POLICY NAME:	SOUTH CANTERBURY DISTRICT HEALTH BOARD ORGANISATIONAL WIDE			
CHILD PROTECTION (CHILD ABUSE AND NEGLECT) POLICY AND PRACTICE GUIDANCE	**SLT Sponsor:** Lisa Blackler	**Authorised by:** Nigel Trainor	**Cultural Safety Check:** Ruth Garvin	**No. of Pages:** 44 **Date for Review:** May 2019
	Designation: Director Patient, Nursing and Midwifery Services	**Designation:** CEO	**Designation** Director Maori Health	**Policy No:** HR29
	Date: May 2017	**Date:** May 2017	**Date:** May 2017	**Distribution:** All
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	Review Dates: 07/07, 05/09, 2/10, 4/11, 07/12, 11/13, 02/15, 5/17			

Contents

Overview

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

The South Canterbury District Health Board (SCDHB) is committed to a 'whole-of-system' approach to the issue of child protection (CP) ie, working across primary and secondary care. This is in recognition that child abuse and neglect (CAN) are important health issues. They can lead to immediate physical and mental health consequences and are significant precursors to a range of poor health outcomes and long-term conditions. Health care providers are ideally placed for early identification of and intervention in family violence because most people use health services at differing times in their lives.

Purpose

- The SCDHB recognises that staff competence, and clarity of roles and responsibilities, are essential to effective and safe child protection interventions.
- This supports the accurate detection of suspected and or actual CAN, the early recognition of children at risk of abuse and adults at risk of abusing children.
- This policy seeks to promote and ensure the safety and wellbeing of children/tamariki and their whanau. Associated procedures, referral pathways, paper and electronic documentation requirements (including patient warnings-alerts), provides SCDHB community and hospital-based staff, facility users (includes volunteers, students) and contractors with a framework to identify, support, assess and respond to actual and/or suspected child abuse and neglect.

  Electronic systems include the SCDHB patient management system (HPS), Health Connect South (HCS), National Health Index Warning System (NHI) and/or eProsafe (see Appendix 12).

Principles

- The rights, welfare and safety of the child/tamaiti and young person/rakatahi, are our first and paramount consideration.
- The Ministry of Health (MoH) *Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence* (2016) document guides this policy.
- Health services should contribute to the nurturing and protection of/advocate for children as part of their role to promote and preserve health. It is important for children/tamariki and young persons/rakatahi that services are provided in environments which are comfortable and appropriate to their needs and age.
- Health services for the care and protection of children are built on a bicultural partnership in accordance with the Te Tiriti o Waitangi/Treaty of Waitangi. Maori children/tamariki and young persons/rakatahi are assessed and managed within a culturally safe environment. All staff are to recognise and be sensitive to other cultures.
- Wherever possible the family/whānau, hāpu and iwi participate in the making of decisions affecting their child/tamaiti and young person/rakatahi. Their primary role in providing the care, welfare and safety of their children must be valued.
- The SCDHB provides an integrated service and works with external agencies to provide an effective and coordinated approach to child protection.
- Staff are competent in identification and management of actual or suspected abuse and/or neglect through the organisation's infrastructure including policy and procedural structures, Violence Intervention Programme (VIP) training, and access to consultation. The VIP training comprises core and refresher training.
- Child protection work is complex and stressful; a consultative and multi-disciplinary approach is considered best practice. Health care workers should not work in isolation.
- Early intervention is recognised as best practice to maximise the opportunity for best outcomes.

Scope

This policy applies to all cases of actual and/or suspected CAN encountered by staff and people working at SCDHB or under a contract for service.

Terms and definitions

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

Organisational Responsibilities

Executive Responsibilities

- Ensure there is an organisation-wide policy for the management of CAN and associated policies as indicated.
- Ensure staff have regular training on the policy.
- Ensure that all Service Agreements with relevant contracted providers include the standard contractual clause relating to the requirement for the provider to develop and complete a CP policy (see Appendix 9 for legal and privacy issues).
- Ensure contracted providers have access to a template and guidance information for developing and completing a CP Policy.
- Ensure engagement with interagency processes such as Memorandum of Understanding (MOU) between SCDHB, the Ministry of Vulnerable Children, Oranga Tamariki (to be known Oranga Tamariki, previously known as Child Youth and Family or CYF) and the Police, that supports effective collaboration.
- Ensure there are organisational processes to make certain the policy is adhered to, such as quality improvement activities.
- Ensure staff working in the Ministry of Health (MoH) designated areas of maternity, child health (inpatient and outpatient), emergency department, mental health, public health and sexual health, attend VIP training that meets the national training standards and requirements (see training, support and supervision).
- Ensure organisational procedures exist to provide appropriate, adequate support (eg, access to consultation) and supervision of staff affected by CAN.
- Ensure the CAN and IPV policies and procedures comply with legislative requirements, the principles of Te Tiriti o Waitangi/The Treaty of Waitangi and best practice standards.
- Ensure the VIP activities are properly resourced and evaluated.

Service Responsibilities

- Ensure that staff responsible for the clinical care of children/young persons are familiar with and adhere to the CP and related policies.
- Ensure clinical care staff attend training regarding CAN and IPV.
- Ensure staff follow the brief intervention model (Six-Step Process).
- Ensure reporting and auditing procedures and recommendations are effected.
- Ensure support systems and/or supervision is available for staff when CAN is suspected or identified.
- Communicate issues relating to CAN to the VIP Coordinator–CP, including bringing cases to the Child Protection Advisory Group (CPAG) for review.

Staff/Contractor Responsibilities

- All health professionals employed or contracted by SCDHB have a responsibility for the safe management of identified and suspected cases of CAN, IPV and elder and vulnerable adult abuse and neglect (EAN).

- Attend mandatory VIP initial training and at least 2-yearly refresher training appropriate to their area of work. Advanced training for the clinical champions working in the designated areas will be explored.
- Be conversant with DHB management of actual or suspected CAN and associated policies.
- Understand the referral and management process of actual or suspected CAN, and take action when CAN is suspected or identified.

  This process must include referral to–consultation with the VIP Coordinator–CP.
- Practice safely eg, always consulting with a senior colleague during the intervention and seeking peer-support/supervision when CAN is suspected or identified. This includes situations where CAN is disclosed but the child may not be present (eg, child of an adult patient).
- Ensuring accurate, informative and timely documentation.
- Provide or access SCDHB health services that may include:
  - Cultural assessments
  - Mental health assessments
  - Diagnostic medical assessments
  - Social work services, counselling and therapy resources
  - Paediatric assessment for any children who may be at risk.

Violence Intervention Programme Coordinator Responsibilities

- Coordinate programme implementation within services, working with service leaders to ensure the system supports are available.
- Ensure the DHB-wide CP policy is current and aligned with national standards.
- Ensure provision of training in accordance with the DHB VIP training plan; this will include ensuring that the VIP training is available cyclically.
- Provide consultation service for staff managing child protection cases.
- Provide peer support for staff who have been involved in the reporting and management of CAN.
- Oversee/manage the eProsafe child protection and family violence application.
- Attend multi-disciplinary–multi-agency case management meetings
- Facilitate communication with Oranga Tamariki/CYF and other key community agencies.
- Ensure regular audits and other quality improvement activities in regard to policy compliance are undertaken and reported on at least bi-annually.
- Develop and/or maintain functional internal and external relationships with key stakeholders (government, local government and community based organisations).
- Attend at multi-agency–multi-disciplinary groups working collaboratively to improve and introduce child protection initiatives.

Child Protection Advisory Group (CPAG) Responsibilities

- Guide child protection practice and processes by providing a professional forum to clinically review CAN cases (suspected and/or actual).
- Place Child Protection (CPAS) Alerts for at-risk babies/children/young people on the SCDHB patient management system (HPS), National Health Index Warning System and eProsafe (see Appendix 12).
- Support safe clinical practice by promoting the appropriate identification and management of CAN.
- Provide recommendations to SCDHB management and staff/facility users/contractors that will improve child protection practices.
- Reviewing all notifications made to Oranga Tamariki/CYF by staff–contractors and consider appropriate health intervention/s including:

- Internal and agreed external communication process where concerns exist.
- Placement of national Child Protection Alerts (CPAS) on the National Health Index Warning System and other applications eg, eProsafe, as applicable.

Violence Intervention Programme Steering Group Responsibilities

- Provide guidance and advice to support the VIP Coordinators in the implementation and monitoring of VIP within the DHB ie, meet at least quarterly.
- Provide a forum which includes representation (both internal and external key personnel), including relevant community agencies, to strengthen linkages, relationships and facilitate effective networking.
- Develop, review and endorse policy and procedures related to the programme.
- Advocate for resources as identified and as required for effective improvement and/or maintenance of the programme. Work collectively on policies, procedures, guidelines, protocols and initiatives that are relevant to VIP improvement and/or maintenance.

Human Resource Responsibilities

South Canterbury DHB recruitment policies reflect a commitment to child protection by including comprehensive pre-employment screening procedures in accordance with the Vulnerable Children Act, 2014. See Appendix 9 for legal and privacy issues.

Where suspicion exists of child abuse or family violence (and/or conviction for the same), perpetrated by an employee/volunteer/contractor in the organisation the matter will be dealt with in accordance with the Disciplinary Policy and Code of Behaviour (HR2), available on iHub/Policies/Organisational Policies.

Staff training, support and supervision

Training

Violence Intervention Programme initial (core) training day is mandatory for all clinical staff working with children and women. This includes staff who work within the MoH six designated services: emergency, maternity, child health (inpatient and outpatient), mental health, public health and sexual health.

Initial or core training comprises:

- Pre-training information (pre-reading document/online training package).
- 8 hours training; 4 hours IPV and 4 hours CAN.

Registration for VIP training is through the VIP Coordinator–CP on extension 8778 or the VIP Coordinator IPV–EAN on extension 8294.

Staff are also required to undertake in-service training as indicated and least 2-yearly refresher training (1-hour minimum). Advanced training for the clinical champions working in the designated areas will be explored.

Support and supervision

- Support (clinical supervision and/or peer support) for staff is recognised as an important requirement to ensure the practice of routinely enquiry for family violence remains safe for patients as well as for staff. The process needs to include consulting with peers and senior colleagues.
- The Employee Assistance Programme (EAP) is available for:
  - Staff who require further counselling for involvement in a CAN case or following a disclosure of IPV
  - Staff experiencing or perpetrating family violence.
- Contracted professional staff provide this confidential offsite support and staff are encouraged to self-refer. To access the service contact the EAP Coordinator, Human Resource Department at the DHB.

Associated documents and legislation

SCDHB Policies	Number and location
Cultural Safety Policy	A33, iHub/Policies/Organisational Policies
Māori Health Policy	AF34, iHub/Policies/Organisational Policies
Disciplinary Policy and Code of Behaviour	HR2, iHub/Policies/Organisational Policies
Employment Assistance Programme (EAP) Policy	HR5, iHub/Policies/Organisational Policies
Child Protection Alert Management Policy	HR19, iHub/Policies/Organisational Policies
Elder and Vulnerable Adult Abuse and Neglect Policy	HR23, iHub/Policies/Organisational Policies
Critical Incident Debriefing Policy	HR27, iHub/Policies/Organisational Policies
Intimate Partner Violence Policy	HR28, iHub/Policies/Organisational Policies
Incident Management Policy	QR8, iHub/Policies/Organisational Policies
Informed Consent Policy	CSPM I2, iHub/Policies/CSPM
Interpreters Policy	CSPM I6, iHub/Policies/CSPM
SCDHB Protocols–Procedures	**Number and location**
Child Protection Advisory Group (CPAG) Terms of Reference	CG30, iHub/Knowledge Base/Violence Intervention Programme (VIP) CPAG
Clinical Record and Documentation Standards	CSPM C10, iHub/Policies/CSPM
Uplift of a Baby-Child to a place of safety	CSPM U1, iHub/Policies/CSPM
Clinical Unit Entry Restriction	CSPM C17, iHub/Policies/CSPM
Memorandum of Understanding (MOU) between Women's Refuge and SCDHB	CG30, iHub/Knowledge Base/Violence Intervention Programme (VIP)
Memorandum of Understanding (MOU) between SCDHB, Oranga Tamariki/CYF and NZ Police (September 2011) and associated schedules (S)	CG30, iHub/Knowledge Base/Violence Intervention Programme (VIP). MOU S1 Non-accidental injuries S3 Medical Neglect S4 Clandestine Labs
Police Request for Information Form	iHub/Forms/Clinical
Sexual Assault–Abuse	J Drive/Service Framework/Emergency Department/ED S1
SCDHB Forms	**Number and location**
Ministry for Vulnerable Children Oranga Tamariki/CYF (MVCOT) Report of Concern	iHub/Forms/Clinical/Ministry for Vulnerable Report of Concern Print or Electronic
Intimate Partner Violence (IPV)–Family Violence (FV) Identification Documentation Form	iHub/Forms/Clinical/Intimate Partner Violence (IPV)–Family Violence (FV) Identification Documentation Form Print or Electronic
Child Protection Checklist & Flowchart	J Drive/Service Framework/Emergency Department/ED
Legislation	
Children, Young Person and Their Families Act (1989) and Amendments (1994/1995/2016)	
Care of Children Act (2004)	
Vulnerable Children Act (2014)	
Code of Health and Disability Services Consumers Rights (1996)	
New Zealand Bill of Rights (1990)	
Official Information Act (1982)	
Legislation	
Privacy Act (1993) and Health Information Privacy Code (1994)	
Crimes Act (1961) and Amendments (2012)	
Domestic Violence Act (1995)	
Summary Offences Act (1981)	

Other resources
Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence (2016).
A number of other resources are available to support safe practice in family violence. These include a director of community family violence services, cue cards with sample framing and risk assessment questions, specific intimate partner/family violence documentation form and a support card for victims. Contact the VIP Coordinators for supplies of current resources.

For further information contact the SCDHB Coordinator–CP on extension 8778 or the VIP Coordinator IPV–CAN on extension 8294.

Māori and the Violence Intervention Programme

Māori are significantly over-represented as both victims and perpetrators of whānau violence. This should be seen in the context of colonisation and the loss of traditional structures of family support and discipline. However, child abuse and neglect is not acceptable within Māori culture. The SCDHB Child Protection Policy has been developed in accordance with the principles of action including the Te Tiriti o Waitangi/Treaty of Waitangi principles, recognising Te Whare Tapa Wha and kaupapa practices. This is consistent with cultural training offered and mandated within SCDHD.

Family violence intervention for Māori is based on victim safety and protection being the paramount principle.

- Ensure practice is safe clinically and culturally;
- Affirm with the person(s) experiencing IPV their right to be safe in their home; and
- Have Māori staff available to offer support to the family whenever possible.

Whenever possible an appropriate staff member of the same ethnicity as the child/tamaiti should be involved in decision making and consultation.

See Appendix 2 for Māori and family violence.

Pacific Peoples and the Violence Intervention Programme

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

Family violence intervention for Pacific Peoples is based on victim safety and protection being the paramount principle. Offer support to the family whenever possible, and if abuse is disclosed and talk about possible plans of action they would like to take, including appropriate referral options.

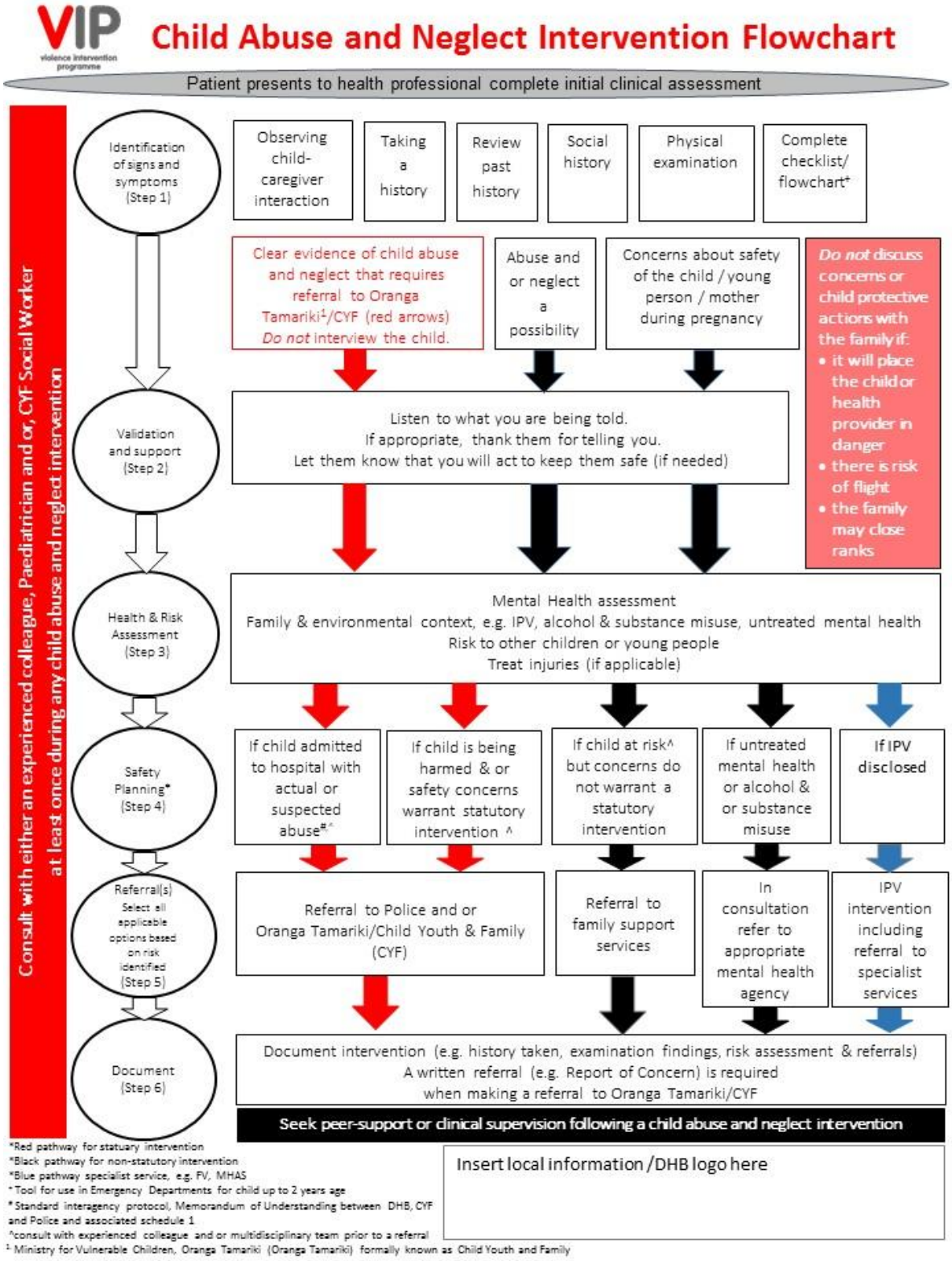
See Appendix 3 for Pacific Peoples and family violence.

Minority Ethnicities/Refugees

Staff need to consider the increased isolation of patients/clients from minority ethnic groups. They may have few support structures outside of the direct family. Different cultures may have different value bases and this may differ from those predominately represented in New Zealand. The potential for minority ethnicities and refugees to identify as being abused and to access help may be difficult.

Staff are to be aware of the potential risks to the person experiencing IPV when accessing interpreters from ethnic groups. A family member should NOT be used as an interpreter for the victim.

Child Abuse and Neglect Intervention Flowchart



*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
[1] Ministry for Vulnerable Children, Oranga Tamariki (Oranga Tamariki) formally known as Child Youth and Family

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 on-call paediatrician should determine if there are other siblings and if so report to Oranga Tamariki/CYF. It is also important for SCDHB to work closely with the Police, and Oranga Tamariki/CYF in accordance with the 2011 MOU between Oranga Tamariki/CYF, Police and SCDHB.

Child Protection Intervention: A Six-Step Process

Step 1: Identification of signs and symptoms

Step 2: Validation and support

Step 3: Health and risk assessment

Step 4: Intervention/safety planning

Step 5: Referral and follow-up

Step 6: Documentation.

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.

Consultation with and referral to key clinical staff is essential.

The following staff are available:

- Clinical nurse coordinator (CNC), charge nurse manager (CNM), duty nurse manager (DNM), service level manager
- VIP Coordinator–CP VIP Coordinator–CP or VIP Coordinator IPV–EAN
- DHB social worker
- Paediatrician
- Psychiatrist
- Psychologist
- Oranga Tamariki/CYF DHB Liaison Social Worker
- Mental health case workers.

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

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

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

All health workers can refer a case for discussion to the Child Protection Advisory Group (CPAG), an interdisciplinary/interagency team within SCDHB who can advise, support and assist staff regarding situations of abuse, alleged abuse or risk of abuse and offer advice on future options.

It is mandatory for all concerns about a child being or likely to be abused by an adult or another child, to be reported/referred to the VIP Coordinator–CP in a timely manner that allows for meaningful consultation.

See Appendix 4 for four recognised categories of child abuse.

See Appendix 5 for signs and symptoms of abuse and neglect in recognised categories of child abuse

Contact the VIP Coordinator–CP on extension 8778 or the VIP Coordinator IPV–EAN on extension 8294.

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. They should also be aware that if they are concerned about a child all the aspects described in this first step need to be assessed.

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

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

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

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 eg, 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–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.

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.

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 eg, '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 CAN, but there are other possible explanations for the things causing you concern, then seek advice from the VIP Coordinator–CP, paediatrician, psychiatrist, psychologist, social worker with experience in child protection, mental health case worker or Oranga Tamariki/CYF.
- Privacy is just as important as with adults. Giving an adolescent a chance to talk to you alone should be part of your routine practice. With younger children, you should consider carefully whether or not it is appropriate. A hasty conversation in a gap is unlikely to create the time and space necessary for disclosure by an anxious child.
- Use age-appropriate language; children may not know what to say and use different words to express what is going on. You need to create an atmosphere where the child feels safe to talk to you.

  What should be asked?

  If you are going to have this kind of conversation, you need to frame it in a way that makes sense in terms of the signs and symptoms for which the child has come to see you, or in terms of your usual practice. For example: '*Sometimes when I see children with pain in their tummy like this, it's because they're worried or anxious about something. Is there anything that's making <u>you</u> 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.

Asking young people about possible abuse

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

See Appendix 7 for HEEADSSS assessment.

Past history

- Review the child's clinical record (previous presentations or admissions, particularly multiple presentations for illnesses and injuries, may indicate risk).

- Check for the presence of a local or national warning–alert on HPS (ED Red Book alert or national CPAS alert), and on the NHI Warning System (national CPAS alert).
- If a national alert exists, follow the SCDHB Child Protection Alert Policy to access the health information in the child's paper medical record and/or on eProsafe, and take this information into consideration when assessing the child.

  See Appendix 12 for eProsafe.

Social history

- Take a social history; a variety of factors may have an effect on the risk of child abuse and neglect eg, 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.

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 of age (even if they have no symptoms of concussion) will almost always require a CT scan of the head. A skeletal survey will be required in most children under two years of age with suspected physical abuse, and in some older children. Full blood count and coagulation studies may be required in the presence of bruising.
- Cases of sexual abuse, or suspected sexual abuse, should always be discussed with a doctor specifically trained in this field. Always refer to the on-call Sexual Assault Assessment and Treatment Service (SAATS) doctor or the on-call paediatrician before you decide whether or not to examine the child.
- Consent to examine a competent child (regardless of age) is required before any examination is required. Refer to SCDHB Informed Consent Policy (CSPM I2).

Using a child protection checklist for children under two years of age

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

See Appendix 11 for ED Child Protection Checklist

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 on-call paediatrician 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 (eg, 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.

Step 2: Validation and support

- If you have concerns about the safety of a child then you will need to act on these. At some time, someone will need to have a frank conversation with the parents–caregivers and (if old enough to understand) with the child.
- While your actions are intended to support and validate the child they may not (depending on the circumstances) be seen as supporting or validating their parents–caregiver.
- Do not assume that raising care and protection concerns with a family will necessarily result in a hostile reception. Some parents–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–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 protection 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.

Talking with the parents–caregivers of the child

- If you are unsure about how to talk with the parents–caregivers; consult with health professionals as appropriate to your area of work ie, VIP Coordinator–CP, paediatrician, psychiatrist, psychologist, social worker, mental health case worker, senior colleague eg, clinical nurse coordinator (CNC), charge nurse manager (CNM), duty nurse manager (DNM) or service level manager.
- Basic principles are:
  - Create time and space for a private conversation.
  - Be professional (be calm, start with the facts before you, explain the reasons for your concern and the reasons for the actions you need to take).
  - Do not 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. It is important that contacting such support does not delay any referral to Oranga Tamariki/CYF.
  - Use interpreters (not family members) if there are language barriers.
  - Be transparent about what happens next.
- If circumstances permit discussing concerns with a victim's parents–caregivers, follow these principles:
  - Broach the topic sensitively
  - Help the parents–caregivers feel supported, able to share any concerns they have with you
  - Help them understand that you want to help keep their child safe, and support them in the care of their child.

Health care provider response to child's disclosure of abuse

- Listen. Do not put words in a child's mouth. Allow them to tell only as much as they want. Act on the assumption that the child is telling the truth.

- Keep any questions to a minimum. Use open ended questions and use age appropriate language.
- Do not over-react.
- Do not panic.
- Do not criticise.
- Do not make promises you can't keep.
- Ensure the child's immediate safety. Try not to alert the alleged perpetrator.

Health care provider response to parents–caregivers disclosure of abuse

- Listen to what the parent–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

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

Risk to the child

- Health care providers are responsible for conducting a preliminary risk assessment with victims of CAN, 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 CAN, which is the role of Oranga Tamariki/CYF or the Police.
- Immediate protection of a child is required if the child has suffered harm which in your view is a result of CAN, and the environment to which the child is returning is unsafe. Obviously, the more serious the harm and the more vulnerable the child (eg, a baby or a preverbal child), the more critical the risk becomes.
- Safe process means:
  - Never make decisions about risk in isolation.
  - Do not jump to conclusions.
  - Consult with experienced staff eg, VIP Coordinator–CP, paediatrician, health social worker or youth health service, or with the duty social worker at Oranga Tamariki/CYF as you work to determine what level of risk the child might be facing.
  - Appreciate that other organisations eg, Oranga Tamariki/CYF may hold information that is crucial to determining the safety of the child.
- You do not need proof of CAN, and do not need to seek permission from a child's family, prior to talking with colleagues or a Oranga Tamariki/CYF social worker about a child.
- Early communication with Oranga Tamariki/CYF can help identify if there have been other concerns raised about the safety of the child. It can be considered an additional component of reviewing the child's history. This early communication does not need to result in a Report of Concern to Oranga Tamariki/CYF, which is a decision that ideally should only be made after a thorough assessment
- *Subsequent children*; Sections 18B of the Children, Young Persons and their Families Act 1989, outline the requirement for parents/caregivers to demonstrate to Oranga Tamariki/CYF that they are safe to parent subsequent child(ren) when a child has been previously removed from their care or they have been convicted of the murder, manslaughter or infanticide of a child.
- If you are aware, or suspect, that a parent–caregiver meets the criteria of 18B or has had a child permanently removed from their care, consult with your VIP Coordinator–CP and discuss any concerns you have with Oranga Tamariki/CYF.

Mental health assessment

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

  'Do you ever think about hurting yourself?'

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

  'Do you ever feel like crying a lot?'
- Do NOT ask questions using the words 'suicide' or 'killing oneself.' These can suggest behaviours that the child may not have thought of.

  See Appendix 8 for assessment and referral for children under 12 years at risk of suicide.
- The level of assessed risk (based on the assessment) will inform the referrals required. A referral to the appropriate child or adolescent mental health service may be indicated, but if abuse or neglect issues are also present, referral to Oranga Tamariki/CYF is also warranted, particularly if the child cannot be cared for safely within their home. Remember that the most helpful intervention to reduce suicide risk may be to assist the person to obtain safety from the abuse.

Risk to other children or young people

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

Co-occurrence of intimate partner violence

- If child abuse is identified, assess the mother–female caregiver's safety. Follow the procedure outlined in IPV policy (HR28, available on iHub/Policies/Organisational Policies).
- Victims of IPV are frequently threatened by the perpetrator that if they disclose the violence, s/he will tell Oranga Tamariki/CYF that the non-abusive partner is a bad parent and/or abusive to the children, and that Oranga Tamariki/CYF will take the children away. Careful assessment needs to be undertaken to ensure that children's 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.

Other risk factors

- If the social history identified other risk factors (Step 1, Social history), then refer to other services eg, serious untreated mental illness should be referred to the mental health crisis team (TACT) and alcohol and drug addiction to Mental Health and Addiction 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 and Oranga Tamariki/CYF 0508 326 459 (0508 FAMILY) followed up with a written Report of Concern.

- Information from the health and risk assessment process will help to ensure that acute needs are identified and can be included in the safety plan.
- All healthcare providers can undertake basic intervention and safety planning activities if they have received training, and have access to support.
- Note that the purpose of risk assessment is to ascertain the likely level of immediate risk for a patient leaving the health care setting. Actual injuries or other evidence of CAN are not required for referral to Oranga Tamariki/CYF, particularly if there is risk to children.
- Assessing for positive/protective factors eg, family's efforts to actively pursue the safety and well-being of the child and their willingness and capacity to respond or engage, is an important part of identifying resources that may help improve the situation during safety planning.
- The identification of support needs within the family eg, 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 eg, 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 eg, 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.

Child being harmed

- A child who, in the opinion of the healthcare provider, is already coming to harm should be notified to Oranga Tamariki/CYF as a Report of Concern who will then form their own opinion on the level of risk for the child and triage accordingly.
- Children admitted to hospital with actual or suspected CAN should be managed in accordance with the Memorandum of Understanding (2011) between DHBs, Oranga Tamariki/CYF and the NZ Police.

  and the associated Schedule 1 (Children admitted to hospital with suspected or confirmed abuse or neglect), Schedule 3 (Neglect of Medical Care Guideline) and Police-CYF Standard Operating Procedure (SOP) for Children in Clandestine Labs

Child at Risk

- Identify the safety, care or behavioural issues that exist. Consider if the risk is likely to be mitigated by the family engaging further with your service, or another health or social agency. Will the family accept this referral? What positive or protective factors exist that could be enhanced?
- If you are unsure, discuss the situation and your concerns with Oranga Tamariki/CYF to determine if a written Report of Concern should be made.
- If Oranga Tamariki/CYF determines that the whānau is actively pursuing the safety and well-being of the child and has the willingness and capacity to respond then a Report of Concern to Oranga Tamariki/CYF may not be indicated. Likewise if you consider that engagement by

an agency with the family is likely to achieve positive outcomes and the family is willing to accept the referral(s), Oranga Tamariki/CYF is also likely to suggest that a written Report of Concern may not be necessary.

- If there is a Children's Team in the area, this may provide another avenue for effective action.

Co-occurrence of child abuse and Intimate partner violence

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

Talking to parents and caregivers about referral to the statutory authorities

- If it is safe to do so, discuss referral to Oranga Tamariki/CYF with the child's parents–caregivers.
- Broach the topic sensitively and reasonably, in the light of the concerns you have.
- Help the parents–caregivers feel supported, able to share any concerns they have with you.
- Help them understand that you want to help keep their child safe, and support them in the care of their child.
- 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 parents–caregiver's fears about Oranga Tamariki/CYF.
- However, be clear that your role is to keep the child safe. Do *not* seek permission to consult with Oranga Tamariki/CYF. You may do this at any time.

See Appendix 9 for Legal and Privacy Issues.

At times it may be necessary to suppress patient details and or provide secure processes at the time of discharge eg, where the risk to the victim's safety is assessed to be high risk.

See Appendix 10 for Safety and Security guidelines.

Step 5: Referral and follow-up

Oranga Tamariki/CYF.should be notified of all cases of suspected child abuse and neglect as per the MOU between SCDHB, Oranga Tamariki/CYF and Police (2011).

- 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 and/or agencies.
  - Ensure there is a plan for review and follow-up eg, what is the timeframe for the referral and follow-up plan? Who, when, and how, will the plan be reviewed?
  - A phone referral to Oranga Tamariki/CYF must be followed up by a written Report of Concern to Oranga Tamariki/CYF and a copy placed in the paper clinical record of the child (or mother when the concerns reported relate to the antenatal period). A copy must be sent to the VIP Coordinator–CP in accordance with the SCDHB National Child Protection Alert System policy.

Child being harmed

- To support follow-up, consider if and how the information should be transferred to the GP/primary care provider eg, written discharge summary, telephone call, or other agreed SCDHB procedure.
- Continue to provide follow-up to children and families notified to Oranga Tamariki/CYF.; the DHB remains responsible for the follow-up of the health care needs of the child and family.

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 eg, clinical nurse coordinator (CNC), charge nurse manager (CNM), duty nurse manager (DNM), service level manager, VIP Coordinator–CP and/or Oranga Tamariki/CYF.
- Document child protection concerns in the child's paper and/or clinical record.
- There are opportunities for early intervention (even when a Report of Concern is not made):
  - 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 eg, 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 eg, 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 eg, budgeting advice, alcohol and drug addiction services, mental health services.

Co-occurrence of CAN and IPV

- Make sure that the person experiencing IPV has contact details for local support agencies.
- Provide the person experiencing IPV with a private area to make phone contact with a family violence (FV) service.

Step 6: Documentation

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

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 parent–caregiver responded. Use direct quotes.

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 eg, 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.

Photographs

- The use of photographs to document injuries may be appropriate in some circumstances. Note that thorough documentation and body maps are always required, and cannot be replaced by photographs.
- To ensure the photographs are appropriate, accurate and admissible as evidence, it is recommended that the Police are contacted. The Police Request Form is available on iHub/Forms/Clinical and will be required if the Police are to take the photographs.
- The Police photographer is normally available during office hours on 021 190 9496 or call 03 687 9816 asking for on-call photographer.

Document the results of your risk assessment

- Be sure to include suspected or confirmed risk to other family members eg, other children in the family, parents–caregivers who may be at risk.

Document the consultative process you undertook

- Who did you speak with? At what points?

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

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

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 perpetrator finds out that the victim has disclosed CAN, the victim may be at increased risk of retribution for having revealed this abuse.
- Children's health records are private to them. Parents can ask to access their children's notes until they are 16 years old, but they are not automatically entitled to them. All requests to access health records should be managed in accordance with the SCDHB Collection, Access and Disclosure of Personal Information policy (AF7, available on iHub/Policies/Organisational Policies); 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.

Appendix 1: Terms and definitions

Child	Unborn children and children aged 0–18 years.
Child Protection	Means the activities carried out to ensure the safety of the child/tamaiti/rakatahi 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/tamaiti (0-17 years) (Section 14b Children, Youth and their Families Act 1989). This includes actual, potential and suspected abuse.
CPAS	(National) Child Protection Alert System. A national Child Protection Alert (CPAS) will be considered for: – Any child up to 18 years of age where child abuse is suspected and/or confirmed and a referral is made to Oranga Tamariki/CYF. – A Gateway referral. – A medical assessment request by Oranga Tamariki/CYF. – A pregnant woman where there are identified vulnerabilities. This alert can be viewed on the National Medical Index (NHI) Warning System and local DHB patient management systems ie, HPS and HCS.
Child Physical Abuse	Child physical abuse is any act or acts that may result in inflicted injury to a child.
Child Sexual Abuse	Child sexual abuse is any act or acts that result in the sexual exploitation of a child, young person, whether consensual or not.
Child 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.
Gateway Service	Collaboration between Health, Education and Oranga Tamariki/CYF. This service assesses the needs of children engaged with Oranga Tamariki/CYF.
MEDSAC	MEDSAC or Medical Sexual Assault Clinicians Aotearoa is the training and accreditation body for sexual assault clinicians.
Ministry for Vulnerable Children – Oranga Tamariki (MVCOT, or Oranga Tamariki/CYF)	Government agency that carries out the legislative requirements of the Children, Young Persons, and their Families Act 1989 and Amendments and the Vulnerable Children Act 2014. 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.
Child Neglect	Child neglect is any act or omission that results in impaired physical functioning, injury, and/or development of a child.
Police	Government agency responsible for: – Working cooperatively with Oranga Tamariki/CYF 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 Oranga Tamariki/CYF.

eProsafe	eProsafe is an electronic application that has been specifically designed to promote the health and wellbeing of children, adults, and their families who are experiencing abuse and neglect. It ensures that frontline staff, managing acute and at times severe situations of violence and abuse, can obtain information held by DHBs in a timely manner.
SAATS	The sexual assault service is called SAATS (Sexual Assault Assessment and Treatment Services). The SAATS provider offers the actual clinical and forensic assessment and treatment service. This service locally can be accessed by contacting Timaru Hospital, phone (03) 687‑2100 and asking to speak to the on-call SAATS doctor.

Appendix 2: Māori and family violence

This section is drawn from the *Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence* (2016). This was developed with leadership from the roopu, Te Korowai Atawhai. This appendix offers some background and context for family violence in relation to Māori, and identifies key principles and actions for effective identification and intervention. To strengthen the way health services respond to Māori individuals who are experiencing violence within their whānau, it is recommended that DHBs continue to implement He Korowai Oranga, the Māori Health Strategy in their planning, governance, ethos, and staff development.

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

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

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

Health care providers 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 (tikaka) and which involve the wider whānau, may be more likely to achieve the best outcomes. For this reason it is important for health care providers 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* (2014) is divided into three areas of action:

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

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

Principles for action

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

Building on the principles of Te Tiriti o Waitangi/Treaty of Waitangi are twelve kaupapa, which health care providers 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. **Wairuataka –** Wairuataka 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 (spiritual health), tinana (physical health), hinekaro (mental health), and whānau (family) 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 family violence with compassion, warmth and respect.

2. **Whakapapa** – refers to the genealogical descent of all living things from Rakinui (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 providers, it is beneficial to share with each other information about your genealogical ties and where you and your ancestors come from.

3. **Atuataka –** 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 the key to this approach.

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

   Ways to put this into practice

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

5. **Whānaukataka** – 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. **Rakatirataka** – is about demonstrating the qualities of a good leader (rakatira); 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 Rakatirataka.

   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 tikaka and kawa (cultural protocols) they wish to follow. Honour their decisions wherever possible.

7. **Manaakitaka –** 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 care providers).
   - 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. **Kaitiakitaka –** refers to the guardianship or protection of people, taoka (cultural treasures), and the environment so that they continue to thrive from generation to generation.

   Ways to put this into practice

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

9. **Oritetaka –** 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. **Kotahitaka –** 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 providers in your community.

11. **Pukekataka** – 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/whanau is 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.

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 Peoples 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

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.

Actions and behaviours to ensure victim safety and protection:

- Routinely enquire about experience of IPV for women aged16 years and over; ask men and adolescents when signs and symptoms are present. 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.
- 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.

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.
- 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.

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.

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 intersectional approach:

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

Appendix 4: Four recognised categories of child abuse

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

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).

Sexual Abuse

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

Non-contact abuse

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

Contact abuse

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

Emotional/Psychological Abuse

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

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

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

Neglect

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

- Physical neglect; failure to provide the necessities to sustain the life or health of the child.
- Neglectful supervision; failure to provide developmentally appropriate and/or legally required supervision of the child leading to an increased risk of harm.
- Medical neglect; failure to seek, obtain or follow through with medical care for the child resulting in their impaired functioning and/or development. Refer to the Neglect of Medical Care Guideline, Schedule 3 of the Police, Oranga Tamariki/CYF and SCDHB MOU.

  See Appendix 6 for Child Neglect Assessment Guideline.
- Emotional neglect; not giving children the comfort, attention and love they need through play, talk, and everyday affection.
- Educational neglect; allowing chronic truancy, failure to enrol children in school, or inattention to special education needs.
- Abandonment; leaving a child in any situation without arranging necessary care for them and with no intention of returning.
- Refusal to assume parental–caregiver responsibility; unwillingness or inability to provide appropriate care or control for a child.

Appendix 5: Signs and symptoms of abuse and neglect in recognised categories of child abuse

Physical abuse: injuries that don't make sense

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

Sexual abuse

- In sexual abuse particularly, physical signs or symptoms are usually absent and behavioural changes may not be evident.
- If a child tells you they have been abused ie, 'makes a disclosure', this should always be taken seriously and referred to Oranga Tamariki/CYF.
- 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 MEDSAC (Medical Sexual Assault Clinicians Aoteroa) trained doctor experienced 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. This does not necessarily indicate sexual abuse, and should be discussed with clinicians experienced in child behaviour or child sexual abuse.
  - *Fear of a certain person or place***.** Children might try to express their fear without saying exactly what they are frightened of, so listen carefully, and take what they say seriously. However, never jump to conclusions.
  - Other behavioural change suggesting emotional disturbance (see below).

Emotional abuse

- Most forms of abuse, exposure to violence or neglect are accompanied by emotional effects, which may or may not cause behavioural changes. The changes in behaviour noted below are not however specific for the emotional consequences of abuse or neglect.
- *Sleep problems;* like bed-wetting or soiling with no medical cause, nightmares and poor sleeping patterns.
- *Frequent physical complaints***;** real or imagined, such as headaches, nausea and vomiting, and abdominal pains

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

Neglect

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

See Appendix 6 for Child Neglect Assessment Guideline

Appendix 6: Child neglect assessment guideline

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

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

To answer these questions, sufficient information is required to assess the degree to which neglect can or may result in significant harm or risk of significant harm. The decision often requires considering patterns of caregiving over time.

The analysis should focus on examining how the child's basic needs are met and on identifying situations that may indicate specific omissions in care that have resulted in harm or the risk of harm to the child. While information on all these domains will not be accessible to all health care providers, the list provides some indications of issues that may require consideration.

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

- Have the parents–caregivers failed to provide the child with needed care for a physical injury, acute illness, physical disability or chronic condition?
- Have the parents–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–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 (eg, exposed wiring or easily accessible toxic substances) or unsanitary conditions (eg, faeces- or trash-covered flooring or furniture)?
- Does the child experience unstable living conditions (eg, frequent changes of residence or evictions due to the parent-caregiver's mental illness, substance abuse or extreme poverty)?
- Do the parents–caregivers fail to arrange for a safe substitute caregiver for the child?
- Have the parents–caregivers abandoned the child without arranging for reasonable care and supervision?

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

Appendix 7: HEEADSSS; Psychosocial interview for adolescents

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

Home	Drugs
Who lives with you? Where do you live? Do you have your own room?	Do any of your friends use tobacco? Alcohol? Other drugs?
What are relationships like at home?	Does anyone in your family use tobacco? Alcohol? Other drugs?
To whom are you closest at home?	Do you use tobacco? Alcohol? Other drugs?
To whom can you talk at home?	Is there any history of alcohol or drug problems in your family? Does anyone at home use tobacco?
Is there anyone new at home? Has someone left recently?	Do you ever drink or use drugs when you're alone?
Have you moved recently?	(Assess frequency, intensity, patterns of use or abuse, and how youth obtains or pays for drugs, alcohol, or tobacco)
Have you ever had to live away from home? (Why?)	(Ask the CRAFFT questions)
Have you ever run away? (Why?)	
Is there any physical violence at home?	

Education and employment	Sexuality
What are your favourite subjects at school? Your least favourite subjects?	Have you ever been in a romantic relationship?
How are your grades? Any recent changes? Any dramatic changes in the past?	Tell me about the people that you've dated. OR Tell me about your sex life.
Have you changed schools in the past few years?	Have any of your relationships ever been sexual relationships?
What are your future education/employment plans/goals?	Are your sexual activities enjoyable?
Are you working? Where? How much?	What does the term 'safe sex' mean to you?
Tell me about your friends at school.	Are you interested in boys? Girls? Both?
Is your school a safe place? (Why?)	Have you ever been forced or pressured into doing something sexual that you didn't want to do?
Have you ever had to repeat a class? Have you ever had to repeat a grade?	Have you ever been touched sexually in a way that you didn't want?
Have you ever been suspended? Expelled? Have you ever considered dropping out?	Have you ever been raped, on a date or any other time?
How well do you get along with the people at school? Work?	How many sexual partners have you had altogether?
Have your responsibilities at work increased?	Have you ever been pregnant or worried that you may be pregnant? (females)
Do you feel connected to your school? Do you feel as if you belong?	Have you ever gotten someone pregnant or worried that that might have happened? (males)
Are there adults at school you feel you could talk to about something important? (Who?)	What are you using for birth control? Are you satisfied with your method?
	Do you use condoms every time you have intercourse?
	Does anything ever get in the way of always using a condom?
	Have you ever had a sexually transmitted disease (STD) or worried that you had an STD?

Key:
Green = essential questions

Blue = as time permits

Red = optional or when situation requires

Eating	Suicide and depression
What do you like and not like about your body?	Do you feel sad or down more than usual? Do you find yourself crying more than usual?
Have there been any recent changes in your weight?	Are you 'bored' all the time?
Have you dieted in the last year? How? How often?	Are you having trouble getting to sleep?
Have you done anything else to try to manage your weight?	Have you thought a lot about hurting yourself or someone else?
How much exercise do you get in an average day? Week?	Does it seem that you've lost interest in things that you used to really enjoy?
What do you think would be a healthy diet? How does that compare to your current eating patterns?	Do you find yourself spending less and less time with friends?
Do you worry about your weight? How often?	Would you rather just be by yourself most of the time?
Do you eat in front of the TV? Computer?	Have you ever tried to kill yourself?
Does it ever seem as though your eating is out of control?	Have you ever had to hurt yourself (by cutting yourself, for example) to calm down or feel better?
Have you ever made yourself throw up on purpose to control your weight?	Have you started using alcohol or drugs to help you relax, calm down or feel better?
Have you ever taken diet pills?	
What would it be like if you gained (lost) 10 pounds?	

Activities	Safety
What do you and your friends do for fun? (with whom, where, and when?)	Have you ever been seriously injured? (How?) How about anyone else you know?
What do you and your family do for fun? (with whom, where, and when?)	Do you always wear a seatbelt in the car?
Do you participate in any sports or other activities?	Have you ever ridden with a driver who was drunk or high? When? How often?
Do you regularly attend a church group, club, or other organized activity?	Do you use safety equipment for sports and or other physical activities (for example, helmets for biking or skateboarding)?
Do you have any hobbies?	Is there any violence in your home? Does the violence ever get physical?
Do you read for fun? (What?)	Is there a lot of violence at your school? In your neighbourhood? Among your friends?
How much TV do you watch in a week? How about video games?	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)
What music do you like to listen to?	Have you ever been in a car or motorcycle accident? (What happened?)
	Have you ever been picked on or bullied? Is that still a problem?
	Have you gotten into physical fights in school or your neighbourhood? Are you still getting into fights?
	Have you ever felt that you had to carry a knife, gun, or other weapon to protect yourself? Do you still feel that way?

Source: Goldenring and Rosen 2004

Appendix 8: Assessment and referral for children age under 12 years 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

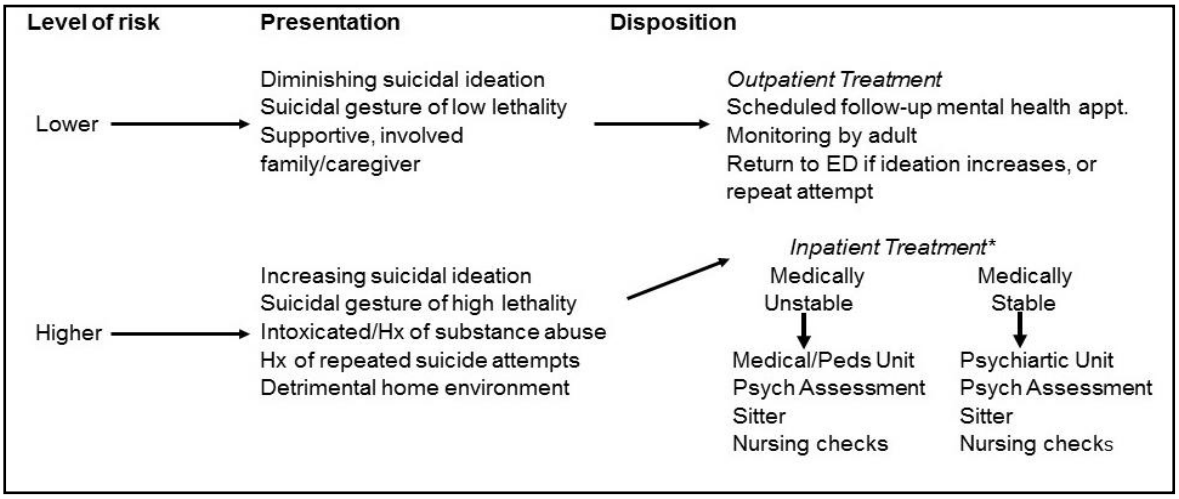
Alcohol and Substance Use

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



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

Appendix 9: Legal and privacy issues

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

As well, all privacy restrictions are over-ridden by certain sections of the Children, Young Persons and their Families Act (1989) and the Vulnerable Children Act (2014). 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.

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

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

Children, Young Person's and their Families Act 1989

S6 *Paramountcy principle*

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

S15 Reporting of ill treatment or neglect of a child

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

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

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

S66 Government Departments may be required to supply information

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

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

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

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

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.

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

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 person's and their Families Act (1989), for the purposes of exercising or performing any of that person's powers under that Act.

Always seek advice prior to release of information.

Vulnerable Children Act 2014

The Vulnerable Children Act (VCA) 2014 forms a significant part of comprehensive measures to protect and improve the wellbeing of vulnerable children and strengthen New Zealand's child protection system.

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

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

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

Part 2, covering child protection policies, states:

'The purpose of this Part is to require child protection policies (that must contain provisions on the identification and reporting of child abuse and neglect) to be –

(a) Adopted and reported on by prescribed State services and DHBs boards; and

(b) Adopted by school boards; and

(c) Adopted by certain people with whom those services or boards enter into contracts or funding arrangements.'

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

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

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

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

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

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

Appendix 10: Safety and security guidelines

This guideline sets out SCDHB's procedures for staff when there is a need to access support to optimise the safety for persons experiencing family violence when the risk to the person's safety is assessed to be a high. These guidelines will provide information to support staff to:

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

And should be discussed with the person experiencing abuse and their consent obtained.

The safety of the person is the paramount consideration. If a child experiencing abuse and/or neglect, 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 the person's details and to facilitate the person leaving the hospital for a place of safety.

Procedure to establish confidentiality for victims of abuse in the SCDHB computer system, ensuring persons making public enquiries are given no details about the victim

- The person experiencing the abuse identifies that s/he is concerned that the perpetrator may trace them to the hospital.
- The staff discuss with the person the potential to place the word 'Confidential' on the person's details. The person consents to this being actioned.
- The charge nurse manager (CNM), duty nurse manager (DNM) or service level manager is informed and s/he directs the switchboard/unit/ward staff to place the 'Confidential' flag against the person's details on the patient inquiry screen.
- The person's name is replaced with a pseudonym on all patient detail boards in the unit/ward.
- The following staff are informed of name confidentiality being actioned:
  - CNM, DNM and/or service level manager.
  - Switchboard staff.
  - All relevant staff within the unit/ward.
- This directive against the person's details is valid for the duration of their hospital visit or until appropriate personnel remove the directive.
- The CNM responsible for the person's care and/or DNM will remove the name confidentiality at discharge or when the person requests this.
- The DNM or service level manager is responsible for informing the Police as required.

Procedure for staff to follow when confidentiality has been granted

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

- Inform the caller s/he is unable to provide any information.
- Ask for the caller's name and write this down (if provided).
- Notify the CNM responsible for the person's care and/or the DNM.
- Notify the DNM and/or service level manager if the caller is the suspected perpetrator of an assault and Police charges are likely.

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

- Arrange the discharge plan in consultation with the patient and the discharge agency concerned. For example, ensure the person speaks to the agency eg, Women's Refuge, concerned and that all parties are in agreement with the discharge plan.
- Complete the 'Confidential' process as above if appropriate.

- Ensure that the following people are informed of the discharge plan process this may include:
  - Appropriate clinical staff, CNM, DNM.
  - The Police (if risk is considered high by department staff).
- The discharge plan may include the person leaving the ED/unit/ward or by an agreed safe route.
- Document the discharge plan on the IPV–FV Assessment and Intervention Documentation Form (available on iHub/Forms/Clinical, also attached to policy on Intranet) and forward to the VIP Coordinators.
- Advise the DNM of the discharge outcome.

NB: Complete a Safety First Form if any unexpected outcomes/incidents occur.

South Canterbury District Health Board

ED CHILD PROTECTION CHECKLIST

Name Label

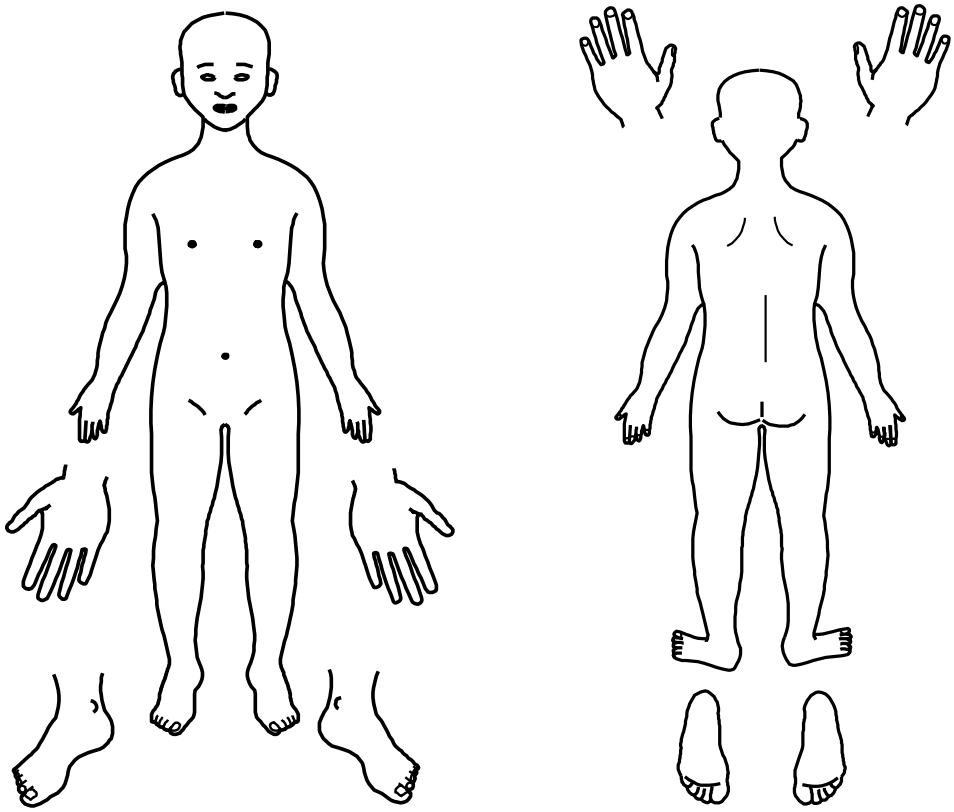
COMPLETE a)–e) FOR **ALL PATIENTS UNDER 2 YEARS OF AGE**			
a)	Has a child assessment been completed?	☐ Yes	☐ No
a)	Is there a pre-existing CHILD PROTECTION ALERT?	☐ Yes	☐ No
b)	Is there any concern about the child and/or family's BEHAVIOUR?	☐ Yes	☐ No
c)	Is there a past history of PREVIOUS INJURIES?	☐ Yes	☐ No
d)	On examination, does the child have any UNEXPLAINED INJURIES?	☐ Yes	☐ No
e)	Any other concern?	☐ Yes	☐ No
COMPLETE f)–j) FOR **ALL PATIENTS UNDER 10 YEARS OF AGE PRESENTING WITH AN INJURY**			
f)	Is there a pre-existing CHILD PROTECTION ALERT?	☐ Yes	☐ No
g)	Has there been a DELAY between the injury and seeking medical advice, for which there is no satisfactory explanation?	☐ Yes	☐ No
h)	Was the EVENT NOT WITNESSED?	☐ Yes	☐ No
i)	Is the HISTORY INCONSISTENT with the injury and/or with the child's developmental level?	☐ Yes	☐ No
j)	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/or **Paediatrician** and ensure **routine enquiry for intimate partner violence** is completed

☐ No suspicion of NAI

Name:..... Signature:..... Date:.....



CHILD PROTECTION FLOW CHART – EMERGENCY DEPARTMENT

NON-ACCIDENTAL INJURY (NAI) OF A CHILD OR YOUNG PERSON < 18 YEARS. ALL CASES *MUST BE DISCUSSED WITH* AND/OR EXAMINED BY A PAEDIATRICIAN

DECISION PATHWAYS

Serious Abuse / Assault Identified

ED staff

- Immediately contact Oranga Tamariki /CYF[1], Ph 0508 326 459 (24 hours). Phone call must be followed up by written Report of Concern (ROC) by ED staff; copy of written ROC to be put with the patient's clinical records
- Contact Police Ph 111, stating you must immediately be put through to the Timaru Duty Sergeant as a child is in the ED with a non-accidental injury (NAI)
- Notify the Duty Nurse Manager (DNM) there is a serious abuse/assault case.

Refer to Child Protection Policy (HR29) on iHub/Policies/Organisational Policies

Watch to be implemented immediately and safety planning commenced
(may be required in ED prior to admission to the paediatric ward)
As per Schedule 1 of the Oranga Tamariki/CYF/Police/SCDHB Memorandum of Understanding in Violence Intervention Programme (VIP) Red Folder or on Ihub/Knowledge Base/Violence Intervention Programme/SCDHB-CYF-Police MOU

Admit to the paediatric ward

- NAI assessment form (in Red Folder) to be completed by the paediatrician
- Copy of Report of Concern to be sent to the Violence Intervention Programme (VIP) Child Protection Coordinator
- VIP Child Protection Coordinator, DHB social worker and Oranga Tamariki/ CYF Hospital Liaison social worker to be advised of admission, to assist with safety planning and providing any additional information to Oranga Tamariki/ CYF.

Admit to ICU or general medical/surgical areas

- Refer to Child Protection Policy (HR29) on iHub/Policies/Organisational Policies
- Copy of Report of Concern to be sent to the Violence Intervention Programme (VIP) Child Protection Coordinator
- VIP Child Protection Coordinator and DHB social worker to be advised of admission, to assist with safety planning and providing any additional information to Oranga Tamariki/CYF.

IF PARENT/CAREGIVER REMOVES CHILD OR REFUSES ADMISSION, IMMEDIATELY CONTACT POLICE AS ABOVE

Suspected Abuse / Assault

Refer to Child Protection Policy (HR29) on iHub/Policies/Organisational Policies

- Is medical follow-up required?
- Is paediatric assessment required?
- Is social worker assessment required?
- Are there safety concerns if discharged?

Yes

Admit to paediatric ward

- NAI assessment form (in red folder) to be completed by paediatrician
- Paediatrician to phone and forward written Report of Concern to Oranga Tamariki/CYF once paediatric examination completed
- Copy of Report of Concern to be sent to the Violence Intervention Programme (VIP) Child Protection Coordinator
- Police to be contacted as above left
- VIP Child Protection Coordinator, DHB social worker and Oranga Tamariki/CYF Hospital Liaison social worker to be advised of admission, to assist with safety planning and providing any additional information to Oranga Tamariki/CYF.
- Notify the Duty Nurse Manager (DNM) there is a suspected abuse/assault case.

IF PARENT/CAREGIVER REMOVES CHILD OR REFUSES ADMISSION, IMMEDIATELY CONTACT POLICE AS ABOVE LEFT.

No

Document presentation and no further action required.

[1] Ministry for Vulnerable Children, Oranga Tamariki (Oranga Tamarariki) previously known as Child, Youth and Family or CYF.

Appendix 12: eProsafe

Introduction

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

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

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

eProsafe enhances practice by:

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