessment could form part of crisis intervention, specialist referrals or take place within a general social service provision.

Risk assessment should be undertaken when it is safe for the worker and for the client. This will involve developing clear protocols to address confidentiality, privacy and the sharing of information.

There is a need to be aware of and be prepared for the potential emotional impact on the client of any assessment and disclosure process.

4.3.7 What should a risk assessment include?

Factors that are commonly covered in risk assessment tools/instruments include:

- (1) *Context:*
 - (a) Past history of family/whānau violence (to include a history of harm or threats to the partner and/or children);
 - (b) History and whakapapa (investigation of the family/whānau and their knowledge of what is occurring amongst family members including an assessment of whether violence is a common feature within the whānau environment);
 - (c) The history of extended family members;
 - (d) Frequency and severity of violence;
 - (e) History of animal abuse by any family member;
 - (f) Potential triggers for family/whānau violence, including;
 - (i) Separation
 - (ii) Day-to-day care and contact disputes
 - (iii) New relationships
 - (iv) Alcohol and drug abuse
 - (v) Complaints to police or other agencies
 - (vi) Applications for protection orders.

- (2) *Is the perpetrator:*
 - (a) Obsessed with, dependent upon, or stalking the victim?
 - (b) Responsible for incidents of animal abuse?
 - (c) Demonstrating jealous, controlling or threatening behaviour?

- (3) *Does the perpetrator have:*
 - (a) Easy access to or contact with the victim or other family members?
 - (b) A history of violence-related offending (including abusive acts in concurrent and past intimate relationships and previous violations of protection orders and bail conditions)?
 - (c) A history of past attempts to strangle the victim?
 - (d) A known personality disorder that predisposes them to violence?⁶²
 - (e) A history of alcohol or drug abuse/misuse?
 - (f) A history of depression, which may, or may not, have been medically diagnosed?⁶³
 - (g) Access to weapons, particularly firearms and have a history of using, or threatening to use them or have training in martial arts or similar training?
 - (h) A history of threatening to harm or to kill the victim or other family members?⁶⁴
 - (i) A history of hospitalisation or police involvement due to a mental health disorder?⁶⁵
 - (j) A history of threatening to commit suicide? or
 - (k) A brain injury resulting in increased aggression or disinhibition?⁶⁶

(4) *Does the victim:*

- (a) Believe the perpetrator could injure or kill her/him?
- (b) Believe the perpetrator could injure or kill the children?
- (c) Fear returning home or anywhere else the abuse has occurred?

None of these risk factors, alone or in combination are a guaranteed predictor of interpersonal or family/whānau violence or a prerequisite either. However, experiences from front line staff working with those living with family/whānau violence report they have all been plausibly and reliably linked with such violence.

The level of risk increases drastically with any combination of these factors.

Because of the high co-occurrence of different types of abuse and violence, where partner abuse is identified, it is essential to assess the risk to any child(ren) and other family members.

4.3.7.1 How to assess the risk to children?

Information should be sought on:

- (a) Does the abuser have or had contact with the child(ren)?
- (b) Has the abuser ever hurt or threatened to hurt or kill any child(ren)?
- (c) Has the abuser ever forcefully removed or threatened to remove the child(ren) from their partner's or others' care?
- (d) Has the child(ren) ever witnessed partner abuse (physical or verbal) occurring?
- (e) Has the abuser hit the child(ren) with belts, straps, or other objects that have left marks, bruises, welts, or other injuries?
- (f) Has the abuser ever touched or spoken to the child(ren) in a sexual way?
- (g) Has the child(ren) tried to intervene to protect the partner from the abuser?
- (h) Was the child(ren) injured as a result of the above?

In some situations it may also be appropriate to assess the risk the abused partner may pose to the children.

Some questions that could be appropriate to ask include:

- (i) When women are experiencing the sort of abuse you have described to me, it can affect their ability to parent in the way they would if they were free from abuse. Is this true for you?
- (j) Are you ever afraid that you might hurt your children?
- (k) Have you ever hurt your children?
- (l) Do you know what practical help there is to assist you?

Asking these questions of the abused partner will provide some information about the child's safety, but will not necessarily provide a complete picture. Information from other sources (e.g. grandparents, other family members, CYF) may also be needed.

If there are concerns that a child may be being abused or neglected, then a referral to CYF shall be made. Once a notification is received by CYF, an assessment that covers screening and risk assessment of that child and their family, including extended family, will be carried out by the allocated social worker.

4.3.8 Assessment of the level of risk

No single instrument, however thorough or seemingly in tune with research findings, should form the sole basis for risk assessment. Any assessment or score should be considered in conjunction with other relevant information, including the victim's perceptions and knowledge. In some situations referral to or consultation with an expert family violence service may be indicated. If there is doubt about the level of risk, it is better to take actions that err on the side of safety.

4.3.9 Dealing with perpetrators

It is not appropriate to perform routine screening or risk assessment of perpetrators as this is an area of expert practice most usually carried out by specialist agencies and domestic violence programme providers.

There will however, be times when the perpetrator will initiate a conversation about their behaviour. The perpetrator may present as angry, abusive, depressed or remorseful. The purpose of any intervention is:

- (a) To reduce any immediate risk of further violence or abuse to self or others;
- (b) To protect victims from further harm;
- (c) To ensure that the perpetrator is informed of resources and avenues available to assist them.

If there is a risk of further self-harm or harm or imminent danger to any other person is identified, then the agency's or professional guidelines should be followed or immediate assistance sought from such agencies as NZ Police, local mental health teams, CYF or Women's Refuge.

4.3.9.1 If the perpetrator wants to end the violence and/or abuse

The perpetrator's concern and desire to end the violence and/or abuse should be acknowledged. Provide support and information so appropriate intervention and referral can take place.

It may be appropriate to use the following which should relate to or be based on what the perpetrator has said:

- (a) "It sounds as if you get very angry at times";
- (b) "You are saying you hit her and knocked her out";
- (c) "You seem upset at how you behaved";
- (d) "Do you worry you might hurt someone?"
- (e) "It sounds like you would like help to change the way you react in those circumstances";
- (f) "Sounds like you realise it isn't ok to hurt other people in that way";
- (g) "Would you like me to give you the names of some agencies/services who could help you?"

4.3.9.2 Immediate safety risks

If there are concerns about the perpetrator's behaviour:

- (a) Remain calm and respectful in your approach;
- (b) Be aware that some forms of questioning or other contact could increase the client's agitation and aggression and may put others at risk;
- (c) Ring 111 or call for assistance if you fear for your own immediate safety or believe the perpetrator is an imminent threat to others;

- (d) If you believe the perpetrator is likely to go home and hurt someone you need to call the police; and
- (e) Do **not** disclose any information from the victim.

Clarify details for referral and risk assessment purposes if it is safe for you to do so, such as:

- (f) “Are you saying you have a gun in the car?”
- (g) “Where did you say you were living currently?”
- (h) “What exactly happens at home when you argue?”

These situations are stressful; it is recommended that support be sought from an appropriate person or agency for personnel/practitioners who need it and that facilitated incident debriefing be held as required (see 4.1.3.4).

4.3.10 Risk of suicide or self-harm

In the area of family/whānau violence, workers must always be alert to multiple risk factors. Victims may also be abusers, and both perpetrator and victim may be at risk of self-harm or suicide. The very process of risk screening and risk assessment may increase a feeling of hopelessness or guilt. Some people who make threats of suicide or self-harm will go on to harm or kill both themselves and others within that domestic relationship – this can include children and new partners. Times of high risk may include:

- (1) Separation;
- (2) Court orders/proceedings;
- (3) Day-to-day care and contact disputes;
- (4) New relationships.

Signs associated with high risk of suicide include:

- (a) Previous suicide attempts;
- (b) Stated wish to die;
- (c) Planning for suicide (e.g. putting affairs in order);
- (d) A well developed concrete suicide plan (including either a previous attempt or the discovery or a revelation of a plan); and
- (e) Access to the method to implement the previous or current plan.

Other factors that may be associated with the risk of suicide or self-harm can include depression, extreme anxiety, agitation or enraged behaviour, excessive drug and/or alcohol use or abuse.

The NZ Guidelines Group and Ministry of Health⁶⁷ suggest that while there is no evidence that asking a person directly about suicide increases their likelihood of making a suicide attempt, the following questions are aimed at not alarming a person. Rather they ‘warm up’ a person who might be having suicidal ideation.

If in doubt about safety, it is important to make direct enquiries to assess if the client is thinking about committing suicide, or has attempted suicide in the past. Examples of softer questions that may be appropriate to ask include:

- (i) “How has your mood been lately?”
- (ii) “Has anything been troubling or worrying you?”
- (iii) “Have you had times when you have been feeling sad or ‘down’?”

- (iv) “Have you ever felt like life is just getting on top of you?”
- (v) “Do you sometimes wish you could just make it all stop, or that you could just end it?”
- (vi) “Some people get so desperate they hurt themselves or think dying is the only option – have you ever found yourself thinking like that?”
- (vii) “What were you thinking about doing to hurt/kill yourself?”
- (viii) “Do you have access to . . . (whatever is needed to implement the plan)?”
- (ix) “Have you hurt yourself before?”

If in doubt about a client’s risk to self or others, they should be referred for specialist help, e.g. to the local mental health specialist team or a GP. If there is fear for their immediate safety, this should be acted on whether or not a client gives permission. Unless otherwise indicated, the person should be told of the actions taken and an explanation provided.

4.3.11 Documentation

It is essential to have a method of recording information from assessments in a manner which ensures confidentiality and safety for personnel/practitioner and clients. The use of a standard assessment tool/questionnaire assists a comprehensive risk assessment and is a means of recording information. When standard forms are not used, information should still be recorded with clear notes of any high risk and proposed course of action.

Documentation shall include:

- (a) Clear accurate notes;
- (b) Copies of any standard forms used;
- (c) Secure storage;
- (d) Policy covering who can access information and information sharing;
- (e) Processes to protect the client from inadvertent disclosure to the perpetrator;
- (f) Adherence to agency/organisation policies.

4.3.12 Examples of risk assessment resources

Risk assessment tools shall be used only by those with sufficient training and support.

See Appendix H for specific examples of risk assessment resources provided by New Zealand Police, Preventing Violence in the Home and the Ministry of Health. These resources are:

- (1) ‘Identifying Red Flags’– risk factors used by the New Zealand Police. This tool outlines high risk factors for predicting dangerousness and lethality.
- (2) ‘Family Violence Intervention Risk and Lethality Assessment’ used by personnel/practitioners and trained volunteers working for the Preventing Violence in the Home – Community Agency. This tool is adapted from the work of Fernando Mederos, Denise Gamache and Ellen Pence and uses a standard form to contribute to the final determination of level of risk.
- (3) Ministry of Health^{68,69} provides sets of risk screening questions – see 4.2. These questions may be used with children, elderly people or caregivers where abuse and/or neglect are suspected. In situations involving children the level of risk to the child would be assessed based on responses provided by both the child and the caregiver. It may be necessary to use an adult risk assessment tool with the caregiver.

4.4 Safety planning

Safety planning is a process of thinking through risks and possible dangers and planning for ways to prevent, or minimise harm and maximise safety. Such planning is a vital next step after screening and risk assessment and when violence/abuse has been disclosed. It enables a victim of family/whānau violence, sometimes with the support of an advocate, to develop a plan to achieve and maintain safety from an abuser. A safety plan generally includes a range of interventions, to avoid serious injury and escape violence, prepare for separation and/or maintain long term safety after separation.

A safety plan or intervention could be a referral straight to CYF or the Police (by dialing 111) or it can be just giving a person the emergency numbers for their area and affirming that it is okay to call/seek help.

The Good Practice Guidelines for Co-ordination of Family Violence Services⁷⁰ identify safety planning as central to the support for victims. The UK Domestic Violence Good Practice Indicators⁷¹ state that “safety oriented practice is crucial in any circumstances where domestic violence may be an issue”.

4.4.1 Purpose

The central purpose for undertaking family/whānau violence screening and risk assessment is to ensure the safety of adults and children who are victims of violence and prevent further violence and harm. Where family/whānau violence is identified or suspected, it is essential to assist victims plan for ways to keep themselves and any children safe.

Safety planning alone will not prevent violence. Victims do not have control over the violent person’s actions but they can make choices about how to respond to the violence and plan for ways to get help and/or to get to safety.

4.4.2 Safety planning principles/guidelines

Safety planning shall:

- (1) Recognise that family/whānau violence, in all its forms, is unacceptable behaviour;
- (2) **Not** compromise the safety of people affected by any risk of family/whānau violence;
- (3) Be the priority for all agencies and individuals working with people affected by family/whānau violence;
- (4) Be one of the key interventions to ensure the safety of people affected by family/whānau violence, particularly women and children;
- (5) Use processes which do not compromise the safety of people affected by family/whānau violence;
- (6) Involve victims, and be based on their specific needs, strengths, circumstances and choices;
- (7) See safety plans for adults include planning for the safety of any children;
- (8) Ensure that safety plans for a child involve the child and include appropriate actions, taking into account their age, understanding, and capabilities;
- (9) Achieve safety plans that are practical and detailed, considering and preparing for a number of scenarios that may need to be taken into account;
- (10) Be an on-going process. The plan will need to be reviewed and may change over time depending on the victim’s circumstances and the actions of the abuser.

4.4.3 When to develop a safety plan?

Safety plans should be developed following the risk assessment process, when:

- (a) Victims (adults and children) are intending/considering leaving a violent person or seek help;
- (b) Victims (adults and children) have left the violent person/situation;
- (c) Victims (adults and children) are staying in the situation where they are at risk of violence, returning to, or having contact with the violent person;
- (d) The presence of abuse/violence has been identified.

Safety will also be a consideration for agencies/services and individuals who are undertaking the screening, risk assessment and other family/whānau violence services.

All safety plans need to be reviewed when there are changes to circumstances or risk such as when:

- (e) The victim leaves the situation;
- (f) A new relationship develops;
- (g) The victim applies for a protection order;
- (h) There are disputes over child care, property or finances;
- (i) There have been threats or escalating violence;
- (j) There has been a suicide threat or attempt;
- (k) There are changes in drug and alcohol misuse.

4.4.4 Who needs a safety plan?

Adults and children need safety plans when family/whānau violence has been identified. Specific plans, recognising the specific needs, strengths, circumstances and choices of the victim(s), should be discussed and then documented (where it is safe to do so). Separate plans for each child as appropriate to their developmental age should be developed.

Safety plans should be developed in conjunction with the victim when violence/abuse/neglect has been identified.

Personnel/practitioners working with victims and/or perpetrators need to plan for their own personal safety.

4.4.5 Who will develop and be involved in the safety plans?

Safety plans are best developed by the victim and a specialist advocate in family/whānau violence who is trained to do this. However, any support person can assist with the development of a safety plan, or a victim may develop a plan alone, usually using a prepared checklist.

In cases of high risk where the safety plan involves other agencies, e.g. a rapid response by police, the specialist advocate should consider making suitable arrangements to ensure that the agency can respond accordingly and that safety is not compromised.

Model safety plans are available from family/whānau violence agencies and on the internet and examples are provided in 4.4.9 and Appendix J, examples 1 and 2.

4.4.5.1 Where will the safety plans be developed?

Agencies and individuals should take every opportunity to ensure victims of family/whānau violence are safe. Safety-related information should be provided and the victim should be encouraged to develop or participate in the development of a safety plan whenever possible.

Safety planning should happen in an environment where victims are safe, have support, and are able to make safe choices for themselves and any children.

4.4.6 Factors to be considered in making a safety plan

Particular factors that could be considered by the victim and/or support person in developing the safety plan include:

- (a) What have they tried before to keep safe? E.g. is there a protection order already in place, and have they already been able to use it?
- (b) How did it work?
- (c) What was the violent person's reaction?
- (d) Would they try it again? If not, why not?
- (e) What resources do they have to draw on?
- (f) How do they think the violent person will react to the safety plans they are making?

NOTE – It should be acknowledged in exploring these factors that it can be very difficult for abused individuals to initiate their own safety plan.

4.4.7 What resources can be used?

While there are features in common in all safety plans, there are different safety considerations when victims stay with or return to any violent person, when they are about to leave, or when they have left. Examples of different safety plans are included in Appendix J.

When it is suggested that a risk assessment take place there should be strong cautions on the information provided to other agencies. In addition the victim shall be centrally involved in risk planning and provided with support resources as it is common to be overcome by the emotional experience of going through such an inventory of her/his life with a complete stranger.

There are many common features found in safety plans used by agencies dealing with family/whānau violence. These include:

Immediate actions whether or not the victim and their children have left the violent situation they could, in the first instance, while ensuring they are safe, seek assistance from:

- (a) CYF, where there are care and protection issues for children;
- (b) A local Women's Refuge or specialist domestic violence service provider or other agreed service provider;
- (c) Friends;
- (d) Family/whānau;
- (e) Neighbours.

Short/medium term actions that could be considered include:

- (f) Identifying support people (e.g. safe friends, whānau, neighbours);
- (g) Identifying local agencies/services and professionals that can help (e.g. Victim Support, doctor, social worker, police, lawyer);

- (h) Improving home and personal security by:
 - (i) changing locks or installing alarms
 - (ii) talking to friends and neighbours about regular checking on the victim's safety
 - (iii) obtaining a mobile phone;
- (i) Obtaining a protection order through a lawyer and resolving issues for the safe care of children, (e.g. parenting order);
- (j) Seeking legal and/or financial advice;
- (k) Identifying essential items to take when leaving the violent person:
 - (i) copies of important documents such as birth certificates, passports, immigration papers etc.
 - (ii) driver's licence
 - (iii) copies of protection order or any other court orders and documents
 - (iv) bank account information, credit and EFTPOS cards
 - (v) mobile phone and/or important phone numbers
 - (vi) clothing and personal items
 - (vii) medication
 - (viii) copies of keys for house and car
 - (ix) children's toys
 - (x) treasured items (photos and jewellery);
- (l) Making suitable arrangements for the care of pets;
- (m) Attending education and support programmes for adults and children. These are provided free and required to be taken up within three years of any protection order being issued;
- (n) Having a plan of what to do if there is unexpected contact with the violent person in the home, at work, at school, or in any other place.

Long term actions concern how a victim can keep themselves safe for the following months or years. These actions will depend on the victim's (and any children's) specific needs, strengths, circumstances and choices, as well as the ongoing level of risk based on the behaviour of the perpetrator. Some actions may include safe housing, confidential phone numbers, name changes, removal of personal details from public records e.g. electoral roll.

Emergency action is needed where there is immediate danger. Where there is a life threatening situation, always call 111 – Police/Ambulance.

4.4.8 Documentation

It is usual practice for individual safety plans to be written, however this is not always safe or practicable. There are several factors that should be considered to ensure the safety of the victim including any children:

- (a) Is it safe for the victim to have a copy of the safety plan where it could be discovered by the violent person?
- (b) What would the likely reaction of the violent person be if they read the safety plan? ➤

- (c) If a written copy is kept by the agency/service, is it in a safe and secure place? Can it be accessed by the violent person?
- (d) Is the safety plan to be shared between agencies? If so, has the victim been informed and consented to this?
- (e) Have all reasonable steps been taken to avoid inadvertent disclosure?

Documentation shall include:

- (f) Clear accurate notes;
- (g) Copies of any standard forms used;
- (h) Secure storage;
- (i) Policy covering who can access information and information sharing;
- (j) Processes to protect client from inadvertent disclosure to the perpetrator;
- (k) Adherence to agency/organisation policies.

4.4.9 Examples of safety planning resources

Experience shows that safety plans work best when they are developed by the victim with the assistance of a trained support person.

The first two following summarised examples are set out more fully in Appendix J.

- (1) The National Collective of Independent Women's Refuges⁷² offers three safety plan fact sheets for women who:
 - (a) Are thinking about how they might leave a violent situation;
 - (b) Have left and need to know how to remain safe; and
 - (c) Are not ready to leave yet.
- (2) The Preventing Violence in the Home⁷³ organisation offers a three-part safety plan for women and children focusing on:
 - (a) Safety to avoid serious injury and to escape an incident of violence;
 - (b) Preparation for separation; and
 - (c) Long term safety after separation.
- (3) The Family Court⁷⁴ takes domestic violence very seriously, and the options and support mechanisms available to victims of domestic violence who wish to stop this abuse are reported on its website. Information on protection orders and support programmes is also available on the website. Information on how to respond to a protection order can be found on the Ministry of Justice website.
- (4) The Ministry of Health Family Violence Intervention Guidelines 2002⁷⁵ provide a safety plan focusing on:
 - (a) Safety to avoid serious injury and to escape an incident of violence;
 - (b) Preparation for separation; and
 - (c) Long term safety after separation.

APPENDIX A LIST OF REFERENCES

(Informative)

The following numbered references are cited in this document. Other references are also given where relevant in each Appendix.

- 1 National Health Committee. Screening to improve health in New Zealand. National Health Committee. Wellington. 2003
- 2 This section is taken from Te Rito: New Zealand Family Violence Prevention Strategy. Ministry of Social Development, Wellington. 2002 pp. 8-9 and Family Violence Prevention Strategy. Families and Whānau Living Free from Violence. Public Education Awareness Framework Area of Action 13
- 3 Leibrich, J., Paulin, J. and Ransom, R. Hitting Home: Men speak about abuse of women partners. Wellington. Department of Justice. 1995
- 4 New Zealand Health Information Services (NZHIS). Morbidity and Mortality Data from the National Minimum Data Set. 1993-1998
- 5 Young, W., Morris, A., Cameron, N. and Haslett, S. New Zealand National Survey of Crime Victims 1996. Wellington. Victimisation Survey Committee. 1997
- 6 Ministry of Health. Our children's health: Key findings on the Health of New Zealand Children. Wellington. Ministry of Health. 1998
- 7 Fergusson, D.M., Horwood, L.J. and Woodward, L.J. The stability of child abuse reports: a longitudinal study of the reporting behaviour of young adults. *Psychological Medicine* 2000:30 pp. 529-544
- 8 New Zealand Health Information Services (NZHIS). Morbidity and Mortality Data from the National Minimum Data Set. 1993-1998
- 9 Fergusson, D.M., Horwood, L.J. and Woodward, L.J. The stability of child abuse reports: a longitudinal study of the reporting behaviour of young adults. *Psychological Medicine* 2000:30 pp. 529-544
- 10 Anderson, J., Martin, J., Mullen, P. et al. Prevalence of childhood sexual abuse experiences in a community sample of women. *J Amer Acad Child and Adol Psychiatry*. 1993:32 pp. 911-919
- 11 Fanslow, J. and Robinson, E., Violence against women in New Zealand: prevalence and health consequences. *New Zealand Medical Journal* 2004:117 1206
- 12 Fanslow, J. and Robinson, E., Violence against women in New Zealand: prevalence and health consequences. *New Zealand Medical Journal* 2004:117 1206
- 13 Edleson, J. (1999) The Overlap Between Child Maltreatment and Women Battering. *Violence Against Women* 1999:5(2) pp. 134-154 as cited in University of Auckland, Injury Prevention Research Centre Fact Sheet #34, Partner Abuse and Child Abuse in New Zealand. 2001
- 14 These statistics are from provisional data that New Zealand Police hold which is drawn from a dynamic operational database. It is subject to change as new offences are continually recorded. Provisional data cannot be reliably compared to official crime statistics.

- 15 Age Concern New Zealand. Promoting the Rights and Well-being of Older People and Those who Care for them. A resource kit about elder abuse. Age Concern 1992 and Ministry of Health. Family Violence Intervention Guidelines – Elder Abuse. (Final draft). Wellington. 2004
- 16 Age Concern New Zealand. Age Concern Elder Abuse and Neglect Services – An analysis of referrals 1998 – 2001. Wellington. 2002
- 17 Ministry of Social Development. Te Rito: New Zealand Family Violence Prevention Strategy. Wellington. 2002
- 18 From Department of Social Welfare. Good Practice Guidelines for Co-ordination of Family Violence Services. Wellington. 1996
- 19 Ministry of Social Development. Te Rito: New Zealand Family Violence Prevention Strategy. Wellington 2002
- 20 New Zealand Children and Young Persons Service. Breaking the cycle – Interagency protocols for child abuse management. Wellington. 1996 (a companion booklet to read in conjunction with Breaking the cycle – An interagency guide to child abuse. Wellington. 1995.)
- 21 Ministry of Health. Family Violence Intervention Guidelines – Child and Partner Abuse. Wellington. 2002
- 22 Mikaere, A. Māori Women: Caught in the Contradictions of a Colonised Reality. Waikato Law Review 1994:2 pp. 125-149
- 23 Wainohu, R. Correcting the Stories – Te Whakamarama. The Māori Law Bulletin 1991:10 pp. 5-6
- 24 Ministry of Health. Family Violence Intervention Guidelines – Child and Partner Abuse. Wellington. 2002
- 25 Public Health Commission. He Mataariki: A strategic plan for Māori public health – He kaupapa whaingā roa mo te hauora tumatanui Māori. Wellington. 1995
- 26 Morris, A., Reilly, J., Berry, S. et al. New Zealand National Survey of Crime Victims 2001. Ministry of Justice. Wellington. 2003: pp. 137-158
- 27 Durie, M. Whaiora Māori Health Development. Oxford University Press. Melbourne. 1994
- 28 National Collective of Independent Women's Refuges Annual Statistics for 2004
- 29 National Collective of Independent Women's Refuges Annual Statistics for 2004
- 30 Balzer, R., Haimona, D., Henare, M., Matchitt, V. Māori Family Violence in Aotearoa. Te Puni Kokiri. Wellington. 1997
- 31 Barnes, H.M. Kaupapa Māori: Explaining the ordinary. Pacific Health Dialog 2000 7(1) pp. 13-16
- 32 Leahy, H. Te Puni Kokiri response to Māori Family Violence. Presentation to 'Children and Family Violence Effective Interventions Now' Conference 4-5 July 1999
- 33 Rorie, J.L., Paine, L.L., Barger, M.K. Primary care for women: Cultural competence in primary care services. Journal of Nurse-Midwifery 1996:41(2) pp. 92-100
- 34 Durie, M. Whaiora Māori Health Development. Oxford University Press. Melbourne. 1994
- 35 Ministry of Health. He Taura Tieke: Measuring effective health services for Māori. Wellington. 1995

- 36 Kōrero with Roma Balzer, Acting CEO National Collective of Independent Women's Refuges Friday 14 June 2002
- 37 Williams. 1992. In Gray, A. Intervention programmes for domestic violence abusers: A literature review. Family Violence Prevention Co-ordinating Committee, Department of Social Welfare, Wellington. 1994
- 38 Tau Huirama (2002). Personal communication. Cited in Ministry of Health, Family Violence Intervention Guidelines – Child and Partner Abuse. Wellington. 2002
- 39 National Collective of Independent Women's Refuges Annual Statistics 1999-2000, 2000-2001
- 40 Department of Child, Youth and Family Services Annual Statistical Report 2002. Wellington
- 41 Asiasiga, L. and Gray, A. Intervening to Prevent Family Violence in Pacific Communities: A literature review for the Offending by Pacific Peoples Project. Ministry of Justice. Wellington. 1998
- 42 New Zealand Police. Apprehension data for "Male assaults Female" offence category, 2003. Source: www.statistics.govt.nz-Tablebuilder, and Conviction rate for "Male assaults Female" offence category, 2003. Justice data Warehouse, Ministry of Justice <http://www.justice.govt.nz/pubs/reports/>
- 43 Heise, L., Ellsberg, M., Gottemoeller, M. 1999. Ending violence against women. In: Population Reports Series L (11). Baltimore. Johns Hopkins University School of Public Health, Population Information Program
- 44 Ministry of Health, Family Violence Intervention Guidelines – Child and Partner Abuse. Wellington. 2002
- 45 World Health Organization. World report on violence and health, E. Krug, et al., Editors. Geneva. 2002
- 46 Hegarty, K. and Taft, A. Australian and New Zealand Journal of Public Health 2001.26:5 pp. 437-442 in Laing, L. Routine screening for domestic violence in health services. Australian Domestic and Family Violence Clearinghouse Topic Paper. Sydney
- 47 Irwin, J. and Waugh, F. Unless they're asked: routine screening for domestic violence in NSW Health: an evaluation report of the pilot project. NSW Health Department, Sydney. 2003
- 48 Carter, Y.H., Davidson, L.L., Feder, G., Ramsay, J., Richardson, J. Should health professionals screen women for domestic violence? Systematic Review. BMJ 289:5 pp. 601-605
- 49 Ministry of Health. Family Violence Intervention Guidelines – Child and Partner Abuse. Wellington. 2002
- 50 Ministry of Health. Family Violence Intervention Guidelines – Child and Partner Abuse. Wellington. 2002
- 51 Royal New Zealand Plunket Society Inc. Family Violence Policy and Protocol. 2003
- 52 Ministry of Justice. National Survey of Crime Victims 2001. Wellington. 2003
- 53 Bonner, M., Campillo, L., and Cosier, G. I Have Learnt How to Ask Questions – Implementing Screening for Domestic Violence Paper. Expanding Our Horizons. Sydney. 2002

- 54 Ministry of Health, Family Violence Intervention Guidelines – Child and Partner Abuse. Wellington. 2002
- 55 Goldenring, J.M., and Cohen E. Getting into Adolescent’s Heads. Contemporary Paediatrics. 1988 pp. 75-90
- 56 Age Concern New Zealand. Elder Abuse and Neglect : A handbook for those working with older people. Auckland. 1999
- 57 Age Concern New Zealand. Elder Abuse and Neglect : A handbook for those working with older people. Auckland. 1999
- 58 Age Concern New Zealand. Elder Abuse and Neglect : A handbook for those working with older people. Auckland. 1999
- 59 Royal New Zealand Plunket Society Inc. Screening for family/whānau violence including child abuse and neglect. Wellington
- 60 Royal New Zealand Plunket Society Inc. Family Violence Policy and Protocol. March 2003.
- 61 Ministry of Health. Family Violence Intervention Guidelines – Elder Abuse. (Final draft). Wellington, 2004
- 62 Bonta, J., Law, M. and Hanson, K. The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. Psychological Bulletin 1998:122 pp. 123-142
- 63 University of Canterbury, Te Awatea Violence Research Centre. Te Awatea Review December 2005
- 64 Blackburn, R. The psychology of criminal conduct. Wiley. Chichester. 2002.
- 65 Blackburn. 2002
- 66 Department of Corrections. National Study of Psychiatric Morbidity in New Zealand Prisons. Wellington 2002 and Blackburn. 2002
- 67 New Zealand Guidelines Group. Ministry of Health. The Assessment and Management of People at Risk of Suicide for Emergency Departments and Mental Health Service Acute Assessment Settings. Ministry of Health. Wellington. 2003
- 68 Ministry of Health. Family Violence Intervention Guidelines – Child and Partner Abuse. Wellington. 2002
- 69 Ministry of Health. Family Violence Intervention Guidelines – Elder Abuse. (Final draft). Wellington. 2004
- 70 Department of Social Welfare. Good Practice Guidelines for Co-ordination of Family Violence Services. Wellington. 1996
- 71 United Kingdom Domestic Violence Good Practice Indicators. London. 2002
- 72 Safety Plan Fact Sheets are available from National Collective of Independent Women’s Refuges. Website address: <http://www.refuge.org.nz>
- 73 Safety Plan is available from Preventing Violence in the Home. Website address: <http://www.preventingviolence.org.nz>
- 74 Available from The Family Court. Website address: <http://www.justice.govt.nz/family>
- 75 Ministry of Health. Family Violence Intervention Guidelines – Child and Partner Abuse. 2002

APPENDIX B THE EXTENT OF FAMILY VIOLENCE

(Informative)

B1 Introduction

Violence is a global public health problem occurring in communities both in and outside the family unit. Worldwide, violence is among the leading causes of death for people aged 15-44 years.¹ This appendix describes the prevalence of family violence with particular reference to data from New Zealand where local data is available.

Violence occurring within families as defined by Te Rito, New Zealand Family Violence Prevention Strategy, includes:

- (a) Spouse/partner abuse;
- (b) Child abuse/neglect;
- (c) Elder abuse/neglect;
- (d) Parental abuse;
- (e) Sibling abuse.

B2 Spouse or partner abuse

A high proportion of family violence occurs in the context of intimate relationships and is now increasingly referred to as intimate partner violence. Other terms used are partner or spouse abuse. The term family violence while often used interchangeably to mean intimate partner violence may also be used as a global term for all violence occurring within families including Child, Sibling, Parent and Elder abuse. More commonly now, this is referred to as family violence and the term domestic violence is not as commonly used.

Intimate partner violence (IPV) is defined in the recent WHO "World Report on Violence and Health" as:

"...any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Such behaviour includes:

- *Acts of physical aggression – such as slapping, hitting, kicking and beating*
- *Psychological abuse – such as intimidation, constant belittling and humiliating*
- *Forced intercourse and other forms of sexual coercion*
- *Various controlling behaviours – such as isolating a person from their family and friends, monitoring their movements, and restricting their access to information and assistance."*²

IPV is the most common form of physical violence experienced by women whereas men are more likely to be attacked by a stranger or an acquaintance. Psychological and sexual abuse may be associated with physical abuse or each other. Most affected women experience multiple acts of aggression over time.

Rates of prevalence of IPV vary between studies because of the particular definitions used, the way the questions are asked, the target population and the degree of privacy during the interview with the subject. A recent large population study of New Zealand women reported rates of IPV of 33 % in Auckland and 39 % in rural Waikato.³ Exposure to IPV was associated with an increased risk of physical and mental health effects including risk of

suicide. Another recent New Zealand study found that 21 % of women presenting for Emergency Department care in South Auckland screened positive for a history of IPV in the past year and 44 % reported partner violence at some time in their adulthood.⁴

When both partners are questioned rates of intimate partner violence can be higher from women as perpetrators than men. Data from 21-year-old men and women from the Dunedin Health and Development study reported a rate of perpetration of physical violence of 37.2 % for women and 21.8 % for men.⁵ Violence perpetrated by men was more likely to be associated with deviant characteristics such as violence towards strangers or criminality. This study did not, however, collect data on the frequency of violent behaviours nor on the degree of coercive control and intimidation associated with such violence. This meant that severity according to gender could not be evaluated. When this was analysed in the same cohort, women were found to have experienced more incidents of abuse by a partner and were more likely to suffer serious injury.⁶ Also women in New Zealand reporting violence by partners are more likely than men to report that as a result of the violence they were afraid for themselves and for their children.⁷

In the Christchurch Health and Development Study participants were asked at the age of 18 about their experience of interparental violence during childhood. Overall rates were around 38 % with equal rates of violence reported as being perpetrated by mothers and fathers.⁸ Violence initiated by fathers was associated with an increased risk at 18 years of age of conduct disorder, anxiety disorder and property offending. Exposure to violence initiated by mothers was associated with an increased risk of alcohol abuse or dependence. While violence perpetrated by mothers is not without its negative effects, exposure to violence by fathers appears to have more damaging developmental effects on children.

The higher risk to women from IPV is indicated from studies that indicate that in developed countries 40-70 % of female murder victims are killed by their husbands or boyfriends in the context of an ongoing abusive relationship.⁹ In New Zealand 90 % of partner homicides are committed by men against their female partner or ex-partners.¹⁰ This contrasts with data from the United States and Australia where only 4 % and 8.6 % respectively of males were murdered over the time periods studied by their wives, ex-wives or girlfriends.¹¹

B2.1 Relationship of spouse/partner abuse to child abuse

The presence of intimate partner violence in a family is a significant risk factor for child abuse. When Police-reported abuse was the standard for diagnosis of IPV in pregnancy this was found to increase the risk of neonatal death nearly 3.5 times and infants were 3.7 times more likely to deliver very preterm.¹² Abdominal assault during pregnancy has been reported to cause foetal demise because of placental abruption.¹³

The presence of IPV significantly increases the risk of child abuse especially in early childhood and this risk increases with the frequency of the interparental abuse.^{14, 15, 16} In a group of 164 consecutive children and young people seen in a sexual abuse clinic, 52 % reported spousal violence in their homes.¹⁷ In another American study in a population considered at-risk of child maltreatment, child physical assault was more strongly related to parents' psychopathology and domestic violence than income, race and maternal education.¹⁸ The clinical rule of thumb should be that when a woman or man presents to Health Services, the Police or the Family Court in the context of partner abuse, there is a 50 % chance of there also being child abuse occurring in the family unit. Also when a child presents to Health Services or the Police or Family Court as part of an investigation regarding child abuse there is a 50 % chance that intimate partner violence will also be occurring in the home. In New Zealand notifications to Child, Youth and Family increased

over a three year period (from 27,507 cases for 2001-2002 to 43,314 cases for 2003-2004).¹⁹ The percentage of cases requiring further action has stayed essentially the same at 83-85 %. It is reasonable to assume that 50 % of these children will be living in environments where intimate partner violence is prevalent.

B2.2 Cost of spousal /partner abuse

The outcomes of IPV are costly as well as damaging. A report released in 2004 by the Australian Government estimated that in 2002-2003 the total annual cost to the country of domestic violence was \$8.1 billion.²⁰ These estimates relate to healthcare costs, costs caused by offending and loss of the ability of those affected to contribute economically to the workforce. They do not count the long term costs to families and in particular the next generation who have spent their formative years exposed to family/whānau violence on a daily basis.

B3 Child abuse/neglect

There are four main types of child abuse recognised. These are physical abuse, sexual abuse, emotional abuse and neglect. These are all defined in Appendix C. Emotional abuse can be a component of all the other three types of abuse and indeed it is not uncommon for all forms of abuse to co-occur. The Christchurch Health and Development Study asked just over 1000 18-year-olds about childhood experiences related to abuse. In this group 8 % reported that their parents used physical punishment regularly and 4 % reported that their parents used physical punishment too often or too severely or treated them in a harsh or abusive way.²¹ Rates for experience of sexual abuse before the age of 16 in the same cohort were 17.3 % of females and 3.4 % of males.²²

The first Child and Youth Mortality Review Committee Report published in February 2004 provides data on cause of death for 1999 New Zealand young people between the ages of 1 month and 24 years of age. For children aged between 1 and 4 years of age, 8 % of deaths were due to inflicted injury. This is very similar to rates of death in this age group due to infection (7 %), cancer (8 %) and central nervous system diseases (9 %).²³ Homicide was the fifth leading cause of injury-related death in the 0-4, 5-9 and 10-14 year-old age groups in New Zealand between 1994 and 1998.²⁴

B4 Elder abuse

Elder abuse has been increasingly reported as an important issue for our elderly population and referrals to Age Concern Elder Abuse and Neglect Services in New Zealand are increasing. In New Zealand 745 cases were referred to Age Concern Services in the year 2001-2002 with a total of 1546 cases being referred from the years 1998-2001.²⁵ Referrals come from across the age range from 65 onwards and women and Māori are over-represented in the sample. In 43 % of cases the elderly person was living with their abuser. Abusers come from across the age range but the majority are 30-59 years of age.

B5 Parental abuse

In the New Zealand National Survey of Crime Victims 2001, the relationship between victim and offender for the most recent incident of violence experience was reported for 236 women and 136 men. A child or stepchild was the offender for 9.1 % of women and 1.6 % of men.²⁶ Abuse of parents by children may also be documented as elder abuse if the victim is over 65 years of age.

B6 Sibling abuse

In the New Zealand National Survey of Crime Victims 2001, the relationship between victim and offender for the most recent incident of violence experience was reported for 236 women and 136 men. A brother or stepbrother was the offender for 8.4 % of women and 11 % of men. Pacific victims were more likely than victims of other ethnicities to say that the offender was a brother or stepbrother.²⁷ In a review of general practice consultations regarding family/whānau violence in New Zealand, for 3 % of the consultations the perpetrator was a sibling.²⁸ In overseas studies perpetrating and experiencing sibling violence have been found to be risk factors for perpetrating and experiencing dating violence.^{29, 30}

Sibling abuse has also been reported in the context of incest. Adult self-report of sexual play and development in childhood indicates that children are more likely to explore their sexuality with peers rather than siblings.³¹ Also in a review of 17 cases of older brother – younger sister incest, all complainants reported coercion.³² When incest perpetrated by a brother, father or stepfather was compared in a group of 72 girls, few differences were seen in the characteristics of sexual abuse between the three groups (24 girls in each group). However, penetration was much more frequent in the sibling group and sibling perpetrators were more likely to be raised in families with more children and more alcohol abuse than were father and stepfather perpetrators.³³ The authors concluded that sibling incest was as harmful to girls as that perpetrated by adults in the family.

References for Appendix B

- 1 World Health Organization. World report on violence and health, E. Krug, et al., Editors. Geneva. 2002
- 2 World Health Organization. World report on violence and health, E. Krug, et al., Editors. Geneva. 2002
- 3 Fanslow, J., Robinson, E. Violence against women in New Zealand: prevalence and health consequences. NZ Medical Journal 26 November 2004:117 (1206)
- 4 Koziol-McLain, J., Gardiner, J., Batty, P. et al. Prevalence of intimate partner violence among women presenting to an urban adult and paediatric emergency department. NZ Medical Journal 26 November 2004:117 (1206)
- 5 Magdol, L., Moffit, T., Caspi, A., et al. Gender differences in partner violence in a birth cohort of 21 year olds: Bridging the gap between clinical and epidemiological approaches. J Consul Clin Psychol 1997:65 pp. 68-78
- 6 Langley, J., Martin, J., Nada-Raja, S. Physical assault among 21-year-olds by partners. J Interpers Viol 1997:12 pp. 675-684
- 7 Morris, A., Reilly, J., Berry, S. et al. New Zealand national survey of crime victims 2001. Ministry of Justice. Wellington. New Zealand. pp. 137-158. 2003
- 8 Fergusson, D.M. and Horwood, L.J. Exposure to interparental violence in childhood and psychological adjustment in young adulthood. Child Abuse and Neglect 1998:22 pp. 339-357
- 9 World Health Organization. World report on violence and health, E. Krug, et al., Editors. Geneva. 2002
- 10 Fanslow, J., Kotch, J. and Chalmers, D. Partner homicide in New Zealand 1978-1987. Unpublished manuscript
- 11 World Health Organization. World report on violence and health, E. Krug, et al., Editors. Geneva. 2002

- 12 Lipsky, S., Holt, V., Easterling, T.R., et al. Impact of police-related intimate partner violence during pregnancy on birth outcomes. *Obstet Gynecol* 2003;102 pp. 557-564
- 13 Ribe, J., Teggatz, J. and Harvey, C. Blows to the maternal abdomen causing fetal demise: report of three cases and a review of the literature. *J Forensic Sci* 1993;38 pp. 1092-1096
- 14 Rumm, P., Cummings, P., Krauss M. et al. Identified spouse abuse as a risk factor for child abuse. *Child Abuse and Neglect* 2000;24 pp. 1375-1381
- 15 McGuigan, W. and Pratt, C. The predictive impact of domestic violence on three types of child maltreatment. *Child Abuse and Neglect* 2001;25 pp. 869-883
- 16 Ross, S. Risk of physical abuse to children of spouse abusing parents. *Child Abuse and Neglect* 1996;20 pp. 589-598
- 17 Kellogg, N. and Menard, S. Violence among family members of children and adolescents evaluated for sexual abuse. *Child Abuse and Neglect* 2003;27 pp. 1367-1376
- 18 Windham, A., Rosenberg, L., Fuddy, L. et al. Risk of mother-reported child abuse in the first 3 years of life. *Child Abuse and Neglect* 2004;28 pp. 645-667
- 19 Department of Child, Youth and Family Services Annual Report. 2004
- 20 Australian Government's Office of the Status of Women. *The Cost of Domestic Violence to the Australian economy: Part 1. Report prepared for the Commonwealth of Australia: Canberra. 2004*
- 21 Fergusson, D.M. and Lynskey, M.J. Physical punishment / maltreatment during childhood and adjustment in young adulthood. *Child Abuse and Neglect* 1997;21 pp. 617-630
- 22 Fergusson, D., Lynskey, M. and Horwood, L. Childhood sexual abuse and psychiatric disorder in young adulthood. Prevalence of sexual abuse and factors associated with sexual abuse. *J Am Acad Child Adolesc Psychiatry* 1996;35 pp. 1355-1364
- 23 Ministry of Health. *Child and Youth Mortality Committee Annual Report. Wellington. 2004.*
- 24 University of Otago. Injury Prevention Research Unit. *Fact Sheet 29 Injury Causes by Age. 2003*
- 25 Age Concern New Zealand. *Elder Abuse and Neglect Services – An analysis of referrals 1998-2001 Age Concern. Wellington. 2002*
- 26 Morris, A., Reilly, J., Berry, S., et al. *New Zealand national survey of crime victims 2001. Ministry of Justice: Wellington, New Zealand. 2003 pp. 137-158*
- 27 Morris, A., Reilly, J., Berry, S., et al. *New Zealand national survey of crime victims 2001. Ministry of Justice, Wellington. 2003. pp. 137-158*
- 28 Miller, D., Thow, N., Hall, J. et al. Documentation of family/whānau violence in New Zealand. *NZ Med J* 2005;118
- 29 Noland, V., Liller, K., McDermott, R. et al. Is adolescent sibling violence a precursor to college dating violence? *Am J Health Behav* 2004;28(suppl1) pp. S13-S23
- 30 Simonelli, C., Mullis, T., Elliott, A. et al. Abuse by siblings and subsequent experiences of violence within the dating relationship. *J Interpers Viol* 2002;17 pp. 103-121
- 31 Ryan, G.. *Childhood sexuality: A decade of study. Part I – Research and curriculum development. Child Abuse and Neglect* 2000;24 pp. 33-48

- 32 Laviola, M. Effects of older brother-younger sister incest: a study of the dynamics of 17 cases. *Child Abuse Negl* 1992;16 pp. 409-21
- 33 Cyr, M., Wright, J., McDuff, P. et al. Intrafamilial sexual abuse: brother-sister incest does not differ from father-daughter and stepfather-stepdaughter incest. *Child Abuse and Neglect* 2002;26 pp. 957-973

APPENDIX C GLOSSARY

(Normative)

For the purpose of this Standard, the definitions below apply:

Abuse – The intentional harming (whether physically, emotionally or sexually), ill-treatment, abuse, neglect or deprivation of a person.

Forms of abuse can include:

- (1) Emotional/psychological abuse – any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child, young person or person. It may include, but is not restricted to: rejection, isolation or oppression; deprivation of affection or cognitive stimulation; deprivation of affection or cognitive stimulation; inappropriate and continued criticism, threats, humiliation, accusations, excitations, expectations of, or towards, the child, young person or person; exposure to family/whānau violence; corruption of the child, young person or person through exposure to, or involvement in, illegal or anti-social activities; the negative impact of the mental or emotional condition of the parents or caregiver; the negative impact of substance abuse by anyone living in the same residence as the child, young person or person.
- (2) Physical abuse – any act or acts that result in inflicted injury to a child, young person or 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. Such injury or injuries may be deliberately inflicted or the unintentional result of rage. Regardless of motivation, the result for the child, young person or person is physical abuse.
- (3) Sexual abuse – includes unwelcome sexual advances or unwanted sexual contact. It may include but is not restricted to:
 - (a) Non-contact abuse: exhibitionism; voyeurism; suggestive behaviours or comments; exposure to pornographic material;
 - (b) Contact abuse: touching breasts; genital/anal fondling; masturbation; oral sex; object or finger penetration of anus or vagina; penile penetration;
 - (c) Involvement of the child, young person or person in activities for the purpose or pornography.
- (4) Neglect – any act or omission to provide a level of support to a dependent person, e.g. child, young person, disabled or older person.

Assessment – Considers the short and long term needs of a victim of family/whānau violence, primarily in terms of safety, together with a focus on practical needs and forms of assistance such as financial, housing and legal.¹

Child – Boy or girl under the age of 14 years. ➤

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

- (1) Physical neglect – failure to provide the necessities to sustain the life or health of the child or young person;
- (2) 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;
- (3) Medical neglect – failure to seek, obtain or follow through with medical care for children or young person resulting in their impaired functioning and/or development;
- (4) Abandonment – leaving a child or young person in any situation without arranging necessary care for them and with no intention of returning;
- (5) Refusal to assume parental responsibility – unwillingness or inability to provide appropriate care or control for a child or young person.

Child witness – A child who has witnessed violence and/or abuse, and is at risk of being adversely affected by this experience.

The Department of Child, Youth and Family Services (CYF) – The Department of Child, Youth and Family Services (CYF) is the leading central government agency responsible for delivering and funding social services to support children, young people and their families who are at risk.

CYF's central legislative mandate is the Children, Young Persons and Their Families Act 1989, which provides CYF social workers with unique statutory powers and responsibilities. CYF is the principal agency which has the legislative power to gather information from a range of sources to ensure a full investigation is completed. It is the principal agency that has statutory powers to intervene in a family to ensure the safety of children and young people. In applying the Act, CYF has its own screening and assessment tools that all its social workers must follow, which will be supported by this Standard.

Memoranda of Understanding and protocols exist between the Department of Child, Youth and Family Services and a number of government agencies, which set out mutual responsibilities and under-pin the relationships between each agency.²

Competencies – Core competencies represent a set of clearly defined skills, knowledge, and attitudes necessary for the specific area of practice.

Contact – This is when a child spends time with a parent or other person who does not have day-to-day care of the child. Contact used to be called 'access'. In certain cases contact may need to be supervised contact.

Cultural competence – Cultural competence is about the acquisition of skills to achieve a better understanding of members of other cultures (Mason Durie³).

Cultural safety – The effective and appropriate practice of a person or organisation from another culture, as determined by those receiving the service including the requirement of the person providing the service to understand their own culture and to be able to recognise the impact this has on their client. Unsafe cultural practice includes any action which diminishes, demeans or discriminates the cultural identity and well-being of an individual.

Cultural values and competencies – Māori and Pacific people’s competencies outline practical steps for providing services and relating to Māori in a manner that recognises and respects Māori and Pacific people’s values and beliefs.

Dangerousness – The capacity to inflict damaging injuries.

Day-to-day care – This means having a child live with you on a daily basis, and being responsible for everyday things, like making sure they are safe, that they attend school, receive dental and medical care and that they’re warm, clean and properly fed. Day-to-day care used to be called ‘custody’.

Debriefing – Is an opportunity to vent feelings and/or tell a story of distress and trauma, in order to assist with closure and moving forward and to reframe thinking to enable solutions. To be effective, debriefing should be available in a structured way soon after an event.

Domestic violence – Domestic violence is an abuse of human rights. The Courts and the Police take domestic violence very seriously. At the heart of the Domestic Violence Act 1995 is the protection order. A protection order names the person who is abusive (the respondent) and states what behaviour is illegal under the order.

Elder abuse – 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 an older person. Perceptions of what constitutes harm will vary between groups and across cultures. Four commonly used categories of abuse are:

- (1) Physical abuse involves infliction of physical pain, injury or force. Includes medication abuse (deliberate or accidental misuse of medication and prescriptions that sedate or result in harm to the older person) and inappropriate use of restraint or confinement that causes pain or bodily harm;
- (2) Sexual abuse includes any forced, coerced or exploitive sexual behaviour or threats imposed on an individual, including sexual acts imposed on a person unable to give consent, or sexual activity an adult with mental incapacity is unable to understand. Sexual abuse is sometimes included as a subset of physical abuse;
- (3) Psychological/emotional abuse includes any behaviour that causes anguish, stress or fear. Includes verbal abuse, intimidation, harassment, damage to property, threats of physical or sexual abuse, and the removal of decision-making powers;
- (4) Financial/material abuse involves illegal or improper exploitation and/or use of funds or other resources. Includes financial abuse occurring when a person who has been given enduring power of attorney (EPA) abuses their powers and fails to operate in the best interests of the older person.⁴

Elder abuse and neglect – Occurs when an older person experiences harmful effects as a result of another person failing to perform behaviours which are a reasonable obligation of their relationship to the older person, and are warranted by the older person’s unmet needs. This includes abandonment. Three categories of neglect are:

- (1) Active neglect – the conscious and intentional deprivation by a carer of basic necessities, resulting in harmful physical, psychological, material and/or social effects;
- (2) Passive neglect – the refusal or failure by a carer, because of inadequate knowledge, infirmity, or disputing of the value of a service, to provide basic necessities, resulting in harmful physical, psychological, material and/or social effects;

- (3) Self-neglect occurs when a person refuses to accept or fails to provide themselves with basic necessities, resulting in harmful physical, psychological, material and/or social effects.⁵

Event – An incident or situation, which occurs in a particular place during a particular interval of time. The event can be certain or uncertain, a single occurrence or a series of occurrences.

Family/whānau violence – Covers a broad range of controlling behaviours, commonly of a physical, sexual, and/or psychological nature which typically involve, fear, intimidation and emotional deprivation. It occurs within a variety of close interpersonal relationships, such as between partners, parents and children, siblings, and in other relationships where significant others are not part of the physical household but are part of the family and/or are fulfilling the function of family. Common forms of violence in families/whānau include:⁶

- (1) Spouse/partner abuse (violence among adult partners);
- (2) Child abuse/neglect (abuse/neglect of child(ren) by an adult);
- (3) Elder abuse/neglect (abuse/neglect of older people aged approximately 65 years and over, by a person with whom they have a relationship of trust);
- (4) Parental abuse (violence perpetrated by a child against their parent); and
- (5) Sibling abuse (violence among siblings).

HEADSS assessment – A structured behavioural assessment for adolescents that includes enquiry about home, education, activities, drugs/alcohol, sexuality and suicide.⁷

Intervention – Action taken using risk assessment information:

- (1) For the support and safety of victims of family/whānau violence, abuse or neglect;
- (2) To address the perpetrator's use of violence; and/or
- (3) To address identified policy and practice issues.

Lethality – The likelihood of inflicting deadly injury.

Likelihood – Is the chance that something will happen in a given time frame (probability or frequency). It is expressed in terms of number of incidents per time period or series of activities.

Mentoring – A structured and trusting relationship established for an experienced person to offer guidance, support and encouragement aimed at developing the competence of the person being mentored.

Monitor – To check, supervise, observe critically or measure the progress of an activity, action or system on a regular basis in order to identify change from the performance level required or expected.

Monitoring – Monitoring encompasses supervising, observing, testing, analysis and reporting to responsible individuals or entities. Monitoring provides an ongoing verification of progress toward the achievement of objectives, goals and targets.

Offence – Is a breach of criminal law. A non-offence incident describes a situation where NZ Police do not encounter an offence.

Organisation – A group of people and facilities with an arrangement of responsibilities, authorities and relationships. The organisation can be public or private, includes associations, agencies, groups, independent practitioners and individuals accountable for the delivery of services to the client.

Examples include government agencies/services such as NZ Police, the Department of Child, Youth and Family Services or Ministry of Health and non-governmental organisations such as the Royal New Zealand Plunket Society, Relationship Services, Domestic Violence Centre (e.g. National Collective of Independent Women’s Refuges), and Age Concern New Zealand.

Parenting Order – An order made by the Family Court, which sets out who is responsible for day-to-day care of a child, and when and how someone else important in the child’s life can have contact with them. Parenting orders can be enforced just like any other order of the Court. Parenting order is the new name for custody or access order.

Partner abuse – Physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners.⁸ 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.

Perpetrator – An individual who intentionally commits a harmful, illegal or immoral action.

Prevention – (in relation to family/whānau violence) – Programmes, education and support systems that address the elements that correlated with family/whānau violence. These may prevent family/whānau violence from occurring at all or may prevent recurrence.

Protection order – Is applied for by a person who is a victim of domestic violence. The order is issued by the Family Court to protect people from domestic violence. It is a criminal offence to disobey a protection order. When a protection order is in place respondents are required to attend a Stopping Violence programme. The adults and the children protected by the order are eligible to attend a free education, information and support programme within three years of the order being issued.

Risk – The likelihood of an adverse event or outcome. Risk occurs when the outcome of a particular course of action is uncertain. Risk is often specified in terms of an event or circumstance and the consequences that may flow from it. For the purposes of this Standard, ‘risk’ refers specifically to the risk of a re-occurrence of violence/abuse, particularly the risk that the offender will inflict upon the victim severe injury or death.

Risk assessment – Assessment of risk to the victim of recurring violence/abuse, particularly an assessment of the dangerousness as well as lethality potential of the offender in order to provide adequate protection to past and potential victims. It is generally most helpful to assess risk in terms of various categories, with the highest level of risk (most acute and severe) requiring the most urgent and intensive response. The goal of risk assessment is to provide more information on the level and urgency of response/intervention that is required.

Risk assessment mechanisms or tools – Risk assessment mechanisms or tools provide specific questions to be asked or categories of information to be gathered in order to assess risk to victims.

Risk factor – A characteristic of a person, group or situation that has been shown to correlate to a higher or lower likelihood of a particular adverse outcome occurring. For example, a high risk factor for an escalation of intimate partner violence (the adverse outcome) is an attempt by the abused partner to leave the relationship, as an attempt to leave has been shown to be highly correlated/associated with this outcome.

Routine screening – Is a routine enquiry, whether written or verbal, by healthcare providers to individuals about their personal history of abuse or neglect. Unlike indicator-based screening, routine screening means routinely questioning all individuals, or specified categories of individuals, about abuse. Routine screening of all older people in the absence of signs and symptoms of abuse is currently not recommended, due to a lack of validated abuse screening methods where the safety and benefits have been evaluated.⁹

Safety – Ensuring security or protection from harm of physical, sexual or psychological abuse or neglect for all members of the family.

Safety planning – Safety planning refers to a victim of family/whānau violence, sometimes with the support of an advocate, developing a plan to achieve and maintain safety from an abuser. Safety planning generally involves planning to avoid serious injury and escape violence, prepare for separation.

Screening – The systematic application of enquiry, either written or verbal, by agencies to clients about personal history with domestic violence to identify individuals who would benefit from further investigation to determine if they would profit from some form of intervention. Enquiry can move from general framing statements such as “Because violence is so common I’ve begun to ask all my clients about it” to direct questions like “Are you in a relationship with a person who physically hurts or threatens you?” Screening can be conducted routinely on all individuals, or specified categories of individuals, or can be indicator-based.

Sensitivity – The ability of a screening tool to accurately detect if family/whānau violence is an issue, and of a risk assessment tool to accurately detect the level of risk involved.

Specificity – The ability of family/whānau violence screening and assessment tools to accurately determine when family/whānau violence and risk is not an issue.

Stakeholders – Those people and agencies/services who may affect, be affected by, or perceive themselves to be affected by the decision or activity, including members, personnel/practitioners and volunteers, and clients. It may also include interested parties.

Supervision – Supervision is a process which facilitates critical reflection upon actions, processes, people and the context of practice. This process takes place within a professional relationship between supervisor and supervisee(s) which models best practice. A supervisor can also be a sounding board for exploring effective ways of dealing with challenging situations.

The purpose of professional supervision is best practice with clients.

Agency or managerial supervision, on the other hand, is part of the leadership and controlling function of management and involves a supervisor overseeing the worker’s work for the purpose of compliance with agency policy and the achievement of the agency’s goals. Supervision can be internal or external to an organisation and can also be used for managing stress resilience, communication issues, debriefing, difficult situations, work/life balance, boundary and ethical issues.

Treatment – The process or manner of treating someone or something in a certain way, including the presentation or discussion of a subject.

Validated tools – Are those developed, independently piloted (internally or externally) and evaluated for reliability. Tools may be validated for sensitivity as well as specificity.

Victims – All victims of family/whānau violence, child abuse and neglect, including children and young people who witness family/whānau violence, child abuse and neglect.

Violence – Violence or abuse is any act that results in, or is likely to result in physical, sexual or psychological harm or suffering, including threats of such acts, coercion or arbitrary deprivation of liberty. It involves fear, intimidation and emotional deprivation, assault with or without weapons and sexual violation.

Whānau – A family including extended family, ancestors and descendants (kin group) linked by a common tipuna/tupuna (ancestor).

Young person – A boy or girl of or over the age of 14 years but under 17 years; but does not include any person who is or has been married.

References for Appendix C

- 1 Ministry of Social Development, Te Rito: New Zealand Family Violence Prevention Strategy. Wellington 2002.
- 2 New Zealand Children and Young Persons Service. Breaking the cycle – Interagency protocols for child abuse management. New Zealand Children and Young Persons Service. Wellington. 1996 (a companion booklet to read in conjunction with Breaking the cycle – An interagency guide to child abuse. 1995)
- 3 Durie, M. Whaiora Māori Health Development. Oxford University Press. Melbourne. 1994
- 4 Ministry of Health. Family Violence Intervention Guidelines – Elder Abuse. (Final draft) Wellington. 2004
- 5 Ministry of Health. Family Violence Intervention Guidelines – Elder Abuse. (Final draft) Wellington. 2004
- 6 Ministry of Social Development, Te Rito: New Zealand Family Violence Prevention Strategy. Wellington 2002.
- 7 Goldenring, J.M. and Cohen E. Getting into Adolescents' Heads. Contemporary Paediatrics 1988 pp. 75-90
- 8 Ministry of Health. Family Violence Intervention Guidelines – Child and Partner Abuse. Wellington. 2002
- 9 Ministry of Health. Family Violence Intervention Guidelines – Elder Abuse. (Final draft). Wellington. 2004

APPENDIX D THE CYCLE OF VIOLENCE

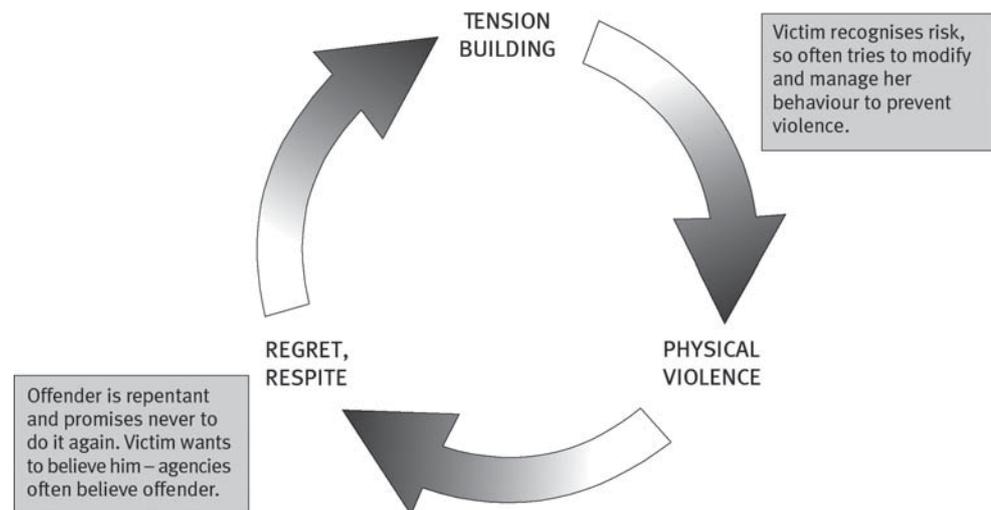
(Informative)

Violence can occur at any point of this cycle. Disclosure from a client may or may not occur at any time. Screening and risk assessment should be ongoing, recognising that the nature of family/whānau violence is cyclical.

Dr Lenore Walker describes in her book “The Battered Woman” what she calls the “Cycle of Violence”— A cycle of escalation and de-escalation in the levels of tension and violence which takes place in some abusive relationships.

Although not every abused woman experiences the cycle as described by Dr. Walker, for many, this cycle takes place around each abusive incident. The more times the cycle is completed the less time it takes to complete:

- (a) The longer the cycle is uninterrupted, the worse the violence gets;
- (b) The longer the cycle is uninterrupted, the shorter the third stage (i.e. respite, regret) becomes;
- (c) When the offender reaches the stage of no remorse, the victim is in the most danger.



Reference for Appendix D

- 1 Walker, Lenore. The Battered Woman. Harper and Row. New York. 1979

APPENDIX E

THE WHARE TAPA WHĀ MODEL

(Informative)

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

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

He Taura Tieke – measuring effective health services for Māori

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

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

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

There are a number of potential frameworks for describing health service effectiveness. He Taura Tieke consists of three key elements which research shows are consistent with Māori views. These elements are technical and clinical competence, structural and systemic responsiveness, and consumer satisfaction.¹

Reference for Appendix E

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

APPENDIX F SIGNS AND SYMPTOMS ASSOCIATED WITH PARTNER ABUSE

(Informative)

This appendix has been adapted from the Ministry of Health *Family Violence Intervention Guidelines – Child and Partner Abuse 2002*. The signs and symptoms listed below are not diagnostic of abuse. However in certain situations, context and combinations they will raise the practitioner’s suspicion of partner, child abuse and neglect. The guidelines recommend it is better to refer on suspicion. If you wait for proof, serious harm can occur.

Partner Abuse

Physical signs

- Injuries to the head, face, neck, chest, breast, abdomen or genitals
- Bilateral distribution of injuries, or injuries to multiple sites
- Sexual assault (including unwanted sexual contact by a husband or partner)

Patient’s manner

- Hesitant or evasive when describing injuries
- Distress disproportionate to injuries
- Explanation does not account for injury (for example, “I walked into a door”)

Illnesses

- Headaches, migraines, depression, musculoskeletal complaints
- Eating disorders, anxiety

Serious psychosocial problems

- Alcohol abuse or addiction, severe depression, drug abuse or addiction

History

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

Child Abuse and Neglect

Physical signs

- Multiple injuries, especially of different ages; bruises, cuts, welts, abrasions
- Scalds and burns, especially in unusual distributions such as glove and sock patterns
- Genital injuries
- Patterned bruising
- Dehydration or malnutrition
- Poor hygiene

Behavioural and developmental signs

- Aggression, anxiety and regression, defiance, obsessions, frozen watchfulness, withdrawal from family, self-mutilation
- Suicidal thoughts/plans
- Patchy or specific delay: motor, emotional, speech and language, social, cognitive, vision and hearing

History

- Inconsistent with the injury presented
- Past abuse or family violence
- Neglecting the child
- Disclosure by the child
- Terrorising, humiliating , or oppressing
- Inappropriate or inconsistent discipline (especially thrashings or any physical punishment of babies)
- Mental illness, including post-natal depression.

APPENDIX G EXAMPLES OF RISK SCREENING RESOURCES

(Informative)

Example 1 Based on the Royal New Zealand Plunket Society Inc. Family Violence Policy and Protocol¹

G1 Identification of partner violence

Overseas experience indicates that when women are questioned directly in the context of a professional relationship they will commonly disclose partner violence. Disclosure rates are much higher than when women are not questioned directly.²

All personnel/practitioners should include a question about partner violence in their initial history taking. The question should be matter of fact and included with other questions asked about the mother's health.

G2 Preparing to ask about partner violence

Knowing the indicators of partner violence, set out in G3, will be useful. In addition:

- (a) Ensure that your working relationship is as good as possible and that you have gained rapport;
- (b) Ensure you have taken every opportunity to provide support when you can;
- (c) Look for an opportunity to raise the issue of violence during a time when the client is feeling reasonably at ease.

NOTE – It is important that the client's partner, or another person who may potentially be an abuser, is not present at this time.

G3 Indicators of partner violence

These include:

- (a) Physical signs:
 - (i) Bruising, particularly on the face or arms
 - (ii) Other injuries with suspicious explanations (seeking help for the injury may be delayed – there may be inconsistent stories of how injury occurred)
 - (iii) Stress related illness—headaches, digestive upsets.
- (b) Personality/behaviour indicators:
 - (i) Low self-esteem, anxiety, depression, social isolation, alcohol or drug abuse, helplessness, hopelessness, blaming self, making excuses for partner's behaviour

NOTE – These may be more relevant if occurring in association with known violent behaviour from the partner.

 - (ii) If the partner is around, the client becomes unavailable for health visit/contact.
- (c) Partner characteristics:
 - (i) Anxiety, hostility towards family member and health workers
 - (ii) Drug and alcohol abuse

- (iii) History of violence outside home (e.g. violent offending at any time in the past)
- (iv) Violence in partner's extended family
- (v) Unwilling to leave their partner alone with you
- (vi) Partner very domineering while you are visiting, or reported as such by the client.

G4 Asking direct questions

It is important the questions you ask are direct so the client is very clear what they are being asked. The following question is an example:

Have there ever been any times when you have been hurt by, or felt afraid of, your partner or someone important to you?

If the answer is "yes", provide affirming, supportive statement, such as: *You do not deserve that.*

In addition, explore the circumstances of the violence further: *Would you like to tell me more about it?*

It will also be appropriate to ask:

Has your partner ever hurt any of your children? This is to help you assess whether the children are in any danger.

Because not all women will disclose partner violence, or it may not exist at the time you ask the question, you should monitor for indicators of partner violence in an ongoing way. If any are apparent, you may wish to ask the direct questions again.

Example 2 Elder abuse screening recommendations³

(From Ministry of Health, Family Violence Intervention Guidelines – Elder Abuse, [Final draft 2004])

G5 Healthcare settings

Screening for elder abuse is recommended when signs and symptoms or other alert features are present. Routine screening of older people for elder abuse is not recommended because of the lack of validated abuse screening methods where the safety and benefits have been evaluated. However, healthcare providers should always remain vigilant and be aware of risk factors and alert features. Proactive questioning about abuse may be indicated in the absence of signs and symptoms when multiple risk factors are present.

Healthcare providers need to be aware that older women may also be at risk of partner abuse and should maintain a higher index of suspicion.

G6 When should screening for elder abuse occur?

Primary care settings:

- (a) When the older person presents with signs and symptoms indicative of abuse;
- (b) Whenever alert features or signs and symptoms are identified;
- (c) Where proactive or comprehensive health assessment⁴ reveals alert features or signs and symptoms;
- (d) Screening for abuse may be indicated in the absence of signs and symptoms when there are multiple risk factors present.

Emergency Department/urgent care settings:

- (e) At any Emergency Department visit when the older person presents with signs and symptoms indicative of abuse;
- (f) Prior to discharge from Emergency Department when proactive assessment identifies alert features or signs or symptoms;
- (g) Screening for abuse may be indicated when there are multiple risk factors present.

Mental health settings:

- (h) When the older person presents with signs and symptoms of abuse;
- (i) When comprehensive assessment identifies alert features or signs and symptoms;
- (j) Screening for abuse may be indicated when there are multiple risk factors present.

Inpatient settings:

- (k) When the older person presents with signs and symptoms of abuse;
- (l) When there are multiple risk factors present;
- (m) Prior to discharge when proactive assessment identifies alert features or signs or symptoms;
- (n) On request by older person/carer/family/whānau support.

Residential care settings:

- (o) When the older person presents with signs and symptoms of abuse;
- (p) When comprehensive assessment identifies alert features or signs and symptoms;
- (q) On request by older person/carer/family/whānau support;
- (r) Screening for abuse may be indicated when there are multiple risk factors present.

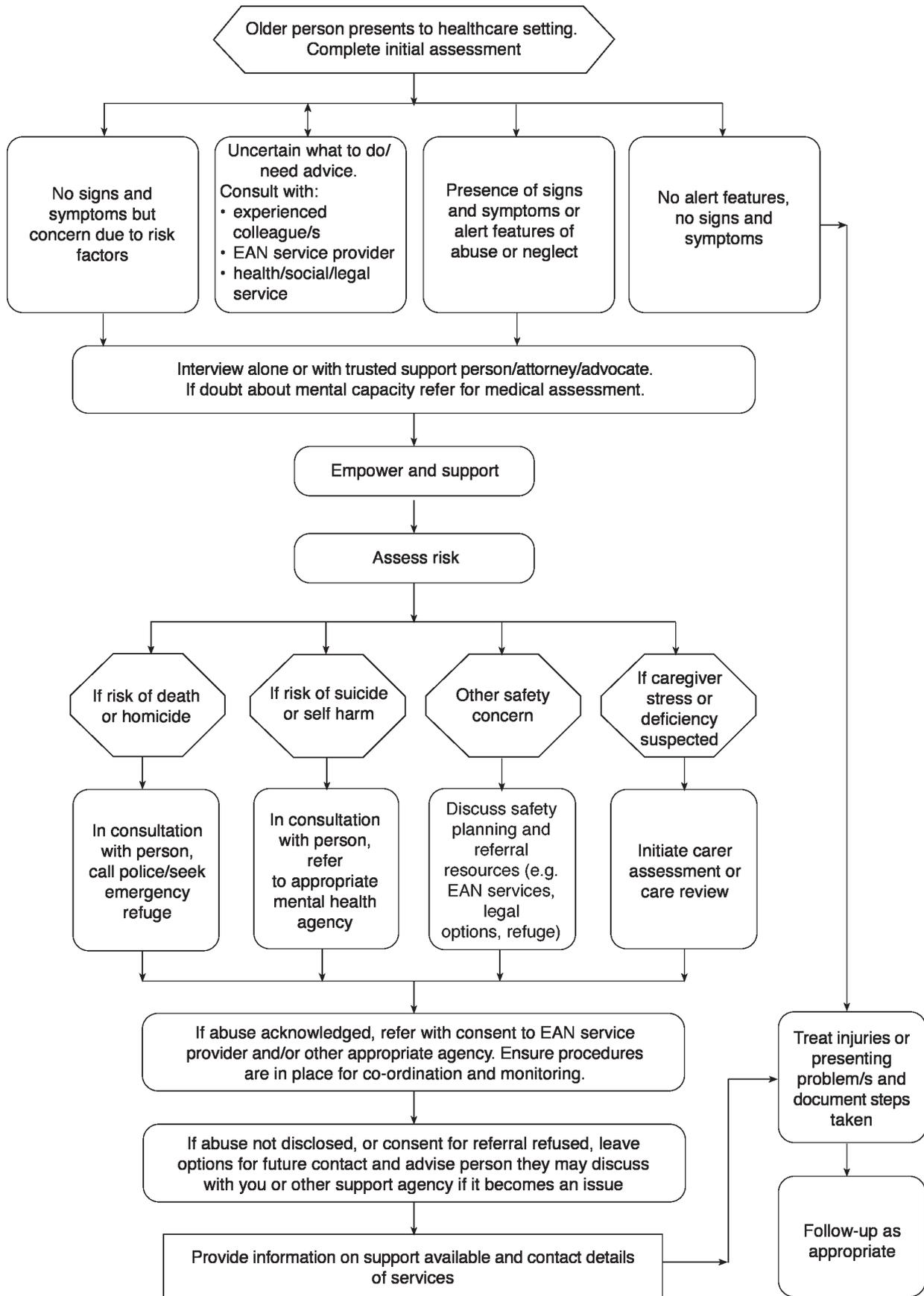


Figure G1 – Elder abuse assessment and response – flow chart

References for Appendix G

- 1 Royal New Zealand Plunket Society Inc. Family Violence Policy and Protocol. Wellington. 2003
- 2 Siegal, R.E.M., Hill, T.D., Henderson, V.A. et al. Screening for Domestic Violence in Community Paediatric Setting. Paediatrics 1999:104 pp. 874-877.
- 3 Ministry of Health. Family Violence Intervention Guidelines – Elder Abuse. (Final draft). Wellington. 2004
- 4 Proactive and comprehensive assessment recommendations are outlined in Ministry of Health and NZGG Guidelines on Assessment Processes for Older People. Ministry of Health. Wellington. 2003.

APPENDIX H EXAMPLES OF RISK ASSESSMENT RESOURCES

(Informative)

Example 1 Identifying Red Flags – Risk Factors

(From New Zealand Police¹)

IDENTIFYING RED FLAGS – RISK FACTORS		
<p>Investigators should consider the following RED FLAGS to alert them that this situation may be high risk – that someone is at risk of dying or suffering serious harm. Indicate all those Red Flags (risk factors) that are present.</p>		
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	The offender is obsessed with, dependent upon, or is stalking the victim.
<input type="checkbox"/>	<input type="checkbox"/>	Recent separation, issue of a court order, or divorce and responding in a dangerous manner.
<input type="checkbox"/>	<input type="checkbox"/>	The victim believes the offender could injure or kill her/him.
<input type="checkbox"/>	<input type="checkbox"/>	The offender has strangled or attempted to strangle the victim.
<input type="checkbox"/>	<input type="checkbox"/>	There is a history of family violence and it is getting more severe or increasing in frequency.
<input type="checkbox"/>	<input type="checkbox"/>	The offender has threatened / attempted to commit suicide, or to kill the victim, children or other family members.
<input type="checkbox"/>	<input type="checkbox"/>	The offender has access to weapons, particularly firearms and has used, or threatened to use them. They may have convictions involving weapons (knives, firearms).
<input type="checkbox"/>	<input type="checkbox"/>	The offender has easy access to the victim, children or other family members.
<input type="checkbox"/>	<input type="checkbox"/>	Children are in the home when the violence occurred or have been hurt or threatened in family violence situations.
<input type="checkbox"/>	<input type="checkbox"/>	Incidents of animal abuse by the offender.
<input type="checkbox"/>	<input type="checkbox"/>	The offender has a history of alcohol or drug problems.
<input type="checkbox"/>	<input type="checkbox"/>	The offender has a history of violent behaviour against non-family members.
<p>Describe any other factors that you consider could contribute to risk for any parties involved:</p> <hr/> <hr/> <hr/>		

Example 2 Risk and Lethality Assessment

(From Preventing Violence in the Home²)

Family Violence Intervention – Risk and Lethality Assessment

ASSESSING RISK

1. Where does s/he think the abuser is now?
2. Does she feel s/he is currently safe from him?
3. Does she feel safe to stay here/go home?
4. Is s/he concerned, right now, for the safety of anyone else involved?
5. How is s/he managing and coping?
6. Does s/he feel low/suicidal/at risk of self harm?
7. Does s/he need emergency services right now?
8. Is she able to get help if s/he needs it?

ASSESSING THE LEVEL OF DANGER

1. Does s/he feel in danger?
2. Has the abuser made threats of violence to her/him/others?
3. Has the abuser threatened to kill her/him/others?
4. Does the abuser have access to weapons?
5. Has s/he been violent to other partners?
6. Does s/he have a criminal record for violence?
7. Does s/he drink heavily or take drugs?
8. Does s/he have a mental health condition?
9. Is s/he involved with a gang?
10. Is s/he obsessed about his/her relationship with her/him?
11. Have there been any recent adverse changes to her/his life?

SAFETY OF CHILD, OR YOUNG PERSON

1. Is s/he concerned about how s/he treats the child, or young person?
2. Does s/he state s/he abuses the child, or young person?
3. Does s/he target any particular child, or young person?
4. Are children or young person aware s/he is being abused?
5. Are the children, or young person involved in incidents?
6. How is s/he able to protect the child, or young person?
7. Is s/he worried about the child, or young person's safety in her/his care?

LEVEL OF ASSESSMENT RISK/DANGER

HIGH-URGENT

MEDIUM-FOLLOW UP

LOW-NON URGENT

Example 3 Child and partner abuse assessment and response³

(From Family Violence Intervention Guidelines – Child and Partner Abuse, Ministry of Health, 2002)

H1 Identify

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

H2 Provide emotional support for identified or suspected victims

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

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

- (d) If it will place with the child or you, the healthcare provider, in danger;
- (e) Where the family may close ranks and reduce the possibility of being able to help a child;
- (f) If the family may seek to avoid child protection agency staff.

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

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

H3 Assess risk

Immediate protection of children is required if:

- (a) The child has been severely abused;
- (b) There is immediate danger of death or harm;
- (c) Abuse has occurred and is likely to escalate or recur;
- (d) There is immediate risk to the child, or the environment to which the child is returning is unsafe.

Refer to CYF if:

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

Consider the risk of self-harm or suicide.

Assess for co-occurrence of partner abuse.

H4 Safety planning and referral

If there are concerns about immediate safety (including your own) contact the Police. If there are no concerns about immediate safety contact CYF. When child abuse is a possibility, but you are uncertain about what to do, consult:

- (a) An experienced colleague;
- (b) A paediatrician;
- (c) CYF.

Take advice from the person you consult.

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

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

- social support
- parenting skill support/assistance
- well child services.

H5 Document your concerns

Include relevant history, any current or past injuries.

H6 Further assistance

Refer the patient to a specialist social service agency, legal agency or CYF if required.

References for Appendix H

- 1 New Zealand Police: Identifying Red Flags – Risk Factors
- 2 Available from Preventing Violence in the Home – Safety Plan and Family Violence Intervention Risk and Lethality Assessment. 2003
- 3 Ministry of Health. Family Violence Intervention Guidelines – Child and Partner Abuse. Wellington. 2002

Child abuse: assessment and response – flowchart

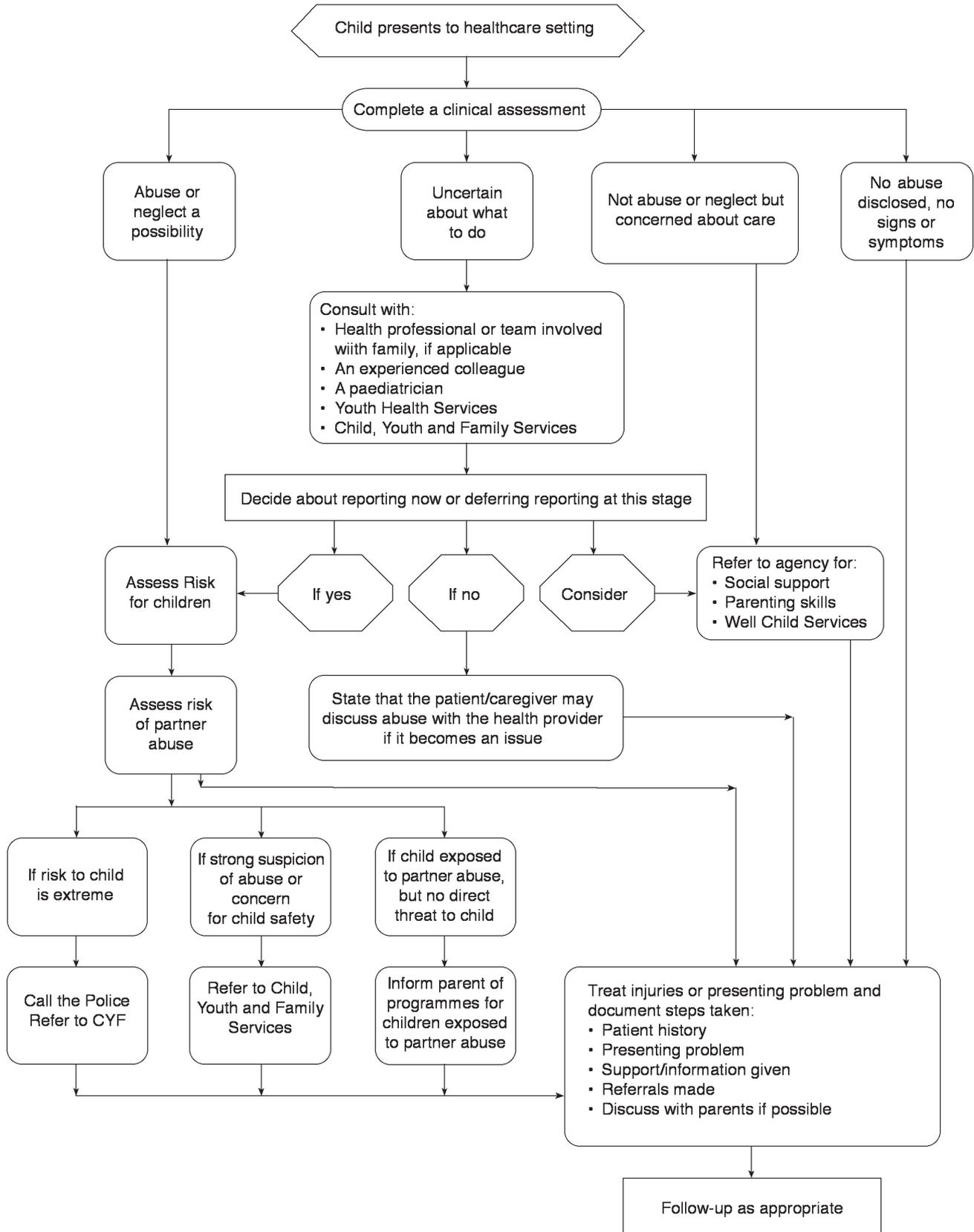


Figure H1 – Child abuse assessment and response – flow chart

Partner abuse: assessment and response – flowchart

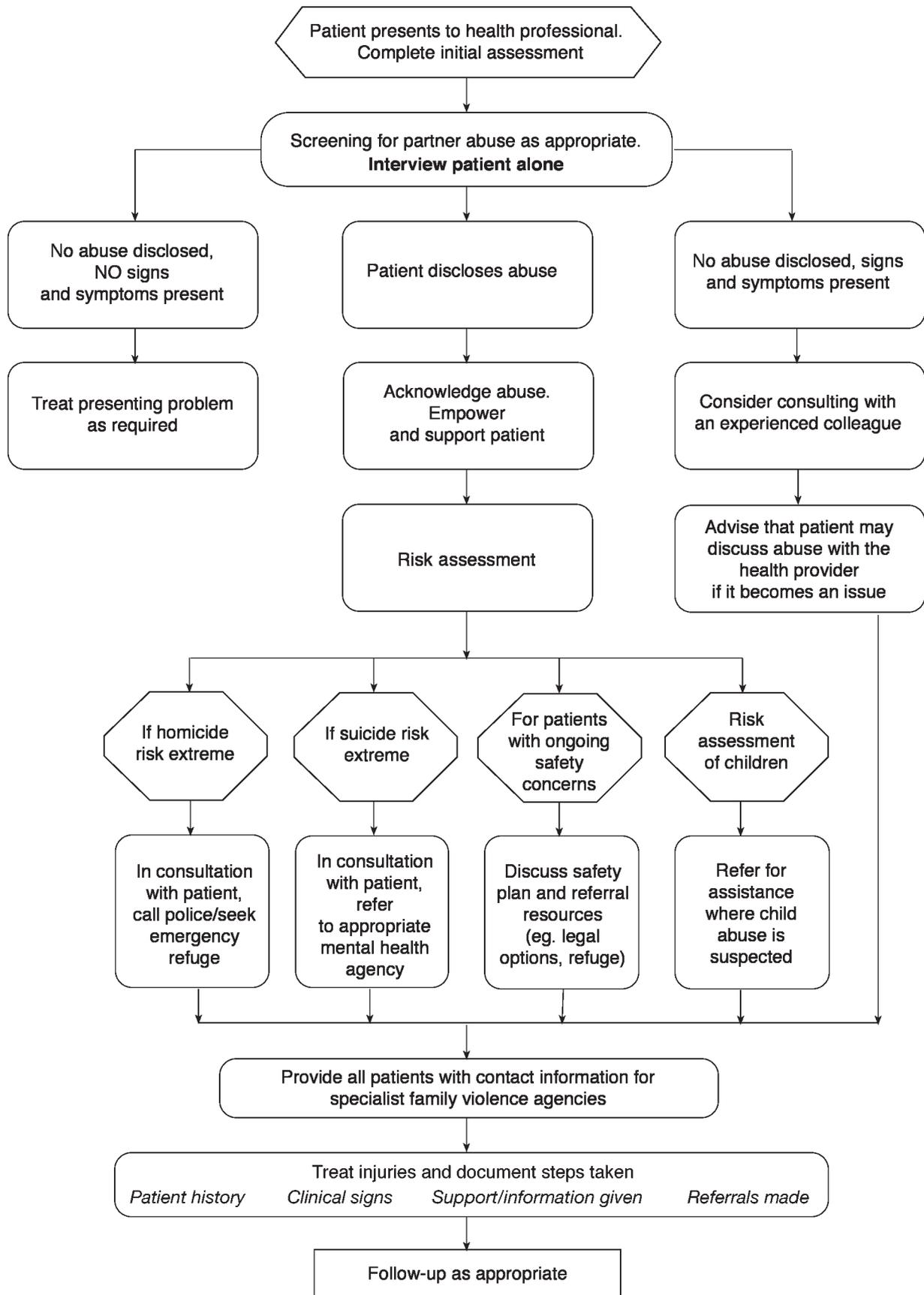


Figure H2 – Partner abuse assessment and response – flow chart

APPENDIX J EXAMPLES OF SAFETY PLANNING RESOURCES

(Informative)

Example 1¹

(From National Collective of Independent Women's Refuges Inc.)

(a) Thinking about how client might leave a violent situation: Safety Plan 1

	FACT SHEET: Safety Plan for leaving
<p><i>This is a guide to help you think about how you might leave a violent situation. Women have told us that these things have helped them keep safe. You will know what is safest for you and your children. Trust your instincts.</i></p> <p><i>Women's Refuge advocates can support you and your children, and help you with everything that is listed here. We can help with Benefits and Protection Orders too.</i></p> <p>If it's safe, get together a bag that you can leave with a friend or whanau/family member, including:</p> <ul style="list-style-type: none"> • Copy of Protection Order • Medicine for you and your children • Copies of Birth certificates for you and your children • Passports for you and your children • Clothes • Toiletries • Children's toys • Spare cash, ATM card and money for taxi/bus if needed • Drivers licence • Copies of bank details • Any other important documents eg insurance, residency • Important phone numbers • Your loved and treasured items like photos or jewellery <ul style="list-style-type: none"> • Find out the emergency numbers you may need - Police, Women's Refuge, Doctors, Lawyers, friends and whanau/family. Keep these with you. You can contact Women's Refuge through the Police. 	<ul style="list-style-type: none"> • If possible get a cell phone and keep this with you. WINZ may be able to help you buy a cell phone. Even a pre-pay cell phone with no money on it can be used to call Emergency 111. • If you think it is safe, talk to your friends and neighbours. Let them know that your and your children's safety is at risk. Ask them to watch out, and to ring the Police if they hear anything. • If you do not want the abuser to know you have rung Women's Refuge, just pick up the phone and push any number afterwards and then they will not be able to use Redial. • Plan a safe time to leave, and a safe route to take, and a way to get there (taxi, bus, Refuge van). Get your own house and car keys. • Organise somewhere to go straight away (e.g. go to a friend's house, arrange a Refuge worker to come and pick you up, go to a safe place in the community like the Police Station). • Organise a place to stay for a while (Women's Refuge safe house, friend's place, another house/ flat) . If you need to move to another city or country, Women's Refuge can help you organise this. <p><i>The most important thing is for you and your children to get out safely. If the time is right to leave, just leave. It doesn't matter if you haven't made a plan, or got your things with you.</i></p>
Women's Refuge FACT SHEET - Safety plan for leaving	
To contact your local Women's Refuge look under "W" in the White Pages, call the Police, or check out the website www.womensrefuge.org.nz . In an emergency call 111. For further information, contact Women's Refuge National Office at info@refuge.org.nz , or PO Box 11074, Wellington. To donate \$20 to Women's Refuge call 0900 REFUGE (0900 73384).	

(b) Safety plan after client has left. Safety Plan 2



This is a guide to some safety measures. Women have told us that these things have helped them and their children to keep safe. You will know what is safest for you and your children. Trust your instincts.

Women's Refuge advocates can support you and help you with everything that is listed here. We can help even if you don't come into the safe house.

- Talk to Women's Refuge or your lawyer about a Protection Order, Tenancy or Occupation Order (so that you can stay in your house) and sorting out custody and access arrangements.
- Find out the support numbers you may need – e.g. Women's Refuge, Doctors, Lawyers, Schools, friends and whanau/family. Keep these with you. If you're ever in danger, call 111.
- If possible, get a cell phone and keep this with you. WINZ may be able to help you get a phone. Even a pre-pay cell phone with no money on it can be used to call Emergency 111.
- If you haven't got a home phone, Women's Refuge can help you get a free one that can be used only for 111 calls.
- Make the area around your home safer: change the locks, get outside lights, repair damaged windows, trim underneath bushes and trees so you can see if anyone is hiding in them, etc.
- Tell all your neighbours and friends that you have a Protection Order and/or that the abuser is not

allowed to come to your place. Ask them to ring the Police if they see anything suspicious. You could set up a code that will tell the neighbours you are in trouble e.g. ringing, hanging up, ringing again.

- Use your own bank account.
- Have your address and phone number removed from public access - eg. get a confidential number (Telecom won't give it out); go on the unpublished Electoral Roll; get your details removed from any council register; tell WINZ, your employer, landlord, schools, doctor, etc to keep your details confidential.
- To hide your phone number from someone's Caller Display:
 - if you're dialling from a Telecom or Vodaphone phone or mobile: dial 0197 before dialling their phone number,
 - if you're dialling from a TelstraClear phone: dial *32 before dialling their phone number
- Use a third party when dealing with the abuser (eg. for mail, when picking up the children, when returning their property). Always take someone with you if you cannot avoid seeing the abuser.
- Develop a plan for yourself and the children about what to do in any situation - home, school, shops - if you feel threatened. Role play and practice the plan so you remember it.
- Help your children understand about what is going on. They might not need to know the details, but they do need to feel reassured.
- Ask for help from friends and whanau/family.

Women's Refuge | FACT SHEET - Safety Plan for after you've left

To contact your local Women's Refuge look under "W" in the White Pages, call the Police, or check out the website www.womensrefuge.org.nz. In an emergency call 111. For further information, contact Women's Refuge National Office at info@refuge.org.nz, or PO Box 11074, Wellington. To donate \$20 to Women's Refuge call 0900 REFUGE (0900 73384).

(c) Safety plan if client decides to stay. Safety Plan 3

	FACT SHEET: Safety Plan for Staying
<p><i>You may decide you are not ready to leave yet. You will know what is safest for you and your children. Trust your instincts. These are some things that you could consider for your and your children's safety.</i></p> <p><i>Women's Refuge advocates can support you and help you with everything that is listed here. We can still help you while you are living with the abuser.</i></p> <ul style="list-style-type: none"> • Find out the emergency numbers you may need - Police, Women's Refuge, Doctors, Lawyers, schools, friends and whanau/family. Keep these with you. • If possible get a cell phone and keep this with you. WINZ may be able to help you get a phone. Even a pre-pay cell phone with no money on it can be used to call Emergency 111. • If its safe, you could apply for a Protection Order (see Women's Refuge or your lawyer) • Develop a plan for yourself and the children- what to do if violence happens at home, or when you are out. Role play and practice the plan so you remember what to do. • Tell your friends and neighbours. Let them know that you have fears for your safety. Ask them to watch out, and to ring the Police if they hear anything. You could set up a code that will tell the neighbours you are in trouble e.g. ringing, hanging up, ringing again. 	<ul style="list-style-type: none"> • Tell the abuser, friends and whanau/family that you are not going to put up with violence. • Get your own house and car keys. • Open your own bank account, and try to save some money. • If you have no money, talk to Women's Refuge about getting a benefit before you leave. • Photocopy personal documents and keep them with you.
Women's Refuge FACT SHEET - Safety Plan for Staying	
To contact your local Women's Refuge look under "W" in the White Pages, call the Police, or check out the website www.womensrefuge.org.nz . In an emergency call 111. For further information, contact Women's Refuge National Office at info@refuge.org.nz , or PO Box 11074, Wellington. To donate \$20 to Women's Refuge call 0900 REFUGE (0900 73384).	

Example 2²

(From Preventing Violence in the Home)

A safety plan needs to be in three parts:

- (1) Current safety, to avoid serious injury and to escape an incident of violence;
- (2) Preparation for separation;
- (3) Long term safety after separation.

J1 Avoiding injury, escaping violence

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

- (a) Leave if you can. Know the easiest escape routes – doors, windows, etc. What's in the way? Are there obstacles to a speedy exit?;
- (b) Know where you're running to. 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 for you and your children with a neighbour;
- (c) 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;
- (d) If you can't leave the house, try to move to a place of low risk. Try to keep out of the bathroom, kitchen, garage, away from weapons, upstairs or rooms without access to outside;
- (e) 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:
 - (i) Run to a neighbour and ask them to call the police. A child should remain with the neighbour until help arrives.
 - (ii) 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.")
 - (iii) Go to a safe place outside the house to hide. Arrange this in advance.
- (f) Use judgement and intuition – when the situation is very serious you may have to do what the attacker wants until things calm down. Then be on the alert for your chance to escape and get help;
- (g) 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;
- (h) 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.

J2 Preparation for separation – Flight plans

Advance arrangements

- (a) Arrange transport in advance. Know where you'll go. Advise the refuge or safe house;
- (b) Tell only one or two trusted friends or a refuge worker about your plans. Go through the details together;

- (c) Start a savings account. Arrange to have statements sent to another address. A small amount of money saved weekly can build up and be useful later;
- (d) 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;
- (e) Ask your family doctor to carefully note any evidence of injuries on your patient records.

What to take:

- (f) Documents for yourself and children;
- (g) Keys to house, garage, car, office;
- (h) Clothing and other personal needs including medication;
- (i) Phone card and list of important addresses and phone numbers;
- (j) For children take essential school needs, favourite toy or comforter;
- (k) Photograph of your partner so that people protecting you know what he looks like.

Playing it safe:

- (l) 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;
- (m) Try not to react to your partner in a way which might make him suspicious about your plans. Always be aware of your need for safety;
- (n) 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.

J3 Long term safety, after separation

- (a) Teach your children what to do if your ex-partner makes contact with them unexpectedly, breaching access arrangements, i.e. rules about checking first before opening the door, coming inside or going to neighbours if he comes to the house, telling a teacher if they are approached at school;
- (b) Obtain a protection order from your local District Court or Family 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;
- (c) Teach your children what to do if your ex-partner takes them, e.g. calling the Police on 111;
- (d) Tell other adults who take care of your children which people have permission to pick them up and who is not permitted to do so (e.g. school teacher, day-care staff, baby sitter);
- (e) Consider installing an outside lighting system that lights up when a person comes near your house at night;
- (f) Tell neighbours that your partner does not live with you and ask them to call the Police if he is seen near your house;

- (g) Ask your neighbours to contact the police if they hear sounds of an assault occurring;
- (h) Tell your employer that you have a protection order, or that you are afraid of your ex-partner;
- (i) Ask for your telephone calls at work to be screened;
- (j) If your ex-partner breaches the protection order, telephone the Police and report it, contact your lawyer and your advocate;
- (k) If the Police do not help, contact your advocate or lawyer for assistance to make a complaint;
- (l) Ask Telecom to install "Caller ID" on your telephone and ask for an unlisted number. WARNING: make sure that emergency services (Police / Fire / Ambulance) are allowed access to your telephone number;
- (m) Contact the Electoral Enrolment Centre on 0800 36 76 56 and ask for your name and address to be excluded from the published electoral roll;
- (n) Attend a woman's education programme to help you grow strong and understand what has happened to you;
- (o) If possible, use different shops and banks to those you used when you lived with your ex-partner;
- (p) Keep a record of any breaches, noting the time, date and what occurred and what action you took;
- (q) 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.

References for Appendix J

- 1 Women's Refuge Fact Sheets taken from <http://www.refuge.org.nz>
- 2 Available from Preventing Violence in the Home – www.preventingviolence.org.nz

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