TARANAKI DISTRICT HEALTH BOARD

Violence Intervention Programme

Taranaki DHB
Child Protection
Policy and Procedures

Funded by Ministry of Health & TDHB

TABLE OF CONTENTS

Purpose....3
Scope....3
Terms and Definitions....3
Principles....4
Organisational Responsibilities....4
Maori and the Violence Intervention Programme....6
Pacific Peoples and the Violence Intervention Programme....6
Flowchart for Responding to Actual or Suspected Child Abuse and/or Neglect....7
Step 1: Identification of signs and symptoms....8
Step 2: Validation and Support....12
Step 3: Health and Risk Assessment....13
Step 4: Intervention/Safety Planning....14
Step 5: Referral and Follow-up....16
Step 6: Documentation....17
Staff Support and Safety....18
Death of A Child and Sibling Assessment....18
References....19
APPENDIX 1 Terms And Definitions....20
APPENDIX 2 MAORI AND FAMILY VIOLENCE....21
APPENDIX 3 Pacific Peoples and Family Violence....25
APPENDIX 4 Four Recognised Categories of Child Abuse....27
APPENDIX 5 Signs and Symptons of Abuse and Neglect in Recognised Categories of Child Abuse....29
APPENDIX 6 Child Neglect Assessment Guideline....31
APPENDIX 7 HEEADSSS: Psychosocial Interview for Adolescents....32
APPENDIX 8 Assessment and Referral for Children Under 12 at Risk of Suicide....34
APPENDIX 9 Legal and Privacy Issues....35
APPENDIX 10 Safety and Security Guidelines....38

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

CHILD PROTECTION POLICY

Department:	Clinical Board
Date Issued:	December 2016
Review By Date:	December 2019
Responsibility:	Violence Intervention Coordinator
Authorised By:	Chief Executive
Version:	1
Page:	1 of 4

Introduction

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

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

Purpose

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

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

Scope

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

Terms and Definitions

5. **Child:** Unborn children and children aged 0-14 years old.
6. **Child Protection:** Activities carried out to ensure the safety of the child/ tamariki, young person/rangatahi in cases where there is abuse or risk abuse.
7. **Child Abuse:** Harming (whether physically, emotionally, or sexually), ill treatment, abuse, neglect or serious deprivation of any child/tamariki, young person/rangatahi (section 14b Children, Young Persons and their Families Act 1989). This includes actual, potential and suspected abuse.
8. **Physical Abuse:** Child physical abuse is any act or acts that may result in inflected injury to a child or young person.
9. **Sexual Abuse:** Child sexual abuse is any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not.
10. **Emotional/Psychological Abuse:** Child emotional/psychological, social, intellectual and/or emotional functioning and development of a child or young person.

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

11. **Neglect:** Child neglect is any act or omission that results in impaired physical functioning, injury, and/or development of a child or a young person.
12. **Child Youth and Family:** Government agency that carries out the legislative requirements of the Children, Young Persons, and their Families Act 1989. Responsibilities are to:
    - Investigate causes of actual and suspected child abuse and/or neglect.
    - Completed diagnostic interviews.
    - Complete evidential interviews in cooperation with the New Zealand Police.
    - Provide care and protection for children found to be in need.
13. **Police:** Government agency responsible for:
    - Working collaboratively with Child, Youth and Family in child abuse and /or neglect protection work.
    - Investigating cases of abuse and/or neglect where an offence has or may have been committed.
    - Prosecuting offenders where an offence has been committed.
    - Accepting reports of suspected abuse and/or neglect and referring these to Child, Youth and Family.
14. **Young Person:** 14-17 years old.

Principles

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

Organisational Responsibilities

26. The **Taranaki DHB** is responsible for ensuring:
    - An organisation-wide framework for the management of child abuse and neglect and associated policies and procedures.
    - Engagement with interagency processes such as the Memorandum of Understanding between the DHB, Child Youth and Family (CYF) and the Polices that support effect collaboration.
    - Regular training for staff on the policy and related procedures.
    - Regular monitoring of the policy to assess compliance.
    - Adequate support (e.g. access to consultation) and supervision for staff.
    - Activities are properly resourced and evaluated.

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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

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

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

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

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

Supporting Information

32. Legislation:
    - Care of Children Act
    - Children's Young Persons and their Families Act and Amendments
    - Code of Health and Disability Services Consumers' Rights
    - Crimes Act
    - Domestic Violence Act
    - Health Act
    - New Zealand Bill of Rights
    - Privacy Act

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

- Summary of Offences Act
- Vulnerable Children's Act

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

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

Maori and the Violence Intervention Programme

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

Family violence intervention for Maori is based on victim safety and protection being the paramount principle. Ensure practice is safe clinically and culturally. Affirm with the person(s) being abused of their right to be safe in their home. Have Maori staff available to offer support to the family whenever possible.

See Appendix 2 for Maori and family violence

Pacific Peoples and the Violence Intervention Programme

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

See Appendix 3 for Pacific peoples and family violence.

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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

Consult with either an experienced colleague, Paediatrician and or, CYF Social Worker at least once during any child abuse and neglect intervention

Identification of signs and symptoms (Step 1)

- Observing child-caregiver interaction
- Taking a history
- Review past history
- Social history
- Physical examination
- Complete checklist/ flowchart*

Clear evidence of child abuse and neglect that requires referral to CYF (red arrows) *Do not* interview the child.

Abuse and or neglect a possibility

Concerns about safety of the child / young person / mother during pregnancy

Do not discuss concerns or child protective actions with the family if:

- it will place the child or health provider in danger
- there is risk of flight
- the family may close ranks

Validation and support (Step 2)

Listen to what you are being told.
If appropriate, thank them for telling you.
Let them know that you will act to keep them safe (if needed)

Health & Risk Assessment (Step 3)

Mental Health assessment
Family & environmental context, e.g. IPV, alcohol & substance misuse, untreated mental health
Risk to other children or young people
Treat injuries (if applicable)

Safety Planning* (Step 4)

- If child admitted to hospital with actual or suspected abuse#^
- If child is being harmed & or safety concerns warrant statutory intervention ^
- If child at risk^ but concerns do not warrant a statutory intervention
- If untreated mental health or alcohol & or substance misuse
- If IPV disclosed

Referral(s) Select all applicable options based on risk identified (Step 5)

- Referral to Police and or Child Youth & Family (CYF)
- Referral to family support services
- In consultation refer to appropriate mental health agency
- IPV intervention including referral to specialist services

Document (Step 6)

Document intervention (e.g. history taken, examination findings, risk assessment & referrals)
A written referral (e.g. Report of Concern) is required when making a referral to CYF

Seek peer-support or clinical supervision following a child abuse and neglect intervention

*Red pathway for statuary 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

Six Step Child Protection Intervention

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

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

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

See Appendix 4 for the categories of abuse.

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

Consultation should occur at least once. The following staff are available:

- An experienced colleague
- Paediatrician
- Child Protection Coordinator/Violence Intervention Programme Coordinator
- DHB Health Social Worker
- CYF DHB Liaison Social Worker.

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

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 or young person, all the aspects described in this first step need to be assessed.

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

If there is clear evidence of child abuse or neglect, sufficient in your opinion to justify referral to 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 the paediatrician, a social worker with experience in child protection or 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*

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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

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

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

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

1.4 Asking young people about possible abuse

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

See Appendix 7 for the HEEADSSS assessment

1.5 Past history

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

1.6 Social history

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

1.7 Physical examination

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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

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

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

CHILD PROTECTION CHECKLIST **to be completed for ALL children under the age of 2 presenting to ED**			
COMPLETE a)–d) FOR **ALL PATIENTS UNDER 2 YEARS OF AGE**			
a)	Is there any concern about the child and/or family's BEHAVIOUR?	☐ Yes	☐ No
b)	Is there a past history of PREVIOUS INJURIES or does a CHILD PROTECTION ALERT exist?	☐ Yes	☐ No
c)	On examination, does the child have any UNEXPLAINED INJURIES?	☐ Yes	☐ No
d)	Any other concern?	☐ Yes	☐ No
ALSO COMPLETE e)–g) FOR **ALL PATIENTS UNDER 2 YEARS PRESENTING WITH AN INJURY**			
e)	Has there been a DELAY between the injury and seeking medical advice, for which there is no satisfactory explanation?	☐ Yes	☐ No
f)	Is the HISTORY INCONSISTENT with the injury and/or with the child's developmental level?	☐ Yes	☐ No
g)	Is the child UNDER 12 MONTHS of age?	☐ Yes	☐ No
ANY SUSPICION OF NON-ACCIDENTAL INJURY (NAI)?			
☐	Uncertain or possible ("Yes") to any answer above → **Discuss with ED Senior Doctor** and ensure **routine enquiry for intimate partner violence** is completed		
☐	No suspicion of NAI		
Name:...	Signature:...	Date:	

1.9 Collection of physical evidence

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

Steps for collection and safe storage of evidence include:

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

Step 2: Validation and Support

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

2.1 Talking with the parents/caregivers of the child

- If you are unsure about how to talk with the parents/caregivers; consult with a paediatrician / senior colleague / CYF
- Basic principles are:
  - create time and space for a private conversation
  - be professional (be calm, start with the facts before you, explain the reasons for your concern and the reasons for the actions you need to take)
  - don't accuse anyone. For example, if a child has an injury, you have reached the appropriate point in the consultation and have explained the features of the injury that are unusual, you might use phrasing such as *"I am concerned that someone may have injured your child"*
  - access cultural support, e.g. Maori Health Unit. It is important that contacting such support does not delay any referral to 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 the child safe, and support them in their care of the child.

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

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

- 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 or young person

- Thorough risk assessment needs to be conducted prior to the development of appropriate intervention plans
- Health care providers are responsible for conducting a preliminary risk assessment with victims of abuse and/or neglect, in order to identify appropriate referral options. Note that this is different from the role of conducting investigations to determine who is responsible for perpetrating the abuse and/or neglect, which is the role of 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 senior staff e.g., a paediatrician, a health social worker or youth health service, or with the duty social worker at CYF as you work to determine what level of risk the child might be facing
  - appreciate that other organisations (e.g., 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 CYF social worker about a child
- Early communication with 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 CYF, which is a decision that ideally should only be made after a thorough assessment

3.2 Mental health assessment

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

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

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

  "Do you ever feel like crying a lot?"

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

See Appendix 8 for 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 CYF is also warranted, particularly if the child or young person cannot be cared for safely within their home. Remember that the most helpful intervention to reduce suicide risk may be to assist the person to obtain safety from the abuse.

3.3 Risk to other children or young people

- Consider possible risk to other members of the family because of the high co-occurrence/entanglement of multiple types of violence within families. This includes establishing the whereabouts and safety of other children in the home.
- 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 safety. Follow the procedure outlined in Intimate Partner Violence (IPV) policy (TDHB IPV Management Policy and Guidelines).
- Victims of IPV are frequently threatened by the perpetrator that if they disclose the violence, s/he will tell CYF that the non-abusive partner is a bad parent/abusive to the children, and that 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 (Phone 111) and contact CYF (phone 0508 326 459 followed by a Report of Concern template).

- Information from the health and risk assessment process will help to ensure that acute needs are identified and can be included in the safety plan. Work with a multi-disciplinary team whenever possible or consult with a senior colleague
- All healthcare providers can undertake basic intervention and safety planning activities if they have received training, and have access to support
- Note that the purpose of risk assessment is to ascertain the likely level of immediate risk for a patient leaving the health care setting. Actual injuries or other evidence of abuse are not required for referral to 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/young person, their willingness and capacity to respond or engage is an important part of identifying resources that may help improve the situation during safety planning

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

- 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 CYF as a 'Report of Concern'. 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, CYF and the Police and the associated Schedule 1.

4.2 Child at Risk

- Identify the safety, care or behavioural issues that exist. Consider if the risk is likely to be mitigated by the family engaging further with your service, or another health or social agency. Will the family accept this referral? What positive or protective factors exist that could be enhanced?
- If you are unsure, discuss the situation and your concerns with CYF to determine if a formal report of concern should be made
- If CYF determine that the whānau is actively pursuing the safety and well-being of the child or young person, and has the willingness and capacity to respond then a report of concern to 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), 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 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 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 a child protection report or report of concern has been made in the past, and what the abuser's reaction was.

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

- If the abuser is present in the health care facility, ask the abused partner whom they would like to inform the abuser about the report, e.g., would they like the health care provider to do it? Does the abused partner want to be present when the abuser is told? Do they want to do it?
- Make sure the abused partner has information on how to contact support agencies (e.g., Police, refuge, CYF) if problems arise.

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

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

Child, Youth and Family should be notified of all cases of suspected child abuse and neglect. Memorandum of Understanding between DHB, CYF and Police (2011)

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

5.1 Child being harmed

- To support follow-up, consider if and how the information should be transferred to the GP (e.g., written discharge summary, telephone call, other procedure)

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

- Continue to provide follow-up to children and families notified to CYF; Taranaki DHB remains responsible for the follow-up of the health care needs of the child and family.

5.2 Child at risk

- If you have concerns about risk, but there has been no disclosure, and no definitive signs or symptoms, consult with an experienced colleague and/or CYF
- 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

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

6.1 History

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

6.2 Examination

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

6.3 Photographs

- Many healthcare organisations now regard photography as a routine supplement to the medical records (refer to Taranaki DHB policies and procedures regarding consent to photograph).

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

- The taking of photographs should be done by a suitably qualified person in accordance with Taranaki DHB's Digital Photography Procedure (Patient Clinical Images).
- Note that thorough documentation and body maps are always required, and cannot be replaced by photographs.

6.4 Document the results of your risk assessment

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

6.5 Document the consultative process you undertook

- Who did you speak with? At what points?

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

- Record the actions taken, referral information offered, follow-up care arranged (e.g., report of concern to 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 the violence, the victim may be at increased risk of retribution for having revealed the "family secret"
- Children's health records are private to them. Parents can ask to access their children's notes until they are 16 years old, but they are not automatically entitled to them. All requests to access health records should be managed in accordance with Taranaki DHB's Policy Appropriate Access to Health Information Policy; there may be grounds for withholding information when the healthcare provider believes that it is not in the child's best interests to give the parents access
- The health notes for each individual should be stored in a separate file.

Staff Support and Safety

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

Death of A Child and Sibling Assessment

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

References

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

Legislation:

- Health Act (1956)
- Children's Young Persons and their Families Act (1989) (and Amendments 1994/95)
- Privacy Act (1993) and Health Information Privacy Code (1994)
- Code of Health and Disability Services Consumers Rights (1996)
- New Zealand Bill of Rights (1990)
- Crimes Act (1961)
- Domestic Violence Act (1995)
- Summary Offences Act (1981)
- Care of Children Act (2004)
- Vulnerable Children's Act (2014)

Other:

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

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

APPENDIX 1 Terms And Definitions

Child	Unborn children and children aged 0–14 years old
Child Protection	Means the activities carried out to ensure the safety of the child/tamariki, young person/rangatahi in cases where there is abuse or risk of abuse.
Child Abuse	Refers to the harming (whether physically, emotionally, or sexually), ill treatment, abuse, neglect, or serious deprivation of any child/tamariki, young person/rangatahi (Section 14b Children, Young Persons and their Families Act 1989). This includes actual, potential and suspected abuse.
Physical Abuse	Child physical abuse is any act or acts that may result in inflicted injury to a child or young person.
Sexual Abuse	Child sexual abuse is any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not.
Emotional/ Psychological Abuse	Child emotional/psychological abuse is any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person.
Neglect	Child neglect is any act or omission that results in impaired physical functioning, injury, and/or development of a child or a young person.
DSAC	Doctors for Sexual Abuse Care. National organisation advancing knowledge and improving medical care for those affected by sexual abuse. Only DSAC trained practitioners should perform medical examinations for child sexual assault.
Child, Youth and Family	Government agency that carries out the legislative requirements of the Children, Young Persons, and their Families Act 1989. Responsibilities are: ▪ To investigate cases of actual and suspected child abuse and/or neglect ▪ To complete diagnostic interviews ▪ To complete evidential interviews in cooperation with NZ Police ▪ To provide care and protection for children found to be in need.
Police	Government agency responsible for: ▪ Working cooperatively with Child, Youth and Family in child abuse and/or neglect protection work ▪ Investigating cases of abuse and/or neglect where an offence has or may have been committed ▪ Prosecuting offenders where an offence has been committed ▪ Accepting reports of suspected abuse and or neglect and referring these to Child, Youth and Family.
Young person	14-17 years old

APPENDIX 2 MAORI AND FAMILY VIOLENCE

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

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

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

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

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

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

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

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

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

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

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

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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

Principles for action

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

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

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

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

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

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

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

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

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

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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.

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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

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

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

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

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

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

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

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

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

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

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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).

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

Actions and behaviours to ensure victim safety and protection:

- routinely enquire about experience of IPV for women, and about intimate partner violence if there are signs and symptoms for men. Be alert for indication of abuse and neglect among children
- follow the health and risk assessment procedures outlined, and, wherever possible, involve the person in determining the plan of action they would like to take
- your communication style is important. Your language and tone should convey respect and a non-judgemental attitude. Preferably communicate in the language of the victim
- affirm the person's right to a safe, non-violent home
- offer referral to either specialist Pacific or mainstream family violence advocates.

2 The provision of a Pacific-friendly environment

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

Actions and behaviours that contribute to Pacific people feeling comfortable:

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

3 The provision of culturally safe and competent interactions

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

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

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

4 A collaborative community approach to family violence should be taken

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

Actions and behaviours that contribute to a collaborative intersectoral approach:

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

APPENDIX 4 Four Recognised Categories of Child Abuse

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

1. **Physical Abuse**

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

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

2. **Sexual Abuse**

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

Non-contact abuse

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

Contact abuse

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

3. **Emotional/Psychological Abuse**

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

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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

4. Neglect

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

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

APPENDIX 5 Signs and Symptons of Abuse and Neglect in Recognised Categories of Child Abuse

Physical abuse: Injuries that don't make sense

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

Sexual abuse

- In sexual abuse particularly, physical signs or symptoms are usually absent and behavioural changes may not be evident.
- If a child or young person tells you they have been abused (i.e., 'makes a disclosure'), this should always be taken seriously and referred to 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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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

Neglect

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

See Appendix 6 for further information for assessing neglect

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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.

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

APPENDIX 7 HEEADSSS: Psychosocial Interview for Adolescents

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

Home	**Drugs**
Who lives with you? Where do you live? Do you have your own room? 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?	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	**Sexuality**
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?)	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?

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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

Eating	Suicide and depression
What do you like and not like about your body? 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?	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	**Safety**
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?	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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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

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

Seriousness of injury

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

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

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

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

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

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

ED disposition of suicidal children

Level of risk	Presentation	Disposition
Lower →	Diminishing suicidal ideation Suicidal gesture of low lethality Supportive, involved family/caregiver	→ *Outpatient Treatment* Scheduled follow-up mental health appt. Monitoring by adult Return to ED if ideation increases, or repeat attempt
Higher →	Increasing suicidal ideation Suicidal gesture of high lethality Intoxicated/Hx of substance abuse Hx of repeated suicide attempts Detrimental home environment	→ *Inpatient Treatment** Medically Unstable ↓ Medical/Peds Unit, Psych Assessment, Sitter, Nursing checks Medically Stable ↓ Psychiartic Unit, Psych Assessment, Sitter, Nursing checks

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

APPENDIX 9 Legal and Privacy Issues

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

As well, all privacy restrictions are over-ridden by certain sections of the Children, 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

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

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

CHILDREN, YOUNG PERSONS 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 child or young person

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

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

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

S66 Government Departments may be required to supply information

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

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

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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

PRIVACY ACT

Principle 11 (f) (ii)

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

PRACTICE NOTE: INTERAGENCY INFORMATION SHARING

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

HEALTH INFORMATION PRIVACY CODE

Rule 11 subsection 2 (d) (ii)

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

HEALTH ACT 1956

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

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

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

VULNERABLE CHILDREN ACT 2014

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

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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.

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

APPENDIX 10 Safety and Security Guidelines

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

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

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

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

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

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

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

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

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

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

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

1.7. Complete the name suppression documentation form)

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

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

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.

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

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

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

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

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

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

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

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

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

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

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

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

3.6. Advise the Duty Manager of the discharge outcome.

This is a Controlled Document. The electronic version of this document is the most up-to-date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by third parties for any purpose whatsoever.