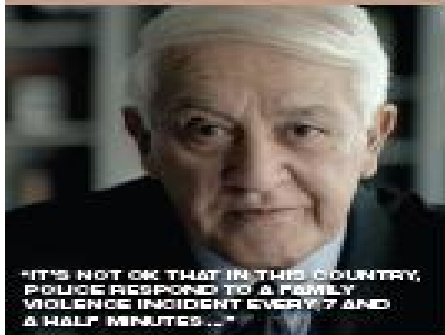


Invisible Families & Children at risk





FAMILY VIOLENCE ARE YOU OK WITH THIS?

NEW ZEALAND HAS A SHAMEFUL RECORD OF FAMILY VIOLENCE.

- Half of all murders are domestic violence related.
- On average, 14 women – 6 men – and 10 children are killed by a member of their family every year.
- Police deal with more than 70,000 family violence calls a year – and those are only the cases that are reported.

The Campaign for Action on Family Violence aims to change the way New Zealanders think and act about family violence.

What happens in families affects our neighbourhoods, schools, workplaces and communities. It has far reaching and devastating social and economic costs.

The campaign will increase awareness and understanding of family violence and promote changes in behaviour to reduce the incidence of family violence.

It will build on the work that's already being done in communities throughout New Zealand.

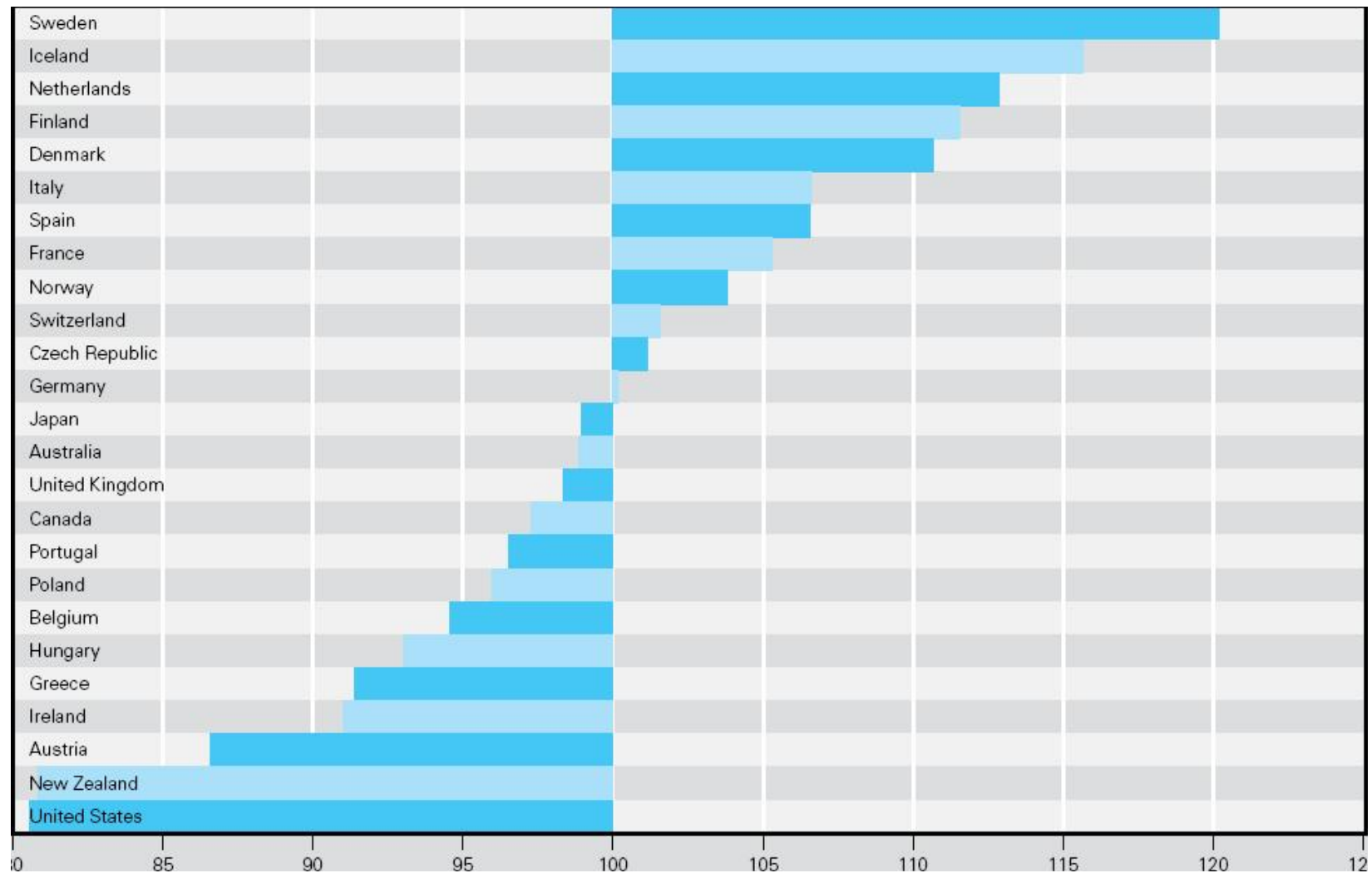
- A Community Action Fund provides financial support for community-led activities, recognising that local communities know what works best for them.

- TV advertisements will support community projects at a national level, leading with a message that: family violence is not ok – but it is ok to ask for help.
- An 0800 Family Violence Information Line (0800 458 450) provides self-help information and connects people to services where appropriate. It is available seven days a week, from 9am-11pm, with an after-hours message redirecting callers in the case of an emergency.
- The campaign website plays an important part in mobilising New Zealanders. It contains information for personal change for people who are violent and people who influence them, as well as information for community engagement and for media.
- A Community Action Toolkit provides practical information about how to get involved in community action. Other resources are also available through the 0800 number, website and community organisations.
- A research and evaluation programme will inform ongoing development of the campaign.



Child Health & Safety

UNICEF Innocenti 2007



Two NZ Longitudinal studies

- Dunedin – 980 children, followed for 26 yrs
- 24% reported threats of or actual violence between parents
- Christchurch – 1265 children, 18 years
- 38% reported interparental violence
- NZ Police stats – 51.5% of Domestic Violence attendances **children present**



Family Violence as a Health Care Issue

- How is it relevant w.r.t. an individual's health care?
- What can we as doctors do?
- **How can we do it in General Practice?**

A tired teenager

- Dec 2003 aged 13yr
- NZ born Samoan girl presents to High School nurse
- “Family problems” “dizziness”
- BP 120/80
- Hb = 55!!
- Rxd oral Fe + Vit C - lost to f/u until
- Feb 2004 refd to Public Health Nurse

She's hard to track down ...

- Public Health Nurse contact at new college after shift of house and school
- The history
- Feb 04 Hb = 100
- Seen at Youth Health Clinic March 04
- Continue Ferrogradumet
- More bloods arranged & clinic review

Blood results

- **Nov 03** **Hb 55** PCV 0.23 (0.35 – 0.47) MCV 58 (78 – 94) MCH 14 (25 – 34)
Plats 556 ovals
- Fe = 2 (10 – 30) IBC = 83 (45 – 72)
Ferritin = 5 (12 – 140)
- **Feb 04** Hb = 100 PCV 0.33 MCV 70
- Fe = 3, IBC = 80, Iron sat = 4% (20 – 45)
Ferritin = 3

“Why don’t some people get it together?”

- Mar 04 – not had bloods, needs support accessing Lab
- Lost Lab form Lost script
- DNA Youth Clinic April 04
- Public H N visits school May 04
- Absent from school

Fourth form year continues ...

- May 04 **Hb = 74** PCV = 0.27
- Youth Clinic Dr review June 04
- Combined Oral Contraceptive Pill for heavy irregular periods + oral iron
- July 04 DNA Youth Clinic **Hb = 82**
- Aug 04 School Dr + Mum present – poor dietary intake ++

Fourth form year finishes

- Aug 04 **Hb = 94** hair falling out
- Sep 04 “coping w school work”
“no complaints”
- Nov 04 “easier to concentrate”
- Plan for review Term 1 2005

The medical model continues

- Feb 05 S/B School Dr says “have another blood test” but again she “lost that form”
- April 05 **Hb = 66 PCV 0.24**
- Comb.d Oral C. Pill - Did it work?
- Periods heavy ++ clots, pain, 5 - 7 days long and every 3 weeks or less
- New ward at Waitakere Hospital
- An medical admission

A Youth Health Model



- **Home**
- **Education**
- **Activities**
- **Drug – substance – alcohol use**
- **Sexual history – consent, protection**
- **Suicide / Safety – risk - depression**

Disclosures ... two types

- (Accidental &) **Purposeful**
- Consciously decides to tell
- Many reasons
- Fear of pregnancy
- Protecting younger siblings
- ***Receives education/*** aware not happening to other children / ***relationship with trust***
- Usually wants situation to change

“Sort out the underlying problem”

- 2 u packed cells
- Review 3wk later at school Dr K
- Offered choices for menorrhagia
- Combined OCP re-try
- Oral progestagen / NSAIDs
- Tranexamic acid
- Depo Provera injection

The “underlying problem”

- Running out of Fe tablets
- Feels no better – tired
- Admits stress in household
- Discloses physical abuse
- Plan for safety
- “Child Youth & Family” notification
- 3 days later removed from home

Back to the bloods

- May 2005 Hb = 123
- July 05 – 125
- Hair thick and growing
- Appetite good!
- Returned home after 1 month away
- Willing to continue on Depo Provera & no bleeding

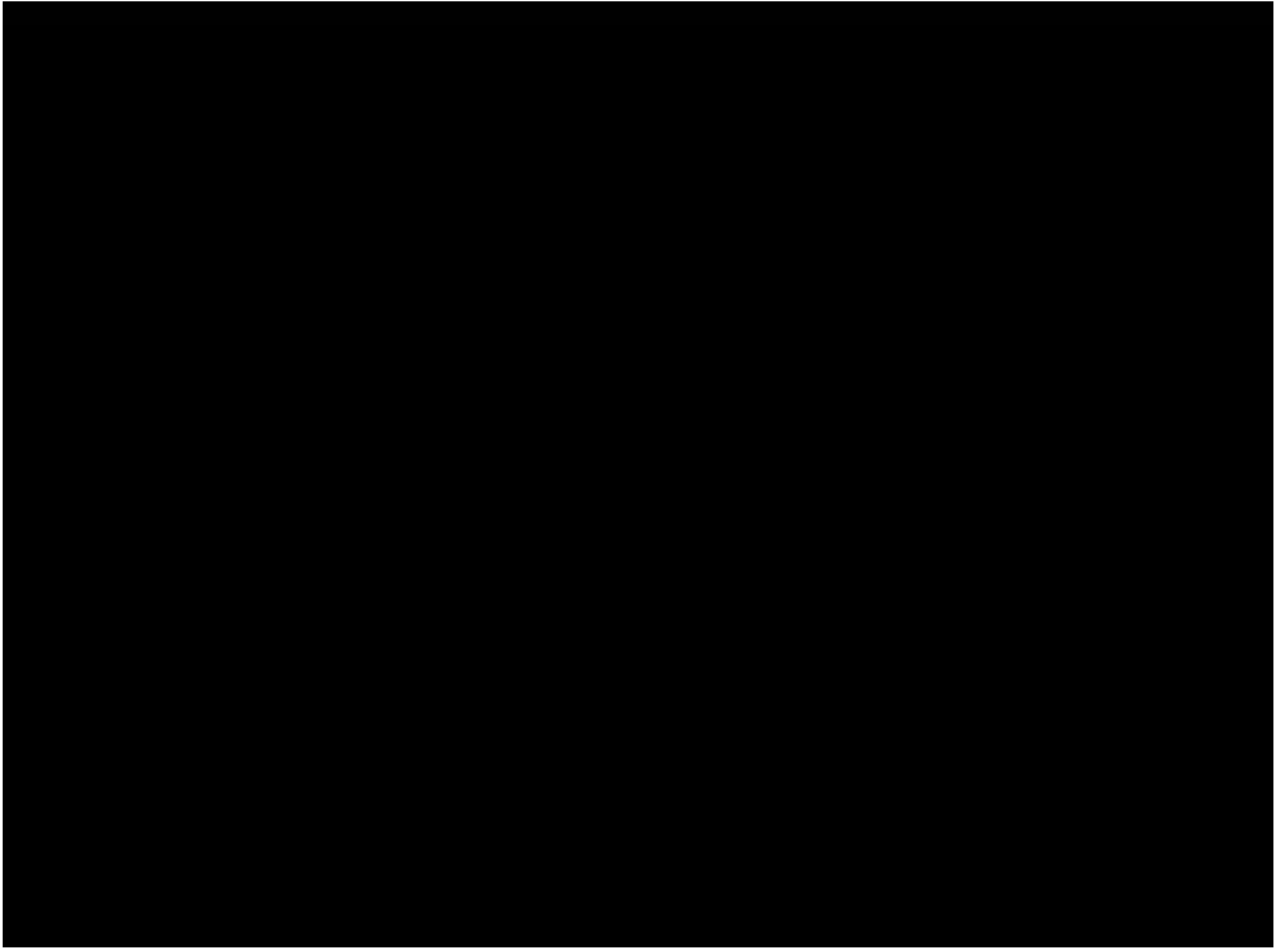


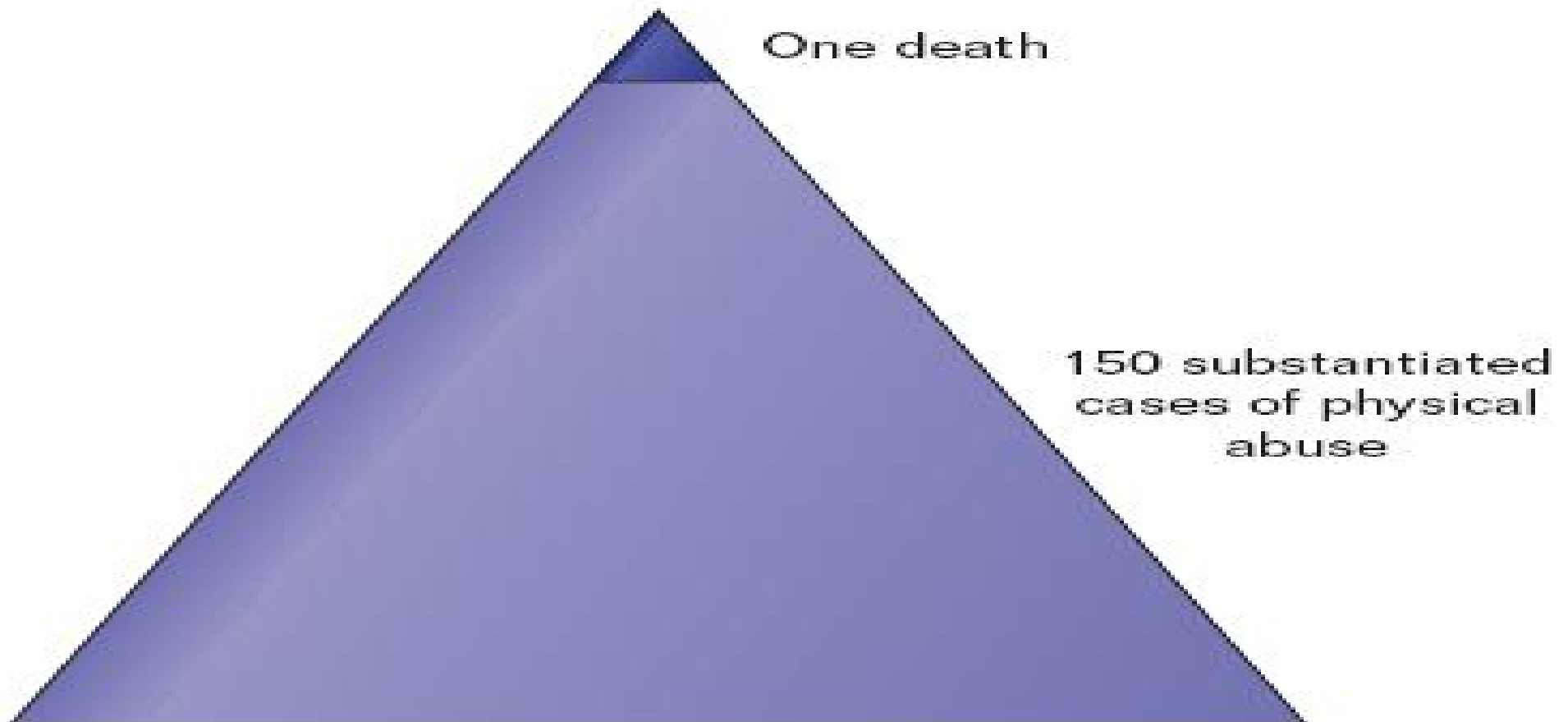




Figure 9

The physical maltreatment 'iceberg'

For every one death from maltreatment among children under the age of 15 years in Australia during 1999-2000 there were 150 cases of physical abuse that were substantiated following investigation.





NIR: Recording immunisation history

Medical Applications Portal

Please enter your user ID and password

User ID

Password

Login



Status Query Report for:



Individual status as at 23/11/2006 11:55

Note: Immunisation history may be incomplete due to individual being (a) enrolled on the MeNZB programme but not within the NIR birth cohort, or (b) within the NIR birth cohort but with earlier tasks not recorded on the NIR

NHI: RZL5603
Database Status: ACTIVE
Status Created: 08/03/2005

Last Name: _____ **First Name:** _____
Date of Birth: 04/01/2005 **Age:** 22 months
Gender: M **Ethnicity:** _____
GP: _____ **WCP:** Wellchild Plunket
GP Clinic: Family Practice and Medical Centre

Childhood Immunisation Programme **ONHOLD - Non-Status: Responding** Status Created: **02/07/2006**

Task Status Due Completed Provider Clinic Batch Expiry Diluent Batch Diluent Site

Task	Status	Due	Completed	Provider	Clinic	Batch	Expiry	Diluent Batch	Diluent Expiry	Site
DTaP-IPV-6w	Completed	15/2/2005	21/2/2005		Family Practice and Medical Centre					
Hib-HepB - 6w	Completed	15/2/2005	21/2/2005		Family Practice and Medical Centre					
DTaP-IPV - 3m	Completed	4/4/2005	6/4/2005		Family Practice and Medical Centre	ac20b021ba	May-07			RVL
Hib-HepB - 3m	Completed	4/4/2005	6/4/2005		Family Practice and Medical Centre	f0573	Jun-06			LVL

3m

Medical Centre

DTaP-IPV - Overdue 4/6/2005
5m

HepB- Overdue 4/6/2005
Paed - 5m

MMR - 15m Overdue 4/4/2006

Hib-15m Overdue 4/4/2006

Well Child

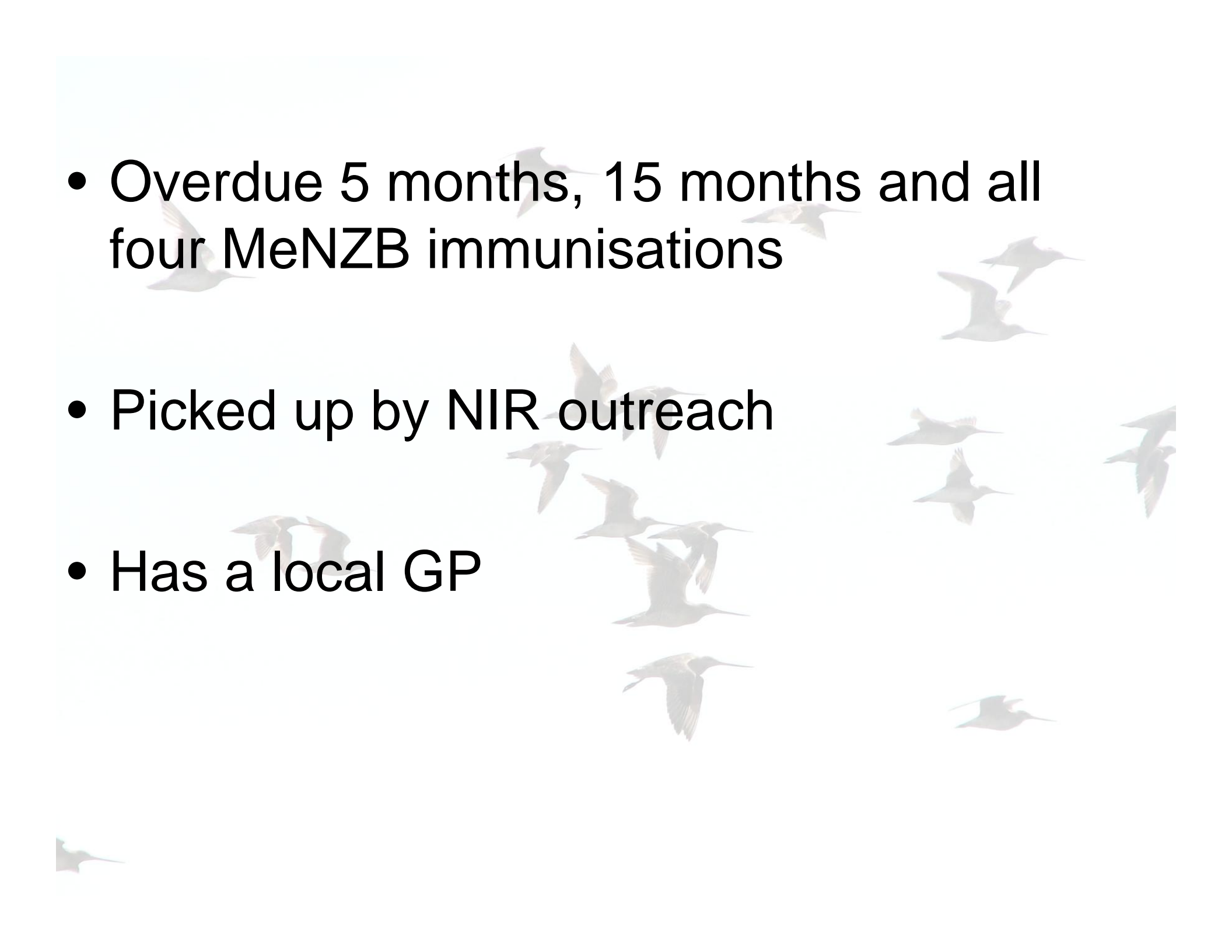
Programme Status: **INACTIVE - Inactive**

Status Created: 16/04/2005

Task	Status	Due	Completed	Provider	Clinic	Batch	Expiry	Diluent Batch	Diluent Expiry
------	--------	-----	-----------	----------	--------	-------	--------	---------------	----------------

Register a Child	Completed	5/1/2005	7/1/2005	Kidslink Provider	Kidslink Migration				
------------------	-----------	----------	----------	-------------------	--------------------	--	--	--	--

Well Child - 9 months	Completed	4/10/2005	10/3/2005	Wellchild Plunket	CMDHB Plunket				
-----------------------	-----------	-----------	-----------	-------------------	---------------	--	--	--	--

- Overdue 5 months, 15 months and all four MeNZB immunisations
 - Picked up by NIR outreach
 - Has a local GP
- 

The NIR Outreach Nurses

- Repeated phone contacts
- Appointments not kept
- Maternal grandfather's help
- Drive-by visits
- Return phone call 31/7/06 after CYF mentioned
- 13 contacts Jan 06 – July 06
- Comment from the Practice Nurse

Clinical Documents

Date Category Service Author
Last Hours Advanced

- Summary
Paediatric MED (1 items)
29/08/06 Discharge Summary Mandy Mas

Discharge Summary Print



Waitakere Hospital
Discharge & Coding Summary
Paediatric MED
(Standard IP Template)

Auckland, New Zealand Ph: (09) 833 8223 Cc: Discharged To: Home	
Admitted: 29/08/2006 14:00	Discharged On: 29/08/2006 17:17
	Discharged From: ECC Rangitira
	Discharge Method: Discharge to Care of GP

Diagnoses

- Primary Diagnosis:
- LRTI unspecified - includes bronchitis

Clinical Management

Fever and cough for at least 24 hours. Off feeds. Is drinking but reduced amounts. Puing Ok . No diarrhoea or vomiting. Miserable. Not immunised- mum been travelling but intending to immunise. No rash.Has just finished a course of antibiotics as was unwell 1/52 ago. Seen by GP today and given a script for augmentin. Seen by Stefan on Rangitira ward.
OE wt 9.1kg T settled from 39.9 to 37 after pamol and RR settled from 72 to 34 Hr 150. sat 97 % on air. Runny nose, mildly dehydrated. no rash . ears- poorly visualized but probably normal, throat- normal. chest- good AE, equal, coarse BS , no wheeze or crackles. subcostal indrawing.
CXR - peribronchial shadowing, no focal changes.

Consistent with viral LRTI.

Read All

Ph: 021-135-6647

Cc:

Discharged To: Home

Admitted: 29/08/2006 14:00

Discharged On: 29/08/2006 17:17

Discharged From: ECC Rangitira

Discharge Method: Discharge to Care of GP

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Seen by [redacted] on Rangitira ward.

OE wt 9.1kg T settled from 39.9 to 37 after pamol and RR settled from 72 to 34 Hr 150. sat 97 % on air. Runny nose, mildly dehydrated. no rash . ears- poorly visualized but probably normal, throat- normal. chest- good AE,

Is this child at risk?

- What is the most concerning piece of information?
- A phone call to CYF
- An inquiry, not a notification
- Some information about Mum.....
- Information from the GP practice – did he get checked?

The GP's Surgery

- Immunisations til aged 3 mths
- 30/6/06 17 mths viral illness (afebrile)
- 18/8/06 respiratory infection – a.b.s
- 29/8/06 seen by locum, Rxd and referred to Waitakere Hospital
- 10/10/06 – skin rash & script
- GP knows Mum+ family situation well

Johnny's birth

- Johnny born Mum aged 22
- X 2 previous deliveries at Waitakere Hospital
- Presents to GP, wants a scan
- USS at 20 wk
- Presents in labour at term

A Paediatrician is called

- 3420g
- Unbooked, GBS, Chlamydia +ve
- The midwives have some information
- Baby “irritable” Day1, starting to feed
- Check glucose, obs, withdrawal score
- Urine toxicology screen eventually accepted (Mum is stressed & angry!)

A Social Worker & a Meeting

The background of the slide features a repeating pattern of stylized, grey-toned birds in flight, scattered across the white background.

- Day 2 baby settling
- Social worker “has things in place”
- Paediatrician OK’s discharge
- Home!
- (What did that urine show?)



Date Type Abnls

Observation Report Cumulative Report Graphical Report Observation Details



Print Comment Phone Library Mark

Displaying patients 1-1 of 1

- ULLUTUKI, Sefa T
- 07.Jan.2005 18:24
- BLOOD BANK
- 07.Jan.2005 16:15
- General Chemistry
- Full Blood Count
- 06.Jan.2005 07:55
- Toxicology**
- 04.Jan.2005 19:00
- Chlamydia/Gono. DNA amplif
- 04.Jan.2005 19:00
- Chlamydia/Gono. DNA amplif
- 04.Jan.2005 19:00
- Auckland Sendaway
- Auckland Sendaway

Observations

Later >>

Toxicology

Report viewed and accepted by Donna Raymond

Filler's Order #	Priority	Requestor	Specimen Collected	Specimen Received
05/7786859003700	Routine	P MEYER	06.Jan.2005 07:55	06.Jan.2005 08:35

Urine Opiates	Negative	
Barbiturate urine	Negative	
Amphetamine urine	Negative	
Benzodiazepine urine	Negative	
Salicylate urine	Negative	
Paracetamol urine	Negative	
Cannabinoid Urine	82	ng/ml
Ethanol Urine	< 3 mmol/L	mmol/L
Creatinine casual urine	14.7	mmol/L

TLC Comment:
Comment:

TLC Comment:
[Thin Layer Chromatography Comment: Urine contains: Drug/substance unable to be identified, possible antibiotic](#)

Comment:
[This urine drug screening and toxicology is for diagnostic purposes only.](#)

Surveillance (or otherwise)

- Family Start whanau programme
- Community Alcohol & Drug Service
- Well-child provider referral – what information to share?
- West Auckland Plunket's first meeting 9 weeks, non-attendances ++

The Family Start worker

- Good engagement til aged 12 months
- Change in family dynamics and no access since Jan 06
- Almost due to discharge as voluntary
- A worried Key Worker!
- A hurried visit encouraged
- Some reassurance ...



NIR: Recording immunisation history

Medical Applications Portal

Please enter your user ID and password

User ID

Password

Login

A flock of birds is flying in a white sky. The birds are scattered across the frame, with some in the foreground and others in the background. The text "Is this child at risk?" is centered in the middle of the image.

Is this child at risk?

Without doubt he is at risk ...

- At risk for preventable diseases!
- Acute presentations are an opportunity to *endorse immunisations*
- In Waitakere 34% of children at 18 months are incompletely immunised.
- At 18 months, 43% Maori incompletely immunised.

Different kinds of “risk”

- GCS, AHA anaesthetic class, TPR, triage scores
- Think “child protection risk” when
- History doesn’t agree with presentation
- A feeling that something else is going on

Different ways of “seeing”



Te Whare Tapa Wha

- **Taha Wairua** - Spiritual well-being; being content
- **Taha Hinengaro** - Mental well-being; being calm
- **Taha Tinana** - Physical well-being; being safe
- **Taha Whanau** - Social well-being, being connected
- ***“The individual should not be considered or treated in isolation”***

“Taha Whanau”

- NZ Ministry of Health



CHILD ABUSE & NEGLECT BRIEF INTERVENTION

1. Identify: take a thorough history if high risk &/or there are signs/symptoms suggestive of abuse
2. Provide emotional support for identified/ suspected victims
3. Assess risk (including co-occurrence of partner abuse)
4. Safety planning and referral
**If immediate safety concerns call Police and refer to CYFS*
5. Document current / past injuries
6. Referral to CYFS or specialist social service agency

Consultation is important:
Consult with staff trained in child protection e.g. Social Worker, Senior Nurse/ Paediatrician /CYFS

Seek peer-support/supervision for self

CHILD ABUSE & NEGLECT 1. IDENTIFY

Take a thorough history for child abuse and neglect if concerns exist or if abuse is disclosed.

Red Flags

- Uncorroborated history e.g. discrepancy between history/injury history/developmental age
- Inappropriate parent response
- History of CYFS engagement
- Delay in seeking medical advice
- History of repeated trauma
- Varying/changing history

Assessing questions

Who makes the rules at home?

What happens if the rules are broken?

Do you ever fear for your child's safety?

CHILD ABUSE & NEGLECT PRELIMINARY RISK ASSESSMENT

1. Family Violence
2. Parent indifferent, intolerant – view child as particularly troublesome
3. Severe social stress
4. Severe isolation and lack of support
5. Parents abused as children
6. Alcohol and drug use
7. Mental illness including post natal depression
8. Parent very young
9. Frequent changes of address, more than 2 over last year
10. At risk family actively avoids family support agencies

CHILD ABUSE & NEGLECT RISK ASSESSMENT & REFERRAL

- Nature of abuse and/or neglect
- Trend of abuse: constant, increasing or decreasing
- Details of: how, where, when, who saw it happen
- Are adequate protectors available e.g. adult (family/other) who will keep the child safe
- Safety of sibling(s) in household
- Child's ability to protect self e.g. baby/young child
- Other agencies involved with the family

CONSULTATION / SUPPORT

- Paediatrician / Senior clinician in child protection / CYFS

REFERRAL

- CYFS (0508 326459)
- Police (112)

Trying to identify (“see”)

From Ministry of Health

CHILD ABUSE & NEGLECT

1. IDENTIFY

Take a thorough history for child abuse and neglect if concerns exist or if abuse is disclosed.

Red Flags

- Uncorroborated history e.g. discrepancy between; history/injury history/developmental age
- Inappropriate parent response
- History of CYFS engagement
- Delay in seeking medical advice
- History of repeated trauma
- Varying/changing history.

Assessing questions

Who makes the rules at home?

What happens if the rules are broken?

Do you ever fear for your child's safety?

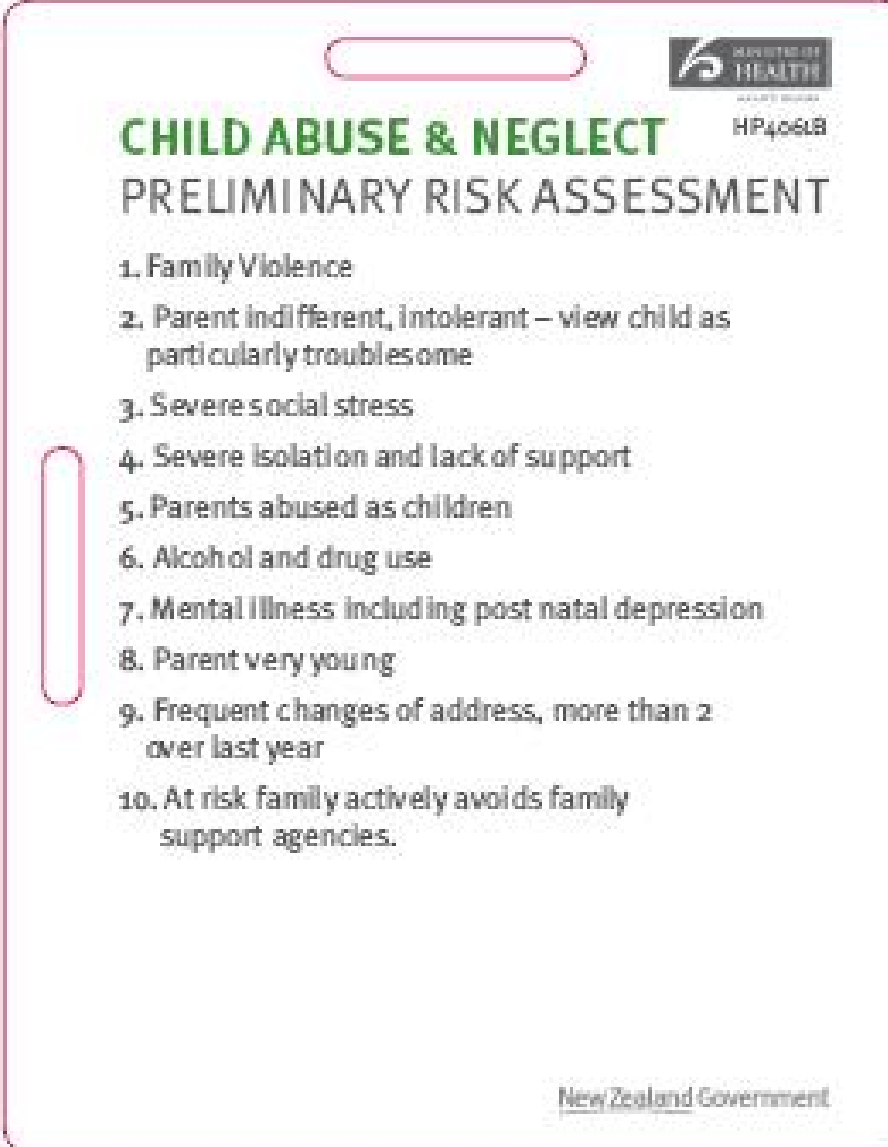
IDENTIFY (if there is a disclosure or concerns)

CHILD ABUSE & NEGLECT

1. IDENTIFY

Take a thorough history for child abuse and neglect if concerns exist or if abuse is disclosed.

Otherwise ... think about RISK



 DEPARTMENT OF HEALTH
HP40608

CHILD ABUSE & NEGLECT
PRELIMINARY RISK ASSESSMENT

1. Family Violence
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3. Severe social stress
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7. Mental illness including post natal depression
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10. At risk family actively avoids family support agencies.

New Zealand Government

Take a closer look



CHILD ABUSE & NEGLECT

HP4061B

PRELIMINARY RISK ASSESSMENT

1. Family Violence

“... you usually need to look at
the **whole family**”

Dr Russell Wills, Paediatrician (MoH 2007)

- **Family Violence** is
- Risk factor for neglect / abuse to children
- Shown by research to underlie a multitude of health problems
- **Routinely enquiring** by health providers shown to be
- Effective
- Acceptable to women

“If you’re not asking, you might be wasting time on other interventions that won’t work”

Dr Russell Wills

Paediatrician

“Working as a community paediatrician, I see one or two new children every week who have been scarred by witnessing violence to others in the home or have experienced actual abuse themselves.

The consequences of experiencing violence can be bleak for children. There’s a profound life-long effect. Little children become fearful and anxious. They don’t learn that adults are reliable and trustworthy, and that becomes a core part of how they think. High rates of mental illness, early unwanted pregnancy and alcohol and drug abuse follow in train.

Act early enough, however, and you can see good gains. Intervention success rates for these children at preschool are 80%. They are 60% at age eight, but fall to 20% by the time someone reaches their teens.

So the object is to identify families as early as possible. Routinely including a question about domestic violence, and asking the parents how they parent their children is critical. To identify child abuse you usually need to look at the whole family.

I also sometimes wonder what happens to a woman in a violent relationship who doesn’t get asked about it. What does it mean for her to come in with injury, depression, severe child behaviour, and not have that question asked?

If you’re not asking, you might be wasting time on other interventions that won’t work. And also missing a chance to turn a potentially damaged child’s life around.”



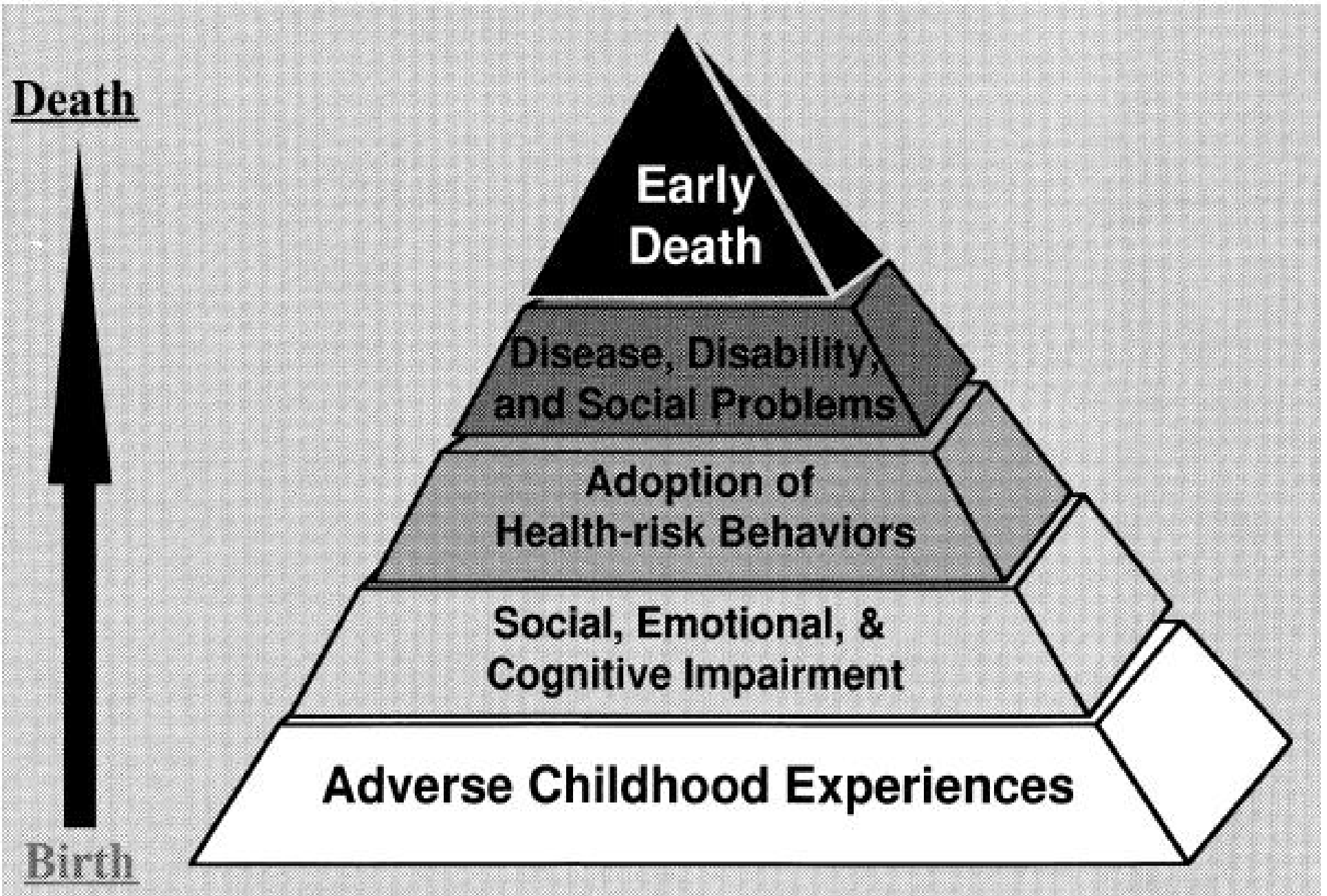
Effects of parental violence on children

Infant	Preschool	School-age	Adolescent
Attachment needs disrupted	Their world is not safe or stable	Greater willingness to use violence	Feelings of rage, shame, betrayal
Routines (sleeping, eating) disrupted	Yelling, irritability, hiding, and stuttering	Hold self responsible for violence at home	Headaches, somatic complaints
50% eating & sleeping problems, ↓ responsiveness to adults, ↑ crying	Many somatic complaints and regressive behaviours	Shame and embarrassment of the family secret	Short attention span Disruptive and angry Truancy, educational failure
<u>Risk of injury</u>	Anxious attachment behaviours of whining, crying, and clinging	Distracted & inattentive, Poor educational achievement	Alcohol and Substance use/ abuse ↑ Teen suicide attempts
Failure to thrive	Increased separation and stranger anxiety	Bedwetting and soiling	Violence and Youth offending
	Insomnia, sleepwalking, nightmares, bedwetting	Limited range of emotional responses	Early sexual activity / incd teen pregnancy rate
	Vomiting and diarrhea	Psychosomatic complaints	Increased risk of STIs ↑ risk of dating violence
	Speech disorders Developmental delay	May be uncooperative, suspicious, or guarded	Boyhood exposure to IPV - ↑ risk of involmt in a teen pregnancy

Lifetime Health Impact

Adverse ***childhood experiences*** including exposure to domestic violence puts ***adults*** at higher risk for: (Felitti, 1998)

- alcoholism
 - substance abuse
 - obesity
 - depression
 - suicide
 - skeletal fractures
- pulmonary disease
hepatitis
heart disease
diabetes
cancer



Women's Health

- Stomach ulcers *Coker et al, 2000*
- Frequent indigestion, diarrhoea, constipation *Drossman et al, 1995*
- Irritable bowel syndrome *Kernic et al, 2000*
- Spastic colon *Talley et al, 1994*
- Pain during sex, dysmenorrhoea, vaginitis
- Chronic pelvic pain *Coker,* **PID** *Schei, 1991*
- Ca Cx *Coker et al, 2000*
- Bladder infections

Family Violence in Obstetrics

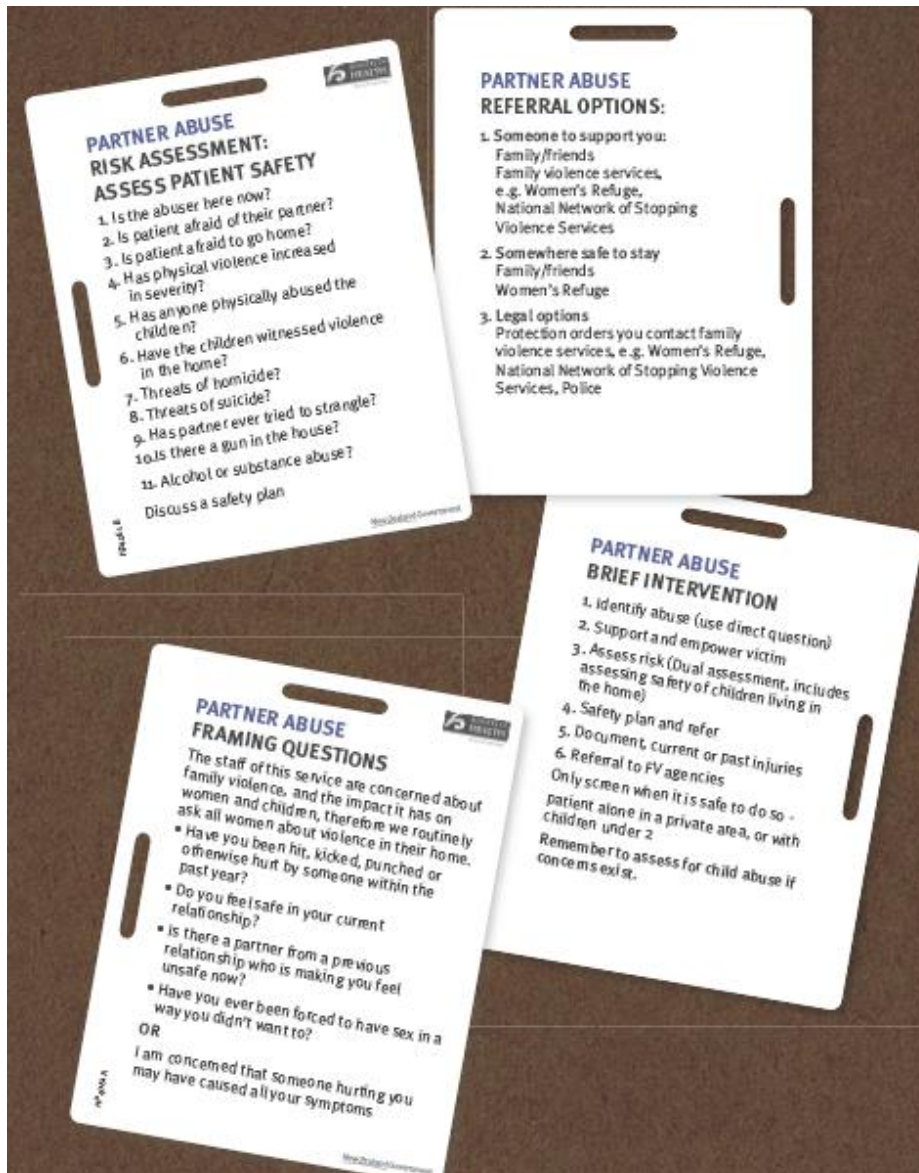
- Increased risk of STI's
- X6 unplanned pregnancy rate
- More likely to use substances before & during pregnancy
- Increased risk of miscarriage
- Increased risk of preterm labour, premature rupture of membranes, chorioamnionitis
- Homicide from IPV

- ***Abuse in pregnancy more common than gestnl diabetes or pre-eclampsia*** Gazmararian et al, 1996

The list goes on

- Alcohol & substance problematic use
- Chronic headaches
- Depression
- Tobacco use
- Missed mammograms
- Increased prescriptions
- ED visits

Research shows ... more likely to have visited a Health Professional



"I'm not at all the type you would expect to tolerate abuse..."

"People tell me that I come across quite confidently – not at all the type they would expect to tolerate abuse. But when I first met my boyfriend with his nice soft voice he didn't seem the type to inflict abuse either.

It began with mind games. He would deliberately let my dog out so I'd have to pay a fine for its straying. Then came constant verbal attack, pummellings and sexual abuse. It seems incredible, but I was convinced I was somehow to blame.

When I fell pregnant, I would cry when I saw my family doctor and the midwife, but they didn't ask any questions or offer help. It was a hospital social worker, who I'd been referred to for a potential abortion, who proved the catalyst for change: simply by asking directly if violence was part of my life.

I think if someone is attacking your very character eventually it changes you. You start thinking, 'Oh, it must be something that I am doing wrong.' **But once you have said, 'Yes I have been abused,' there is no turning back, no denying it any more.**

The social worker gave me a card and said, 'Phone these people and they will help you.' It took me out of that denial. Once I had said it out loud I couldn't retract it.

It wasn't until quite a while after that I phoned the number she gave me. But I often say to my friends now that if it hadn't been for that lady asking me then I wouldn't be here."

Research

Women who had experienced intimate partner violence (IPV) in their lifetime were two times more likely than women who had not experienced IPV to have visited a healthcare provider in the previous four weeks.

Fanslow, J. & Robinson, E. (2004). Violence against women in New Zealand: prevalence and health consequences. *New Zealand Medical Journal*, 117 (1206).



Responsiveness to partner abuse has improved by 150%

Guiding Principles (M.O.H.2001 Recommended Referral Process - G.P.s)

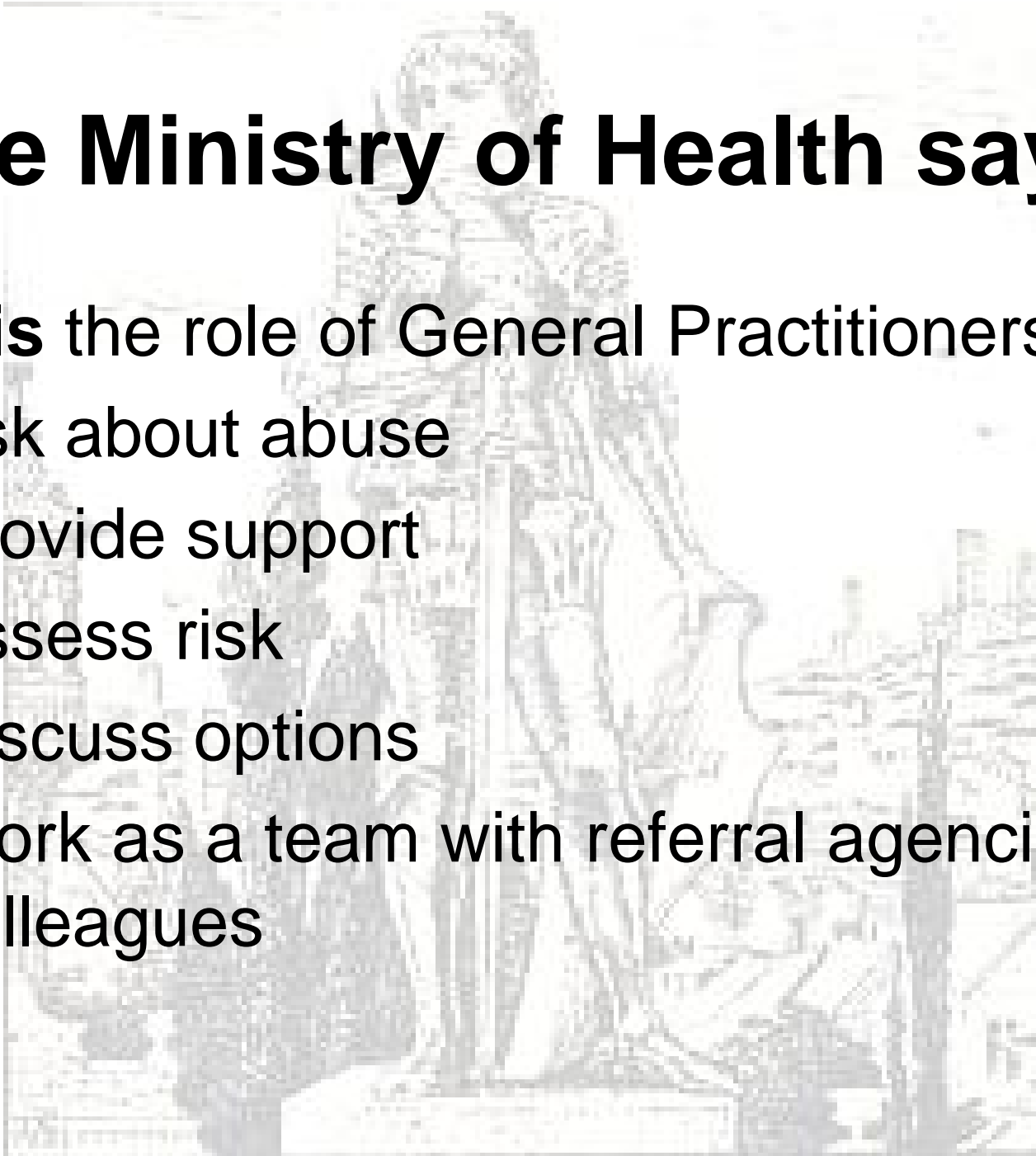
- To identify Family Violence, it is essential to ask questions because
- Very few people volunteer information about their abuse
- Most people do not have signs and symptoms of abuse

But to ask is usually shorter!

- Research shows women take on average ***five times*** being asked about Intimate Partner Violence before they say “Yes”
- Just being ***asked*** can make a huge difference - ***it is an intervention***
- (this can take less than a minute!)

The Ministry of Health says ...

- It **is** the role of General Practitioners to
- Ask about abuse
- Provide support
- Assess risk
- Discuss options
- Work as a team with referral agencies and colleagues



But (M.O.H 2001)

- It is not the doctor's role
- To “fix the problem”
- To investigate the abuse

When to ask about abuse (M.O.H. 2001)

- All patients over 14 years with signs and symptoms that suggest abuse, and
- consider in all patients *especially women over 16 years*, during **appropriate** consultations –
- As part of a routine health history
- During a health check (e.g. Cx smear)
- Sexual health consults (e.g. OCP, ECP)
- Mental health consultations
- Chronic undiagnosed pain
- When something doesn't fit

Screen for Abuse:

Pediatric Setting

Length: 4:44

Remember . . . *(and Family Violence Training teaches this)*

- If partner abuse is identified, someone needs to ask about child abuse / assess safety of children living in the home
- **Only screen when safe to do so ...**
- Patient in a private area
- **Alone**
- Or with children not older than 2 years

What is success?

- Disclosure is not the goal
- Raising awareness is, & reducing isolation
- Family Violence **is** a public health issue
- An issue for individual medical care
- It's something a doctor **can** do something about
- Just by asking
- **That's an intervention!**

FOUR STEPS TO INSTITUTIONAL CHANGE

PROTOCOLS

TRAINING

CLINIC ENVIRONMENT

UNDERSTANDING SUCCESS

Think: *“Family Violence”*

- Cancelled and missed appointments
- Poor medical compliance
- Persistent somatic complaints
- Poor response to standard treatments



Tips for starting to ask

- “We are asking ALL women
- “Doctors now better understand the effects on HEALTH
- “Are you safe?”

A Disclosure

- **Give messages of support**
- “You don’t deserve this I’m glad you told me I want to try to help.....”
- **Assess patient safety** and that of children in the home
- **CYF** – tel **0508FAMILY** – intake social worker
- (Some support for yourself / pathways of referral)



doctors for sexual abuse care

PO Box 90723, 5/4 Warnock Street, Grey Lynn, Auckland, New Zealand
Telephone: 09 376 1422 Facsimile: 09 376 0790 Email: dsac@ihug.co.nz

Recognition & Response to Partner Abuse

Despite the increased awareness of domestic violence in the community, many health professionals still do not feel confident about identifying and responding.

DSAC, as contracted by the MOH, offer a FREE training programme to General Practice team members that offers some practical ways of asking the hard questions and an equally practical response to assisting those who experience violence in the home.

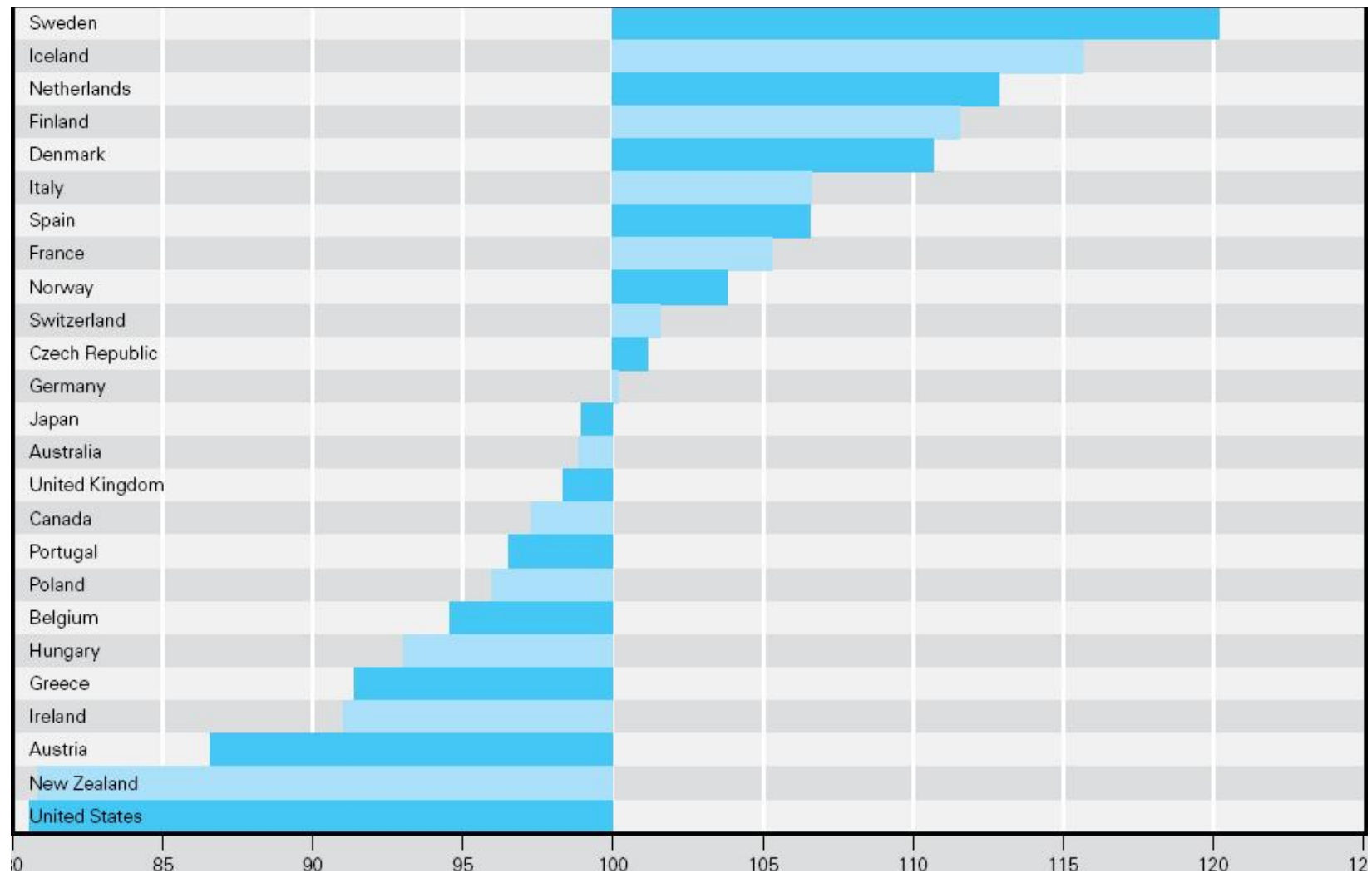
For further information on the DSAC Domestic Violence Intervention Training Programme, please contact the DSAC Office at dsac@ihug.co.nz or phone 09 376 1422 (www.dsac.org.nz)

Do Family Violence Training

- Training for the **whole** practice
- Get to know
- your **local community resources**
- Local **Women's Refuge** personnel
- www.womensrefuge.org.nz
- www.preventingviolence.org.nz
- Family Court
- DHB – Paediatricians, Public Hlth Nurses
- Get to know **CYF!**
- Tel **0508FAMILY**

Child Health & Safety

Innocenti 2007



Only 20% avoidable child abuse deaths are known to CYF

Craig, E. et al (ed.s) "Monitoring the Health of NZ Children and Young People." 2007

- “It is likely that many victims of child abuse presenting to health care settings in NZ each year remain undetected.”

“If you’re not asking, you might be wasting time on other interventions that won’t work”

Dr Russell Wills

Paediatrician

“Working as a community paediatrician, I see one or two new children every week who have been scarred by witnessing violence to others in the home or have experienced actual abuse themselves.

The consequences of experiencing violence can be bleak for children. There’s a profound life-long effect. Little children become fearful and anxious. They don’t learn that adults are reliable and trustworthy, and that becomes a core part of how they think. High rates of mental illness, early unwanted pregnancy and alcohol and drug abuse follow in train.

Act early enough, however, and you can see good gains. Intervention success rates for these children at preschool are 80%. They are 60% at age eight, but fall to 20% by the time someone reaches their teens.

So the object is to identify families as early as possible. Routinely including a question about domestic violence, and asking the parents how they parent their children is critical. To identify child abuse you usually need to look at the whole family.

I also sometimes wonder what happens to a woman in a violent relationship who doesn’t get asked about it. What does it mean for her to come in with injury, depression, severe child behaviour, and not have that question asked?

If you’re not asking, you might be wasting time on other interventions that won’t work. And also missing a chance to turn a potentially damaged child’s life around.”

