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Tēnā koe

Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence ('the guideline')

The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to review the above guideline which has been updated from the 2002 original. The Guideline and accompanying flowcharts, and policy documents have been reviewed by members of our College of Child and Youth Nurses, Women's Section, and College of Primary Health Care Nurses, and NZNO's nursing, research and policy advisers. NZNO warmly endorses the guideline which we believe will be welcomed not just by health practitioners but by all those attending to the health care needs of those in their communities. We trust that it will be finalised soon and that it will be a catalyst for much-needed professional development around issues concerning intimate partner violence (IPV) and child protection.

The following comments may be of interest:

We agree with adjusting the language from 'routine screening' to 'routine enquiry' to be more in line with international trends.

We suggest that data could be presented more consistently in the report. A consistent format enables the reader to focus on the facts, rather than be distracted by calculations. Eg It is difficult to compare incidences of IPV between men and women when data is expressed as a ratio (1:25) for men and with percentage (4 %) for women (p5). Similarly, on p6 data for rates of co-occurrence of IPV with child abuse is presented as a number for men and as a percentage for women: *A man who has committed 50 or more acts of violence against his female partner is almost certain to also have been physically abusive to their children. For females who have hit their partners, the association with perpetration of child abuse is less*

pronounced, with: 30 percent of chronic female partner abusers likely to have physically abused their children (Ross 1996) (p6).

We strongly support the inclusion of ethical principles as a basis for taking action on IPV and Child abuse (p15).

We strongly support the inclusion of ways to implement the 12 kaupapa provide health professionals the opportunity to reflect on their practice in engaging with Māori (Pp23-26)

Section 1.1 The identification of signs and symptoms, further defining different forms of neglect is very useful, and may support greater confidence in assessment, documentation, or framing reports of concern (p34).

We suggest replacing the word 'prospectively' with 'promptly' in section 1.1.1 Observing child-caregiver interactions on p34. Prospective action implies doing something beforehand, or in preparation, rather than as soon as possible after it is actually indicated.

The *status* of any discussions with CYF "to determine if a formal report of concern should be made" when the health professional holds suspicions of abuse or risk (p42) needs to be clarified. The discussions should be comprehensively documented – whom with, when, what information was shared, as well as what the resulting advice was.

With regard to Section 1.5.2, p49 we question whether it is appropriate to use the term 'definitive' in relation to signs and symptoms of abuse for the audience the resource is intended for which is not the group of practitioners who have the skills for diagnosing abuse (p49). We tentatively suggest 'unequivocal' as an alternative.

The guideline advises using written communication in situations where the person is deaf and a sign-language interpreter is not available (p52). We suggest further guidance is necessary regarding the appropriateness or otherwise of using written resources to support enquiry in situations where children older than 2 years are present, or where the mother/client is on her own with the health professional while other adults are present in another room of the building (ie potentially within earshot but out of line of sight, for example when home visiting)? For instance, would the situation described be deemed grounds for not safely enquiring about IPV at that visit?

We suggest that encouragement should be given for health professionals to complete routine enquiry soon after the establishment of rapport, and not so long into the consultation that they might think that it is being asked of them on the basis of information that they have already shared with the health professional (p53). The framing of the enquiry process is important in indicating that it is universal, but the perception of universality for the patient/client may be clouded if it occurs later in the interview.

With regard to signs and symptoms indicative of IPV where there is no disclosure (Pp56-57), we suggest an additional bullet point is needed to remind health professionals to consider as part of their decision-making, if the suspected adult victim has responsibility for children. There is a potential professional risk if this is not done as reassessment at a future opportunity may be too late in terms of what needed to be done to protect children.

We commend the example of a health professional's response to the person (following no disclosure) that signals that s/he will be continuing to ask the person about IPV during future visits. This gives the individual realistic expectations for future visits, and frames routine enquiry as best practice (p57).

We suggest that the examples given with respect to individuals' role in determining with whom information should be shared (p69) could be more positively framed, with less risk of a refusal for permission to share, even in circumstances where permission is not required and/or where the practitioner may have a greater obligation to share it than not. Eg "I'd like to let your GP, Dr X know… That way…" followed by the question 'Do you agree?'

We suggest that a priority for responding at follow-up (section 2.5.3, p70) should be to review the outcome of the agreed plan from the prior visit even if the plan was to do nothing between visits. This would encourage the identification of any barriers to implementing an aspects of the plan, or changing circumstances. Repeating the enquiry at the follow-up visit, should follow rather than precede enquiry and review of the outcomes of the previous visit.

An additional circumstance should be noted with regard to Section 2.5.4 Co-occurrence of child abuse and IPV (p70). Where no abuse is disclosed on routine enquiry about IPV, but where risks to children are suspected/assessed, referral to CYF for child abuse may be indicated (as per Appendix Q). We suggest this is included in an additional bullet point at the top of the page 71.

In the same section under the subheading *Referral options when intimate partner violence is disclosed and child(ren) are present in the home*, reference is made to the multidisciplinary team (MDT) in Point 3 statutory intervention. We note that this is one of only two references to the MDT in the document, which is surprising in itself, but also that not all practitioners will have access to a MDT in their workplace. We suggest that this step could include reference to senior clinical staff/clinical manager/clinical supervisor as an alternative. We further note that the statement that the MDT will *advise* on the best process is not reflected in the diagram on p73 which indicates that the MDT supports/approves the report of concern to Child, Youth and Family (CYF) and then the health professional makes the report of concern to CYF ie the MDT's role is in approving submission of a report of concern rather than 'advising on the best process'. The process and role of the MDT needs to be clarified in this respect. It may also be useful define what health professional roles the MDT would normally encompass. Similarly we suggest that the interface with professionals besides health workers, eg social workers, parole officers etc. ie interdisciplinary or interprofessional team could be explored and clarified.

We strongly support the guideline for documentation (p73) and particularly the unambiguous instruction for health practitioners to document actual appearance and observed demeanour rather than inference or opinion.

Section 2.6.4 (p74) should also reference health professionals' obligations regarding the assessment of the safety of any children, where IPV is not disclosed where there are grounds to suspect it is occurring.

With regard to photographic documentation (p75), we strongly recommend including a reminder to health professionals that it is not appropriate to use personal electronic devices to record information about patients (e.g. taking photos on smart phones), indeed direction on the use of new IT platforms and social media would be useful.

Appendix A provides a very useful and concise guide to assessing child neglect, and will be also be a helpful for health professionals to refer to for documentation.

We note that all the appendices are very useful for health professionals to refer to and some could potentially be useful for handouts for patients/clients where safe and appropriate (e.g. I, J, K, L) and the summaries of the guidelines re: IPV and Child abuse for HPs.

Typographical errors

P9 -1st line – 'effecting' should be 'affecting'

P18 - 2nd bullet point – no apostrophe needed for 'patients'

P42 - remove the 'z' on the 4th last line after "why did you let him?"

P46 - second bullet point remove full stop after Specify and the words 'What are' to read 'specify what support or safety procedures need to be put into place'.

We trust the above comments are useful. NZNO strongly agrees with your observation that it is enhanced health sector and community collaboration and collective ownership that provides the foundation for a coordinated and comprehensive approach to reducing family violence and child abuse and neglect. Once again thank you for the opportunity to review the guideline, which we value. NZNO endorses the guideline and looks forward to its final publication.

Nākū noa, nā

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NEW ZEALAND NURSES ORGANISATION (NZNO)

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 47,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse.*