

## CHILD PROTECTION - POLICY & PROCEDURE

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## POLICY - OVERVIEW

Family violence is a global issue and is not limited to any one gender, sexual orientation, religious, cultural or income group.

Nelson Marlborough Health (NMH) is committed to a whole health systems population approach to the issue of Child protection i.e. working across primary and secondary care. This is in recognition that child abuse and neglect are important health issues. They can lead to immediate physical and mental health consequences and are significant precursors to a range of poor health outcomes and long-term conditions. Health care providers are ideally placed for early identification of and intervention in family violence because most people use health services at differing times in their lives.

## PURPOSE

NMH recognises that staff competence, and clarity of roles and responsibilities, are essential to effective child protection interventions. This supports the accurate detection of suspected and or actual child abuse and neglect, the early recognition of children at risk of abuse and adults at risk of abusing children. This policy seeks to promote and ensure the safety and wellbeing of children and their whanau.

Associated procedures, referral pathways and electronic documentation requirements e.g. patient management systems, alert/memos and eProsafe requirements, provides NMH community and hospital-

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based staff with a framework to identify, support, assess and respond to actual and/or suspected child abuse and neglect.

## PRINCIPLES

The rights, welfare and safety of the child/tamaiti, are our first and paramount consideration.

Health services should contribute to the nurturing and protection of children and advocate for them as part of their role to promote and preserve health.

Health services for the care and protection of children are built on a bicultural partnership in accordance with the Te Tiriti o Waitangi/Treaty of Waitangi.

Maori children/tamariki are assessed and managed within a culturally safe environment. The Maori Health Unit is available for cultural support/advice.

Wherever possible the family/whānau, hāpu and iwi participate in the making of decisions affecting their child/tamaiti. Their primary role in providing the care, welfare and safety of their children must be valued.

NMH provides an integrated service and works with external agencies to provide an effective and coordinated approach to child protection.

Staff are competent in identification and management of actual or suspected abuse and/or neglect through the organisation's infrastructure including policy and procedural structures, workforce development and access to consultation.

It is important for children/tamariki that services are provided in environments which are comfortable and appropriate to their needs and age.

Child Protection work is complex and stressful; a consultative and multi-disciplinary approach is considered best practice. Health care workers should not work in isolation.

All staff are to recognise and be sensitive to other cultures.

Early intervention is recognised as best practice to maximise the opportunity for best outcomes.

## SCOPE

This policy applies to all cases of actual and/or suspected child abuse and neglect encountered by employees, students and people working at NMH under a contract for service.

## TERMS AND DEFINITIONS

All terms and definitions related to this document have been defined (*see Appendix 1*).

## ORGANISATIONAL RESPONSIBILITIES

### ***Executive Responsibilities***

The NMH is responsible for ensuring it has;

- an organisation-wide policy for the management of child abuse and neglect and associated policies as indicated
- engaged with interagency processes such as Memorandum of Understanding between Health, Ministry for Vulnerable Children, Oranga Tamariki (CYF) and the Police that support effective collaboration
- regular workforce development for staff on the policy
- to ensure staff attend workforce development that comprises of mandatory core and refresher training. NMH requires core training and at a minimum, refresher training every two years, for staff working in the MoH designated areas.
- processes to ensure the policy is adhered to, such as quality improvement activities
- adequate support (e.g. access to consultation) and supervision for staff.

These activities need to be properly resourced and evaluated.

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## Steering Group Responsibilities:

- To meet on a regular basis
- To provide guidance and support to the Violence Intervention Programme (VIP) / Child and Family Safety Service (C&FSS)
- Participate in reviews and endorse the policy and procedures related to VIP/C&FSS
- Advise and support the implementation and maintenance of violence intervention services within NMH.
- Champion the service throughout NMH.

## Service Responsibilities

All services/departments will support the implementation of this policy within services as coordinated by the Violence Intervention Programme (VIP) Co-ordinator(s). Divisions who provide care for children and youth can have divisional level child protection policies based on this policy which reflect their philosophy of care.

## Employee Responsibilities

All employees of NMH have responsibility for the management of actual or suspected abuse and neglect. Responsibilities are:

- To be conversant with DHB management of actual or suspected child abuse and neglect and associated policies
- To understand the referral and management process of actual or suspected abuse and neglect
- To take action when child abuse and or neglect is suspected or identified
- To inform to the (VIP) / Child & Family Safety Service (C&FSS) when there is suspected or actual child abuse and neglect of a child.
- To attend mandatory NMH Family Violence/Child Protection training and regular updates appropriate to their area of work.
- To provide or access DHB specialist health services that may include:
  - Cultural assessments.
  - Mental health assessments.
  - Diagnostic medical assessments.
  - Social work services, counseling and therapy resources.
  - Paediatric assessments.
- To practice safely, for example consulting with a senior colleague during the intervention and seeking peer-support/supervision when child abuse is suspected or identified. This includes situations where child abuse is disclosed but the child may not be present (e.g. child of an adult patient).

## Human Resource Responsibilities

NMH recruitment policies will reflect a commitment to child protection by including comprehensive pre-employment screening procedures (in accordance with the Vulnerable Children's Act 2014).

Where suspicion exists of child abuse perpetrated by an employee or volunteer in the organisation, the matter will be dealt with in accordance with the Human Resource disciplinary procedures, Disciplinary Policy.

## Child Protection / Child and Family Safety Services Coordinator Responsibilities

- Coordinate Violence Intervention Programme (VIP) implementation within services, working with service leaders to ensure the system supports are readily available
- Ensure the DHB-wide policy remains current and aligned with national standards
- Ensure provision of workforce development in accordance with the DHB VIP training plan; this will include ensuring that the VIP training is available cyclically
- Ensure quality improvement activities in regard to policy compliance are undertaken and reported on at least biannually.
- Provision of consultation service for staff managing child protection cases.

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- Provision of peer support for staff who have been involved in the reporting and management of child abuse and/or neglect.
- Management of eProsafe child protection and family violence application
- Attendance at multi-disciplinary/multi-agency case management meetings
- Attendance at multi-agency /multi-disciplinary groups working collaboratively to improve and introduce child protection initiative.
- Participation in VIP whanau ora meetings and initiatives
- Support implementation of Child protection audits.
- To facilitate communication with Oranga Tamariki/CYF and other key community agencies
- Coordinate/facilitate WCIM, MCIM and Mental Health/AOD forums

## MĀORI AND THE CHILD AND THE FAMILY SAFETY SERVICE PROGRAMME

Māori are significantly over-represented as both victims and perpetrators of whānau violence. This should be seen in the context of colonisation and the loss of traditional structures of family support and discipline. However, child abuse and neglect is not acceptable within Māori culture. The NMH Management of Child Abuse and Neglect Policy has been developed in accordance with the principles of action including the Te Tiriti o Waitangi/Treaty of Waitangi principles, recognising Te Whare Tapa Wha and kaupapa practices. This is consistent with the eLearning MOH endorsed Foundation course in Cultural competency.

<https://learnonline.health.nz/login/index.php>

Family violence intervention for Māori is based on victim safety and protection being the paramount principle. NMH has Māori services available to offer support to families. Whenever possible an appropriate staff member of the same ethnicity as the child/tamaiti should be involved in decision making and consultation.

**See Appendix 2:** Māori and family violence

## PACIFIC PEOPLES AND THE FAMILY SAFETY SERVICE PROGRAMME

Family violence among Pacific communities in New Zealand occurs in the context of social change brought about by migration, alienation from traditional concepts of the village, family support, extended family relationships and in combination with socio-economic stresses.

Family violence intervention for Pacific peoples is based on victim safety and protection being the paramount principle. NMH have Pacific Island staff/services available to offer support to the family whenever possible.

**See Appendix 3 -** Pacific peoples and family violence.

## MINORITY ETHNICITIES/REFUGEES

Staff need to consider the increased isolation of patients/clients from minority ethnic groups. They may have few support structures outside of the direct family. Different cultures may have different value bases and this may differ from those predominately represented in New Zealand. The potential for minority ethnicities and refugees to identify as being abused and to access help may be difficult. Staff are to be aware of the potential risks to the abused person when accessing interpreters from ethnic groups. A family member should NOT be used as an interpreter for the victim and or family.

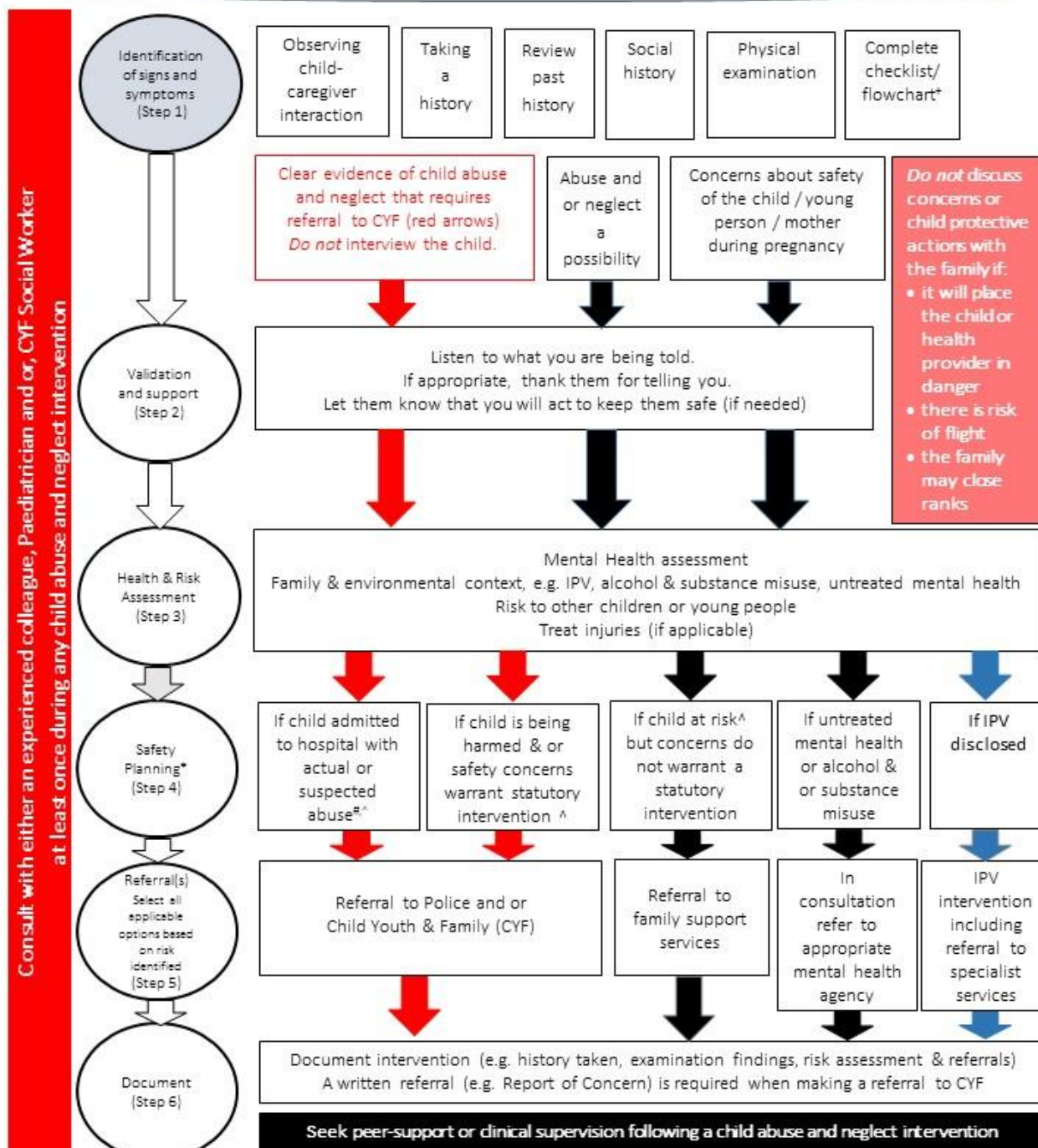


## FLOWCHART FOR RESPONDING TO ACTUAL OR SUSPECTED CHILD ABUSE AND/OR NEGLECT



### Child Abuse and Neglect Intervention Flowchart

Patient presents to health professional complete initial clinical assessment



\*Red pathway for statutory intervention

\*Black pathway for non-statutory intervention

\*Blue pathway specialist service, e.g. FV, MHAS

\*Tool for use in Emergency Departments for child up to 2 years age

\*Standard interagency protocol, Memorandum of understanding between DHB, CYF and Police and associated schedule 1

\*consult with experienced colleague and/or Multidisciplinary team prior to a referral

Peer-support: EAP, CFFS Coordinators, VIP champion, CNM/CTL



## **PROCEDURE: SIX STEP CHILD PROTECTION INTERVENTION**

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

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

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

**See Appendix 4** – Four Recognised Categories of Child Abuse.

**See Appendix 5** - Signs and symptoms of Abuse and Neglect in Recognised Categories of Child Abuse

**Consultation must occur at least once. Consultation with and referral to key clinical staff is essential, they include**

- Supervisor/Manager
- Child Protection Coordinator/Violence Intervention Programme Coordinator
- DHB Social Worker
- Paediatrician
- Psychiatrist
- Psychologist
- Oranga Tamariki/CYF DHB Liaison Social Worker.
- Mental health and Addictions clinicians

It is the health workers responsibility to raise concerns. You do not need absolute proof that child abuse and/or neglect is occurring. A report of Concern to Oranga Tamariki/CYF may be made at any time

All health workers can refer a case for discussion to the Vulnerable pregnant Womens pathway (MCIM) & Well child interagency meeting (WCIM) that are Interdisciplinary/interagency teams within NMH who advise, support and assist staff regarding situations of abuse, alleged abuse or risk of abuse .

It is mandatory for all concerns about a child being or likely to be abused by an adult or another child, that VIP/C&FSS are informed in a timely manner that allows for meaningful consultation.

eProsafe is the NMH CP, IPV, and EAN family violence database that is managed by the VIP/C&FSS. Documentation in eProsafe informs the VIP/C&FSS team and if required the CPC can offer advice, further consultation and follow up if required.

**See Appendix 12: eProsafe**

Contact VIP / C&FSS extn 7440 email; [Childandfamilysafetyservice@nmdhb.govt.nz](mailto:Childandfamilysafetyservice@nmdhb.govt.nz)

## **STEP 1: IDENTIFICATION OF SIGNS AND SYMPTOMS**

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

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

The policy also applies to the unborn child. Management of risk to the unborn child should occur in close consultation with maternity services and the Lead Maternity Carer. Early intervention where care and protection concerns are identified maximises the opportunity for best outcomes. A referral can be made to Oranga Tamariki/Cyf during the antenatal period.

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

## 1.1 Observing child–caregiver interactions

- Observe the caregiver–child interactions at any clinical encounter; these observations are not ‘diagnostic’, but can provide additional information that may be helpful in determining future courses of action (e.g., by providing clues about who the child is comfortable with and seeks support from, or adults whose behaviour towards the child raises some concerns).
- All observations which raise concern should be documented objectively, prospectively and in detail in the clinical records, even if the health care provider is uncertain of their significance at the time. The presence of a documented pattern of concerning behaviours over time may at some stage become very important in enabling the health provider to take effective action on behalf of a child at risk.
- Possible cues/signs and symptoms in parent - child interaction
  - lack of emotional warmth, as opposed to strong attachment/bonding
  - dismissive/unresponsive behaviours as opposed to sympathetic/comforting responses
  - interaction between the child and parent or caregiver seems angry, threatening, aggressive or coercive
  - indications that may raise concern are: a parent/caregiver calling the child names, using harsh verbal discipline, telling the child that they will harm something important to the child, threatening to seriously hurt or abandon the child, mocking the child or putting the child down in front of others.

## 1.2 Taking a history from parents and caregivers

- Your ability to interpret signs and symptoms in a child is reliant on the quality of the history taken from the family and (in some circumstances) the child about those signs and symptoms.
- If a child presents with an injury, it is important to understand how that injury occurred. Essential components of the history include the following:
  - Who is giving you the history (what is their name and relationship to the child)?
  - Who saw it happen (the history should be obtained from an eye-witness, if possible)?
  - When exactly did these events occur (time and date)?
  - How exactly did they occur? For example, if it was a fall, where did they fall; were they stationary or already moving; how did they fall (head first, feet first, arms out); what was the height of the fall (estimated on the eyewitness’ own body); what surface did they fall onto; what



was their position after the fall; were there any complicating factors, like use of a baby walker, or a fall in the arms of an adult?

- When exactly did symptoms begin in relation to the accident? How were they noticed, and who noticed them?
- In a young child, it is important to know the developmental capacities of the child. (Can they crawl, pull to stand, climb, run or manage stairs?) It is also important, especially with babies, to know their usual pattern of feeding, sleeping and behaviour, and when that pattern changed.

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

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

#### What should be asked?

If you are going to have this kind of conversation, you need to frame it in a way that makes sense in terms of the signs and symptoms for which the child has come to see you, or in terms of your usual practice. For example: *'Sometimes when I see children with pain in their tummy like this, it's because they're worried or anxious about something. Is there anything that's making you worried or unhappy?'* Or, *'One of the things I always do with children who come to see me, when they're old enough like you, is to check how things are at home.'*

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

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

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

### 1.4 Asking young people about possible abuse

- Ask in a place that is private, and confidentiality of information needs to be discussed
- Use a developmentally appropriate assessment if signs and symptoms of abuse are detected. Assessment of the causes of violence in this age group is best accomplished as part of a thorough psychosocial assessment for adolescents such as the HEEADSSS assessment

- If the adolescent child is sexually active, it is important to consider the possibility of non-consenting sexual activity. This should be a part of routine HEEADSSS assessment in adolescents.

**See Appendix 7:** HEEADSSS assessment

## 1.5 Past history

- Review the child's clinical record (previous presentations or admissions, particularly multiple presentations for illnesses and injuries, may indicate risk)
- Check for the presence of a National Child Protection Alert/ Local child protection memo- VIP alert; if a National child protection alert exists, follow the NMH Child Protection Alert Policy to access the health information, and take this information into consideration when assessing the child. If a local memo is present access eProsafe for NMH child protection notes.
- Generally it is not in the best interest of a child for a family to be informed that a child protection alert has been placed, as they may not present their child for health care when needed.
- **See Appendix 12:** eProsafe

## 1.6 Social history

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

## 1.7 Physical examination

- A thorough physical examination is indicated in all cases of identified or suspected child abuse and/or neglect, to identify all current and past injuries.
- Further investigations may be necessary, but this will depend on the exact circumstances, including the age and developmental capacities of the child, and the type of abuse or neglect that is suspected. For example, a suspected head injury from child abuse in a child under one (even if they have no symptoms of concussion) will almost always require a CT scan of the head, and a skeletal survey will be required in most children under two years with suspected physical abuse and in some older children. Full blood count and coagulation studies may be required in the presence of bruising
- Cases of sexual abuse, or suspected sexual abuse, should always be discussed with a doctor specifically trained in this field. This discussion should always take place before you decide whether or not to examine the child. See Health Pathways child/adolescent sexual abuse.
- For adolescents 13 years and older are referred to INP Doctors and children under 13 years of age referred to on call paediatrician.

## 1.8 Using a child protection checklist in all children under 2 years old and children up to 5 years when they present with an injury.

- All children under the age of 2 years presented to the emergency department and children up to the age of 5 where they present with an injury should have the Child Protection Checklist as below completed; it is only possible to answer the questions it contains, if you have conducted a thorough assessment following the principles outlined above.
- The tool may be relevant for older children presenting to ED where any of the listed concerns exist

- The checklist is only a guide to assist safe process, not a diagnostic algorithm. Never jump to conclusions.

**See appendix 13: ED Child Protection Checklist**

## 1.9 Collection of physical evidence

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

Steps for collection and safe storage of evidence include:

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

## **STEP 2: VALIDATION AND SUPPORT**

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

## 2.1 Talking with the parents/caregivers of the child

- If you are unsure about how to talk with the parents/caregivers; consult with health professionals as appropriate to your area of work i.e. child protection coordinator, paediatrician, psychiatrist, psychologist, social worker, mental health case worker, and supervisor/manager.
- Basic principles are:
  - create time and space for a private conversation
  - be professional (be calm, start with the facts before you, explain the reasons for your concern and the reasons for the actions you need to take)
  - don't accuse anyone. For example, if a child has an injury, you have reached the appropriate point in the consultation and have explained the features of the injury that are unusual, you might use phrasing such as "I am concerned that someone may have injured your child"
  - access cultural support, e.g. Māori Health Unit. It is important that contacting such support does not delay any referral to Oranga Tamariki/CYF.

- use interpreters (not family members) if there are language barriers
- be transparent about what happens next.
- If circumstances permit discussing concerns with a victim's parents or caregivers, follow these principles:
  - broach the topic sensitively
  - help the parents/caregiver feel supported, able to share any concerns they have with you
  - help them understand that you want to help keep their child safe, and support them in the care of their child.

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

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

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

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

## **STEP 3: HEALTH AND RISK ASSESSMENT**

### 3.1 Risk to the child

#### **A thorough risk assessment needs to be conducted prior to the development of appropriate intervention plans**

- Health care providers are responsible for conducting a preliminary risk assessment with victims of abuse and/or neglect, in order to identify appropriate referral options. Note that this is different from the role of conducting investigations to determine who is responsible for perpetrating the abuse and/or neglect, which is the role of Oranga Tamariki/CYF or the Police.
- Immediate protection of a child is required if the child has suffered harm which in your view is a result of child abuse, and the environment to which the child is returning is unsafe. Obviously, the more serious the harm and the more vulnerable the child (for example, a baby or a preverbal child), the more critical the risk becomes.
- Safe process means:
  - never make decisions about risk in isolation
  - do not jump to conclusions
  - consult with experienced staff e.g., NMH Child Protection Coordinator, a paediatrician, a health social worker or youth health service, or with the duty social worker at Oranga Tamariki/CYF as you work to determine what level of risk the child might be facing
  - appreciate that other organisations (e.g., Oranga Tamariki/CYF) may hold information that is crucial to determining the safety of the child.
- You do not need proof of abuse or neglect, and do not need to seek permission from a child's family, prior to talking with colleagues or a Oranga Tamariki/CYF social worker about a child

- Early communication with Oranga Tamariki/CYF can help identify if there have been other concerns raised about the safety of the child. It can be considered an additional component of reviewing the child's history. This early communication does not need to result in a report of concern to Oranga Tamariki/CYF, which is a decision that ideally should only be made after a thorough assessment
- **Subsequent children** - Sections 18B of the Children, Young Persons and their Families Act 1989, outline the requirement for parents/caregivers to demonstrate to Oranga Tamariki/CYF that they are safe to parent subsequent child/ren when a child has been previously removed from their care or they have been convicted of the murder, manslaughter or infanticide of a child.

If you are aware, or suspect, that a parent or caregiver meets the criteria of 18B or has had a child permanently removed from their care, consult with your DHB Child Protection Coordinator and discuss any concerns you have with Oranga Tamariki/CYF.

## 3.2 Mental health assessment

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

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

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

*"Do you ever feel like crying a lot?"*

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

### See Appendix 8: Assessment and Referral for Children under 12 at Risk of Suicide

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

## 3.3 Risk to other children or young people

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

## 3.4 Co-occurrence of intimate partner violence

- If child abuse is identified, assess the mother's/female care giver's safety. Follow the procedure outlined in NMH Intimate Partner Violence (IPV) policy.

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- Victims of IPV are frequently threatened by the perpetrator that if they disclose the violence, s/he will tell Oranga Tamariki/CYF that the non-abusive partner is a bad parent/abusive to the children, and that Oranga Tamariki/CYF will take the children away. Careful assessment needs to be undertaken to ensure that children's disclosure of violence, or the non-abusive partner's disclosure of violence, leads to further safety for them both, rather than additional trauma through separation or other consequences.
- It is recognised that there are occasions when the only way to ensure the safety of a child in a situation of family violence may be to separate the child from the non-abusive parent, even if only temporarily. In these circumstances, best efforts should be made to mitigate the trauma of the separation to both.

### 3.5 Other risk factors

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

## STEP 4: INTERVENTION / SAFETY PLANNING

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

**If there are concerns about immediate safety (including your own), contact the Police (or in-house security if available) and contact Oranga Tamariki/CYF (phone followed by written referral).**

- Information from the health and risk assessment process will help to ensure that acute needs are identified and can be included in the safety plan.
- All healthcare providers can undertake basic intervention and safety planning activities if they have received training, and have access to support
- Note that the purpose of risk assessment is to ascertain the likely level of immediate risk for a patient leaving the health care setting. Actual injuries or other evidence of abuse are not required for referral to Oranga Tamariki/CYF, particularly if there is risk to children
- Assessing for positive/protective factors e.g., family's efforts to actively pursue the safety and well-being of the child and their willingness and capacity to respond or engage, is an important part of identifying resources that may help improve the situation during safety planning
- The identification of support needs within the family (e.g., health, education or disability) can be a strength if meeting these needs assists in establishing connections with other services
- The tasks at this stage are to:
  - Identify the support and safety procedures that are required e.g., what are the child's needs for; safety, physical and emotional needs, health and rehabilitation, access to caregivers?
  - Specify. What are the support or safety procedures that need to be put in place?
  - Allocate responsibilities for action (e.g., who are the key individuals and agencies that need to be engaged?).
- In non-critical situations, multiple referral and follow-up pathways are possible. The key issue is whether the child is 'at risk' or whether the child is actually already coming to harm.

### 4.1 Child being harmed

- A child who, in the opinion of the healthcare provider, is already coming to harm, should be notified to Oranga Tamariki/CYF as a 'report of concern'. Oranga Tamariki/CYF will form their own opinion on the level of risk for the child and triage accordingly.

- Children admitted to hospital with actual or suspected child abuse or neglect should be managed in accordance with the Memorandum of Understanding (2011) between DHBs, Oranga Tamariki/CYF and the Police and the associated Schedule 1 (Children admitted to hospital with suspected or confirmed abuse or neglect). NMH Hyperlink to MOU

## 4.2 Child at Risk

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

## 4.3 Co-occurrence of child abuse and Intimate partner violence

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

- Any concerns about the safety of the children should be discussed with the abused partner, unless you believe that doing so will endanger the child, another person or yourself. If you or your colleagues decide to notify Oranga Tamariki/CYF, the abused partner should be informed, unless the same concerns apply
- Be aware that actions taken to protect the child may place the non-abusive parent at risk. Always refer this parent to specialist family violence support services, and inform Oranga Tamariki/CYF about the presence of IPV as well as child abuse
- Ask the abused partner how they think the abuser will respond (risk that the abuser will retaliate for disclosure of the family secret).
- Ask if Oranga Tamariki/CYF has been previously involved, and what the abuser's reaction was.
- If the abuser is present in the health care facility, ask the abused partner whom they would like to inform the abuser about the Report of Concern to Oranga Tamariki/CYF, e.g., would they like the health care provider to do it? Does the abused partner want to be present when the abuser is told? Do they want to do it?
- Make sure the abused partner has information on how to contact support agencies if problems arise (e.g., Police, Women's Refuge, and Oranga Tamariki/CYF).
- If the woman is pregnant refer her to your DHB vulnerable pregnant woman's pathway

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

If it is safe to do so, discuss referral to Oranga Tamariki/CYF with the child's parents or caregivers:

- Broach the topic sensitively and reasonably, in the light of the concerns you have
- Help the parents/caregiver feel supported, able to share any concerns they have with you
- Help them understand that you want to help keep their child safe, and support them in the care of their child

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- Keep the parents informed at all stages of the process
- Where options exist, support the parents/caregivers to make their own decisions
- Involve extended family/whānau and other people who are important to them
- Be sensitive to, and discuss the patient or caregiver's fears about Oranga Tamariki/CYF
- However, be clear that your role is to keep the child safe. Do *not* seek permission to consult with Oranga Tamariki/CYF. You may do this at any time.

## See Appendix 9 - Legal and Privacy Issues

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

## **STEP 5: REFERRAL AND FOLLOW-UP**

- Follow-up and referral plans need to be developed for all children and their families, based on the information obtained during the risk assessment and safety planning, and the collaborative planning undertaken.

The tasks at this stage are:

Make referrals as appropriate, and ensure that relevant information is appropriately and accurately transferred to receiving individuals/agencies

### **Referral to children's teams –**

- All Health Professionals should discuss families they feel need a referral to the Children's team in their team meeting/MDT before making the referral.
- The NMH staff member will then contact the Marlborough Children's Team office for the referral and consent form. The Children's Team encourage referrers to have a discussion with them about the intended referral, and the information needed for the panel.

### **Referral to Child Youth and Family –**

- When referring to Oranga Tamariki/CYF, a written referral (e.g., report of concern) must be sent to Oranga Tamariki/CYF and a copy placed in the clinical record of the child (or mother when the concerns reported relate to the antenatal period). A copy must be entered in eProsafe or sent to the VIP/C&FSS child protection coordinator in accordance with the DHB's policy for the National Child Protection Alert System
- Ensure there is a plan for review and follow-up, e.g., what is the timeframe for the referral and follow-up plan? Who, when, and how, will the plan be reviewed?

### **5.1 Child being harmed**

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

## 5.2 Child at risk

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

## 5.3 Co-occurrence of child abuse and intimate partner violence

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

## STEP 6: DOCUMENTATION

Child Protection Resources have been developed to assist documentation (see under child health team sites);

- Child Assessment form- to document admission examination findings includes Discharge checklist and body diagrams
  - Police and Oranga Tamariki/CYF contacts -Nelson/ Wairau
  - Additional body diagrams
  - Sexually transmitted infectious pathways
  - Paediatric Medical Assessment Pathway for Serious Child Abuse- see in appendix 11a
  - Ward Neonatal/Paediatric safety plan
  - Child protection Concerns Parent information sheet
  - Multi agency safety plan
  - Oranga Tamariki/CYFs Report of concern form
  - Flowchart when child admitted in Wairau see in appendix 11b
  - Flowchart when child admitted in Nelson see in appendix 11c
- Thorough documentation on eProsafe of all steps of the health consultation is necessary.
  - Always include the date and time that you saw the child and when you wrote your notes (if different from the time you saw the patient)
  - Always include name, legible signature and practice designation
  - Clearly and thoroughly document the behaviours, signs and symptoms you observed.

## 6.1 History

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

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## 6.2 Examination

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

## 6.3 Photographs

- Many DHB's now regard photography as a routine supplement to the medical records (refer to NMH policies and procedures regarding consent to photograph ;Informed Consent Policy
- Police will take photos where there is suspicion of a non-accidental injury.
- Note that thorough documentation and body maps are always required, and cannot be replaced by photographs.

## 6.4 Document the results of your risk assessment

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

## 6.5 Document the consultative process you undertook

- Who did you speak with? At what points?

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

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

## 6.7 Confidentiality of abuse documentation on the medical record

- Care must be taken to ensure the confidentiality of any information about abuse recorded in any records potentially available to family /whānau members.
- If the abuser finds out that the victim has disclosed child abuse/neglect, the victim may be at increased risk of retribution for having revealed this abuse.
- Children's health records are private to them. Parents can ask to access their children's notes until they are 16 years old, but they are not automatically entitled to them. All requests to access health records should be managed in accordance with NMH policy; Patient Access to Clinical Records, there may be grounds for withholding information when the healthcare provider believes that it is not in the child's best interests to give the parents access
- eProsafe is specifically designed for documentation of concerns about child abuse and neglect and family violence



## STAFF SUPPORT AND SAFETY

In any case where staff have been involved in the reporting and/or management of abuse or neglect they should seek debriefing, supervision or counselling from an appropriately trained senior colleague. Staff may access Peer Support or the Employee Assistance Programme and can also access support following a critical incident. Debriefing can be organised by HOD's or management.

## DEATH OF A CHILD AND SIBLING ASSESSMENT

In the event that a child is brought into the DHB and is deceased on arrival or the child dies in the DHB and the cause of death is suspicious, then an assessment of the safety of any siblings should be urgently undertaken. The Paediatrician on-call should determine if there are other siblings and if so report to Oranga Tamariki/CYF. It is also important for the NMH to work closely with the Police, and Child, Youth & Family in accordance with the MOU between Oranga Tamariki/CYF, The Police and NMH, 2011.

## REFERENCES

### Associated Documents

Refer to Family violence intranet resource page

- NMH - *Child protection alert management policy*
- NMH - *Informed consent policy*
- NMH - *Security Policy*
- NMH - *Privacy Policy*
- NMH – *Disclosure of family violence to the Police and other government agencies*
- NMH – *Sharing of health information between parents and health professionals where conflict exists*
- NMH – *Disclosure of Client Information to Health Professionals and Principal caregivers*
- NMH – *Family Violence Review procedure*
- NMH – *Ministry of Social Development – Report of Concern*
- 
- NMH – *Vetting and Screening Guidelines for people working with children - Toolkit.*
- NMH – *Treaty of Waitangi Policy*
- NMH – *He Oranga Maori Best Practice*
- NMH – *Te Waka Hauora*

### External Documents

- [Privacy Commissioner - Escalation ladder regarding sharing personal information of families and vulnerable children - info](#)
- [Privacy Commissioner - Sharing personal information of families and vulnerable children; Guideline for interdisciplinary groups](#)
- [Treaty of Waitangi](#)

### Legislation:

- [Health Act 1956](#)
- [Ministry of Social Development - Children Young Person and their Families Act 1989](#)
- [Ministry of Social development - Children's Action Plan: Vetting and Screening Guidelines for people working with children - info](#)
- [Ministry of Social Development - Children's Action Plan - info](#)
- [Ministry of Health - Health Information Privacy Code](#)
- [Privacy Act 1993](#)
- [Code of Health and Disability Services Consumers' Rights 1996](#)
- [New Zealand Bill Of Rights Act 1990](#)
- [Ministry of Justice – Amendments to the Crimes Act 2012](#)
- [Ministry of Justice - Domestic Violence Act 1995](#)
- [Summary Offences Act 1981](#)
- [Ministry of Social Development - Vulnerable Children's Act 2014](#)
- [Care of Children Act 2004](#)
- [United Nations Convention on the Rights of the Child](#)

### Other:

- [Ministry of Health - Family Violence Intervention Guidelines - Child and Partner Abuse \(2016\).](#)

**For further information contact the Child Protection Co-ordinator.**

## APPENDIX 1

### TERMS AND DEFINITIONS

<b>Child</b>	Unborn children and children aged 0–17 years old
<b>Child Protection</b>	Means the activities carried out to ensure the safety of the child/tamaiti,/rangatahi in cases where there is abuse or risk of abuse.
<b>Child Abuse</b>	Refers to the harming (whether physically, emotionally, or sexually), ill treatment, abuse, neglect, or serious deprivation of any child/tamaiti,/rangatahi (Section 14b Children, Youth and their Families Act 1989). This includes actual, potential and suspected abuse.
<b>Physical Abuse</b>	Child physical abuse is any act or acts that may result in inflicted injury to a child.
<b>Sexual Abuse</b>	Child sexual abuse is any act or acts that result in the sexual exploitation of a child, whether consensual or not.
<b>Emotional/ Psychological Abuse</b>	Child emotional/psychological abuse is any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child.
<b>Neglect</b>	Child neglect is any act or omission that results in impaired physical functioning, injury, and/or development of a child.
<b>DSAC</b>	Doctors for Sexual Abuse Care. National organisation advancing knowledge and improving medical care for those affected by sexual abuse. Only DSAC trained practitioners should perform medical examinations for child sexual assault.
<b>Oranga Tamariki/CYF</b>	Government agency that carries out the legislative requirements of the Children, young persons, and their Families Act 1989. Responsibilities are: <ul style="list-style-type: none"> <li>▪ To investigate cases of actual and suspected child abuse and/or neglect</li> <li>▪ To complete diagnostic interviews</li> <li>▪ To complete evidential interviews in cooperation with NZ Police</li> <li>▪ To provide care and protection for children found to be in need.</li> </ul>
<b>Police</b>	Government agency responsible for: <ul style="list-style-type: none"> <li>▪ Working cooperatively with Oranga Tamariki/CYF in child abuse and/or neglect protection work</li> <li>▪ Investigating cases of abuse and/or neglect where an offence has or may have been committed</li> <li>▪ Prosecuting offenders where an offence has been committed</li> <li>▪ Accepting reports of suspected abuse and or neglect and referring these to Oranga Tamariki/CYF.</li> </ul>
<b>eProsafe</b>	See Appendix 12

<b>Local memo</b>	A local memo can be viewed in local DHB patient management systems i.e. Concerto indicates to staff that local Child Protection information is held in eProsafe.
<b>NCPAS</b>	National Child Protection Alert System - Any child up to 18 years of age where child abuse is suspected and/or confirmed and a referral is made to Oranga Tamariki/CYF; a Gateway referral and Medical Assessment request by Oranga Tamariki/CYF; or a pregnant woman where there are identified vulnerabilities. This alert can be viewed on the National Medical Warning System and local DHB patient management systems i.e. Concerto
<b>Children's Team</b>	A Children's Team is not a new service but a new approach. It works with existing resources and provides the opportunity for practitioners and professionals in government agencies, iwi and non-government organisations to bring their services together into one personalised plan for each child and their family/whānau.
<b>Gateway Service</b>	Collaboration between Health, Education and Oranga Tamariki/CYF. This service assesses the needs of children engaged with Oranga Tamariki/CYF

## APPENDIX 2

### MĀORI AND FAMILY VIOLENCE

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

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

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

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

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

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

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

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

#### **Safety first**

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

#### **Equity of Health Care for Māori**

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

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



- commitment: providing high-quality health care that meets the health care needs and aspirations of Māori.

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

## Principles for action

Te Tiriti o Waitangi/Treaty of Waitangi/ principles of Partnership, Participation and Protection should underpin efforts to achieve equitable Māori Health outcomes.

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

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

### Ways to put this into practice

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

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

### Ways to put this into practice

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

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

### Ways to put this in to practice

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

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

## *Ways to put this into practice*

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

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

## *Ways to put this into practice*

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

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

## *Ways to put this into practice*

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

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

## *Ways to put this into practice*

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

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

## *Ways to put this into practice*

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

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

### *Ways to put this into practice*

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

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

### *Ways to put this into practice*

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

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

### *Ways to put this into practice*

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

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

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

### *Ways to put this into practice*

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

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

## APPENDIX 3

### PACIFIC PEOPLES AND FAMILY VIOLENCE

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

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

#### ***What family violence means in a Pacific context***

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

#### Risk factors for family violence amongst Pacific people

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

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

#### Protective factors for Pacific families

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

#### Transformation and restoration

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

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



## Principles for action

### 1 ***Victim safety and protection must be paramount***

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

Actions and behaviours to ensure victim safety and protection:

- Wherever possible, involve the person in determining the plan of action they would like to take
- your communication style is important. Your language and tone should convey respect and a non-judgemental attitude. Preferably communicate in the language of the victim
- affirm the person's right to a safe, non-violent home
- offer referral to either specialist Pacific or mainstream family violence advocates.

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

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

Actions and behaviours that contribute to Pacific people feeling comfortable:

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

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

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

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

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

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

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

Actions and behaviours that contribute to a collaborative intersectoral approach:

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

## APPENDIX 4

### FOUR RECOGNISED CATEGORIES OF CHILD ABUSE

These frequently overlap in individual cases. Refer to the “Recognition of Child Abuse and Neglect” published by the Risk Management Project, Children/young person's and Their Families Agency 1997.

#### 1. Physical Abuse

*Child physical abuse is any act or acts that may result in inflicted injury to a child.*

*It may include, but is not restricted to:*

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

#### 2. Sexual Abuse

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

##### Non-contact abuse

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

##### Contact abuse

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

#### 3. Emotional/Psychological Abuse

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

- Rejection, isolation or oppression.
- Deprivation of affection or cognitive stimulation.

- Inappropriate and continued - criticism, threats, humiliation, accusations, expectations of, or towards, the child.
- Exposure to family violence.
- Corruption of the child through exposure to, or involvement in, illegal or anti-social activities.
- The negative impact of the mental or emotional condition of the parent or caregiver.
- The negative impact of substance abuse by anyone living in the same residence as the child.

## 4. Neglect

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

- Physical neglect - failure to provide the necessities to sustain the life or health of the child.
- Neglectful supervision - failure to provide developmentally appropriate and/or legally required supervision of the child leading to an increased risk of harm.
- Medical neglect - failure to seek, obtain or follow through with medical care for the child resulting in their impaired functioning and/or development.

Refer to the Neglect of Medical Care Guideline – Schedule 3 MOU between Oranga Tamariki/CYF, NZ Police & NMH.

Emotional neglect – not giving children the comfort, attention and love they need through play, talk, and everyday affection.

- Educational neglect – allowing chronic truancy, failure to enrol children in school, or inattention to special education needs.
- Abandonment - leaving a child in any situation without arranging necessary care for them and with no intention of returning.
- Refusal to assume parental responsibility - unwillingness or inability to provide appropriate care or control for a child.

## APPENDIX 5

### SIGNS AND SYMPTOMS OF ABUSE AND NEGLECT IN RECOGNISED CATEGORIES OF CHILD ABUSE

#### Physical abuse: injuries that don't make sense

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

#### Sexual abuse

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

#### Emotional abuse

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

- **sleep problems** like bed-wetting or soiling – with no medical cause, nightmares and poor sleeping patterns.
- **frequent physical complaints** – real or imagined, such as headaches, nausea and vomiting, and abdominal pains
- **signs of anxiety**
- **other altered behaviour.** Children who are abused may withdraw, present as sad and alone, or consider hurting themselves or ending their lives. Some children may develop conduct disorder, such as oppositional or aggressive behaviour, acting out or deteriorating school performance.

## Neglect

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

**See Appendix 6 – Child Neglect Assessment Guideline**



## APPENDIX 6

### CHILD NEGLECT ASSESSMENT GUIDELINE

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

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

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

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

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

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

## APPENDIX 7

### HEEADSSS: PSYCHOSOCIAL INTERVIEW FOR ADOLESCENTS

#### Key:

Green = essential questions

Blue = as time permits

Red = optional or when situation requires

#### Home

Who lives with you? Where do you live? Do you have your own room?

What are relationships like at home?

To whom are you closest at home?

To whom can you talk at home?

Is there anyone new at home? Has someone left recently?

Have you moved recently?

Have you ever had to live away from home? (Why?)

Have you ever run away? (Why?)

Is there any physical violence at home?

#### Drugs

Do any of your friends use tobacco? Alcohol? Other drugs?

Does anyone in your family use tobacco? Alcohol? Other drugs?

Do you use tobacco? Alcohol? Other drugs?

Is there any history of alcohol or drug problems in your family? Does anyone at home use tobacco?

Do you ever drink or use drugs when you're alone?

(Assess frequency, intensity, patterns of use or abuse, and how youth obtains or pays for drugs, alcohol, or tobacco)

(Ask the CRAFFT questions)

#### Education and employment

What are your favourite subjects at school? Your least favourite subjects?

How are your grades? Any recent changes? Any dramatic changes in the past?

Have you changed schools in the past few years?

What are your future education/employment plans/goals?

Are you working? Where? How much?

Tell me about your friends at school.

Is your school a safe place? (Why?)

Have you ever had to repeat a class? Have you ever had to repeat a grade?

Have you ever been suspended? Expelled? Have you ever considered dropping out?

How well do you get along with the people at school? Work?

Have your responsibilities at work increased?

Do you feel connected to your school? Do you feel as if you belong?

Are there adults at school you feel you could talk to about something important? (Who?)

#### Sexuality

Have you ever been in a romantic relationship?

Tell me about the people that you've dated. OR Tell me about your sex life.

Have any of your relationships ever been sexual relationships?

Are your sexual activities enjoyable?

What does the term 'safe sex' mean to you?

Are you interested in boys? Girls? Both?

Have you ever been forced or pressured into doing something sexual that you didn't want to do?

Have you ever been touched sexually in a way that you didn't want?

Have you ever been raped, on a date or any other time?

How many sexual partners have you had altogether?

Have you ever been pregnant or worried that you may be pregnant? (females)

Have you ever gotten someone pregnant or worried that that might have happened? (males)

What are you using for birth control? Are you satisfied with your method?

Do you use condoms every time you have intercourse?

Does anything ever get in the way of always using a condom?

Have you ever had a sexually transmitted disease (STD) or worried that you had an STD?

## Key:

Green = essential questions

Blue = as time permits

Red = optional or when situation requires

## Eating

What do you like and not like about your body?  
 Have there been any recent changes in your weight?  
 Have you dieted in the last year? How? How often?  
 Have you done anything else to try to manage your weight?  
 How much exercise do you get in an average day? Week?  
 What do you think would be a healthy diet? How does that compare to your current eating patterns?  
 Do you worry about your weight? How often?  
 Do you eat in front of the TV? Computer?  
 Does it ever seem as though your eating is out of control?  
 Have you ever made yourself throw up on purpose to control your weight?  
 Have you ever taken diet pills?  
 What would it be like if you gained (lost) 10 pounds?

## Suicide and depression

Do you feel sad or down more than usual? Do you find yourself crying more than usual?  
 Are you 'bored' all the time?  
 Are you having trouble getting to sleep?  
 Have you thought a lot about hurting yourself or someone else?  
 Does it seem that you've lost interest in things that you used to really enjoy?  
 Do you find yourself spending less and less time with friends?  
 Would you rather just be by yourself most of the time?  
 Have you ever tried to kill yourself?  
 Have you ever had to hurt yourself (by cutting yourself, for example) to calm down or feel better?  
 Have you started using alcohol or drugs to help you relax, calm down or feel better?

## Activities

What do you and your friends do for fun? (with whom, where, and when?)  
 What do you and your family do for fun? (with whom, where, and when?)  
 Do you participate in any sports or other activities?  
 Do you regularly attend a church group, club, or other organized activity?  
 Do you have any hobbies?  
 Do you read for fun? (What?)  
 How much TV do you watch in a week? How about video games?  
 What music do you like to listen to?

## Safety

Have you ever been seriously injured? (How?) How about anyone else you know?  
 Do you always wear a seatbelt in the car?  
 Have you ever ridden with a driver who was drunk or high? When? How often?  
 Do you use safety equipment for sports and or other physical activities (for example, helmets for biking or skateboarding)?  
 Is there any violence in your home? Does the violence ever get physical?  
 Is there a lot of violence at your school? In your neighbourhood? Among your friends?  
 Have you ever been physically or sexually abused? Have you ever been raped, on a date or at any other time? (If not asked previously)  
 Have you ever been in a car or motorcycle accident? (What happened?)  
 Have you ever been picked on or bullied? Is that still a problem?  
 Have you gotten into physical fights in school or your neighbourhood? Are you still getting into fights?  
 Have you ever felt that you had to carry a knife, gun, or other weapon to protect yourself? Do you still feel that way?

Source: Goldenring and Rosen 2004

## APPENDIX 8

### ASSESSMENT AND REFERRAL FOR CHILDREN UNDER 12 AT RISK OF SUICIDE

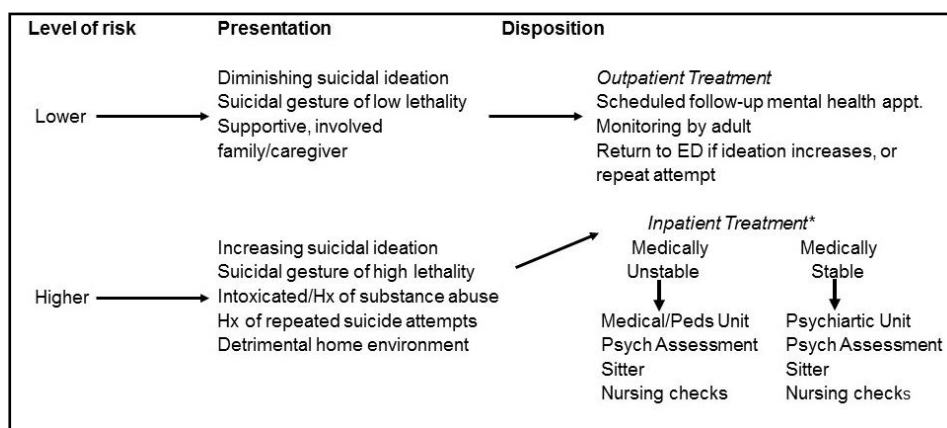
#### Factors to consider when assessing the child's level of risk of suicidal behaviour

<div style="background-color: black; color: white; text-align: center; padding: 5px; margin-bottom: 10px;"><b>Seriousness of injury</b></div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <b>Suicidality History</b>  History (Hx) of prior suicide attempts<sup>1</sup>  Child's Hx of prior suicide attempts<sup>2</sup>  Hx of suicidal ideation<sup>1</sup>  Child's Hx of suicidal ideation<sup>2</sup> </div> <div style="border: 1px solid black; padding: 5px;"> <b>Medical History<sup>2</sup></b>  Hx of psychiatric diagnoses  Hx of mental health treatment and/or psychotropic drug use  Hx of substance use or abuse  Number of previous ED visits for suspicious accidents  Chronic illness-frequency requiring compliance </div>	<div style="border: 2px solid black; padding: 5px; margin-bottom: 10px;"> <b>Current presentation</b>  Intend to die<sup>1</sup>  Child's intent to die<sup>2</sup>  Suicide plan, method, access to method<sup>1</sup>  Current psychiatric symptoms (depression, psychosis, etc.)<sup>1,2</sup>  Child's reasons for living<sup>1</sup>  Current substance intoxication  Cognitive level of child </div> <div style="border: 1px solid black; padding: 5px;"> <b>Environmental factors<sup>1,2</sup></b>  <b>Family</b>  Unsecured potential suicide methods (guns, medications, etc.)  Recent suicide, death, or loss in family  Suicidal ideation or suicidal attempts in family  Presence of child abuse or neglect  Supportiveness of parents or caregivers  Family turmoil  Marital Problems  Domestic Violence  Financial Crisis  Incarceration  Alcohol and Substance Use  <b>Child</b>  Social isolation (ask about the effects)  Bullying or being bullied (ask about the effects)  Changes in school performance </div>
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Notes: 1

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

#### ED disposition of suicidal children



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

## APPENDIX 9

### LEGAL AND PRIVACY ISSUES

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

As well, all privacy restrictions are over-riden by certain sections of the Children, Young persons and their Families Act (1989). These provide for the reporting of child abuse, protection of an individual from proceedings when disclosing child abuse to either a statutory social worker or police, and government agency obligations

NMH encourages good communication between NMH staff and Oranga Tamariki/CYF or the police to keep children safe. Requests for information should be referred directly to Clinical records who are responsible for ensuring such requests are dealt with promptly and appropriately. Information must only be released to a Oranga Tamariki/CYF social worker, police officer or care and protection coordinator (s66 CYPF Act: see below).

Each DHB is therefore, able to give information to Oranga Tamariki/CYF or the Police when reporting abuse or when requested by either agency.

### CHILDREN, YOUNG PERSON'S AND THEIR FAMILIES ACT

#### **S6 Paramountcy principle**

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

#### **S15 Reporting of ill treatment or neglect of a child**

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

#### **S16 Protection of person reporting ill treatment or neglect of a child**

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



## ***S66 Government Departments may be required to supply information***

- (1) Every Government Department, agent, or instrument of the Crown and every statutory body shall, when required, supply to every Care and Protection Co-ordinator, Oranga Tamariki/CYF social worker, or member of the police such information as it has in its possession relating to any child where that information is required -
  - (a) For the purposes of determining whether that child is in need of care or protection (other than on the ground specified in section 14 (1)(e) of this Act): or
  - (b) For the purposes of proceedings under this part of this Act.

Section 66 means that where a care and protection coordinator, Oranga Tamariki/CYF social worker or police officer requires information about a child for the purposes of determining whether the child is in need of care and protection, or for proceedings under the CYF Act, DHB staff must provide that information. A staff member may be asked to provide this information in an affidavit. The DHB recommends that the staff member seeks the support and advice of the unit manager, DHB's child protection coordinator and/or the DHB's legal adviser.

## **PRIVACY ACT**

### ***Principle 11 (f) (ii)***

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

## **PRACTICE NOTE: INTERAGENCY INFORMATION SHARING**

Information is available regarding interagency information sharing from the Privacy Commission website, follow the following links to the *Sharing personal information of families and vulnerable children: A guide for inter-disciplinary groups*

([www.privacy.org.nz/assets/InteractiveEscalationLadder/Escalation-Ladder-FINAL-HiRes.pdf](http://www.privacy.org.nz/assets/InteractiveEscalationLadder/Escalation-Ladder-FINAL-HiRes.pdf)) and the *Escalation ladder regarding 'Sharing information about vulnerable children'* ([www.privacy.org.nz/how-to-comply/sharing-information-about-vulnerable-children](http://www.privacy.org.nz/how-to-comply/sharing-information-about-vulnerable-children)).

## **HEALTH INFORMATION PRIVACY CODE**

### ***Rule 11 subsection 2 (d) (ii)***

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

## HEALTH ACT 1956

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

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

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

### **Vulnerable Children Act 2014**

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

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

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

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

**Part 2**, covering child protection policies, states:

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

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

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

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

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

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

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

## APPENDIX 10

### SAFETY AND SECURITY GUIDELINES

This guideline sets out NMH procedure's for staff when there is a need to access support to optimise the safety for victims of family violence when the risk to the victim's safety is assessed to be high.

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

Where a known 'at risk' admission is occurring – plan for the level of security required prior to the admission. For an acute admission it is important to complete a risk assessment and put urgent requirements as outlined underneath in place for client's protection

Added security measures may include high confidentiality for safety reasons, lockdown of the ward, orderly/ security guard presence or Police involvement.

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

#### 1. Procedure to establish adequate security measures and high confidentiality for victims of abuse attending NMH services and ensuring persons making public inquiries are given no details about the victim.

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

1.2. Staff discuss with the victim the potential to add security measures and to ensure that persons making public inquiries are given no details about the victim The victim consents to this procedure being actioned.

1.3. The following staff are informed of the required security measures and confidentiality and for immediate action to be taken:

1.3.1. Duty Manager

1.3.2. Security/ Manager Hotel Services (via operator)

1.3.3. Switchboard and Reception staff

1.3.4. Other relevant staff within the department. *This information transfers if the patient is admitted to a ward*

1.4. The Shift Co-ordinator/Team Leader responsible for the patient's care and the Duty Manager in consultation with Security/ Manager Hotel Services (via operator) will review/ cease the required security measures at discharge or when the patient requests this.

#### 2. Procedure for staff to follow when additional security measures and confidentiality for victims are in place.

When any staff member (including switchboard, clinical staff and volunteers) receives an enquiry about a patient for whom additional security measures are in place and/ or an 'at risk alert' is active s/he will:

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- 2.1 Inform the caller s/he is unable to provide any information
- 2.2 Ask for the caller's name and write this down (if provided)
- 2.3 Notify the Shift Co-ordinator/Team Leader responsible for the patient's care
- 2.4 To notify Security/ Manager Hotel Services via operator (e.g. if the caller is the suspected perpetrator of an assault and police charges are likely).

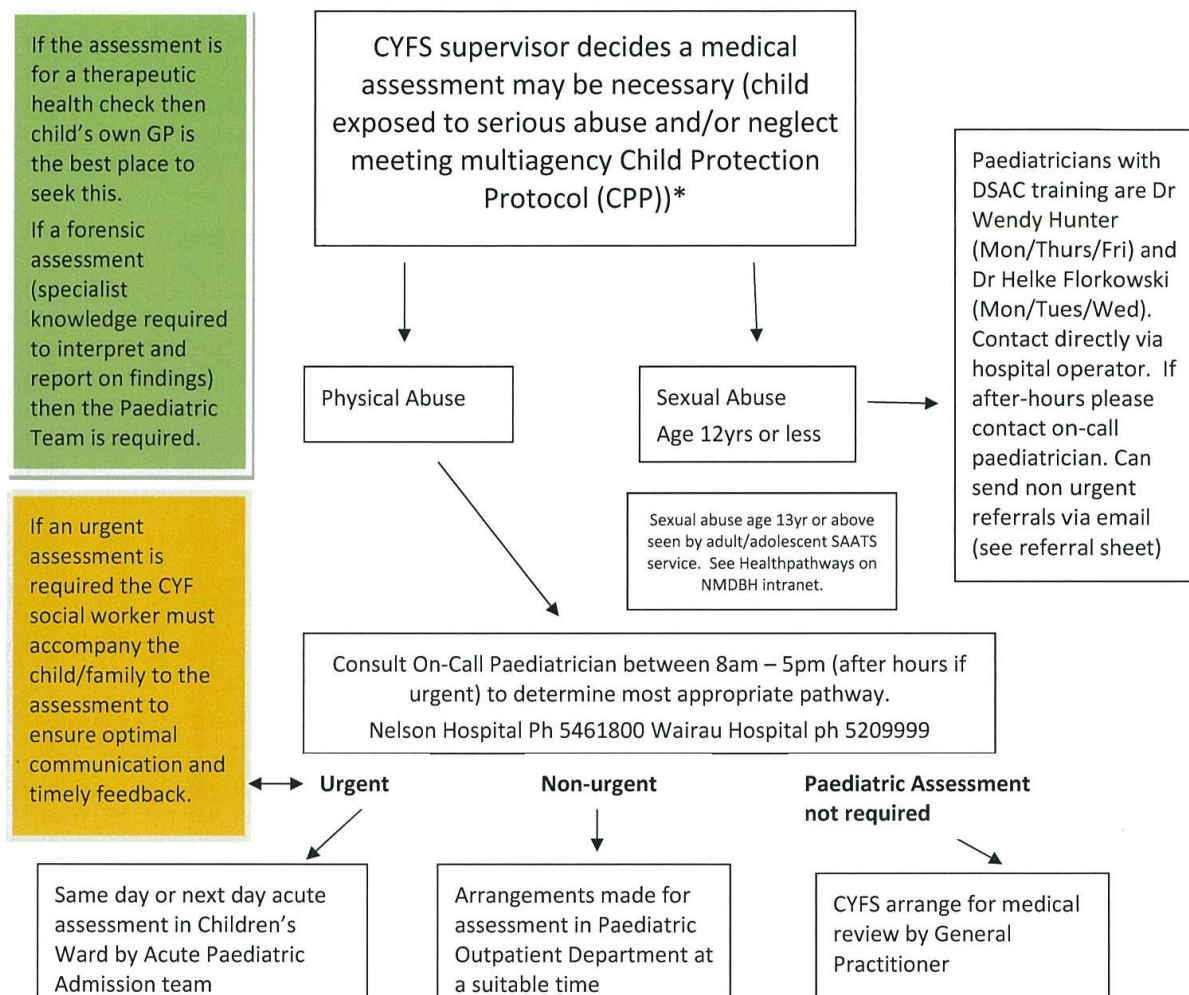
### 3. Process used to discharge a victim of abuse in a safe manner from a department or ward setting when there are high-risk safety issues.

- 3.1. Arrange the discharge plan in consultation with the patient and the discharge agency concerned, e.g. ensure the victim speaks to the agency concerned (i.e. Women's Refuge) and that all parties are in agreement with the discharge plan.
- 3.2. Ensure that the following people are informed of the discharge plan process:
  - 3.2.1. Appropriate Clinical Staff, Clinical Nurse Manager, Duty Manager
  - 3.2.2. Security +/- the Police (if risk is considered high by department staff and security)
- 3.3. The discharge plan may include the leaving the ED / ward or other department by a safe route, in consultation with security staff.
- 3.4. Document the discharge plan on eProsafe (NB: Complete a Safety First event report if any unexpected outcomes occurred).
- 3.5. Advise the Duty Manager and Security/ Manager Hotel Services of the discharge outcome.

## APPENDIX 11a

### Paediatric Medical Assessment Pathway for Serious Child Abuse

#### Paediatric Medical Assessment Pathway for Serious Child Abuse



1. Waiting in emergency is not appropriate; if possible it should be in children's ward where there is more child friendly space.
2. Document assessment using the Child Abuse Assessment Form, found on the Intranet clinical guidelines (CP resources).
3. Written consent is required in sexual abuse medical examination, but is not required for physical abuse and neglect under usual circumstances.
4. Assessment of physical abuse in children <5 years of age will almost always require Paediatric team assessment. Documentation of an inflicted injury in a child >5 years of age may be adequately met by a primary care practitioner (G.P.) or Emergency Department doctor in some cases, but if the CPP threshold has been reached, then usually the Paediatric team is more appropriate.
5. The Gateway process should be organised in all children coming in CYFS care.
6. If forensic photography is required a Police photographer will be organised by CYFS/Police.
7. Dictated Medical reports should be sent to CYFS and/or police in a timely fashion.
8. Note there is no on call service for urgent/acute sexual assault assessment for children <12yrs, however Wendy or Helke may be available if able to be contacted. **If urgent advice is needed around child sexual abuse, and none of the above doctors can be contacted then contact either the Cambridge Clinic in Christchurch(03) 366-0067 or Te Purururuhau Starship 09 307 2860 or 09 3072800**

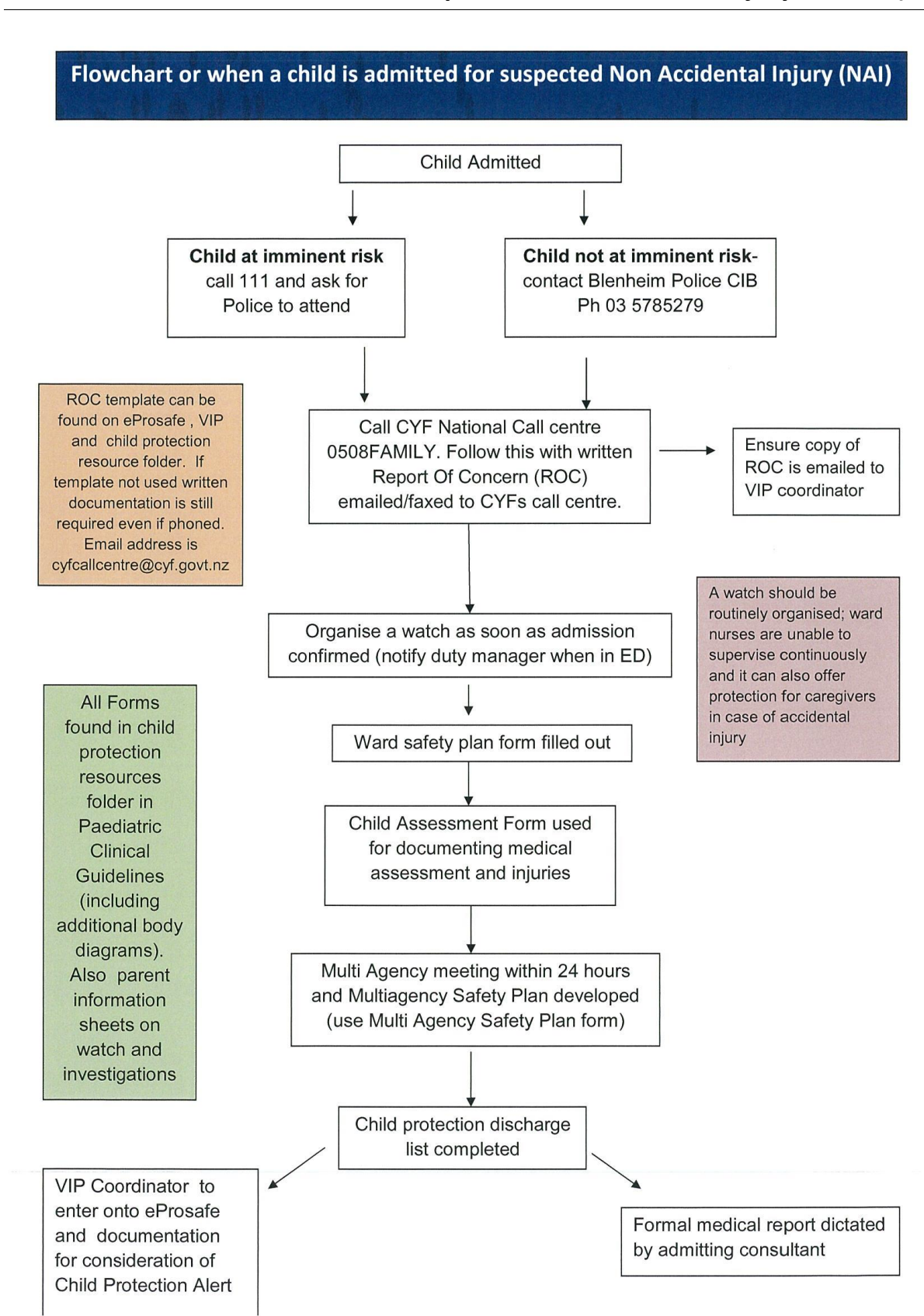
\*Child Protection Protocol: joint involvement of Police and CYFS to investigate and manage serious child abuse





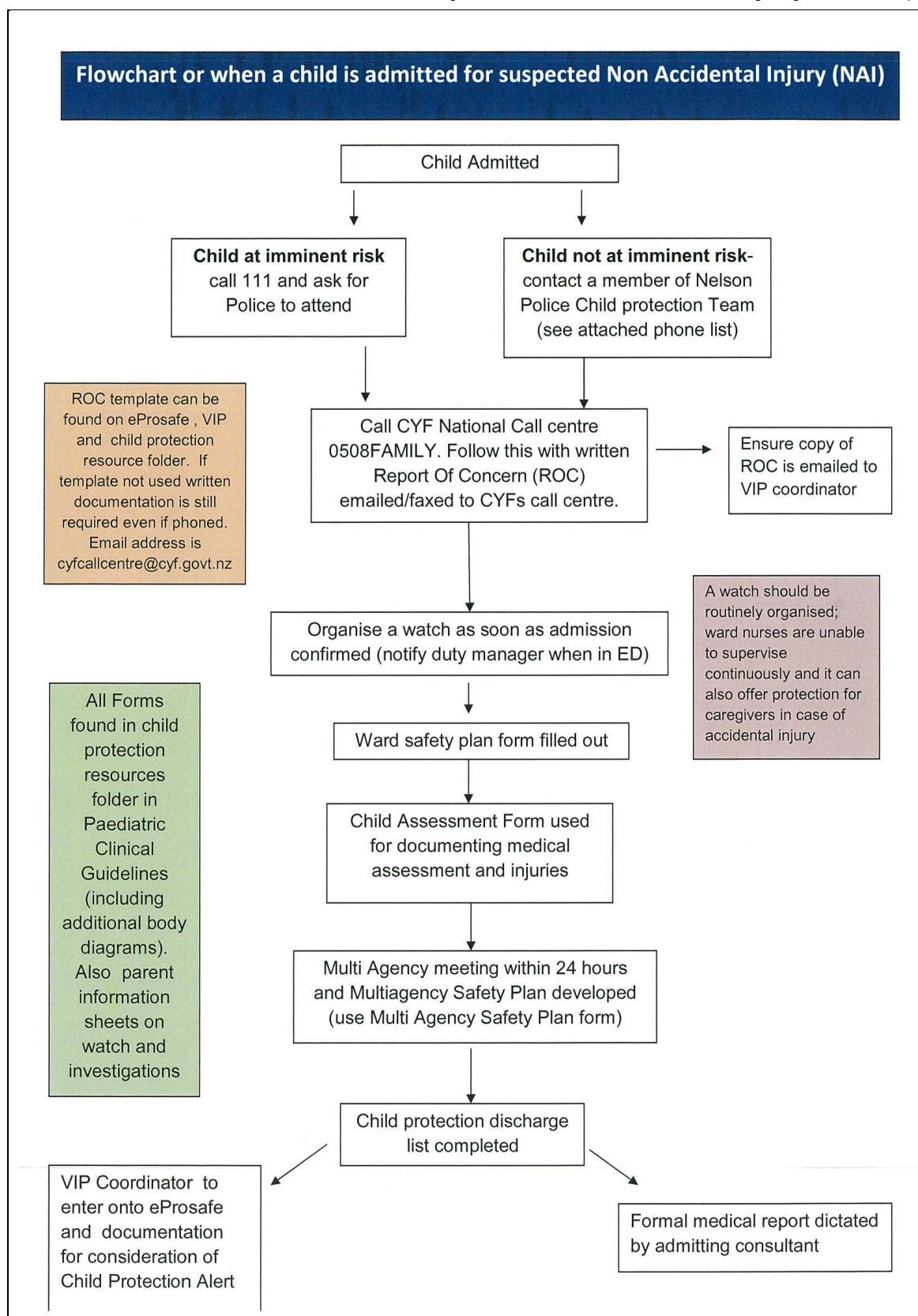
## APPENDIX 11 b

### Flowchart for when child admitted for suspected Non Accidental Injury Wairau (NAI)



## APPENDIX 11 c

### Flowchart for when child admitted for suspected Non Accidental Injury Nelson (NAI)



## APPENDIX 12

### EPROSAFE

#### Introduction

eProsafes is an electronic application that has been specifically designed to promote the health and wellbeing of children, adults, and their families who are experiencing abuse and neglect. It is a purpose built (web) application intended to address and overcome the fractured information technology systems both within the District Health Boards (DHBs) and across DHBs. It ensures that frontline staff, managing acute and at times severe situations of violence and abuse, can obtain information held by DHBs in a timely manner. This enables staff to address safety concerns for children, families and staff appropriately. It also allows those DHB staff employed specifically to provide advice and oversight of these complex cases the ability to track the work undertaken, assess risk more accurately and ensure appropriate measures are implemented.

eProsafes is a standalone web-based application for child protection and family violence that:

- Allows DHB staff to create and manage referrals.
- Allows DHB staff to share cases across local DHB users.
- Allows us to view referrals from other DHBs.
- Provides numeric statistic reports.
- Generates sophisticated surveillance audit log reports.
- Produces announcements to local or other DHB users.
- Is placed within a connected health network.
- Can be accessed via Health Connect South (Orion Health).

#### EProsafes enhances practice by;

- Collating child protection and family violence information in one place which enhances risk assessment and intervention plans.
- Cross referencing family information to allow health staff to see the whole picture in relation to what has occurred in the context of the family environment.
- Providing staff with the ability to track cases through the use of a reminder system. This means that health staff are prompted electronically to ensure follow up tasks occur.
- Assisting with ensuring that patients receive a more holistic assessment and interventions which are designed to address medical and psycho - social needs.
- Improving communication between health professionals
- Improving record keeping and accuracy with child protection and family violence information.
- Ensuring accurate statistical information that is readily available assists with the identification of trends and patterns which allows the DHB to shape future development within services.
- Providing the ability to attach documents or other related files (picture, audio) to ensure that child protection information is better collated and referrals take minimal time
- Ensuring there is a quick and simple way to share child protection and family violence information between DHBs whilst maintaining security and privacy.
- And it is a quick and easy way to share National Alert Information in a secure and private manner.



## APPENDIX 13

### ED CHILD PROTECTION CHECKLIST



Given Name: _____	Gender: _____
Family Name: _____	
<b>AFFIX PATIENT LABEL HERE</b>	
Date of Birth: _____	NHI#: _____

#### CHILD PROTECTION CHECKLIST

Complete for ALL children < 2 years presenting to ED and ALL children < 5 presenting with an injury.

- The checklist is a guide to assist safe process and not a diagnostic algorithm.
- The checklist may be relevant for older children presenting to ED.

**TO be completed by ED clinical staff for ALL PATIENTS UNDER 2 YEARS OF AGE** Yes No

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 1) Does a CHILD PROTECTION ALERT exist? Or Is there a past history of PREVIOUS INJURIES? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Is there a HIGH SUSPICION INJURY (see below)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Is there any concern about the child or family's BEHAVIOUR?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) On examination, does the child have any UNEXPLAINED INJURIES?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Any other concerns?   | <input type="checkbox"/> | <input type="checkbox"/> |

**ALSO COMPLETE FOR ALL PATIENTS UNDER 5 YEARS PRESENTING WITH AN INJURY**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 6) Has there been an unexplained DELAY seeking medical advice?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Is the HISTORY INCONSISTENT with the injury or with the child's developmental level? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Are there INCONSISTENCIES when the history is repeated?                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Is the child UNDER 12 MONTHS of age?   | <input type="checkbox"/> | <input type="checkbox"/> |

**ANY SUSPICION OF NON-ACCIDENTAL INJURY (NAI)?**

- ☐ No suspicion of NAI
- ☐ "Yes" or possible ("Yes") to any answer above, discuss with ED Senior Doctor Paediatrician or Social worker and document this in the clinical record
- ☐ Routine enquiry for family violence completed

Signatures: \_\_\_\_\_ Date: \_\_\_\_\_  
(Initial all entries)

**\*High Suspicion Injuries**

*Subdural hematomas or other intracranial injury, retinal haemorrhage, complex skull fractures.*  
*Rib injuries, metaphyseal fractures.*  
*Fractures – end of clavicle, hands, feet, sternum, scapula and spine.*  
*Injuries in and around mouth, ruptured internal organs, genital or perianal trauma.*  
*Sharply demarcated or patterned burns.*  
*Patterned bruises or bruising in unusual places - cheeks, orbits, behind ear, abdomen.*

ED CHILD PROTECTION CHECKLIST



## APPENDIX 14

### NMH Family violence intranet resource page

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