Section 1

Guidelines

for responding to child abuse, neglect and the impact of family and domestic violence

Government of Western Australia
Department of Health
Child and Community Health

Guidelines

for responding to child abuse, neglect and the impact of family and domestic violence

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GUIDELINES FOR RESPONDING TO CHILD ABUSE, NEGLECT, AND THE IMPACT OF FAMILY AND DOMESTIC VIOLENCE

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GUIDELINES FOR RESPONDING TO CHILD ABUSE, NEGLECT, AND THE IMPACT OF FAMILY AND DOMESTIC VIOLENCE

Please note: For the purposes of these Guidelines, the terms “child” and “children” will be used to describe a person or people up to the age of 18 years.

Health Workers[1] have the responsibility to monitor the care and protection of all clients.

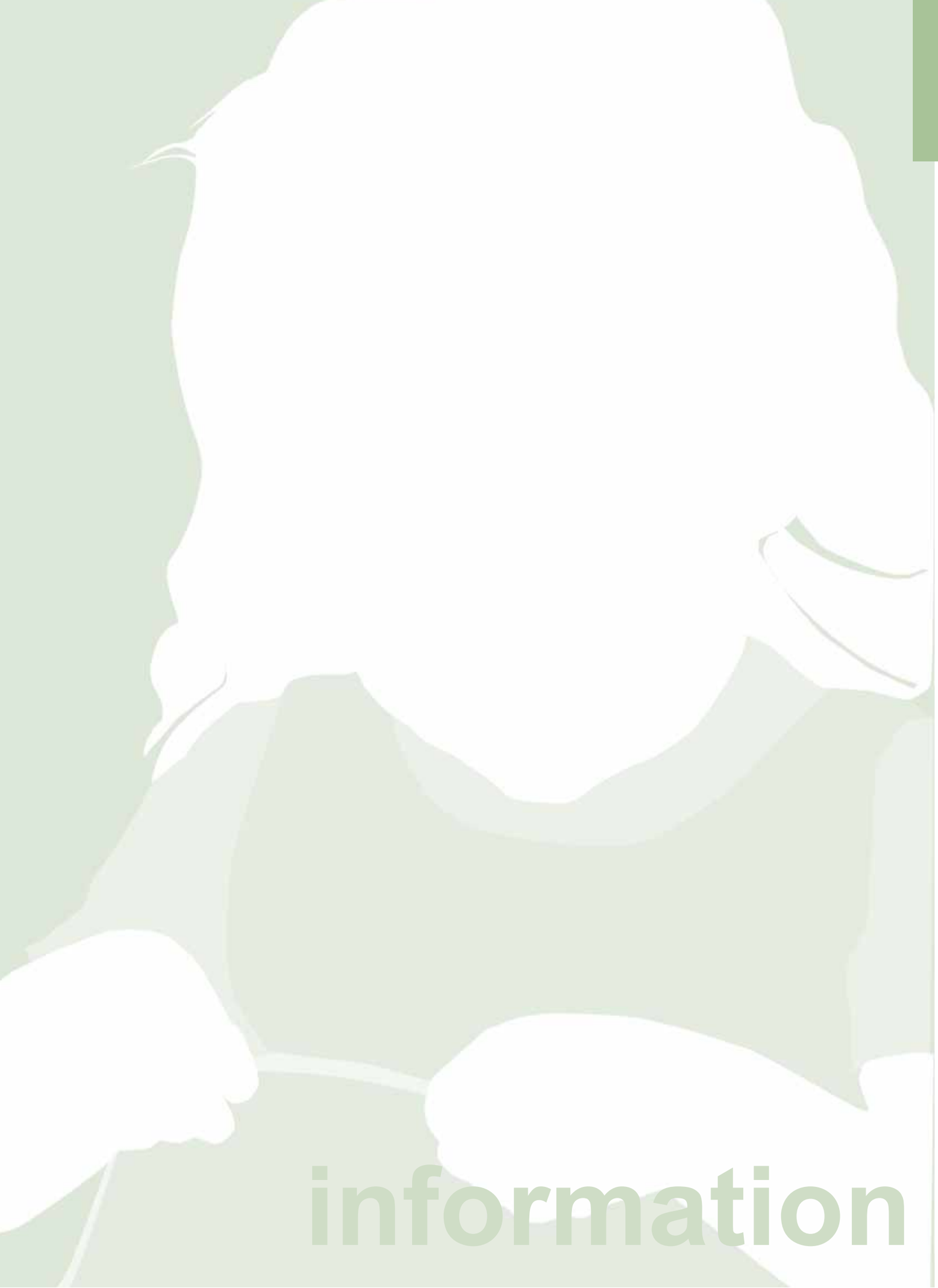
These Guidelines support the development of models of care and provision of services that conform to a State-wide standard of practice and are locally relevant and appropriate to the communities in each Area Health Service.

[1] For the purpose of these Guidelines, Health Worker/s refer to all Government of Western Australia Health employees.

What To Do – A Summary

Identification and Responses to Possible Child Abuse, Neglect, and Family and Domestic Violence

Step 1 IDENTIFY	Step 2 ASSESS, CONSULT	Step 3 NOTIFY	Step 4 MANAGE
Concerns of possible child abuse and neglect You may be concerned about a child because you have… • Observed indicators • Received a disclosure If the concerns relate to: • Any physical abuse in a child under 5 years of age • Serious physical abuse in any child • A disclosure or evidence of sexual abuse then… **GO to STEP 2 (points 1 – 8) and STEP 3** Otherwise… **GO to STEP 2**	You need to: 1. Refer/provide emergency/first aid treatment for injuries 2. Respond to the child eg. not his/her fault, happened to others, help available Respond to the parent/carers eg. be honest as appropriate, supportive, clear about Health Worker responsibilities 3. Consider any cultural or disability issues 4. Consult with an appropriate Health Worker or your Line Manager 5. Consider issues of information sharing and consent to treatment 6. Consult, if required, with other/external agencies eg. PMH Child Protection Unit (08) 9340 8646, Mental Health Services, Department for Community Development, Police Child Abuse Investigation Unit 7. Complete the assessment of the child and the circumstances 8. Document your concerns and observations If you have concerns for the child's safety... • have your notes and the child's details ready • consider the level of immediate danger to the child **GO to STEP 3** If you still have concerns but not for immediate safety issues… **GO to STEP 4**	This is an **Urgent referral** Notify the Department for Community Development (after hours, contact Crisis Care) • It is recommended to seek legal advice before referring a child to the Police Child Abuse Investigation Unit Notify the community-based interagency partnership member/coordinator* • Provide detailed information about your concerns and observations Assessment • A full assessment of the child and the circumstances, including any indications of family and domestic violence should be scheduled • An assessment may also include a physical examination at or in consultation with PMH Child Protection Unit and/or Sexual Assault Resource Centre • (After hours: refer directly to PMH Child Protection Unit and/or Sexual Assault Resource Centre) Case management planning for appropriate interventions is undertaken. These plans should be linked to community-based interagency partnerships via the member/coordinator * Protocols for community-based interagency partnerships will be separate to these Guidelines. Also see pages 53–54.	**Less** Urgent, but may result in notification to Department for Community Development You need to: • Notify or refer to your community-based interagency partnership member* The member will liaise with Health Workers involved with the clients Intervention options may include: • Case Management Meetings • Ongoing monitoring and support • Further assessment to clarify current concerns, to obtain other information about exposure to abuse, neglect, family/domestic violence issues. Assessment may also include a physical examination • Provide intervention as appropriate to your agency/profession • Referral to another agency At any point of intervention, if you still have concerns such as: • Ongoing indicators of abuse, neglect, family and domestic violence • Escalation of concerns about abuse, neglect, family and domestic violence • Multiple risk factors **GO to STEP 3**



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FACTS ABOUT CHILD ABUSE AND NEGLECT, FAMILY AND DOMESTIC VIOLENCE

- In 2002-03, there were 2,293 notifications for possible child abuse and neglect made to relevant authorities in Western Australia. In 2003-04, 2,417 notifications were made. Of these notifications, 48 percent were substantiated at rates of 1.9 per 1,000 children aged 0-16 years in 2002-03 and 2.0 per 1,000 children aged 0-16 years in 2003-04

  Numbers of notifications were slightly lower compared with the previous three years however this difference was associated with organisational and practice changes in the Department for Community Development.

  Child abuse and neglect is often unreported and/or undetected and therefore, these statistics are an underestimate of child abuse and neglect in the community. The true incidence and the prevalence of child abuse and neglect are unknown.

- Of substantiated notifications of abuse or neglect in 2003-04, 33 percent were for neglect, 29 percent for physical abuse, 24 percent for sexual abuse and 14 percent for emotional abuse. Many children experienced more than one type of abuse or neglect in combination

- Younger children have higher rates of substantiated abuse and neglect. In 2003-04, there was one substantiated notification for every 200 children aged under 1 year of age in Western Australia, a rate of 5.0 per 1,000 children. For older children, these rates were 2.2 per 1,000 children aged 1-4 years, 2.1 per 1,000 children aged 5-9 years and 1.8 per 1,000 children aged 10-14 years. By the age of 15-16 years, 0.8 per 1,000 children had a substantiated notification

- In 2003-04, Aboriginal children were 8 times more likely to have experienced substantiated child abuse and neglect, 8.3 times more likely to be on care and protection orders and 9 times more likely to be living in out-of-home care because of abuse and/or neglect than other children in Western Australia

- Abuse of children with disabilities is far more frequent than for other children. Deaf children and those who have severe physical disability are identified as being at particular risk. Children with chronic conditions such as asthma are at higher risk of abuse

- In most cases, the perpetrator has some relationship with the child, such as a parent or other relative, or was known to the child, such as a family friend. Stranger abuse is far less prevalent than popularly believed

- Three-quarters of parents of children with substantiated child abuse and neglect have complex needs with a range of problems and stresses. These may include low socioeconomic status, residential instability, crowded dwellings, domestic violence, alcohol and substance abuse and psychiatric disability

- Children who are abused and/or neglected in their early years of life are at increased risk of a range of adverse long-term developmental outcomes compared to non-abused children. As adolescents, abused children have more drug and alcohol problems, behaviour problems, mental health disorders, and lower academic achievement than non-abused children

- There is an overlap between family and domestic violence and child abuse and neglect. In families where violence is occurring, over half of the children also experience child abuse or neglect

- Research has shown that children and even babies from a few weeks of age show signs that they are being adversely affected by family and domestic violence in the home even though the baby or child has not experienced any direct violence

- Children who witness family and domestic violence develop more behavioural and emotional problems than other children without this situation

- Up to one quarter of children in Australia have witnessed an incident of domestic violence against their mother or stepmother

- Children may also be victims of family and domestic violence and are at higher risk of being a victim or perpetrator in their future relationships

PRINCIPLES AND VALUES

The following principles and values underlie the "Guidelines for Responding to CHILD Abuse and Neglect and the Impact of Family and Domestic Violence"

- The wellbeing, care and protection and rights of children are paramount when making decisions about child protection, abuse and neglect. This is consistent with the United Nations Convention on the Rights of the Child, internationally accepted practice in child protection, abuse and neglect and the *Children and Community Services Act 2004*
- The Department of Health and all Health Workers are to take an active approach in their response to concerns about the care and protection of children
- **A child's best interests must come first where there is a risk of child abuse and neglect. The best interests of the child are paramount**

In determining the best interest of a child consider the following

a) the need to protect the child from harm
b) the parents capacity to protect the child from harm and provide for the child's needs
c) the significant relationships in the child's life and the need for the child to maintain this contact
d) parental attitude and demonstrated responsibility for the child
e) any wishes or views expressed by the child within the context of age and maturity
f) the importance of continuity and stability in living arrangements
g) the child's age, maturity, sex, sexuality, background, language and cultural, ethnic or religious identity
h) the child's physical, emotional, intellectual, spiritual, developmental and educational needs
i) the likely effect of any change in the child's circumstances.

- A child is always considered within the context of their family, culture and community
- The Department of Health believes that a child is in need of protection if

a) A child has suffered or is likely to suffer harm as a result of physical abuse, sexual abuse, emotional abuse, psychological abuse and/or neglect
b) A child's parents are unable to provide or arrange for adequate care and/or the provision of effective medical or other remedial treatment for the child
c) A child has been abandoned by his or her parents or the child's parents are dead or incapacitated and no suitable adult relative or other person can be found who is willing and able to care for the child

d) A child is living in a household where there are incidents of family and domestic violence

- The Department of Health understands that child abuse and neglect is inextricably linked to family and domestic violence. Whilst the emphasis of these Guidelines is on the safety and care of the child, the safety and wellbeing of parent/carers is also a priority
- The Department of Health is committed to working in partnership with Aboriginal communities to protect Aboriginal children. This includes strengthening families by providing services that are holistic, culturally appropriate and community focussed
- The Department of Health acknowledges the individual needs of culturally and linguistically diverse communities and the need for culturally appropriate intervention and management of services
- Children and their families have a right to be informed about any intervention and be provided with an opportunity to express and/or take control of their wishes

DEFINITIONS

Child

Any male or female under the age of 18 years and in the absence of positive evidence as to age, any male or female apparently under the age of 18 years.

Child Abuse

Physical, sexual or psychological/emotional abuse or neglect of a child by any person.

Physical Abuse

Includes acts of violence that may result in pain, injury, impairment or disease. This may include shaking, hitting, choking or in any way assaulting another person. There may be visible evidence of physical abuse (bruising, fractures, burns and lacerations etc) or few readily apparent physical signs. The differences between accidental injury and physical abuse may be slight and require expert investigation to differentiate.

Sexual Abuse

Sexual abuse is any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards. The child is unable to provide informed consent to and is not developmentally prepared for sexual activity.

Child sexual abuse is the involvement of a child in sexual activity of any form. It may involve activities ranging from exposing the child to sexually explicit materials or behaviours, taking visual images of the child for pornographic purposes, touching, fondling and/or masturbation of the child, having the child touch, fondle or masturbate the abuser, oral sex performed by the child, or on the child by the abuser, and anal or vaginal penetration of the child.

Child sexual abuse is further classified as sexual exploitation, which involves touching the child and/or compelling the child to observe, or be involved in exploitation, which involves touching the child and/or compelling the child to observe, or be involved in other sexual activity (for example, watching pornographic videos), prostitution, sexual assault, molestation, victimisation and child rape.

Emotional/Psychological Abuse

Includes any behaviour and attitude that causes anguish or fear. This includes intimidation, harassment, damage to property, threats of physical or sexual abuse and in relation to a child, exposing the child to the physical, psychological and/or sexual abuse of another person, and concerted attacks on an individual's self-esteem and social competence.

Neglect

Occurs when a person fails to perform behaviour that is a reasonable obligation of their relationship to the child. This includes failure to adequately provide for the physical, cognitive, emotional, developmental, material or social needs of the child. It also includes inadequate supervision when the child's behaviour is, or is likely to be harmful to the physical, cognitive, emotional, social or psychological wellbeing of the child or others. It also encompasses the lack of opportunity for the child to form a psychological attachment to others.

A child is neglected if the parents are unable to provide or arrange for adequate care and/or the provision of effective medical or other remedial treatment for the child. A child is neglected if the parents are dead or incapacitated of if the parent abandons the child and no suitable adult relative or other person can be found who is willing and able to care for the child.

Neglect includes situations where parent/carers are unwilling or unable to acknowledge that a child is at risk but can only be determined after a parent/carer has been provided with explicit and culturally appropriate information about the child abuse and/or neglect concerns.

Harm

Harm in relation to a child means any detrimental effect of a significant nature on the child's wellbeing including harm to the child's physical, emotional or psychological development.

Family and Domestic Violence

Family and domestic violence and intimate partner abuse can be defined as any form of abuse of power within intimate relationships or relationships of trust and/or dependency which causes the victims, most often women, to live in fear of an abuser or abusers. It includes an adult or child, related or unrelated carer, a heterosexual or same sex relationship. The violence can include physical or sexual assault, psychological abuse, emotional, spiritual or cultural abuse, social isolation and neglect.

Family violence is most often used to describe violence occurring in the full range of family and/or caring relationships. For many indigenous people the term "family violence" is preferred as it encompasses all forms of violence in intimate, family and other relationships of mutual obligation and support.

Female Genital Mutilation

- The excision or mutilation of the whole or a part of the clitoris, the labia minora, the labia majora, or any other part of the female genital organs
- Infibulation or any procedure that involves sealing or suturing together of the labia minora or the labia majora
- Any procedure to narrow or close the vaginal opening

Institutional Abuse

Occurs when a facility employs an unjustified and/or inappropriate method of intervention that results in harm or risk of harm to the child. Institutional abuse includes physical, sexual and emotional abuse of a child by an employee, volunteer or student.

Institutional Neglect

Occurs when an institution fails to provide for the developmental and psychosocial needs of a child. It includes such things as failure to provide an age appropriate explanation to a child of anticipated procedures, failure to consider a child or child's needs within the context of their family and culture, failure to provide services that are accessible to the child and family.

Notification

Notification is a contact made to the Department for Community Development by persons or other bodies making allegations of child abuse and neglect or harm to a child.

Investigation

Investigation is the process whereby the Department for Community Development obtains more detailed information about the child who is the subject of a notification and makes an assessment of the degree of harm or risk of harm for the child. After an investigation is completed, a notification will either be 'substantiated' or 'not substantiated'.

Substantiation

Substantiation is a notification where it is concluded after investigation that a child has been, is being or is likely to be abused or neglected or otherwise harmed.

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What To Do – A Summary

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Concerns of possible child abuse and neglect You may be concerned about a child because you have… • Observed indicators • Received a disclosure If the concerns relate to: • Any physical abuse in a child under 5 years of age • Serious physical abuse in any child • A disclosure or evidence of sexual abuse then… **GO to STEP 2 (points 1 – 8) and STEP 3** Otherwise… **GO to STEP 2**	You need to: 1. Refer/provide emergency/first aid treatment for injuries 2. Respond to the child eg. not his/her fault, happened to others, help available Respond to the parent/carers eg. be honest as appropriate, supportive, clear about Health Worker responsibilities 3. Consider any cultural or disability issues 4. Consult with an appropriate Health Worker or your Line Manager 5. Consider issues of information sharing and consent to treatment 6. Consult, if required, with other/external agencies eg. PMH Child Protection Unit (08) 9340 8646, Mental Health Services, Department for Community Development, Police Child Abuse Investigation Unit 7. Complete the assessment of the child and the circumstances 8. Document your concerns and observations If you have concerns for the child's safety... • have your notes and the child's details ready • consider the level of immediate danger to the child **GO to STEP 3** If you still have concerns but not for immediate safety issues… **GO to STEP 4**	This is an **Urgent referral** Notify the Department for Community Development (after hours, contact Crisis Care) • It is recommended to seek legal advice before referring a child to the Police Child Abuse Investigation Unit Notify the community-based interagency partnership member/coordinator* • Provide detailed information about your concerns and observations Assessment • A full assessment of the child and the circumstances, including any indications of family and domestic violence should be scheduled • An assessment may also include a physical examination at or in consultation with PMH Child Protection Unit and/or Sexual Assault Resource Centre • (After hours: refer directly to PMH Child Protection Unit and/or Sexual Assault Resource Centre) Case management planning for appropriate interventions is undertaken. These plans should be linked to community-based interagency partnerships via the member/coordinator * Protocols for community-based interagency partnerships will be separate to these Guidelines. Also see pages 53–54.	**Less** Urgent, but may result in notification to Department for Community Development You need to: • Notify or refer to your community-based interagency partnership member* The member will liaise with Health Workers involved with the clients Intervention options may include: • Case Management Meetings • Ongoing monitoring and support • Further assessment to clarify current concerns, to obtain other information about exposure to abuse, neglect, family/domestic violence issues. Assessment may also include a physical examination • Provide intervention as appropriate to your agency/profession • Referral to another agency At any point of intervention, if you still have concerns such as: • Ongoing indicators of abuse, neglect, family and domestic violence • Escalation of concerns about abuse, neglect, family and domestic violence • Multiple risk factors **GO to STEP 3**

WHAT TO DO – A SUMMARY

Step 1 – IDENTIFY

Concerns of Possible Child Abuse and Neglect

Health Workers have a responsibility to monitor the care and protection of all clients. This is particularly important when parents report certain child behaviours such as crying, sleeping and feeding difficulties of their young children. Concerns may be raised in relation to 'naughty behaviour' and injuries and when children are being assessed or treated for developmental issues, physical injuries and chronic conditions such as asthma or depression.

Abuse of babies and young children up to age 5 years, particularly infants (under 1 year of age), can be difficult to recognise because symptoms are often non-specific and there are commonly no obvious external signs of injury.

There are many indicators of child abuse and neglect. One indicator in isolation may not necessarily indicate abuse, neglect and exposure to family and domestic violence however the Health Worker must be alert to the possibility of child abuse and neglect.

The following should alert and raise possible concerns for Health Workers about child abuse or neglect and/or exposure to family or domestic violence.

1. Concerns about the presenting history

- No initial history of trauma given by the carer/s although trauma injury is suspected/obvious
- History of injury which is inconsistent with the physical findings
- History and mechanism of injury or reason for presentation is not consistent with developmental age
- Initial history and mechanism of injury or reason for presentation is changed by the carer/s
- History of injury which is vague or unclear
- Marked delay between injury and presentation for medical assistance

2. The child or someone else mentions/talks about abuse

- Someone else, such as a relative, friend, acquaintance, or sibling of the child, tells you that the child may have been abused
- The child gives some indication that the injury or event did not occur as stated
- The child tells you she/he knows someone who has been abused, she/he may be referring to herself/himself

3. The child discloses abuse

- The child tells you she/he has been abused

4. Concerns because of high risk factors

- Children who have a high number of risk factors are at higher risk of abuse as this cumulation of factors often impacts on parenting as the parent/s are preoccupied by their own stressful issues
- Family breakdown and stressful circumstances often accompany poverty, domestic violence and where the parent/s have mental health issues and/or substance misuse
- Children who have disabilities, chronic health issues, low intellectual capacity, children in care and young people in contact with the police or justice system are more likely to experience abuse and neglect

5. Adult issues that raise concerns for the child

- Adult disclosure of current family/domestic violence
- Adult perceives lack of social support
- Parent has a history of childhood and/or adult abuse
- Parent is insecurely housed, especially for younger parents
- Recent family/domestic violence was associated with the parent having mental disorder and/or substance misuse

There are specific physical, behavioural and parental indicators of abuse and neglect. See pages 23 to 29 for further information on physical abuse, emotional abuse, sexual abuse and neglect.

If any concerns, risk factors or indicators of abuse are possible, the Health Worker will need to ask questions of the parent/s and the child in an appropriate way. Examples of these questions can be found on pages 31 and 32.

<u>If the Concerns Relate to</u>

- **any physical abuse in a child under 5 years of age**
- **serious physical abuse in any child**
- **a disclosure or evidence of sexual abuse**

you will need to assess and consult (Step 2) and then notify the appropriate agency (Step 3).

See pages 31 to 39 for information about communicating with clients.

Step 2 – ASSESS and CONSULT

1. Refer/Provide Emergency/First Aid Treatment for Injuries

Health Workers should perform a brief physical examination to assess the need for emergency/first aid treatment and clinical observation.

Injury in babies and young children up to age 5 years, particularly infants, can be difficult to recognise because symptoms are non-specific and there are commonly no obvious external signs of injury.

2. Respond to the Child and Parent/Carers

- Broach the topic sensitively and be non-judgemental
- Help the parent/carer feel supported, able to share any concerns they have with you
- Keep the parent/carers informed at all stages of the process
- Where options exist, support the parent/carers to make their own decisions
- Tell the child that no-one deserves to be hurt and that it was not their fault
- Tell the child that this has happened to other children
- At the very least, immediately provide information on family and domestic violence services available in the area and the means to contact the service

See pages 33 to 36 for further information.

3. Consider any Cultural or Disability Issues

Before you ask any questions ensure that you have identified any cultural and disability issues that may impact on your contact with and service to the child and their family.

Specific guidelines are provided for communicating with Aboriginal children, people from culturally and linguistically diverse backgrounds and people with disabilities.

See pages 36 to 38 for further information.

4. Consult with an Appropriate Health Worker or Your Line Manager

A Health Worker must immediately consult with an appropriate staff member who has child abuse and neglect expertise, such as a social worker, medical officer, paediatrician or your line manager.

Further assistance may be needed from the other Health Services such as the PMH Child Protection Unit at Princess Margaret Hospital for Children (08) 9340 8646, Sexual Assault Resource Centre services and Mental Health Services.

The expertise of Aboriginal Health Workers and interpreters may be required.

See pages 41 for further information.

5. Consider Issues of Information Sharing and Consent to Treatment

Confidentiality and information-sharing is guided by the current law in Western Australia.

All aspects of consent to treatment or intervention must be fully considered. Children may be detained in a hospital as provided for in the *Child Welfare Act*.

If you are unsure about issues in relation to confidentiality and consent you are advised to obtain legal advice after discussion with your senior manager.

A legal information section is contained at the back of these Guidelines and should be read in conjuction with these issues in the Guidelines.

6. Consult, if Required, with External Agencies

Prior to notification and referral, the Health Worker may need to access emergency consultation with relevant agencies such as the Department for Community Development and the Police Child Abuse Investigation Unit.

See Page 42 for further information.

7. Complete the Assessment of the Child and the Circumstances

Assessment questions gather information about the child's circumstances. This information includes the family (eg. family and domestic violence, risk factors), the nature and extent of the current possible abuse and neglect, the nature of support for the child, his/her level of safety, and overall health and wellbeing.

See pages 43 to 45 for further information.

8. Document Your Concerns and Observations

Client records must be accurate and objective and contain a statement of all the facts. Documentation also includes drawings of injury sites (See Body Maps in the Appendix, pages 62 - 65) and medical photographs if possible.

See pages 51 to 52 for further information.

Consider the level of immediate danger for the child.

The safety of the child is paramount. If you consider the child is in immediate danger, you must go to Step 3 and make a notification.

If you continue to have concerns but not for immediate safety issues, then go to STEP 4.

Step 3 – NOTIFY

Notifications should be made to the Department for Community Development. Seek legal advice before making referrals to the Police Child Abuse Investigation Unit. In addition, you should also refer to your Health Service member or the coordinator of your community-based interagency partnership.

Provide detailed information about the concerns and observations.

Urgent Referrals

If any of the following is present,

- **Indicators of any physical abuse in a child under 5 years, especially if under 1 year of age**
- **Indicators of serious physical abuse in any age child**
- **Disclosure or evidence of sexual abuse**

you must on the same day as the concerns are detected, notify the child to the Department for Community Development. It is recommended that legal advice be sought prior to referring a child to the Police Child Abuse Investigation Unit.

In addition, you should also refer to your Health Service member or the coordinator of your community-based interagency partnership.

Please note: It may not always be in the child's best interests and/or the safety of the Health Worker to inform parent/carers that a referral has been made to the Department for Community Development especially when any the following circumstances exist:

a) It will place the child, the Health Worker or parent/carers in danger

b) If the family may seek to avoid Department for Community Development or Police staff or avoid further contact with Health Services.

PMH Child Protection Unit, the Department for Community Development and the Police Department coordinate investigation and management of physical abuse and neglect cases where there are serious injury, concerns about sexual abuse and significant risk of harm.

Less Urgent Referrals

If any of the following are present:

- Indicators of physical abuse, emotional abuse or neglect
- Multiple risk factors present
- Escalation of abuse/neglect
- Indicators of family violence

you should refer to the community-based interagency partnership member/ coordinator for discussion, clarification and appropriate management.

In addition, a notification for child protection should be made to the Department for Community Development.

See pages 53 to 56 for further information.

Assessment

A full assessment of the circumstances should be scheduled.

See pages 43 to 45 for further information.

Physical Examination

The child may also need a physical examination. It is very important that physical examination is discussed prior to assessment. Where there are concerns about sexual abuse, you should contact PMH Child Protection Unit – (08) 9340 8646 or a Sexual Assault Resource Centre.

See pages 46 to 50 for further information.

Case Management Planning that is Linked to Interagency Services

There are many models of intervention and the choice of intervention will depend on the needs of each child and family. These needs are often complex and therefore it is important that individual Health Workers do not work in isolation.

Step 4 – MANAGE

Less Urgent Referrals

Children who do not have immediate safety needs will require further support and referral to other services.

You should refer to the community-based interagency partnership member/ coordinator for discussion, clarification and appropriate management and liaise with other health workers involved with clients.

Health Services need to participate in interagency partnerships and appoint Health members to these partnerships.

Interagency partnerships provide an organisational framework model to support and encourage the development of networks required to undertake healthy, safe and balanced child protection.

Community-based interagency partnerships[2] ensure that services and organisations work together to support families in their communities where possible and to protect children when necessary in a coordinated, efficient and proactive manner.

[2] Services will need to participate in interagency partnerships in their Health region.

Intervention Options

There are a number of options including case management and ongoing monitoring and support. Further assessment is usually required on a longer term basis to monitor the child and identify any current concerns for the child's safety and wellbeing and exposure to family/domestic violence. It may be necessary to schedule a physical assessment.

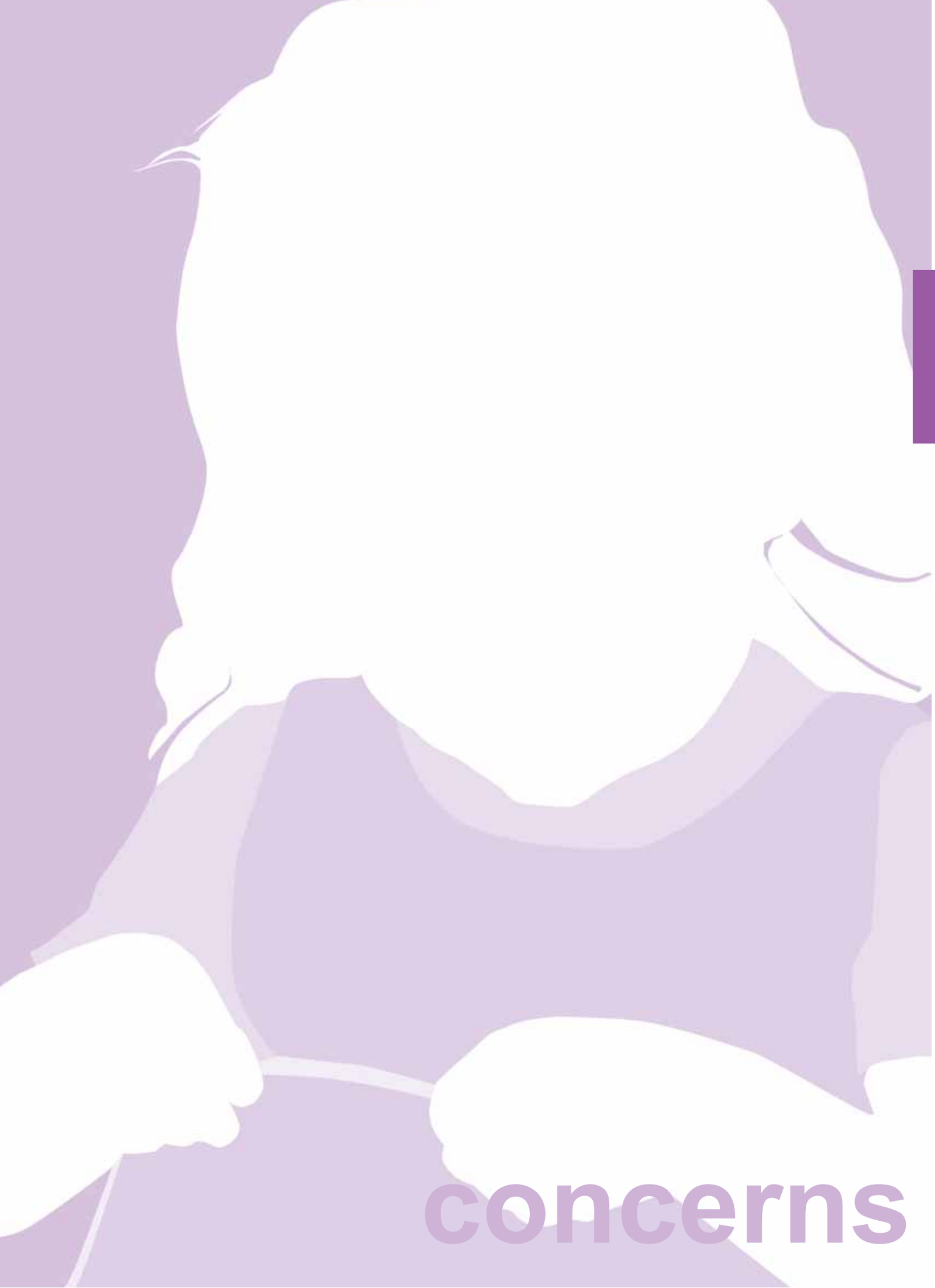
See pages 57 to 58 for further information.

Making a Notification

At any point of intervention, go to Step 3 and make a notification for child protection to the Department for Community Development if there are:

- **concerns about abuse, neglect and family/domestic violence**
- **ongoing indicators of abuse, neglect and family violence**
- **an escalation of concerns or**
- **increased level of need such as ongoing multiple risk factors and stress in the family**

See pages 55 to 56 for further information.



concerns

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Identify Injuries and Refer for Emergency/First Aid Treatment

Health Workers should perform a brief physical examination to assess the need for emergency/first aid treatment and clinical observation.

Injury in babies and young children up to age 5 years, particularly infants (under 1 year of age), can be difficult to recognise because symptoms are often non-specific and there are commonly no obvious external signs of injury.

In a hospital emergency/acute care setting, nursing staff usually perform a brief physical examination to aid referral to the medical practitioner and to assess the need for emergency/first aid treatment.

If a severe injury has occurred or is suspected (eg. requiring inpatient care), immediate consultation with the PMH Child Protection Unit is recommended – (08) 9340 8646. When a medical practitioner is not readily available, nursing staff will need to perform a physical examination and to document the clinical findings. It is essential that there is consultation with the PMH Child Protection Unit in these instances.

Advice may be required through consultation with specialist mental health services, particularly where mental health concerns are identified in a non-mental health setting.

For children with immediate safety issues, a full assessment of the child and the circumstances, including any indications of family and domestic violence, should be scheduled following notification to the Department for Community Development and referral to the Police Child Abuse Investigation Unit.

For these children, the assessment will usually include a physical examination. Liaison with PMH Child Protection Unit and/or the Sexual Assault Resource Centre should occur prior to this assessment to determine who should perform the assessment and the physical examination.

Indicators of Abuse, Neglect, Exposure to Family and Domestic Violence

There are many indicators of child abuse and neglect. The following information is only a guide to assist Health Workers in recognising possible child abuse, neglect and exposure to family and domestic violence situations.

One indicator in isolation may not necessarily indicate abuse, neglect and exposure to family and domestic violence and the information cannot be considered to be a comprehensive list of harm, behaviours or presentations that give rise to concerns. Each indicator needs to be considered in the context of the child's personal circumstances.

Identify and document your initial concerns, then look through the other indicator segments to ensure you have an overview of all your concerns.

General Indicators of Child Abuse or Neglect

- No initial history of trauma given by the carer/s although trauma injury is suspected/obvious
- History of injury which is inconsistent with the physical findings, such as, suspected head trauma/significant trauma with a history of a low impact fall
- History and mechanism of injury/reason for presentation is not consistent with developmental age, such as, the infant who is reported to have fallen prior to being able to pull up to standing
- The initial history and mechanism of injury/reason for presentation is changed by the carer/s
- History of injury which is vague or unclear
- Someone else, such as a relative, friend, acquaintance, or sibling of the child, tells you that the child may have been abused
- The child gives some indication that the injury or event did not occur as stated
- The child tells you she/he has been abused
- When the child tells you she/he knows someone who has been abused, she/he may be referring to herself/himself
- Marked delay between injury and presentation for medical assistance

General Indicators of Family and Domestic Violence

- Adult disclosure of current family/domestic violence
- Adult perceives lack of social support
- Parent has a history of childhood and/or adult abuse
- Parent is insecurely housed, especially for younger parents
- Recent family/domestic violence was associated with the parent having mental disorder and/or substance misuse

Processes of Family and Domestic Violence that Impact on Children

- Being denied a safe and supportive environment in which to grow and develop
- Witnessing their parent being abused
- Hearing and seeing ongoing verbal and/or emotional abuse and degradation and isolation of the parent
- Being physically, verbally or emotionally abused when they attempt to stop the parent being assaulted

- Being denied extended family, peer and broader social supports and connections as a result of the social isolation imposed by the perpetrator
- Being denied the emotional resources of the parent required for the child's emotional, social and physical development and wellbeing
- Feeling responsible for the violence or blaming siblings or the parent
- Having to assume a parental role over younger siblings if the parent is rendered physically incapable or emotionally unavailable, or to protect them from harm during explosive outbursts
- Being pressured to maintain the family secret
- Being subjected to death threats against either themselves or the parent

High Risk Factors Associated with Child Abuse and Neglect

Child Characteristics that May Predispose Them to Be at Risk

- Congenital abnormality or physical disability
- Developmental disability (includes intellectual disability, language impairment, autism, developmental delay)
- Infants with a history of prematurity or neonatal intensive care
- Foster child, adopted child or step-child
- Difficult or demanding temperament
- Unresponsive, rigid or non-cuddly
- Irritability or excessive crying
- Exhibits challenging behaviour
- Recurrent illness or high medical needs

Parent/Carer's Perceptions of the Child that May Predispose the Children to Be at Risk

- "Bad", "naughty" or manipulative
- "Difficult" and unrewarding to care for
- Unloving or rejecting of the parents
- Resembling a disliked person in appearance, behaviour or temperament
- A rival for attention or affection that parents themselves desire

Family/Parental Characteristics

- Domestic violence/partner abuse is present
- Family isolation
- Multiple family stresses (eg. financial, housing, employment)
- Parent engages in substance use/ misuse, including risky and high risk alcohol use
- Parent has a mental health problem or intellectual disability AND is not receiving adequate treatment/support
- Parent suffered abuse or neglect as a child
- History of previous abuse towards this or another child in the family

- Parent with a history of criminal offences
- A parenting style which is harsh and punitive
- Parent has rigid or unrealistic expectations of the child

Please note: Children of parents with mental illness may be vulnerable to a variety of problems which may include poverty, isolation, fear of support services, separation anxiety, family disruption, family and domestic violence, disruption to education and school difficulties, lack of structure in the home, general developmental delay, negative unresolved emotions, illness related issues and increased child protection issues.

Children of parents with a mental illness and/or substance use/misuse are at increased risk of abuse or neglect. It is also necessary to address the needs of the parents in these cases.

Specific Indicators of Child Physical, Emotional and Sexual Abuse, Neglect

Physical Abuse

Physical Indicators

Physical signs of inflicted injury undeniably due to abuse/assault

- Human bite marks
- Specific contact burns (eg. cigarette burns)
- Bruises or welts in the pattern/shape of an implement (eg. buckle mark)
- Bald patches consistent with hair having been pulled out
- Bruise marks in the pattern of a hand due to slapping

Physical signs of inflicted injury which make abuse very likely

- Posterior rib fractures
- Metaphyseal long bone fractures
- Bruising of the pinna (external ear)
- Immersion scalds, especially perineum/buttocks
- Retinal haemorrhages in an infant more than 2 weeks old. These are very likely due to shaken baby syndrome however, a few haemorrhages may still be present up to 6 weeks after the birth or slightly longer in extraordinary cases

Physical Signs of Injury Which Raise the Possibility of Abuse but Which are Not Conclusive

Infants (< 12 months)

- Bruises. Please note that bruises are never trivial in an infant who has not yet achieved crawling. Infants under 6 months, who have a bruise of any size, need further medical assessment for covert injuries related to physical abuse
- Bruises or welts on body areas not usually involved in accidental injury (eg. face, stomach, back, arms, inner thighs, feet, hands, genitals)
- Burns and scalds
- Fractures, especially multiple fractures or several fractures in different stages of healing
- Skull haematoma – after the newborn period
- Cuts or bleeding especially from the mouth, lips, gums, eyes, ears or genitalia
- Internal injuries – signs and symptoms of shock including pallor, cool sweaty skin, listlessness, unresponsiveness
- Limb swelling and lack of movement
- Loss of consciousness, seizures or respiratory arrest
- Vomiting, altered conscious state

Children

- Bruises or welts on body areas not usually involved in accidental injury (eg. face, stomach, back, arms, inner thighs, genitals)
- Burns and scalds
- Fractures – suspect abuse if explanation of event causing injury is either inadequate or inconsistent
- Cuts and abrasions in body areas not usually involved in accidental injury
- Multiple bruises/injuries or recurrent bruising/injury

Behavioural Indicators

- Disclosure that an injury was inflicted by someone else
- Lack of adequate explanation of how the injury occurred
- Signs of anxiety/fear or avoidant behaviour
- Reluctance to go to carer or to go home from school
- Regressive behaviour, such as bedwetting or soiling
- Poor sleeping patterns, nightmares
- Emotional symptoms (eg. sadness, withdrawn behaviour, suicidal feelings)
- "Acting out" behaviour (eg. aggressive, disruptive, destructive behaviour)
- Poor school performance or decline in school performance
- Wearing clothes unsuitable for the weather/activity or reluctance to undress for medical examination

Indicators in Parent/Carers

- Direct admission by carer that they inflicted the injury
- Admission by carer of fear they may injure the child
- Repeated presentations of the child to health or other services with injuries, ingestions or minor complaints
- Repeated absence of the child from school without explanations (eg. parent/carers may be keeping the child at home until signs of injury have resolved)
- Parent/carer is a victim of partner abuse
- Parent/carer admits to use of physical discipline to control child's behaviour
- The account of the injury event is inconsistent with the appearance of the injuries
- The age of the injuries is inconsistent with the account (eg. delay in presentation)
- Unusual lack of parental/carer concern at the severity or extent of the injuries
- Presentation at a time of family stress (eg. recent parental separation, loss of employment)
- Parent engages in substance use/misuse, including risky and high risk alcohol use

Emotional Abuse

Physical Indicators

- Speech and language disorders
- Developmental delay
- Failure to thrive/poor growth

Behavioural Indicators

- Anxiety
- Aggressive, destructive or attention-seeking behaviour
- Overly compliant, passive and undemanding behaviour
- Withdrawn behaviour/poor social interaction
- Poor self-esteem
- Somatic symptoms (eg. headaches, stomach aches, vague complaints)
- Depression, suicidal thoughts
- Overeating or refusal to eat
- Running away
- Drawings or writing expressing emotional disturbance
- Age-inappropriate behaviours (eg. overly adult behaviour [parenting other children]) or infantile behaviour (eg. thumb-sucking, rocking, wetting)

Indicators in Parent/Carers

- Frequent criticism or teasing of a child
- Excessive or unreasonable demands
- Ignoring or withholding praise and affection
- Verbal abuse, rejection and scapegoating
- Use of inappropriate physical or social isolation as punishment
- Victim/perpetrator of family violence witnessed by child

Sexual Abuse

Physical Indicators

- Injury to the genital or rectal area, such as bruising or bleeding
- Vaginal discharge
- Inflammation of the genital area
- Sexually transmissible infection
- Discomfort in urinating or defecating
- Bruising and other injury to breasts, buttocks, thighs and lower abdomen
- Recurrent urinary tract infection
- Presence of foreign bodies in vagina and/or rectum
- Pregnancy

Behavioural Indicators

- Direct or indirect disclosures
- Age-inappropriate sexual behaviour (eg. excessive masturbation, rubbing genitals against others, touching others in the genital area, playing games which act out a sexually abusive event)
- Talking about sexual activity in explicit terms not appropriate to developmental level
- Wearing of provocative clothing, excessive flirting or promiscuity
- Poor hygiene, grooming
- Poor or deteriorating relationships with others
- Poor school performance or decline in school performance
- Reluctance to participate in physical or recreational activities
- Regression in behaviour (eg. bedwetting, speech loss)
- Frequent rocking, sucking or biting
- Symptoms of emotional disturbance (eg. anxiety, fearfulness, sadness/ depression)
- Delinquent or aggressive behaviour
- Truancy or running away from home
- Self-injurious behaviour including attempted suicide, drug/alcohol abuse
- Somatic complaints (eg. recurrent abdominal pain, headaches, feeling sick)
- Arriving at school early and leaving late
- Going to bed fully clothed or reluctance to undress for usual activity
- Difficulties in toileting
- Talking about having a special operation associated with celebrations
- Reluctance to be involved in sport or other physical activities when previously interested

Indicators in Parent/Carers, Relatives and Others

- Person who is a known or suspected perpetrator of child sexual abuse has contact with the child
- Coercing child to engage in sexual behaviour with other children
- Verbal threats of sexual abuse
- Exposing child to prostitution or child pornography or using child in pornography
- Intentional exposure of the child to sexual behaviour of others
- Putting unreasonable restrictions on child going out, seeing friends
- Denial of adolescent's pregnancy by family
- Partner abuse
- Cultivation of friendship with the child by an adult in a secretive way or without parent/carer supervision (eg. spending time alone with the child, frequent gift-giving)
- Parent engages in substance use/misuse, including risky and high risk alcohol use

Neglect

Neglect includes all instances where a person has failed to take adequate precautions to ensure the child's safety and provide food, clothing and shelter for the child. In cases where neglect has resulted in physical injury, emotional harm or health impairment, it should be considered as abuse.

Physical Indicators

- Frequently dirty or in dirty clothes
- Poor hygiene (eg. lack of regular nappy changes)
- Failure to thrive
- Frequently hungry, tired or listless
- Inadequate clothing for weather conditions
- Major injury (including burns, poisoning) which could have been prevented by basic parental supervision or that occurred while the carer was impaired by alcohol or substance use
- Three or more minor injuries or illnesses that could have been prevented by basic parental supervision or that occurred while the carer was impaired by alcohol/substance use

Behavioural Indicators

- Begging, stealing, hoarding or gorging food
- Poor socialisation, withdrawn
- Poor attachment, little positive interaction with carer
- Lack of stranger anxiety or indiscriminate with affection
- Self-comforting behaviour (eg. rocking, thumbsucking)
- Aggressive behaviour
- Delinquent behaviour including vandalism, substance abuse
- Poor or irregular school attendance
- Anxiety (eg. about being abandoned)
- Appearing miserable or irritable

Indicators in Parent/Carers

- Delay in seeking treatment for an injury or illness without adequate explanation for the delay
- Abandonment of a child for one hour or more at health care site without adequate explanation
- Failure to collect child from school or daycare without explanation
- Frequent demands for respite from the child
- Inability to respond emotionally to the child
- Depriving or withholding physical contact or stimulation
- Failure to provide adequate food, shelter, clothing, medical attention, hygienic home or psychological nurturing

- Poor knowledge of normal child development
- Parent engages in substance use/misuse, including risky and high risk alcohol use
- Failure to attend five or more consecutive health care appointments either with inadequate explanation or despite two verbal or written follow-up contacts
- Exposure of child to a hazardous environment without adequate supervision (eg. unattended swimming pool, playing on the road, exposure in home to poisons)

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COMMUNICATING WITH CLIENTS

Health Workers have a responsibility to monitor the care and protection of all clients. This is particularly important when children are being assessed for mental health concerns such as depression, developmental issues or physical injuries.

Before you ask any questions ensure that you have identified any cultural and disability issues that may impact on your contact with and service to the child and their family.

Your professional judgement should guide the manner and extent to which you ask questions when you have concerns about possible abuse and neglect and/or family and domestic violence. You should also inform the family that the questions are asked of all families and that the Health Service priority is to support and enhance the child and family's wellbeing.

If there are concerns about possible family and domestic violence, ensure that the child's medical concerns are addressed before you question the parent/carers about family and domestic violence.

It is essential that when you speak with the parent/carer, this does not occur in the presence of the possible abusing parent/carer or partner.

Also, be aware that if young children are included in your discussion with the parent/carer, they may be capable of informing the abusing parent/carer that a disclosure was made.

It is ideal to speak with the parent/carer alone, but if a child is present, first request permission to ask questions about violence in the home particularly if the child is older than 2 years. The parent/carer can decide how safe it is to openly discuss any concerns.

If there is insufficient time or it is an inappropriate time to explore these issues, schedule a follow-up appointment.

Questions to Elicit Concerns of Child Abuse, Neglect, Family/Domestic Violence

Examples of Questions for the Parent/Carers Concerning Child Abuse and Neglect

- Have you ever been worried that someone was going to hurt your child?
- Has your child been bullied at school?

Examples of Questions for Older Children Concerning Child Abuse and Neglect

- Can you tell me how things are at home?
- Who makes the rules at your home?
- Who does the day-to-day organisation in your home, such as meals, pays the bills, appointments?
- What happens when you break the rules?
- What happens when things go wrong at your house?
- What happens when your parent/carers are angry with you?
- What happens when people disagree with each other in your house?
- When mum and dad (partner) are fighting, what do you worry about the most?
- What do you do when mum and dad are fighting? (eg. Stay in the same room, go to older sibling, leave/hide, ask parents to stop, phone someone, run out/get someone)
- Does your Mum or Dad/carer have mental health problems or problems with drinking alcohol or with drugs?
- Have you talked to any other grown-ups about this problem?
- Have you been bullied at school?

Examples of Questions if You Suspect the Parent/Carer May be the Abuser

- Do you ever worry about your children's safety when they are with you?
- What methods of discipline do you use with your children?
- What do you do when your child misbehaves?
- Are you afraid that you might hurt your child?

Examples of Questions for the Partner Concerning Family and Domestic Violence

Has your partner:

- Threatened to hurt you or your child?
- Hurt you in front of the children?
- Assaulted or threatened you while you were holding your child?
- Are you or your children afraid of anyone close to you, such as a past or current partner or relative either living at your home or living elsewhere?

Has your child:

- Overheard the yelling and/or violence?
- Physically hurt you or other family members?
- Tried to protect you?
- Tried to stop the violence?
- Hurt him/herself?
- Been fearful of leaving you alone?

If the parent/carer answers 'yes' to any of the above questions it is vital that the

Health Worker responds immediately and is repeatedly supportive, non-judgemental and may include comments such as:

- Although abusive and violent behaviour happens to many people by people they know, it is not normal
- It is not your fault and the responsibility for the violence and abuse lies with the perpetrator
- All people have a right to feel safe and not be fearful of anyone in their lives
- There is help available when you are ready
- Getting help does not necessarily mean that your children will be removed from your care

If the Health Worker has asked about family and domestic violence and the parent/carer has responded positively and requested help, the Health Worker must:

- At the very least, immediately provide information on family and domestic violence services available in the area and the means to contact the service and/or
- If possible, during the consultation with the client make an appointment with the appropriate Health Worker who can assist with family and domestic violence in the Health Service such as a social worker and/or
- Provide the name and number of a Health Worker within the Health Service who the parent/carer may contact and/or
- If appropriate, schedule a follow-up appointment or advise the person that they can recontact you at any time for information

For more detailed information, see Section 2 “Guidelines for Responding to Family and Domestic Violence”.

If you are unsure or feel uncomfortable about what questions to ask and how, check with an appropriate staff member with child abuse and neglect expertise.

Responding to Possible Abuse/Disclosure

Child abuse and neglect or family and domestic violence is a difficult realisation for most children and for their parent/carers.

Many children and adults feel shame and guilt and may have been threatened by perpetrators or told that they are responsible for the abuse they experience.

Children and adults of all ages need clear messages from the Health Worker of support and reassurance that they are not at fault and that help is available. Hearing these messages from the Health Worker is one of the most powerful interventions that can be provided.

If a Health Worker fails to validate in some capacity the difficulties that adults

experience in violent households, it may lead to ineffective health care intervention and a perceived expectation that the parent/carer should be able to protect his/her children.

General Approach to Take

- **The safety of the child is paramount.**
- It is important that the Health Worker considers the safety of the child and the level of immediate danger for the child. Can the parent/carer protect the child? Are there concerns about the child's safety? Does this child need protection?
- Ensure that the child understands that what they say may need to be passed on to other appropriate workers if the health and wellbeing of the child is at risk
- **Treat everyone with respect**
- Use language that parent/carers can understand
- Consider the need for a Health Worker of the same gender and/or cultural background as the child
- Acknowledge and validate the roles and responsibilities of parent/carers
- Promote early intervention
- If possible, involve parent/carers in developing a picture of the family's strengths and concerns
- Highlight choices
- Be honest about the role and responsibilities of Health Workers
- **Recognise the limits to any partnership with the parent/carers**
- Follow through on commitments to families
- **Do not make promises you cannot keep**
- Be aware of your own feelings and biases and acknowledge them. This may include disbelief, anger, panic, and fear of inadequacy, being overwhelmed and concern about repercussions for the child and family

The decision-making process must be objective and in consultation with other appropriate Health Workers or your line manager. You also need to discuss any personal beliefs that you consider may impact on any appropriate action.

Communicating with the Child After a Disclosure/Possible Abuse

- Tell the child that no-one deserves to be hurt and that it was not their fault
- Tell the child that this has happened to other children
- Listen carefully to what the child is saying
- Acknowledge that it is hard to talk about such things
- Control expressions of panic or shock
- Make sure you don't make promises you can't keep – particularly around not telling anyone else about the information if there was a disclosure
- Be aware of the need to approach and talk to a child at an age appropriate level
- Tell the child you believe him or her
- Reassure the child that to disclose was the right thing to do

- Let the child know that they can come back and talk to you
- Using direct questions with children **is not** recommended
- Do not ask leading questions (eg. “Did he touch your vagina?”)
- Indicate what you will specifically do. This includes that you will talk to someone who can give you some advice about what should happen next
- Reassure and support parent/carers present

If a child discloses any abuse or neglect or family and domestic violence, record the time and date you spoke to the child and the exact words that the child said to you.

You should not ask children to give details about the abuse and neglect or family and domestic violence. This is the role of the Department for Community Development and/or the Police Child Abuse Investigation Unit.

Disclosure of Sexual Abuse by a Child

A disclosure of child sexual abuse is a crisis situation and must immediately be referred to the Department for Community Development and/or Police Child Abuse Investigation Unit.

The Health Worker must not confront the alleged perpetrator, as this is the role of the Department for Community Development and/or Police Child Abuse Investigation Unit after seeking legal advice.

If a child discloses sexual abuse and the alleged perpetrator is in the health setting or due to pick up the child, relay the immediacy of need for intervention to the Department for Community Development/Police Child Abuse Investigation Unit.

If the Department for Community Development or Police staff are not able to arrive in time to keep the child separate from the alleged perpetrator, seek advice from the Department for Community Development/Police Child Abuse Investigation Unit about how to handle the situation until a Departmental Worker/Police Officer arrive.

If there are concerns about the immediate safety of the child or Health Worker contact the Police or Security staff.

Communicating with the Child’s Parent/Carers

Families generally appreciate an open approach to dealing with any child safety issues. Open communication means that families know where they stand, it makes it easier for them to get help if they are concerned about unsafe situations and lets families know about the commitment to the wellbeing of the child by the Department of Health.

Health Workers are expected to inform parent/carers of referrals to the Department for Community Development and/or other support agencies. Do not discuss a referral with parent/carers if any of the following circumstances exist:

a) It will place the child, the Health Worker or a parent in danger and/or,

b) If the family may seek to avoid Department for Community Development or Police staff or avoid further contact with Health Services.

Follow these principles when you discuss the concerns and any intervention with the parent/carer:

- Broach the topic sensitively and be non-judgemental
- Help the parent/carer feel supported, able to share any concerns they have with you
- Keep the parent/carers informed at all stages of the process
- Where options exist, support the parent/carers to make their own decisions
- Where appropriate, involve extended family and other people who are important to them
- Help the parent/carer understand that you want to help keep the child safe and support them in their care of the child. Most children do not see their mothers as limited in her parenting capacity and even identify their mother as the main source of social support
- Be sensitive to and discuss the fears of parent/carers about approaching other agencies such as the Police, Department for Community Development, hospital staff, social workers and other agencies

If the Health Worker has asked about family and domestic violence and the parent/carer has responded positively and requested help, the Health Worker must remember to provide immediate information on family and domestic violence services available in the area and specific contact details about appropriate services.

People from Culturally and Linguistically Diverse Backgrounds

Wherever possible, you should consult with an Ethnic Health Worker who has an understanding and expertise of the culture of the child and family culture.

Health Services are also required to seek assistance from a professional interpreter (Health and Mental Health specialist interpreters). An interpreter should be engaged as soon as a Health Worker determines that an individual or family member may have difficulty in speaking or understanding English or he/she has a culturally and linguistically diverse background that impacts on the Health Worker's ability to communicate with them.

Where possible, a level III accredited interpreter should be used.

Telephone Interpreter Services (TIS) – phone 131 450 - provides a 24 hour, on-site and telephone interpreter service and has a code of ethics that addresses confidentiality, accuracy and impartiality.

Where Area Health Services have specific, local protocols in place, use these protocols to engage appropriate, professional interpreters.

Working with Interpreters

- **Children or family members should not be used as interpreters**
- If a child is in immediate danger and the interpreter service is not available at the time, be prepared to use an adult family member, a neighbour or a friend **However, this option should only be used as a last resort in an emergency**
- With the client's agreement, work with the same interpreter where there is ongoing contact
- In sexual abuse situations, an appropriate gender match should be sought between the child and the interpreter

General Points to Discuss

- Expressions of parental feelings and styles of child management vary considerably between cultures
- Not all cultures are accepting of outside intervention in the family
- Individual family members and children may hold different views from those held by one or both parents or carers. These may markedly affect the definition and perception of abuse
- The extent to which the family (and individual family members) have assimilated Australian cultural practices and values may vary
- Female genital mutilation is a criminal offence. This may need to be explained to some families
- The definitions of "family", "mother", "father", "sister" may differ depending on the culture
- The impact that war or war camps can have on parent/child bonding and parenting
- People who are from traumatised and war-torn communities may need extended consultation and care in working through the many complex issues
- Child abuse is less common in situations where cultural traditions are alive and functional
- "Non-cultural" factors such as alcohol and drug abuse, marital conflict and mental illness may also contribute to child abuse and neglect. **It is important that care should be taken to ensure that "cultural" explanations of these behaviours are not used as justification of harm to children**

Aboriginal Children and Families

Any intervention with Aboriginal children and families must be culturally appropriate. This may include working in conjunction with a Health Worker who has Aboriginal cultural understanding of communities and family or working longer-term with families to build trust and a network of support.

It is recommended that each Health Area develop its own plan on how to approach the community on child abuse, neglect and family and domestic violence issues. This should involve a process of consultation with relevant sections of the community and collaboration with other government and non-government services.

A Regional plan should include:

- Operational definitions of appropriate standards of care to the Region
- Strategies for preventing abuse and neglect in the community
- Procedures for identification and management of abuse and neglect that wherever possible should include appropriate Aboriginal liaison
- Networks of recognised supports for children who are abused or deemed to be at risk

The Regional plan should be documented, evaluated and up-dated on a regular basis and in an ongoing process of community consultation.

People with Disabilities

If a child and/or their parent/carer have a disability, consider appropriately facilitating communication (eg. signing, interpreters). Such clients should be offered the opportunity to request a support person/advocate and there may be a need for interagency collaboration with the Disability Services Commission.

Staff Conduct Breaches – Possible Child Abuse and Neglect

Health workers are subject not only to the laws of Western Australia but to other various Codes and Guidelines. Any person in breach of these Codes or Guidelines may have disciplinary action brought against them by their employer.

If you are concerned about the conduct of another Health Worker with a child or adult:

- Immediately discuss your concerns with an appropriate staff member with child abuse and neglect expertise and develop an intervention plan
- If the concern relates to a senior staff person, you will need to contact the Health Worker next in line of management
- In an emergency situation (ie. where the Health Worker in question has current responsibility for children), the Department for Community Development and/or Police Child Abuse Investigation Unit should be contacted immediately
- Document all that has been done

It is recommended that

- Health Services develop detailed protocols to manage any concern or allegation of abuse about Health Workers. These protocols must promote the best interests and safety of children

consultation

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Consultation with Other Health Workers

When Health Workers have detected that abuse and neglect or family and domestic violence is a possibility, they must immediately consult with an appropriate staff member who is identified as having child abuse and neglect expertise (eg. paediatrician, medical officer, senior nurse, social worker, psychologist or psychiatrist).

Every Health Worker must know who to contact and how to access an appropriate staff member with child abuse and neglect expertise at all times. Your consultation with this staff member will continue for the duration of your contact with the child.

The Health Worker may also need to consult with other colleagues who are involved with the child and family or a Health Worker from their own professional discipline within the health setting.

Consultation is about sharing the responsibility of dealing with any concerns for the child, as well as, encouraging discussion about the next steps.

Immediately Discuss and Decide On

- The specific indicators of abuse that you have detected and your concerns
- Your communication with the child and other family members up to this point
- Any need to discuss your concerns with the PMH Child Protection Unit, a Sexual Assault Resource Centre and/or specialist Mental Health Services
- Any immediate need to discuss your concerns with the Department for Community Development or the Police Child Abuse Investigation Unit
- What needs to be discussed with the family

What Else to Consider

- If the child and the family are Aboriginal, then consider the cultural issues and the need to consult with a Health Worker who has particular expertise and understanding of working with Aboriginal people and communities
- The need for an interpreter or a Health Worker with the relevant cultural and linguistic background training
- Any disability issues and the need for an advocate

Self Care for Health Workers

Dealing with child abuse, neglect and family and domestic violence can be a stressful and overwhelming experience for any Health Worker. Amongst other things, working with children and families where there is the possibility of abuse may raise personal issues for a Health Worker of a similar nature.

Your direct line manager or another appropriate Health Worker can help identify your options for debriefing or provide some support themselves.

Consultation with Other Agencies

The Department for Community Development

The Department for Community Development has responsibility for child protection through the *Child Welfare Act 1947*, inclusive of Amendments (2002).

Their role includes ensuring and maintaining the safety of children; developing case plans; ensuring the provision of quality out of home care and support services for children unable to live with their family; and initiating action to protect children through dispute resolution or proceedings in the Children's Court.

A Health Worker may consult, prior to referral, with the Duty social worker at the appropriate Department for Community Development district office.

There may be a need to discuss concerns about possible child abuse and neglect and the need for child protection with the Department for Community Development. It is possible to discuss the current concerns without providing the child's name and to inquire whether a child is known (ie. giving the name but not the details of current concerns).

Note: If the name and concerning circumstances are provided by a Health Worker, then the Department for Community Development worker may regard this as a referral.

Department for Community Development staff may consult with appropriate Health Workers when requiring expertise on specific health matters.

Police Child Abuse Investigation Unit

You may need to consult with the Police Child Abuse Investigation Unit after consulting with the Department for Community Development. This will depend on the circumstances and your concerns.

assessment
& examination

ASSESSMENT 43

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ASSESSMENT

<u>Please note:</u> Health Workers are not responsible for conducting full-scale investigations on the likelihood of further child abuse and neglect or to substantiate the current concerns. This is the responsibility of the Department for Community Development.

A General Guide to Assessment

A careful history must be taken that includes the child's development, behaviours and competence; parental attitudes towards the incident; and family functioning.

It is important to gain as much information about your concerns as possible.

The assessment should aim to obtain facts and straightforward observations about the child and the family.

The Health Worker needs to remain objective, limiting opinion to areas in which they have expertise - a professional opinion, and noting observations such as the appearance of children and parent-child interaction that is observed by the Health Worker.

Following the history-taking assessment process, this information should be discussed with your identified staff member who has child abuse and neglect expertise or the interagency partnership member and may lead to further consultation as indicated from the information obtained. It may be necessary to schedule a physical examination if this was not previously scheduled.

The following questions are a guide to determine the circumstances of the child and family, the support available for the child, the child's level of safety and general development, health and wellbeing.

Indicators of Abuse and/or Neglect, Including High Risk Factors

Refer to: Concerns About Possible Child Abuse, Neglect and Exposure to Family And Domestic Violence

Ask questions that fully obtain information about these indicators and risk factors. For example:

Tell me how your injury occurred?
Who was around when the injury occurred?
When did the injury occur?
What were you doing when the injury occurred?

Assessing the Child, Parent/Carers and the Child's Environment

A careful history must be taken that includes the child's development, behaviours and competence; parental attitudes towards the incident; and family functioning.

The Child

- How old is the child?
- What is the overall level of the child's development? Milestones reached? Loss of skill previously attained?
- Does the child cry a lot? Have a difficult temperament? A fussy baby? Whine a lot?
- Does the child have difficulty, toileting, sleeping?
- Any known medical conditions/disability?
- Does the child have special needs that may increase vulnerability?
- How is the child's functioning? Communication skills, friends, getting on with peers? Withdrawn? Aggressive? Angry?
- To what extent can the child recognise danger?
- To what extent can the child articulate a personal protection plan and implement it?
- Does the child display any self-harming or risk-taking behaviours?

The Parent/Carers

Attitude to harm

- What do the parent/carers report about the child's behaviour?
- What is the parent/carer's understanding of how the injury or incident occurred?
- Has the parent/carers acknowledged abuse and/or neglect?
- How did the parent respond to a child disclosure of abuse, neglect or family violence?

Relationship between parent/carers and child

- How does the family interact in your presence?
- Are the parent/carers warm and supportive with the child?

Parenting capacity

- How old are the parent/carers?
- Are there any barriers to the ability of the parent/carers to act protectively? For example, do the parent/carers have: intellectual disability, mental health disorder/s, substance abuse which impairs day-to-day functioning, poor parenting skills

- What is the willingness of the parent/carers to meet the child's protective needs? Have they shown openness to consider other ways of dealing with difficulties they are facing?
- Any comments on the parenting style? Is there a history of parenting concerns that the parents describe to you or you observe?
  (For example, authoritarian, punitive, lax parenting; intrusive, ignoring, angry reaction to the child? How do they usually discipline the child? How closely do they monitor the child?)

The Child's Environment

- Is the person allegedly responsible for the concerns and/or injury or incident still part of the child's environment?
- Has the child mentioned any other support outside the family that the child can access? For example, other family members? Other services?
- What other supports have the parent/carers mentioned?
- What is the willingness of the parent/carers to work with organisations offering assistance?
- Does the child or family move around a lot? Be alert to highly mobile families as abuse, neglect and family violence may be undetected and the family and the child may have less social support
- What is the availability of easily accessed support services for the parent/carers?
- Are you aware of any stresses in the home environment that may impact on family functioning? Family and domestic violence? Financial difficulties? Recent changes, such as loss of a job?

Please note: If child abuse and neglect is identified or suspected, it is important that some assessment of risk to other members of that family is conducted because of the high co-occurrence of multiple types of violence within families.

- If it is possible, request parent/carer consent to access health records for any other siblings. This may assist to identify any parenting patterns or other areas of concern

See "Questions to Elicit Concerns of Possible Child Abuse and Neglect".

Section 2 "Guidelines for Responding to Family and Domestic Violence".

PHYSICAL EXAMINATION

All Health Workers should be alert to and take note of injuries, bruising and other clinical signs of child abuse and neglect such as drowsiness or fitting of small babies. These findings must always be documented by the Health Worker who has noticed these signs and symptoms.

The following provides details of the physical examination of a child who has disclosed abuse or has indicators that abuse, neglect or exposure to family and domestic violence may have/has occurred.

This physical examination will normally be performed by a medical practitioner with expertise in child abuse and neglect.

Note: When a medical practitioner with expertise in child abuse and neglect **is not readily available**, other medical practitioners or nursing staff may need to perform a physical examination and to document the clinical findings. **It is essential that there is consultation with the PMH Child Protection Unit (08) 9340 8646 in these circumstances.**

The Physical Examination Should Include

- Assessment of the child's cleanliness and clothing
- Measurement of height and weight with reference to percentile charts
- Measurement of head circumference. A large or increasing head circumference may be a sign of intracranial injury in a child under 2 years
- General physical examination, including assessment of nutrition and illness
- Developmental assessment – brief assessment of the child's gross motor and language development

Specific Examination for Physical Signs of Injury or Possible Abuse

- Describe bruises, abrasions, lacerations and burns in terms of number, shape (eg. linear, circular, rectangular), pattern (eg. handprint, pattern of object), orientation (eg. horizontal, vertical, circumferential) and location
- Avoid giving an opinion on the age of bruises – better to describe actual colour and appearance
- Do comment on whether every injury appears old or new (eg. healing abrasion, scar)
- Measure injuries with a tape measure and if obtaining photographs, place a ruler adjacent to the injury (see Documentation)
- Document the explanation given by the child and parent/carers for each particular injury seen

Specific Investigations to Be Performed by the Medical Practitioner

- X-Rays: description of fractures should conform to standard medical description of orientation (eg. transverse, oblique, spiral), bone involved (eg. femur) and site along the particular bone (eg. supracondylar-humerus, metaphyseal-tibia, posterior- left 5th rib)
- Full blood count, coagulation screen
- Skeletal survey – all infants under 2 years
- Bone scan – should be considered to detect recent fractures not apparent on X-Ray in infants
- Acute neurological symptoms: head CT scan
- Eye examination by an ophthalmologist as early as possible for infants <12 months, especially if there are neurological symptoms or multiple fractures and/or skeletal injury
- Colposcopy for female genital injury or examination under anaesthesia/sedation if the child is distressed and in pain
- Abdominal injury: urinalysis, liver function, renal function, amylase and abdominal imaging

Physical Assessment of Sexual Abuse

The physical assessment of sexual abuse is a specialised assessment and should only be performed by a medical practitioner who has specialist training to perform this assessment. There is a specialised clinical service for suspected child sexual abuse in the PMH Child Protection Unit (08) 9340 8646 from 09:00 to 17:00 Monday to Friday and it is highly recommended that children are referred to the Child Protection Unit.

Between 17:00 and 09:00 contact the Emergency Department, PMH (After-hours, (08) 9340 8222 for medical assessment of suspected sexual abuse).

Children aged over 16 years could be referred to the Sexual Assault Resource Centre (08) 9340 1828 or 1800 199 888 or to a country Sexual Assault service.

- Health Services outside of the Perth metropolitan area should seek advice from the PMH Child Protection Unit, medical consultant or duty social worker prior to performing the physical assessment of sexual abuse
- Each country Health Region should have a nominated medical practitioner/ paediatrician who has appropriate training and expertise in the physical assessment of child abuse and neglect, including sexual abuse. Other Health Workers or medical practitioners should not undertake physical assessments of sexual abuse, but should refer to the nominated specialist if possible

The initial response to child sexual abuse depends on:

- Timing of the alleged assault
- The presence of any other injuries – do other injuries require emergency treatment?
- Child protection issues – is the child at risk if he/she leaves the health setting?

Timing of the Physical Assessment of Sexual Abuse

- Medical specimens that are suitable for forensic evidence must be collected within **3 days (72 hours)** of the sexual assault. If the abuse/assault occurred in the preceding 72 hours, a medical examination should take place as soon as possible. Consider admitting the child to hospital to allow more detailed assessment by the PMH Child Protection Unit or medical consultant
- If the abuse/assault occurred more than 3 days before presentation, then medical examination should be performed as soon as practically possible, as physical signs fade. However, if the event occurred within the preceding 14 days, then a priority appointment should be arranged for both medical and child protection assessment. This facilitates accurate recall of the event by the child during interview. The PMH Child Protection Unit aims to offer this appointment at 09:00 on the next working day. Contact the PMH Child Protection Unit social worker during office hours to give referral information
- If the abuse/assault occurred more than 14 days earlier, medical examination can be scheduled as appropriate. The PMH Child Protection Unit aims to offer an appointment within 1 week. Contact the PMH Child Protection Unit social worker during office hours to give referral information

The Physical Examination for Sexual Abuse Should Include

- Assessment of the child's cleanliness and clothing
- Measurement of height and weight with reference to percentile charts
- General physical examination including assessment of nutrition and other injuries
- Assessment of the pubertal stage of the child
- Examination of the mouth and throat for oral injury
- External inspection of the genital area, anus and buttocks
- Examination of the vulva and vagina/scrotum and penis. Both a supine position and prone-knee-chest position should be used to facilitate external inspection of the hymen
- Use of a colposcope for magnification (and photography) if available
- Routine use of a speculum is not recommended in the vaginal examination of prepubertal children. Use of a speculum may be indicated in a sexually-active adolescent

- Examination under general anaesthesia should be considered if the child is distressed or if severe genital injuries are suspected
- The examiner should always wear gloves both for hygiene and to avoid DNA contamination of the patient

Forensic Medical Specimens

Forensic medical specimens are collected in order to obtain DNA from the alleged perpetrator of sexual abuse. Specimens must be collected within 72 hours of the sexual assault for viable DNA.

A more comprehensive medical examination and the collection of microbiologic specimens may be performed on follow-up after the initial presentation.

All examiners should wear gloves to prevent DNA contamination**.**

Four initial samples are required: urine, buccal, labial/perineal, clothing.
Note that forensic specimens should not be placed into culture media.

1. **First pass urine** collected in a yellow lid specimen jar (to look for spermatozoa)
2. **Buccal gauze**: instruct the patient to chew, then place the gauze into a yellow lid specimen jar
3. **Labial/perineal gauze**: wipe over the labia/perineum, then place the gauze into a yellow lid specimen jar. Also wipe gauze over any fluid stains on the body
4. Place **clothing** into the brown forensic bag

These should be handed to the police immediately or immediately placed in a locked cupboard/drawer in order to maintain the chain of evidence.

It would then be anticipated that a full examination would take place within the following twenty-four hours. **The child should not shower or wash if possible until a complete forensic examination has taken place.**

Blood/Urine

- Blood and/or urine should be obtained if there are concerns that drugs or alcohol have been administered to the child
- Send specimens to toxicology

Post-coital Contraception

- The medical practitioner should assess the risk of conception. If there is any risk of conception, give emergency contraception (eg. Postinor-2 tablets Levonorgestrel, lactose)

  Postinor-2 dose: 1 tab as soon as possible (≤ 72 hours) after unprotected intercourse, then 1 tab 12 hours after the first dose. Where vomiting occurs < 2 hours after dosing, see medical practitioner for possible additional tab.

HIV/Hepatitis B Post-Exposure Prophylaxis

- Counsel the child/carer after assessing the risk of HIV/Hepatitis B exposure
- Obtain written consent for HIV testing and prophylaxis
- Commence prophylactic medication for HIV with Lamivudine and Zidovudine (eg. Combivir) if assessed as high risk or upon client request
- Refer to prescribing information for lamivudine and zidovudine
- Give Hepatitis B Immunoglobulin and the first dose of Hepatitis B vaccine; arrange follow-up to complete the course of Hepatitis B vaccine

Microbiological Specimens

- Swabs taken from the perineum, labia and vaginal introitus are smeared on glass slides and allowed to air-dry
- The swab sticks should be placed into the Stuart's culture medium
- Swabs may be moistened with normal saline or water to prevent discomfort
- Urine (first pass is best) can be collected for PCR detection of *Neisseria gonorrhoea* and *Chlamydia*
- Collect a dry swab in a yellow lid container for PCR of *Herpes simplex* virus if indicated
- If an ulcer is present, consider an air dry swab for PCR for syphilis

After laboratory confirmation of a notifiable sexually transmissible infection, the medical practitioner should use the appropriate Department of Health Notification Form to notify (by post or fax) the following infections: Chancroid (Soft sore), *Chlamydia* (genital infection), Donovanosis (*Granuloma inguinale*), Gonorrhoea, Syphilis and HIV/AIDS infection.

For cases resident in the metropolitan area, notifications are made to the Communicable Disease Control Directorate, Department of Health. For cases resident in country areas, notifications are made to the appropriate regional Population Health Unit.

Where appropriate, the Health Worker should discuss the notification with children who are considered a mature minor. This will provide an opportunity for the child to raise any concerns he/she may have about telling parents/carers and any issues that affect treatment and safety.

Please note: If the diagnosing practitioner suspects sexual abuse in a child, then an urgent referral should be made to the Department for Community Development. A referral may also be required to the Police Child Abuse Investigation Unit. These referrals should be made irrespective of whether a sexually transmissible infection results from that abuse. Notification of a sexually transmissible infection to the Department of Health, as required under public health legislation is separate to the need to refer the case to child protection agencies.

documentation

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DOCUMENTATION

Documentation includes the case notes that Health Workers have kept and keep when they have ongoing contact with a child and/or a family in a therapeutic context.

Explain to the parent/carers that a record of contact with the Health Worker is kept and what that record may generally entail.

Client records must be **accurate and objective**

- Include the date and time of your contact with the child and when you wrote your notes (if different from time of contact)
- The Health Worker's factual observations must be recorded by description, drawings etc as appropriate. Appendix 2 - Body Map
- Health Workers should be objective, limiting opinion to areas in which they have expertise, noting straightforward observations such as the appearance of children and parent-child interaction that is observed
- Where professional opinions are recorded, they should come from and follow the statements of any observations. Avoid making any assumptions and judgemental comments. The Health Worker must clearly identify between professional opinion and fact
- It is important to document as much of the details as possible as it may be required if the incident goes to court

Record

- All indicators of possible child abuse and neglect, high risk factors and the findings of your assessment
- The stated or suspected cause of any injuries or abnormalities and when they allegedly occurred
- State clearly what you have observed and what was reported to you (second-hand information) and by whom. Use the client's own words as much as possible and in quotation
- If possible, state the identified name of the perpetrator/s or relationship to the victim
- All communication with the family
- Your consultation discussions with the staff member with child abuse and neglect expertise, your consultation with other Health Workers and any other external agency consultations (eg. Department for Community Development/Police)
- Any case discussions and intervention plans
- Details of all family members including other adults and children living in the family home
- Note if the clothes of the parent/carer were soiled when they presented with the child. Children who have experienced shaken baby syndrome/child abuse may have vomited and evidence of this may be on the clothes

Disclosures of Child Abuse and Neglect or Family and Domestic Violence

- The conversational context in which an allegation arose (eg. the question that prompted the disclosure or circumstances when the child disclosed)
- Where the child disclosed
- Who was present when the child disclosed
- The physical proximity of persons in the room to each other and the child
- The duration of any interview or assessment
- Record details and the source of any information obtained prior to the examination taking place or the findings being recorded. Such prior information may be and is usually relevant to the interpretation of any statements made by a child
- If the parent has disclosed family and domestic violence, decide with the identified Health Worker with child abuse and neglect expertise, how and where this information is to be recorded and whether this information should be recorded in the adult's and/or the child's records. There are risks associated with documenting family and domestic violence on a child's records as the abusing parent may access such documentation under FOI legislation

Documentation of Physical Examination

Record a detailed description of the physical findings using drawings and the Body Map.

Medical Photography

- If a camera is available, then medical photography[3] is highly recommended. Non-digital 35 mm cameras are preferred as digital images can be altered
- Take a full body photo, both front and back, to put injuries in perspective
- Take a picture of the child's face for identification and include a medical record label in the photograph
- Use a scale or ruler next to the injuries
- Take close-up photographs of injuries from all angles
- Take repeated photos over time to show evolving patterns (eg. burns, bruises)
- Be aware that flash photography may alter the image
- Consider whether high-speed film is needed
- Sign, record your staff position, your place of work and the date and time on each photograph

Please Note: Medical photography should not be used without accompanying written description and body drawings.

Alternatively, contact the local Police station where photographs may be taken.

[3] Peck, M.D. and Priolo-Kapel, D. (2002). Child Abuse by burning: a review of the literature and an algorithm for medical investigations. *J Trauma*, 53(5), 1013-1022.

referrals & monitoring

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WORKING TOGETHER WITH AND REFERRALS TO OTHER AGENCIES

As an Interagency Partner

The Police Department, PMH Child Protection Unit and the Department for Community Development work closely in partnership to ensure coordination of investigation, management and outcome of physical abuse and neglect cases where serious injury has occurred, where there are concerns about sexual abuse and/or significant risk of harm is present.

The Communicable Disease Control Directorate in the Department of Health on-report to the Police and the Department for Community Development all cases of verified sexually transmissible infections in children aged below 14 years of age that are thought by the diagnosing practitioner to most likely be sexually acquired. Such infections in children aged 14 and 15 years are also on-reported where the Department of Health is given reason to believe, usually by the notifying medical practitioner, that these infections may be the result of sexual abuse. This interdepartmental reporting helps to ensure that the Department for Community Development and the Police become aware of all children who have notifiable sexually transmissible infections that are likely to be due to sexual abuse.

Community-based interagency partnerships that focus on supporting the needs of children in their communities provide an organisational framework to support and encourage the development of networks required to undertake healthy, safe and balanced child protection.

Community-based partnerships make best use of limited resources as they provide efficient formal administrative and clinical frameworks for whole-of-government services to work together with local non-government agencies to support families where possible, and to protect children where necessary.

Interagency partnerships, while recognising the statutory responsibilities of Departments, reaffirm the need for a multidisciplinary approach to child abuse, neglect and family violence.

Interagency partnerships are a practical and effective tool to maximise the skills and resources available in communities to support families, protect children and coordinate service responses efficiently and proactively.

Facilitating the Development of Community-Based Interagency Partnerships

Designated senior Health Workers who have appropriate expertise will provide the overall strategic lead to support community-based interagency partnerships and work with similar senior workers in other agencies to collectively provide interagency strategic leadership.

Services will need to develop and participate in these partnerships at a Regional/Health Service level.

Interagency partnerships should have membership that is locally determined, however, minimum participation could include representatives from Health, Education, Police and Community Development and other government and non-government agencies on a needs basis. For the purposes of these Guidelines, the Health Worker will be referred to as the community-based interagency partnership member.

The goal of these community-based partnerships is to provide regular interagency forums for consultation and case discussion, planning to ensure child safety, ensuring that services are available and that intervention is effective and coordinated. The partnership formulates recommendations to ensure that the activities of the individual agencies are coordinated and informed.

Meetings should be regularly scheduled, formalised within organisational structure (and therefore minuted) and transparent.

Interagency partners should develop strategic and operational plans that include referral, consultation, planning processes, as well as, basic points on chairing and agency representation.

Each local partnership needs to establish relationships with and function together or alongside the Regional Domestic Violence Committees. Specific operational guidelines are required for these partnerships.

REFERRAL TO OTHER AGENCIES

Referral to the Department for Community Development

See also “Communicating with the Child’s Parent/Carers”.

Please note: It may not always be in the child’s best interests and/or the safety of the Health Worker to inform parent/carers that a referral has been made to the Department for Community Development especially when any the following circumstances exist:

a) It will place the child, the Health Worker or a parent/carer in danger
b) If the family may seek to avoid Department for Community Development or Police staff or avoid further contact with Health Services

Urgent Referrals

If **any of the following** is present:

- Indicators of any physical abuse in a child under 5 years, especially if under 1 year of age
- Indicators of serious physical abuse in any age child
- Disclosure or evidence of sexual abuse

you must on the same day as the concerns are detected, notify the child to the Department for Community Development. It is recommended that legal advice be sought prior to referring a child to the Police Child Abuse Investigation Unit.

- Referrals are made to the duty officer of the appropriate Department for Community Development District office during usual working hours. The duty officer will inform the Health Worker of the intake and allocation process and possible time-lines
- After-hours referral may be made to the Crisis Care Unit, Department for Community Development (08) 9223 1100; After Hours 1800 199 008
- The Department for Community Development will accept verbal referrals. These must be followed by a written referral outlining the details of the child and family, the specific concerns and what the Health Worker expects the Department for Community Development to progress
- The Department for Community Development will provide feedback to the Health Worker on the outcome of the investigation and the planned support and protection which will be provided

You should **also notify** the community-based interagency partnership **member/ coordinator**.

Less Urgent Referrals

If any of the following are present:

- Presence of indicators of physical abuse, emotional abuse or neglect
- Multiple risk factors present
- Escalation of concerns about abuse, neglect, family and domestic violence
- Indicators of family violence

you should refer to your community-based interagency partnership **member/ coordinator** for discussion, clarification and appropriate management.

A **referral for child protection** should be made to the **Department for Community Development**.

Referral to the Western Australia Police Service – Police Child Abuse Investigation Unit

The Police Child Abuse Investigation Unit will investigate incidents of **suspected child abuse involving criminality such as sexual and physical abuse and family violence**. They also investigate reports of missing children.

During normal office hours (08:00 – 16:00), child abuse and neglect concerns may be directed personally to the Operations Manager of the Police Child Abuse Investigation Unit situated at Suite 2/250 Adelaide Terrace Perth or telephone contact can be made on (08) 9492 5444.

After hours referrals should be directed to the Duty Inspector of Police Operations Centre on telephone number (08) 9222 1111.

It is recommended that legal advice be sought prior to referring a child to the Police Child Abuse Investigation Unit.

In addition, you should **also notify** your community-based interagency partnership member/coordinator.

ONGOING MONITORING OF CHILDREN

Health services have an important role in offering support and intervention services for children and their families:

- To reduce the risk of child abuse and neglect
- To prevent ongoing or further child abuse and neglect
- To monitor the developmental and emotional wellbeing of children in families with identified risk factors for child abuse and neglect
- To monitor the developmental and emotional wellbeing of children who have experienced abuse, neglect and family violence
- To provide therapy interventions for children who have experienced abuse, neglect and family and domestic violence

Case Management

There are many models of intervention and the choice of intervention will depend on the needs of each child and family. These needs are often complex and therefore it is important that individual Health Workers do not work in isolation. Case management can be facilitated by:

- Deciding on who will be the Health Worker "case manager"
- Deciding on the role of each Health Worker in the case management team
- Using a case conference model with regular scheduled meetings
- Taking minutes at case conferences, which outline the intervention plan
- Setting an appropriate review date after each case conference

Intervention options may include:

- Ongoing monitoring and support
- A further assessment to clarify the current concerns and obtain any other information to inform the abuse, neglect, family and domestic violence issues
- Provide intervention as appropriate to your Health Service/profession
- Referral to another appropriate agency

Role of the Case Manager

The case manager will often be the Health Worker who has the most contact with the child and family. In addition to providing direct client services to the child and family, the case manager will:

- Coordinate and chair case conferences within the Health Service
- Discuss the Health Service intervention plan with the family
- Take on the role of contacting the Department for Community Development for either consultation or referral

- Inform the Health Service of the outcome of consultation or referral to the Department for Community Development
- Communicate with the community-based interagency partnership
- Participate in interagency case conferences
- Inform the Health Service of the interagency partnership intervention plan

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State-Wide Services

Crisis
Crisis Care, Department for Community Development
Office hours – (08) 9223 1100
After hours – 1800 199 008

Interpreter Service
All hours 131 450

Legal and Legislative Directorate
Department of Health – (08) 9222 4038

Police Child Abuse Investigation Unit
(08) 9492 5444
Duty Inspector of Police Operations Centre – After hours (08) 9222 1111

Princess Margaret Hospital
Child Protection Unit – (08) 9340 8646
Fax number – (08) 9340 8822
Social Work Department – (08) 9340 8920
Emergency Department – After hours (08) 9340 8222

Mental Health Services
During business hours, call your local Mental Health Service.
After business hours and at weekends, contact the Psychiatric Emergency Team (PET) on 1300 555 788 or in the country (FREECALL) 1800 676 822
Adult – 1800 220 400
Indigenous Psychiatric Services – (08) 9347 6422
Trans Cultural Unit (no children) – (08) 9224 1760
Princess Margaret Hospital, Child Mental Health – (08) 9340 8398

Sexual Assault Resource Centre
(08) 9340 1828 or 1800 199 888

Communicable Disease Control
Population Health, Department of Health
(08) 9388 4852; After hours (08) 9328 0553
Facsimile (08) 9480 4848

Child Abuse Prevention Service
All hours – 1800 688 009

Domestic Violence Children's Counselling Service
(08) 9388 8001

Financial
Centrelink (Appointment for a social worker) – 13 10 21

Help Lines
Family Help Line – (08) 9223 1100 or 1800 643 000
Kids Help Line - 1800 55 1800
Life Line - 13 11 14
Women's Domestic Violence Help Line – (08) 9223 1188; 1800 007 339
Men's Domestic Violence Help Line – (08) 9223 1199
Parent Drug Information Service – (08) 9442 5050
Parenting Line – (08) 9272 1466
Salvo Care Line – (08) 9227 8655

Incest Survivors Association
(08) 9227 8745

Ngala
For parents with young children (0-6yrs) – (08) 9368 9368
Country access – 1800 111 546
Hey Dad W.A. – 1800 111 545

Victim Support Service (Sexual Abuse)
(08) 9221 0444 or 1800 818 988

Women's Information Service
(08) 9222 0444

Women's Multicultural Support and Advocacy Service
(08) 9325 7716

Youth Link
(08) 9227 4300

Enter Information and Contact Numbers for Local Services Below:

Child Health Clinic
Name:
Telephone:

Child Health Service
Name:
Telephone:

Hospital Services, including social work contacts
Name:
Telephone:

Department for Community Development – District Office
Name:
Telephone:

Police
Name:
Telephone:

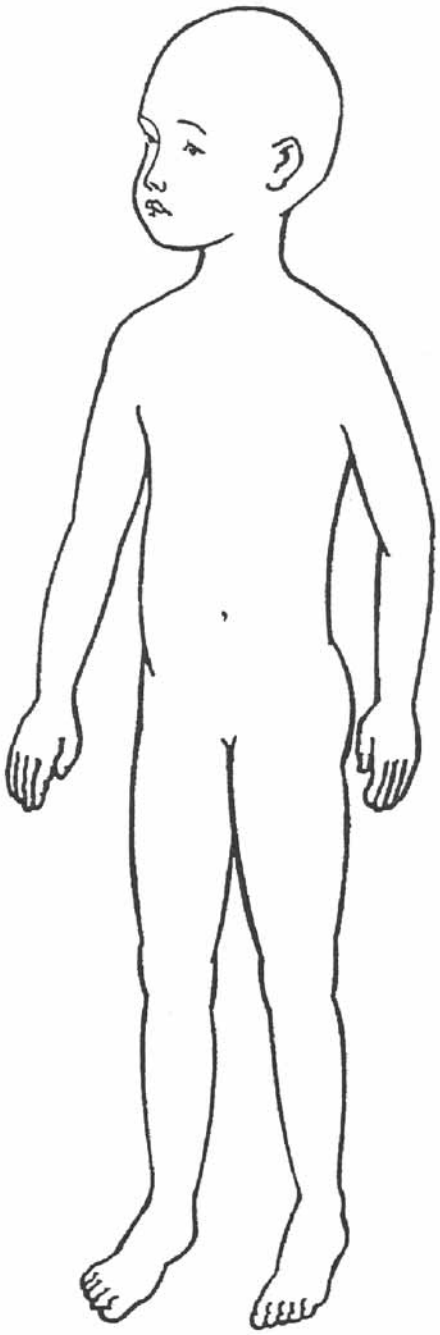
Interagency partnership member
Name:
Telephone

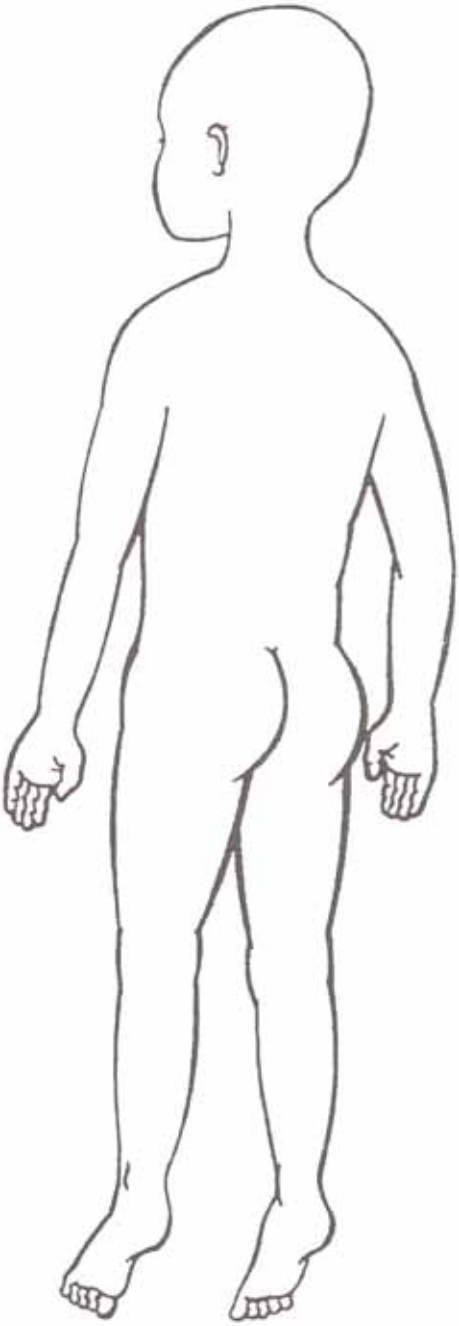
Counselling Services eg. Relationships Australia, Centrecare
Name:
Telephone:

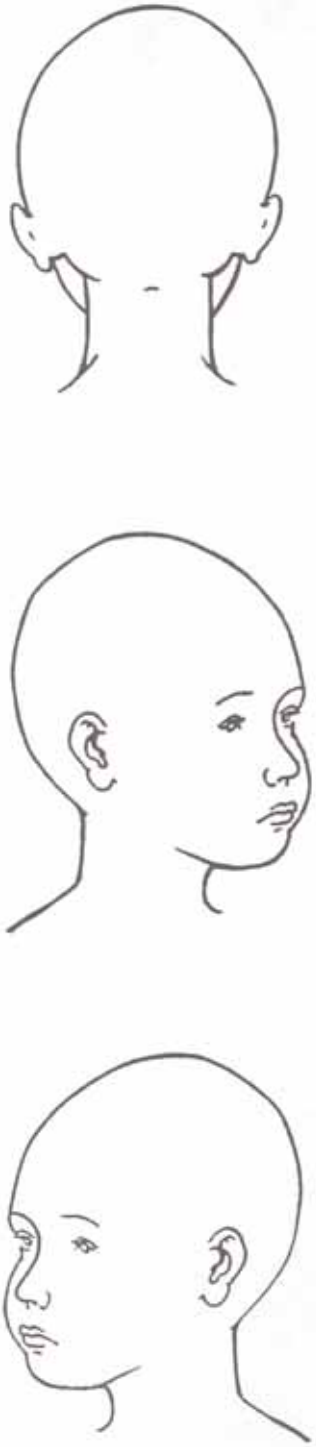
Seniors Services, including local hospital aged care departments
Name:
Telephone:

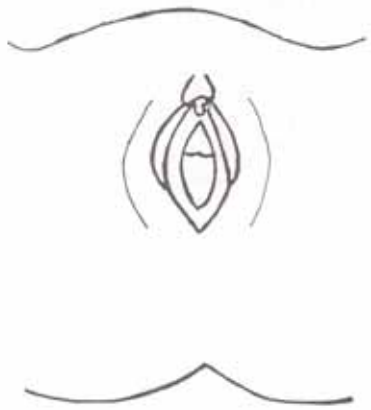
Women's Refuge
Name:
Telephone:

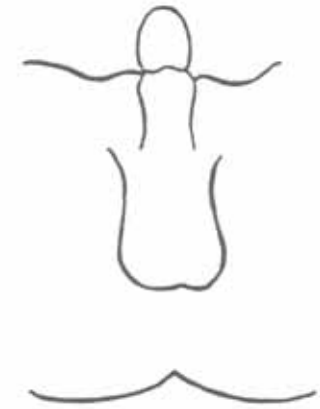
Body Map

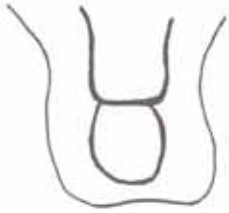












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It is recommended that the following legal information be read in conjunction with the Departmental Operational Circular "Patient Confidentiality and Divulging Patient Information to Third Parties". Copies of all Operational Circulars can be located at: http://intranet.health.wa.gov.au/circular/index.cfm

LEGAL INFORMATION

Disclaimer

The information contained in this section provides a summary and general overview on legal topics relevant to the operation of the Guidelines. It is limited to the laws applicable within Western Australia only.

The law is dynamic and while we attempt to ensure the content is accurate, complete and up-to-date, it cannot be guaranteed.

The information contained in this section is not intended to be comprehensive. Similarly, it is not intended to be, nor should it be relied upon as a substitute for, legal or other professional advice.

If you have a legal problem you should seek legal advice tailored to your circumstance from the Legal and Legislative Directorate at the Department of Health (or from the State Solicitor's Office in the case of teaching hospitals only) before acting or relying on any of the content of this section.

Client Confidentiality and Information Sharing

Health Workers are under a duty of confidence in respect of all information that comes to them in the course of their health care relationship with clients. This duty of confidentiality applies to all persons who come into contact with information as part of the health care process, including administrative staff.

The unauthorised disclosure of confidential information by a Health Worker to third parties (including the Police and the Department for Community Development) will generally involve a breach of confidence.

A breach of the duty of confidentiality may lead to a civil action for damages against the individual who made the unauthorised disclosure and the health service where he or she is employed. It may also be a matter for disciplinary proceedings by the employer of the individual who made the unauthorised disclosure and review by the relevant professional registration body (eg. Nurses Board).

There are a number of well-recognised exceptions that authorise the disclosure of otherwise confidential information to third parties. The relevant exceptions are discussed below.

Consent of Client or Client's Legal Guardian

In general, if a mentally competent adult client consents to the disclosure of confidential information, then the Health Worker(s) to whom consent has been given may disclose the information. The Health Worker may only lawfully disclose the information falling within the scope of the consent and only to those individuals or institutions in respect of which consent has been given.

Where the patient is a minor, the appropriate person to provide consent to the release of information relating to that minor will ordinarily be the patient's parent or other legally appointed guardian.

However, a minor is capable of giving informed consent to the release of confidential information on her/his own behalf where she/he has sufficient understanding and intelligence to enable her/him to understand fully what is proposed and the possible consequences (see mature minor information below).

Other Health Care Professionals

People who have a legitimate therapeutic interest in the care of the client may have access to confidential information concerning the client relevant to the care being provided. Consent to disclosure of confidential information in such circumstances will generally be implied.

If a Health Worker wants advice, or simply wishes to talk over the patient's treatment with a colleague who is not involved with the patient's care but the patient has not expressly consented, then identifying information should not be given.

Subpoena

A Health Worker may be required by subpoena to produce documents to a court and/or attend court to give oral evidence. Where a Health Worker divulges confidential client information to the court in response to a valid subpoena, they will not be in breach of their duty of confidence. Failure to comply with a subpoena (or similar court order) can amount to contempt of court resulting in a prison sentence or fine.

Statutory Obligations to Disclose Information

Where confidential information is disclosed to the appropriate authority pursuant to a statutory obligation there will be no breach of confidence. However, the information disclosed should be limited to that necessary to comply with the statutory reporting requirement.

An example of a statutory reporting requirement is section 300 of the *Health Act 1911*. This section requires medical practitioners to give notification to the Executive Director, Public Health of any person with a venereal disease in an infectious stage.

In Western Australia, there is no specific statutory requirement for the reporting of actual or suspected child abuse to the police, the Department for Community Development or any other authority or person.

Reporting to Department for Community Development

Section 146C(3) of the *Child Welfare Act 1947* provides some protection from personal liability where a person 'on reasonable grounds and in good faith for the purposes of facilitating the enforcement of the provisions of this Act makes a report with respect to the circumstances of a child' to the Department for Community Development.

However, the protection is only available where the report is made on reasonable grounds and in good faith for the purposes of facilitating the enforcement of the provisions of the *Child Welfare Act 1947*.

In general, a person is deemed to be acting on reasonable grounds where the motive for the person's conduct or the basis for the person's belief/suspicion is just and appropriate in all the circumstances of the case (from an objective point of view). Similarly, a person will be deemed to be acting in 'good faith' where he/she acts honestly.

Accordingly, where a Health Worker on reasonable grounds believes that a child's welfare and safety is at risk and that he/she is in need of care and protection, section 146C(3) would appear to permit the reporting of that child's circumstances to Department for Community Development. There is no requirement that the child must be at imminent, likely or serious risk of harm before a report under section 146C(3) can be justified.

It is recommended that a decision to disclose information to Department for Community Development pursuant to section 146C(3) be made by the Health Worker in consultation with senior management within the employing health service. The factors taken into account in reaching a decision to make a section 146C(3) report should be well documented.

Disclosure in the Public Interest

A Health Worker will not be in breach of their duty of confidentiality where there is an overriding public interest in the disclosure to a third party of otherwise confidential information.

Relevant legal authority suggests that disclosure of confidential information in the public interest will only be justified in exceptional circumstances. This usually arises in circumstances where there is a real and immediate risk of danger to the public or an individual. Whether disclosure of otherwise confidential information is justified in the public interest is a question of fact that will need to be determined in the circumstances of each individual case.

The Health Worker, in consultation with senior management, will need to determine whether the public interest served in maintaining the confidence is outweighed by the public interest in disclosing it. This will involve a consideration of the interests of the client, the health service and the community. Assessing where the balance of public interest lies is extremely difficult, not least because there are no clearly defined rules governing when disclosure is permitted.

An example of where it may be appropriate for the nurse to disclose information to a proper authority (Department for Community Development or Police) is where there is a real and immediate danger posed to the life or health of a client.

Any disclosure of otherwise confidential information must only be made to an authority with a proper interest in receiving the information and only the facts necessary to reduce or eliminate the risk concerned should be disclosed. Any such disclosure should be fully documented in the client's medical file.

It is recommended that legal advice be sought prior to a "public interest disclosure" being made.

Duty of Care

Health Workers have a duty to take all reasonable care for the welfare of their clients. Generally, the duty of care will arise when a person presents to the health service for medical attention and that health service expressly or impliedly accepts responsibility for the treatment of that person. The Health Worker also owes a duty to third parties where it is reasonably foreseeable that a person under their control may harm the third party.

A Health Worker may be liable for negligence where they fail to take steps that a reasonable person would to prevent a reasonably foreseeable risk of harm to a person to whom they owe a duty of care. It is arguable that a Health Worker's duty extends to taking reasonable care by predicting whether a child client is at risk of harm from abuse if discharged into the custody the parent/carers.

The court will consider all the circumstances of the case when deciding whether a Health Worker has acted reasonably, including the nature and extent of the risk of harm and the resources available to deal with the risk. The Health Worker will only be liable for a breach of the duty of care where they have not acted reasonably, the breach has caused injury or loss to the person to whom the duty is owed and that injury or loss is not considered too remote.

Client Consent to Treatment and Disclosure of Material Risks

Duty to Obtain Consent

Except in an emergency situation, a Health Worker has a legal obligation to obtain the patient's voluntary consent before any physical examination, test, procedure or other treatment is provided.

Informed Consent

A Health Worker has a duty to inform the client in broad terms about the general nature of the proposed treatment, including any material risks inherent in the treatment, so that the client understands what they consenting to.

A Health Worker may be liable for negligence where a client has been informed of the type of treatment to be undertaken but has not been told of the material risks involved.

Before providing any treatment, the Health Worker providing the treatment should provide the following information to the client in terms that they will understand:

- An explanation of the client's condition
- The reasons for the proposed treatment or care
- The risks involved, including any significant long-term physical, emotional, psychological, social, sexual or other risks
- The expected benefits (noting that the results of treatment can never be guaranteed)
- Alternative treatment options, including the likely result of 'no treatment'
- Whether the treatment is irreversible
- The time involved in the treatment
- The likely recovery period
- Any follow-up care that may be required

Matters that have been discussed should be accurately documented in the client's medical file, including any questions asked by the patient and the answers to those questions.

Legal Capacity to Consent

A client must have legal capacity to consent to the treatment to be performed. A client will have capacity to consent where they are able to understand in broad terms the nature and consequences, including the risks, of the proposed treatment.

In the case of medical treatment to children (persons under 18 years of age), the appropriate person to consent to the treatment of that child will ordinarily be the child's parent or other legally appointed guardian.

However, a child is considered to be a 'mature minor' where the child is capable of giving informed consent to treatment and where that child has sufficient understanding and intelligence to enable her or him to understand fully what is proposed and the consequences of it. The assessment of a child client as a 'mature minor' involves the Health Worker making a judgement about the client based upon the circumstances of the individual case.

Any assessment of a child client as a 'mature minor' and that child's consent to treatment should be clearly documented in that client's medical file.

Duration of a Patient's Consent

A Health Worker's duty to disclose material risks and obtain a patient's consent for treatment is a continuing obligation and should occur as close as is reasonably practical to the commencement of the treatment. The Health Worker should also be mindful of any changed circumstances, which may require further discussion.

Female Genital Mutilation

In Western Australia, section 306 of the *Criminal Code* provides that a person who performs "female genital mutilation" on another is guilty of a crime and is liable to imprisonment for 20 years. The fact that the person or their parent or guardian consented to the "female genital mutilation" is no defence.

Section 306 also provides that a person who takes a child from Western Australia or arranges for a child to be taken from Western Australia with the intention of having the child subjected to female genital mutilation is also guilty of a crime and is liable to imprisonment for 10 years.

A Health Worker who suspects that a person has been subjected to female genital mutilation should contact Legal and Legislative Services for advice.

Sexually Transmissible Infections

The Department of Health Notification Form lists notifiable infectious diseases under the *Health Act 1911*. Medical practitioners are required to send completed notification forms by post or facsimile to the Communicable Disease Control Directorate for cases resident in the metropolitan area or to the appropriate regional Population Health Unit for cases resident in country areas. The notifiable sexually transmissible infections include Chancroid (soft sore), *Chlamydia* (genital infection), Donovanosis (*Granuloma inguinale*), Gonorrhoea, Syphilis and HIV/AIDS infection.

An interagency protocol has been implemented to ensure that the Department for Community Development and the Police become aware of all children with sexually transmissible infections that are notified on the basis of public health legislation. Under the interagency protocol, the Director of the Communicable Disease Control Directorate in the Department of Health, will on-report to the Department for Community Development and the Western Australian Police Service all verified notifications of sexually transmissible infections in children under 14 years of age, where the diagnosing practitioner is of the opinion that the infection was acquired sexually. In addition, the Director will on-report to these agencies any children aged 14 or 15 years who have a verified diagnosis of a sexually transmissible infection, and where possible sexual abuse has been identified by the notifying medical practitioner.

Note: This does not alter the obligation on the diagnosing practitioner to report suspected sexual abuse to the Department for Community as soon as the sexual abuse is suspected. A referral may also be needed to the Police Child Abuse Investigation Unit. These referrals should be made irrespective of whether a sexually transmissible infection results from that abuse.

The reporting of the sexually transmissible infection to the Department of Health is a separate obligation under the *Health Act 1911* provisions for control of infectious diseases. Notification of an infection to the Department of Health does not replace the obligation for notification and referral of children with suspected sexual abuse to the Department for Community Development and the Police Department when appropriate.

Legislative Power to Detain a Child

Section 29(3a) of the *Child Welfare Act 1947* authorises the medical officer in charge of a hospital (or her/his deputy) to order a child to be detained in hospital for up to 48 hours where:

- the child has been admitted to the hospital
- the child is under 6 years
- there are reasonable grounds to suspect that the child is in need of care and protection
- the child is detained for the purposes of observation, assessment or treatment

Section 4(1) (a) to (k) defines a "child in need of care and protection". However, this definition and section 29(3a) of the *Child and Welfare Act 1947* are to be replaced with yet to be enacted provisions in the *Children and Community Services Act 2004*. Should a health worker suspect that a child is need of care and protection the advice of officers of the Department for Community Development should be obtained.

Section 29(3b), that where a child is detained in a hospital pursuant to subsection (3a), on the expiration of that period of detention the child shall

(a) be discharged from the hospital
(b) remain in the hospital with the consent of a parent or guardian
(c) be apprehended and dealt with in accordance with the provisions of this section or of section 47B

Please seek legal advice if you are unsure of you obligations, after you have discussed your concerns with your manager.