Recommended referral process for General Practitioners

Suspected child abuse and neglect

MINISTRY OF HEALTH
MANATŪ HAUORA

The Royal New Zealand College of General Practitioners

NEW ZEALAND MEDICAL ASSOCIATION

child, youth and family

Foreword

The RNZCGP supports the principles for the reporting of child abuse as outlined in this booklet and reference pullout. We endorse the booklet and insert as a useful resource for GPs and general practices. Supplementary information concerning legal aspects of reporting and the reporting process within the Department of Child, Youth and Family Services is also provided.

The resource was developed by the Ministry of Health and Child, Youth and Family with significant input from a group of College members to ensure relevance and usefulness to GPs. This is an important issue for all New Zealanders and I trust these procedures serve you well.

Like all documents of this type, the document needs continued input from the users to ensure future development is relevant to those in practice. We look forward to receiving your feedback and are very interested in any constructive criticism that could lead to improvements should future versions be produced.

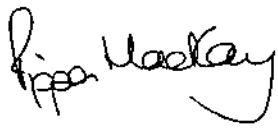
Dr Ralph Wiles
Chairman, Royal New Zealand College of General Practitioners

The NZMA welcomes the development of guidelines for General Practitioners for the referral of suspected child abuse and neglect. The NZMA has strongly advocated for effective and workable solutions to keep children safe and protect those who are at risk.

Dealing with child abuse is not always easy for health professionals, and it is very important that doctors feel supported in this area. With guidelines such as these, health professionals can feel confident that they can identify abuse, and know where to turn for assistance. Doctors must also feel confident that if they report abuse, the outcome will be effective for the child.

It is also important that the guidelines have been developed co-operatively between the different groups involved, so all sectors can be confident of the outcome.

We urge all doctors to take this issue very seriously, and to use the guidelines appropriately.



Pippa MacKay
Chairman, New Zealand Medical Association

In an ideal world all children would be happy, secure and well cared for. Along with many of those working in the health sector, I regard that as an achievable goal in New Zealand. Health professionals in general practice can make a difference for children who may be abused or at risk of abuse. This document is an important step along the path towards a better life for many children.

Dr Karen O Poutasi
Director General of Health

Child, Youth and Family has a mission to provide the most effective intervention for clients at the earliest possible point – by employing the referral process for reporting child abuse recommended in this publication, GPs will help this process. It is a development we welcome in our work.

Our focus is on protecting vulnerable children and young people and to achieve this we need to work together with other community providers such as General Practitioners and Police. We anticipate a more robust reporting process with the advent of these guidelines and thank all who have contributed to their development.

Jackie Brown
Chief Executive, Department of Child, Youth and Family Services

19 December 2000

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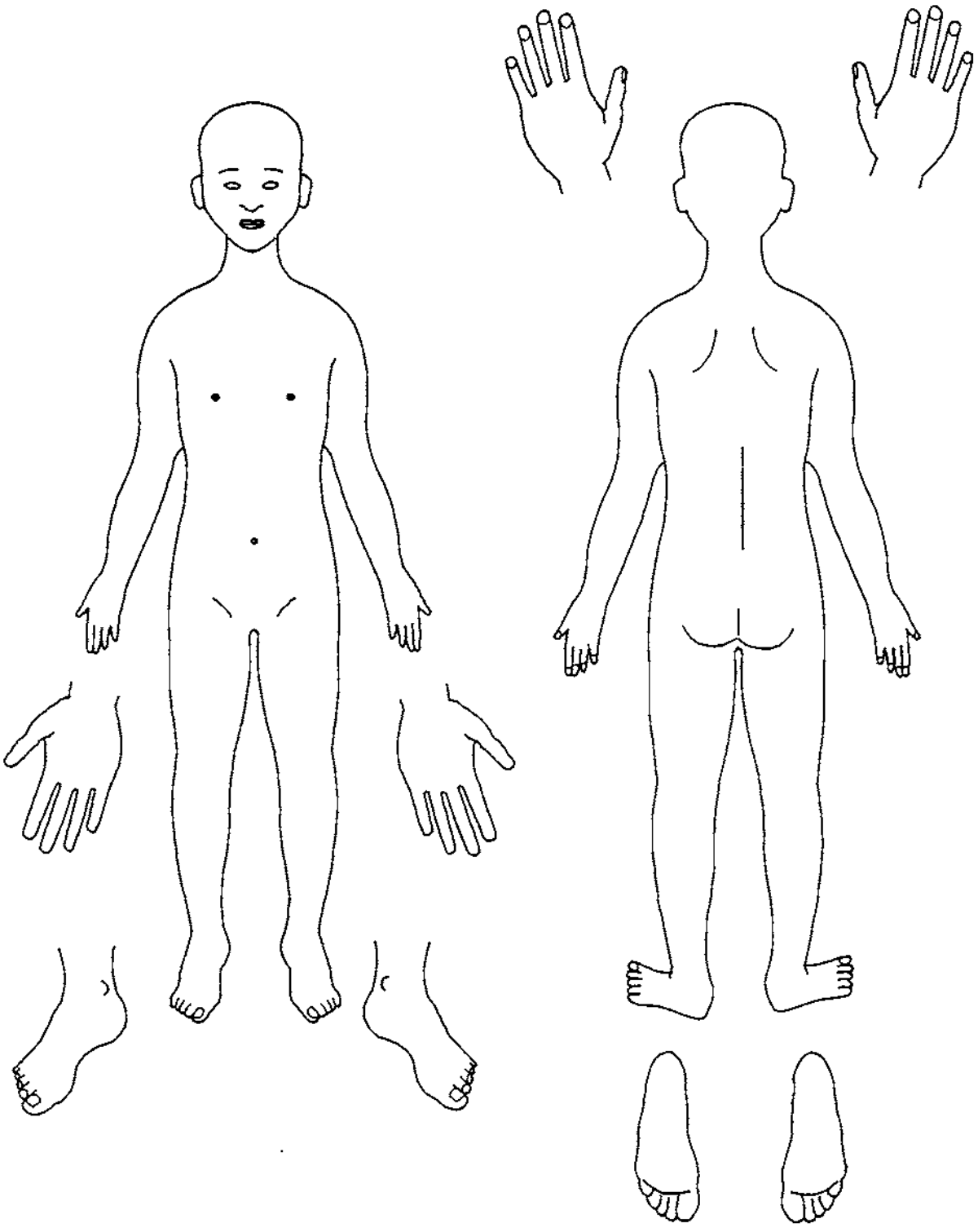
APPENDIX 1

Body diagram sheets

The diagrams on the following two pages were supplied by Dr Patrick Kelly, Director, Whakaruruhau, Starship Children's Hospital.



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Date of birth:	
Address:	

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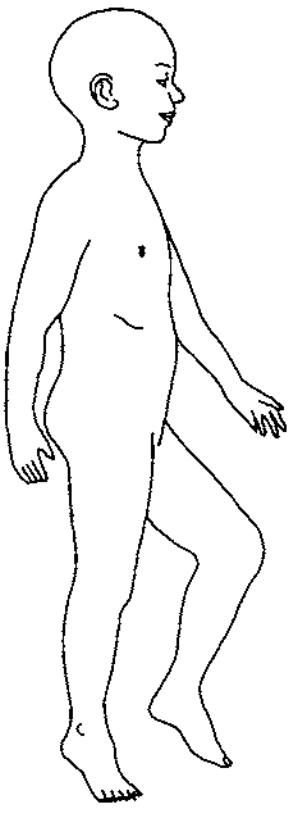
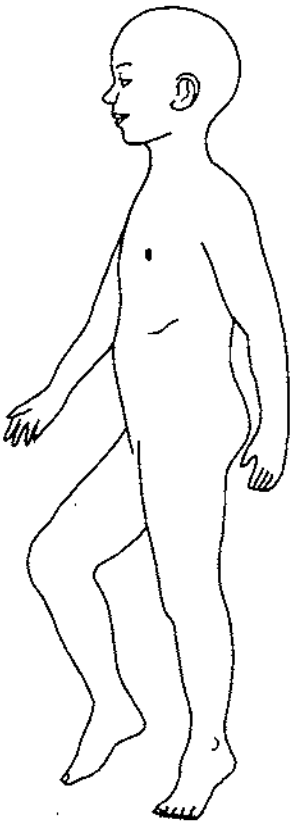
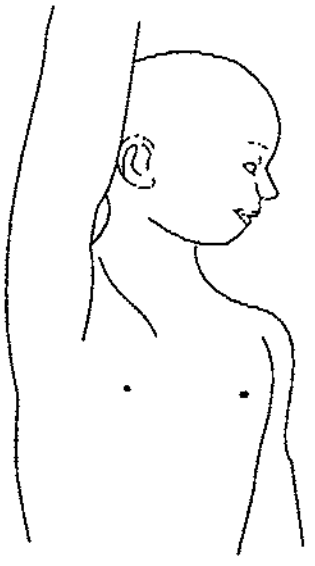
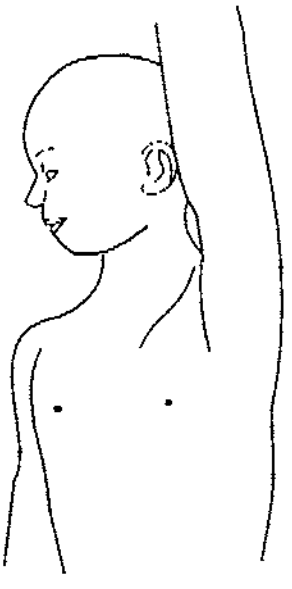








Name:	NHI:
Date of birth:	
Address:	

Used with permission from Dr Patrick Kelly, Director, Whakaruruhau, Starship Children's Hospital.

APPENDIX 2

Referral facsimile

Suggested General Practice follow-up referral/notification facsimile form. The facsimile form is on page 5. Please photocopy for your use, or use as a template for computer referrals.

To: Child, Youth and Family National Call Centre

Fax number: 09 914 1211

From: GP:.....

Practice name:.....

Phone:..... Fax:.....

Date: .....

Child's name:.....

Also known as: .....

Date of birth:..... Ethnicity: .....

Contact address: .....

Phone: .....

Date of presentation: .....

Mother:..... Phone: .....

Address:.....

Father:..... Phone:.....

Address:.....

Caregiver:..... Phone:.....

Address:.....

History and physical findings:

.....

.....

.....

.....

.....

.....

.....

.....

Tick other agencies involved:

Paediatrician Name..... Phone:.....

Police	Public Health Nurse	Homebuilders
Plunket	Iwi/Maori Social Service	Barnardos
Open Home Foundation	Family Start	Pacific Peoples Social Service

Any others:

Signed:..... Date:.....

APPENDIX 3

Child, Youth and Family referral procedures

Definitions:

Care and Protection Coordinator coordinates family group conferences and reconvenes family group conferences for review. They are responsible for ensuring that family/whanau members are invited to the conference and provided with the relevant information to make a plan for the care and protection of the child or young person.

Care and Protection Resource Panel is established under the CYP&F Act 1989 to provide advice to social workers, Police and care and protection coordinators. Most panels include paediatricians.

Police Child Abuse Team works with Child, Youth and Family in the investigation of sexual and serious physical abuse cases. Police make the decision on any prosecution.

Response Time Matrix is a guide used to assess the urgency of an investigation.

Risk Estimation System is used to assess current and future risk of abuse and neglect to the child.

Social worker has a statutory authority to receive reports of abuse or neglect, to investigate, assess and arrange appropriate intervention including family support and alternative care. They have authority to make applications to the Family Court for a Place of Safety Warrant, or make an application for a Declaration that a child or young person is in need of care or protection, or to make referrals for a family group conference.

Different roles are identified for social workers:

- ***Care and protection duty social worker*** *takes referrals.*
- ***Caselkey social worker*** *is allocated the case for investigation and has the main responsibility for the case.*
- ***Community liaison social worker*** *works with the community and professional groups to raise awareness of child abuse and neglect and develops and monitors protocols for the reporting of abuse and neglect.*
- ***Co-social worker*** *works alongside the caselkey social worker in the initial investigation.*
- ***Intake social worker*** *receives the referral and undertakes the initial risk and safety assessment.*

Supervisor has social work experience and provides supervision for social workers, especially for investigation planning and ongoing child protection needs.

Youth Screening Tools are assessment tools. CAGE and Kessler screening tools screen alcohol and drug use, and psychological distress. There are also tools to assess the risk of suicide, and well-being.

A. Making a referral to Child, Youth and Family

For advice on how to proceed **before** making a notification phone:

- the Child, Youth and Family National Call Centre and discuss, or
- the local community liaison social worker. The community liaison social worker will give advice but will not take a notification.

All referrals (notifications) go through the Child, Youth and Family National Call Centre.

1. National Call Centre (Phone 0508 FAMILY or 0508 326 459 and Fax 09 914 1211)

The National Call Centre operates from 8am to 5pm Monday to Friday and is staffed by intake social workers. All after-hours calls are relayed, via the Call Centre, to an after-hours answering service which directs calls to the local office.

The intake social worker will:

(a) Take the details of your referral, such as:

- The notifier, client and family/whanau
- The specific concerns and full details of any previous concern
- The current location of the child or young person
- Any alleged perpetrator and that person's access to the client
- Details of any protector present
- History of violence, stress, substance abuse, mental illness or incapacity, social isolation and potential for flight
- Any physical hazards at the home; for example, weapons, threats of violence, dogs.

(b) Obtain any additional information where required, to determine the appropriate response.

(c) Determine the response time necessary for action to be taken. A *Response Time Matrix* is used to assess vulnerability, access of alleged abuser to the child, ability of the non-offending adult to protect the child, pattern of injuries or conditions, etc. Response times are:

- critical – same day
- very urgent – day of notification plus one day
- urgent - within seven days
- low-urgency – within 28 days.

(d) Advise the *care and protection duty social worker* at the local office by phone if it is a critical or very urgent case (within 15 minutes of the notification being received if critical).

(e) Record the notification on the computer system.

(f) Send notice of the new notification to the care and protection duty social worker at the local Child, Youth and Family Office.

2. Local office

(a) The case is allocated to a *social worker*. Allocations are made at the time of notification if the case is critical or very urgent (refer 1d). Urgent or low-urgency cases are allocated at a later time to meet the response time frame. If the time frame cannot be met for low urgency cases then there is prioritising and daily reviewing until resources become available.

(b) An investigation plan is developed with the *supervisor*.

(c) If sexual abuse or serious physical abuse is alleged the *Police Child Abuse Team* is involved in the investigation plan.

(d) The *case/key social worker* will contact the referring GP about the case. The contact with the GP is to ensure the social worker has full and correct information, to receive any update on further developments and to give the GP information on action being taken. The timing will vary depending on the response time.

(e) The *Care and Protection Resource Panel* provides advice on the investigation. The Panel gives cultural/specialist advice.

(f) Any other parties involved with the family/whanau may be contacted for further information.

(g) Depending on the circumstances, this is usually followed by an initial visit to the home to sight the child and meet the parent(s).

(h) At the end of the investigation (which can take 6 to 12 weeks from referral) the social worker has a legal obligation to inform the GP (as the notifier) that the referral has been investigated and whether any further action has been taken (section 17 (3)).

(i) If abuse or neglect is substantiated, the *Risk Estimation System* is used to determine the safety needs of the child and any other siblings. If the concerns are about the behaviour of a young person then the *Youth Screening Tools* will be used. Follow-up action may include:

- referral to another agency
- an intervention plan negotiated with the family/whanau to address identified problems and showing the services to be provided (eg, counselling and support)
- family group conference
- court action – this can occur at any stage of the investigation if necessary to provide immediate safety pending full investigation.

(j) Where any intervention is put in place regular reviews and monitoring processes are established.

Note: There are some local Child, Youth and Family offices that still manage most of the intake process. The National Call Centre will eventually manage all referrals.

B. After making the referral to Child, Youth and Family

1. Should you inform parents/caregivers of your suspicion?

   The child may be placed at further risk if the parents/caregivers are informed of your suspicion. Consult Child, Youth and Family, or the Police if they are involved, about whether to inform the parents/caregivers.

   Remember the paramount consideration is the immediate safety of the child, and/or the safety of other children.

   If you decide to discuss your concerns with the parents/caregivers (after contacting Child, Youth and Family or the Police) be aware that:

   - You need to be confident the parents/caregivers will follow your advice.
   - If it is a case of serious abuse the Police will be involved and their ability to gain evidence may be hindered if parents/caregivers are alerted.
   - The family may make themselves inaccessible as a result of the discussion.

2. The social worker will consult the referring GP to check they have correct and up-to-date information.
3. The GP may want to further consult the social worker and can use the National Call Centre and/or ask for the direct phone number for the local office or social worker involved.

C. Child, Youth and Family may contact GPs

When they are seeking:

- information for an investigation of abuse or neglect
- advice on the management of a case
- medical advice eg, immunisation
- information for a family group conference
- a medical examination

or:

- to advise GPs on medical risk factors to a child or young person eg, a young person who is suicidal.

APPENDIX 4

Procedures for Practices

It is recommended that procedures:

- identify the roles of all relevant practice staff (eg, GP, practice nurse and receptionist)
- cover the following topics:
  - *cultural considerations (see below)*
  - *assessment (see Reference pullout)*
  - *consultation (see Reference pullout)*
  - *referral to Child, Youth and Family (see Appendix 3)*
  - *social support and child health agencies (see below).*

Cultural considerations

When working with people from other cultures:

- Ask the ethnicity question – do not guess. Note when the person chooses not to answer. Consider too, whether you are asking the question in an appropriate way and the person is given enough time to answer. If in doubt, talk about it among colleagues or seek help or training if necessary.
- Build networks with Maori and Pacific Peoples providers who can assist with understanding cultural practices/beliefs, improve continuity of support that can be offered to patients, and aid ongoing planning for improving the quality of service.
- Encourage patients to bring whanau support to the consultation. Allow whanau who attend the opportunity to participate in the consultation.
- Consider employing Maori and Pacific people.
- Consider offering clinical training to upskill Maori and Pacific staff, or sponsoring training to build capacity for the practice.
- Train staff about cultural issues and cultural barriers. Use your Maori networks to identify suitable people to provide training.
- Encourage staff to attend local hui and fono on Maori and Pacific health issues; presence and participation at hui and fono can be very effective for networking.
- Develop strategies for Maori and Pacific people's health within your practice to achieve improvements in Maori and Pacific health. Obtain help if necessary.

Social support and child health agencies:

Have knowledge and contact details of these agencies who work with children and young people.

Services available in many areas are:

- *Family Start*
- *Public Health Nurses*
- *Plunket*

- *Child, Adolescent Mental Health Services*
- *Iwi/Maori Social Services*
- *Parents as First Teachers (PAFT), and*
- *Women's Refuge.*

Services available in some areas are:

- *Child Abuse Prevention Society (CAPS)*
- *Barnardos*
- *Parentline*
- *Open Home Foundation*
- *Homebuilders*
- *Pacific Peoples Social Services*
- *Presbyterian Social Services*
- *Catholic Social Services.*

Discuss your concerns about support with the parent and refer them to these agencies. Phone the agency to discuss the referral and check whether actioned.

APPENDIX 5

Legal issues

There are no legal barriers to disclosure of patient information relating to suspected or actual child abuse given in good faith to an appropriate authority (CYP&F Act 1989 sections 15 and 16).

The Health Act 1956 protects practitioners acting under section 22C from civil or criminal liability if they act in good faith and take reasonable care.

The statutory responsibility for investigation lies with the Child, Youth and Family social worker or member of the Police. (RNZCGP, 2000, *WELLCHILD*, p42.)

The following are extracts from relevant legislation.

Children, Young Persons, and Their Families Act 1989

Paramountcy Principle (section 6)

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

Reporting (section 15)

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

Protection when disclosing (section 16)

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

Note: Section 16 provides statutory protection for general practitioners who suspect child abuse and/or neglect to report.

Responsibility for investigation (section 17)

> "Where any Social Worker or member of the Police receives a report pursuant to section 15 of this Act relating to a child or young person, that Social Worker or member of the Police shall, as soon as practicable after receiving the report, undertake or arrange for the undertaking of such investigation as may be necessary or desirable into the matters contained in the report and shall, as soon as practicable after the investigation has commenced, consult with a Care and Protection Resource Panel in relation to the investigation."

Health Act 1956

Section 22C of the Health Act provides guidance on when a doctor can release health information.

> "(1) Any person (being an agency that provides health services, or disability services, or both, or being a funder) may disclose health information-
>
> (a) If that information –
>
> (i) Is required by any person specified in subsection (2) of this section; and

(ii) Is required ... for the purpose set out in that subsection in relation to the person so specified; or

(b) "If that disclosure is permitted –

(i) By or under a code of practice issued under section 46 of the Privacy Act 1993 ...

(2) The persons and purposes referred to in subsection (1)(a) of this section are as follows: ...

(c) A Social Worker or a Care and Protection Co-ordinator within the meaning of the Children, Young Persons, and Their Families Act 1989, for the purposes of exercising or performing any of that person's powers, duties, or functions under that Act."

Health Information Privacy Code 1994

"Rule 11 Limits on disclosure of health information

(1) A health agency that holds health information must not disclose the information unless the agency believes, on reasonable grounds: ...

(b) that the disclosure is authorised by:

(i) the individual concerned; or

(ii) the individual's representative where the individual is dead or is unable to give his or her authority under this rule; ...

(2) Compliance with paragraph (1)(b) is not necessary if the health agency believes on reasonable grounds that it is either not desirable or not practicable to obtain authorisation from the individual concerned and:

(a) that the disclosure of the information is directly related to one of the purposes in connection with which the information was obtained;

(b) that the information is disclosed by a registered health professional to a person nominated by the individual concerned or to the principal care giver or a near relative of the individual concerned in accordance with recognised professional practice and the disclosure is not contrary to the express wish of the individual or his or her representative; ...

(d) that the disclosure of the information is necessary to prevent or lessen a serious and imminent threat to:

(i) public health or public safety; or

(ii) the life or health of the individual concerned or another individual; ...

(i) that non-compliance is necessary:

(i) to avoid prejudice to the maintenance of the law by any public sector agency, including the prevention, detection, investigation, prosecution, and punishment of offences; or ...

(ii) for the conduct of proceedings before any court or tribunal (being proceedings that have been commenced or are reasonably in contemplation); ...

(3) Disclosure under subrule (2) is permitted only to the extent necessary for the particular purpose. ...

(5) This rule applies to health information about living or deceased persons obtained before or after the commencement of this code.

(6) [Despite subrule (5), a health agency is exempted from compliance with this rule in respect of health information about an identifiable deceased person who has been dead for not less than 20 years.]

Note: Except as provided in subrule 11(4) nothing in this rule derogates from any provision in an enactment which authorises or requires information to be made available, prohibits or restricts the availability of health information or regulates the manner in which health information may be obtained or made available – Privacy Act, s.7. Notes also that rule 11, unlike the other rules, applies not only to information about living individuals, but also about deceased persons – Privacy Act, s.46(6)."

Should GPs breach the Health Information Privacy Code, a complaint can be laid with the Privacy Commissioner for resolution.

While this resource has been developed with all care and after consultation with many organisations, it is not intended to be legal advice. If you have any concerns about the material or a particular case please contact your local Child, Youth and Family office.

APPENDIX 6

References

Children, Young Persons and Their Families Service. Breaking the Cycle: An interagency guide to child abuse. Wellington, NZ. Children, Young Persons and Their Families Service; 1998.

Collins D B. Medical Law in New Zealand. Wellington, NZ. Brooker & Friend; 1992.

Ministry of Health. Consent in Child and Youth Health – Information for practitioners. Wellington, NZ. Ministry of Health; 1998.

Reder P, Duncan S, and Gray S. Beyond Blame. London, UK. Routledge; 1993

Risk Management Project. Recognition of Child Abuse and Neglect Tirohanga Tukino Tamariki. Wellington, NZ. Children, Young Persons and Their Families Service; 1997.

The Royal NZ College of General Practitioners. WELLCHILD Coordinating child health. A General Practice response to the WellChild strategy (revised 4th edition). Wellington, NZ. RNZCGP; 2000.

The Royal NZ College of General Practitioners. Health for Young People. Effective General Practice care for young people (revised). Wellington, NZ. RNZCGP; 2000.

Recommended referral process for GPs

Suspected child abuse and/or neglect

Guiding Principles

1. The child's safety is the paramount consideration.
2. Early referral to an appropriate authority is essential.
3. It is the responsibility of Child, Youth and Family and/or Police to investigate and interview the child and family. This is not the GP's role.
4. There are no legal barriers to referral to an appropriate authority.

Key Points

1. Keep an open mind to the possibility of child abuse.
2. Take an accurate history and document.
3. Look for signs of abuse and neglect and adequately document.
4. Refer to an appropriate authority.
5. Seek feedback about the child's progress from the agency you made the referral to.
6. Maintain an ongoing relationship with the child and family, where possible.
7. Get support for yourself.

Contents

MINISTRY OF HEALTH
MANATU HAUORA

The Royal New Zealand College of General Practitioners

NEW ZEALAND MEDICAL ASSOCIATION

child, youth and family

Child, Youth and Family – National Call Centre (0508 FAMILY or 0508 326 459) Fax (09) 914 1211

Process for recognition of child abuse and neglect

Remember:

The management of child abuse is complex. We recommend that multi-disciplinary expertise is sought to ensure that:

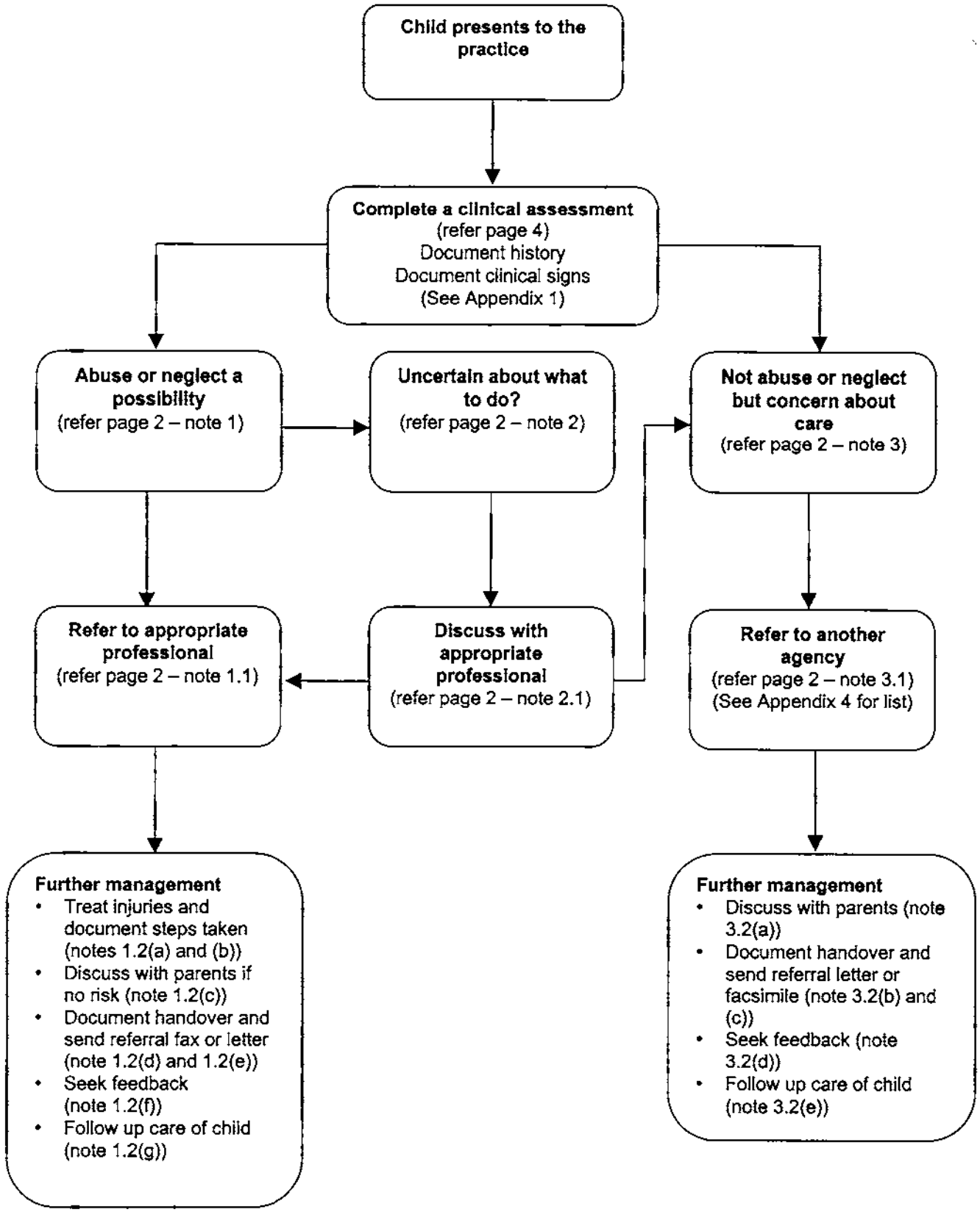
- The safety of the child is paramount.
- Evidence of child abuse is not lost. Careful expert medical assessment will be required with possible collection of forensic evidence.
- Trauma to the child from multiple assessments and questions is minimised.

The best way to ensure this occurs is to refer promptly to experts such as paediatricians or Child, Youth and Family workers.

It is essential to adequately document the history and clinical signs of injury. (See Appendix 1 Body Diagrams.)

Where sexual abuse is a possibility, Doctors for Sexual Abuse Care (DSAC) will be contacted by Child, Youth and Family or the Police.

1. When child abuse is a possibility	**2. When child abuse is a possibility, but you are uncertain about what to do**	**3. When you are concerned about the child's care but not about abuse**
1.1 Contact Child, Youth and Family first – except: • where there are concerns about domestic violence or immediate safety (including your own) contact the **POLICE**. (See Appendix 3 A.)	2.1 Telephone and describe history and findings with: • experienced colleague or • paediatrician or • Youth Health Services or • Child, Youth and Family.	3.1 Refer to an agency for: • social support • parenting skills • Well Child services. (See Appendix 4.)
1.2 Ongoing management: (a) Treat injuries as appropriate or refer. (b) Document what steps have been taken. (c) Discuss concerns with parent/s where child and/or yourself are not placed at further risk. (See Appendix 3 B.) (d) Document that the handover occurred and identify the professional involved. (e) Follow up telephone referral with a facsimile or letter. (See Appendix 2.) (f) Seek feedback about the child's progress from the agency you made the referral to. (g) Follow up the child with routine care.	2.2 Take advice from the person you consult. 2.3 Decide: (a) Report now – refer note 1.1. (b) Defer reporting at this stage – refer note 3.1.	3.2 Ongoing management: (a) Discuss concerns with parent/s. (b) Document that the handover occurred and identify the professional involved. (c) Follow up telephone referral with a facsimile or letter. (d) Seek feedback about the child's progress from the agency you made the referral to. (e) Follow up the child with routine care.


Child presents to the practice
Complete a clinical assessment
(refer page 4)
Document history
Document clinical signs
(See Appendix 1)
Abuse or neglect a possibility
(refer page 2 – note 1)
Uncertain about what to do?
(refer page 2 – note 2)
Not abuse or neglect but concern about care
(refer page 2 – note 3)
Refer to appropriate professional
(refer page 2 – note 1.1)
Discuss with appropriate professional
(refer page 2 – note 2.1)
Refer to another agency
(refer page 2 – note 3.1)
(See Appendix 4 for list)
Further management
• Treat injuries and document steps taken (notes 1.2(a) and (b))
• Discuss with parents if no risk (note 1.2(c))
• Document handover and send referral fax or letter (note 1.2(d) and 1.2(e))
• Seek feedback (note 1.2(f))
• Follow up care of child (note 1.2(g))
Further management
• Discuss with parents (note 3.2(a))
• Document handover and send referral letter or facsimile (note 3.2(b) and (c))
• Seek feedback (note 3.2(d))
• Follow up care of child (note 3.2(e))

Signs of abuse and neglect

The signs, symptoms and history described below are not diagnostic of abuse. However in certain situations, contexts and combinations they will raise the practitioner's suspicion of abuse. It is better to refer on suspicion. If you wait for proof, serious harm can occur.

History

- History inconsistent with the injury presented
- Delay in seeking help
- Past abuse or family violence
- Disclosure by the child
- Exposure to family violence, pornography, alcohol or drug abuse
- Severe social stress
- Isolation and lack of support
- Parent/s abused as child/children
- Mental illness, including post-natal depression
- Unrealistic expectations of child
- Inappropriate or inconsistent discipline (especially thrashings or any physical punishment of babies)
- Terrorising, humiliating or oppressing
- Neglecting the child
- Promoting excessive dependency in the child
- Actively avoiding seeking care or shopping around for care (frequent changes of address).

Physical signs

- Multiple injuries, especially of different ages: bruises, welts, cuts, abrasions.
- Scalds and burns, especially in unusual distributions such as glove and sock patterns
- Pregnancy
- Genital injuries
- Sexually transmitted diseases
- Unexplained failure to thrive (FTT)
- Poor hygiene
- Dehydration or malnutrition
- Fractures, especially in infants or in specific patterns
- Poisoning, especially if recurrent
- Apnoeic spells, especially if recurrent.

Behavioural and developmental signs

- Aggression
- Anxiety and regression
- Obsessions
- Overly responsible behaviour
- Frozen watchfulness
- Sexualised behaviour
- Fear
- Sadness
- Defiance
- Self-mutilation
- Suicidal thoughts/plans
- Withdrawal from family
- Substance abuse
- Overall developmental delay, especially if also FTT
- Patchy or specific delay: motor, emotional, speech and language, social, cognitive, vision and hearing.

Published in February 2001
Ministry of Health
Manatū Hauora
PO Box 5013
Wellington
New Zealand

ISBN 0-478-24314-6 (book)
ISBN 0-478-24317-0 (web)
Further copies of this docum
can be obtained from the Mir
of Health, ph 04 496 2277.
HP3419