



The Royal Australasian
College of Physicians

PROTECTING CHILDREN IS
EVERYBODY'S BUSINESS:
PAEDIATRICIANS RESPONDING TO
THE CHALLENGE OF CHILD
PROTECTION

POLICY DOCUMENT

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1. INTRODUCTION

The previous RACP child protection policy (also named Protecting Children is Everybody's Business), released in 2000, emphasised the role and responsibility of paediatricians in the recognition of child abuse as well as its prevention and management. It highlighted the impact of child abuse on children, reviewed the reporting and substantiation data for New Zealand and recommended a 'systems approach' to the prevention of child abuse; this reflected the New Zealand Government approach and to a variable degree the State and Territory Government approach in Australia. It also discussed physical punishment and discipline, highlighting the role paediatricians could play in changing attitudes and behaviours in this regard (see *Physical Punishment of Children*¹).

This document outlines the roles and responsibilities of paediatricians in responding to child protection issues in Australia and New Zealand. It reflects contemporary Australian and New Zealand approaches to the management of children who may be or are in need of protection and clarifies the role paediatricians can play in supporting and enhancing children's wellbeing. It advocates for a public health approach to protecting children, incorporating the concepts of primary, secondary and tertiary prevention.

It encourages paediatricians to take on stronger primary and secondary roles than previously recommended, as well as maintaining a tertiary role when appropriate. Central to the primary and secondary roles is the conduct of a comprehensive psychosocial assessment and the subsequent provision of or referral to appropriate services.

This position statement recognises that debate on the benefits and drawbacks of mandatory reporting has not been resolved and is ongoing.

2. EXECUTIVE SUMMARY AND RECOMMENDATIONS

Through their training and experience, paediatricians have expertise in the assessment and examination of children and young people for whom there are behavioural, developmental or physical health concerns. These skills are very relevant to protecting children at the primary, secondary and tertiary levels (see definitions in 'Protecting children – the spectrum'). Paediatric involvement in protecting children and related issues can be of value to other professionals working with children and their families:

- The public health model (see definition in 'Protecting children – the spectrum') recognises the importance of primary and secondary child protection activities in addition to those at the tertiary level.
- Primary child protection work in regional centres may be undertaken by primary health care workers (such as general practitioners, nurses, allied health workers and Aboriginal and Torres Strait Islander health workers). Regional paediatricians have a central role in the education and support of these workers in their child protection work.

- Paediatricians can be expected to provide appropriate responses to protect children across the spectrum of primary, secondary and tertiary levels, according to their training and designated responsibilities.
- Paediatricians must be supported in both their practice and continuing education by health departments and statutory child protection agencies, to enable them to work across the protecting children spectrum. In metropolitan Australian centres, child protection/forensic paediatricians practise mainly at the tertiary statutory level, and general and community paediatricians practise at both primary and secondary levels. In regional centres in Australia and in District Health Boards in New Zealand, paediatricians provide professional input at each of the levels – primary, secondary and tertiary.
- Paediatricians should understand the reporting requirements (mandatory or otherwise) in their jurisdiction and be updated by regular information campaigns and educational programs conducted to ensure they and other health professionals have contemporary, relevant information.
- When paediatricians notify statutory agencies of their concern that a child may have been harmed or is at significant risk of harm (refer to local jurisdiction legislation for clarification, Appendix 2), they should include the information obtained from their comprehensive psychosocial evaluation as well as the information they have gathered from other agencies, using appropriate State, Territory or National endorsed 'Information Sharing Guidelines' (see Appendix 3). Following their reporting of a child and family, paediatricians should attempt to remain involved and continue to provide paediatric advice and care.
- Paediatricians should seek and receive timely updates from statutory agencies to enable them to remain involved throughout the investigation and intervention phases of any statutory response as well as comprehensive feedback from statutory agencies regarding the outcome of the statutory agency's assessment and management plans to ensure that they are able to continue to provide a service to the child and family.
- The Common Approach to Assessment, Referral and Support (CAARS) in Australia and the Children's Action Plan in New Zealand provide a framework that health professionals in Australia and New Zealand can use to identify risk factors and protective factors that influence a child's potential vulnerability to abuse.²
- Interprofessional and interagency partnership is crucial at all levels of work to protect children. The professionals include general practitioners, nurses, statutory agency staff, hospital and community social workers, and allied health professionals.³ Paediatricians must be involved in interprofessional and interagency training to improve the assessment and management of vulnerable or abused children and their families.

3. FOREWORD

Australia and New Zealand are both signatories to the *United Nations Convention on the Rights of the Child*.⁴ This international treaty outlines and protects the civil, political, social, economic and cultural rights of children. The four core principles are non-discrimination, devotion to the best interests of the child, the right to life, survival and development, and respect for the views of the child.

Article 19 (out of 54) specifies the responsibilities of states in relation to the protection of children.

Article 19, *United Nations Convention on the Rights of the Child*:

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

This clear statement says that all states are obliged to take measures to protect children from all forms of abuse and neglect, and to ensure that all appropriate protective measures are in place to safeguard children. The Royal Australasian College of Physicians (RACP) *Protecting Children is Everybody's Business* policy document provides paediatricians and other health professionals with guidance in the protection of children and young people from harm.

Moreover, Australia and New Zealand as sovereign states occupying colonised Indigenous lands have deeper responsibilities towards Aboriginal and Torres Strait Islander and Māori peoples. In New Zealand these were formalised in part by *Te Tiriti o Waitangi* (The Treaty of Waitangi), Article 3, of which in its English translation imparts to Māori “all the Rights and Privileges of British Subjects”. This is generally taken to include an assurance of rights of health and physical security. In Australia the legal concept of *Terra Nullius* meant that Aboriginal and Torres Strait Islander lands were occupied without any such assurances; however, documents such as the National Sorry Day Statement of 1998 note a responsibility to acknowledge past wrongs and overcome racism.

In the context of this policy, a paediatrician is a specialist medical practitioner who deals with the medical care of infants, children and young people. Paediatricians in Australia and New Zealand are generally Fellows of the RACP. The practice of general paediatricians extends across the broad range of health issues of infants, children and young people; community paediatricians may practise in one or more of the domains of community child health – developmental and behavioural paediatrics, child population health or child protection. A small group of metropolitan or occasionally regional-

based community or general paediatricians work in tertiary level child protection and may refer to themselves as child protection or forensic paediatricians.

New Zealand's child protection legislation and child protection procedures are applicable nationally, whereas in Australia, child protection legislation, policies and procedures are a state and territory matter. Paediatricians must be versed in the requirements of the jurisdiction in which they work. Those paediatricians working in state border areas, central Australia or under more than one jurisdiction have compounded difficulties as they may be providing a response to protect children in either of two different jurisdictions.

All paediatricians, whether general, community or sub-specialist, will need to address possible maltreatment concerns (commonly divided into physical, sexual, emotional, neglect, illness fabrication or induction) in children and young people and also the presence of adversity in families.

Adversity or vulnerability is identified in a family by a comprehensive psychosocial assessment.⁵ It is important for paediatricians to perform such assessments, which are also undertaken by non-medical child protection professionals such as psychologists and social workers.

Child protection/forensic paediatricians are also required to assess and manage the various forms of suspected child maltreatment in collaboration with the responsible statutory agency and the police.

In this document the term 'paediatrician' applies to the group of paediatricians as a whole. When the term 'child protection/forensic paediatrician' is used, it refers to those paediatricians who most often are working in a metropolitan environment providing a tertiary level forensic medical response. This usually occurs after involvement of a statutory agency and the police but may occur as a preliminary response which then leads to police and statutory agency involvement.

In regional areas in Australia and in the District Health Boards in New Zealand the child protection/forensic paediatric response is usually provided by general or community paediatricians.

This updated RACP policy document highlights the important role played by paediatricians in protecting vulnerable children and the importance of prioritising the prevention and early identification of suspected child abuse or risk of harm to achieve this.

4. HISTORICAL PERSPECTIVE IN RELATION TO THE PAEDIATRICIAN'S ROLE

Reviewing the medical profession's history in dealing with child abuse helps to understand the current role of paediatricians in child protection. In 1961 Dr Henry Kempe and his colleagues successfully lobbied the American Academy of Pediatrics (AAP) to sponsor a symposium on 'The Battered Child Syndrome' as part of its meeting in Chicago. The group published a paper, 'The Battered Child Syndrome', in the *Journal of the American Medical Association* the following year.⁶ This paper is considered by many as the most significant publication in the development of the health system response to child abuse. The authors emphasised to doctors that the battered child syndrome

was a frequent cause of permanent injury or death and drew attention to the responsibilities of doctors to evaluate any suspected instance of the syndrome. Specific and broad aspects of child abuse were further elaborated in a comprehensive text in 1968.⁷ These publications played a significant role in raising awareness of child abuse within the health and medical professions and bringing emphasis to the duty and responsibility of doctors to identify and manage suspected cases of child abuse.

'The Battered Child Syndrome' made prominent the concept of a legislative base requiring mandatory reporting of suspected child abuse and neglect. This legislation was justified by the presence of systemic barriers that were recognised as preventing doctors from reporting suspected child abuse. 'The Battered Child Syndrome' also considered that many doctors lacked an understanding of their legal and moral obligations and often had emotional ties to the particular family of concern that made them less likely to accept the possibility that child abuse was occurring. In addition, less experienced doctors often did not consider the diagnosis of child abuse as an option and many were unaware of reporting procedures if they did have a concern. With the recognition of these barriers, the role of doctors – particularly paediatricians and general practitioners – was seen as crucial given that abused children most often came to attention when a caretaker sought medical assistance for the child.

During the 1970s and 1980s various reports and studies were conducted in both the United States and the United Kingdom. A key theme and recommendation was that education of doctors, social workers and other professionals such as lawyers was imperative to raise awareness, detection and treatment of child abuse. In the UK significant reforms followed the 2003 inquiry into the death of Victoria Climbié, formalised in the Children Act 2004. Lord Laming, who chaired the inquiry, made specific recommendations concerning paediatricians and general practitioners.⁸ He emphasised the important responsibility of the Royal College of Paediatrics and Child Health "to develop models of continuing education in the diagnosis and treatment of the deliberate harm of children and in the multi-disciplinary aspects of child protection investigation".⁹

Of particular note in Lord Laming's report was his recommendation that general practitioners should take a full history of new child patients to include "wider social and developmental issues likely to affect the welfare of the child, for example their living conditions and their school attendance".¹⁰ This recommendation reflected an increased focus on child welfare – addressing the adverse factors that may be associated with child abuse – rather than on child abuse after the fact. This broader approach aimed to address adversity with the goal of preventing or minimising child abuse, rather than the historical approach of identifying and treating child abuse and trying to prevent it once it was already happening.

5. PROTECTING CHILDREN – THE SPECTRUM

This position statement reflects contemporary practices for protecting children in Australia and New Zealand, as laid out in government policy documents in both countries.

In New Zealand the key documents are the White Paper for Vulnerable Children (volumes I, II, III)¹¹ and the Children’s Action Plan (released in 2012).¹² In Australia the Federal Government policy document is the National Child Protection Framework, 2009–2020.¹³ The framework adopts a “public health” approach to protecting children with primary, secondary and tertiary components being emphasised. The Australian Framework was endorsed by the Council of Australian Governments.

Australia’s *National Framework for Protecting Australia’s Children*¹⁴ recognises that:

“Australia needs to move from seeing ‘protecting children’ merely as a response to abuse and neglect to one of promoting the safety and wellbeing of children.... Just as a health system is more than hospitals so a system for the protection of children is more than a statutory child protection service.” (p. 7)

This shift is a significant one and represents a perspective that is different from the historical response to child abuse and neglect. The *National Framework* identifies a spectrum across which activity to protect children should occur. Whereas initially the health system response to protecting children emphasised tertiary activity – treating and protecting children who had already experienced abuse or neglect – it is now considered that all service providers to children and families have a role to play in preventing child abuse at the primary and secondary level before it occurs. This approach is also reflected in the Children’s Action Plan for Vulnerable Children being developed in New Zealand.

The shift in emphasis was also reflected in the *Report of the 2008 Special Commission of Inquiry into Child Protection Services in NSW*. The Commissioner, Justice Wood, set down eight principles to guide protecting children in NSW. These are applicable across Australia and New Zealand. They are very similar to the principles stated in the New Zealand White Paper for Vulnerable Children, volume II.¹⁵

The Wood principles:

1. Child protection is the collective responsibility of the whole of government and the community.
2. Primary responsibility for rearing and supporting children should rest with families and communities, with government providing support where it is needed, either directly or through the funded nongovernment sector.
3. The child protection system should be child focused, with the safety, welfare and wellbeing of the child or young person being of paramount concern, while recognising that supporting parents is usually in the best interests of the child or young person.
4. Positive outcomes for children and families are achieved through development of a relationship with the family that recognises their strengths and their needs.
5. Child safety, attachment, wellbeing and permanency should guide child protection practice.

6. Support services should be available to ensure that all Aboriginal and Torres Strait Islander children and young persons are safe and connected to family, community and culture.
7. Aboriginal and Torres Strait Islander people should participate in decision making concerning the care and protection of their children and young persons with as much self-determination as is possible, and steps should be taken to empower local communities to that end.
8. Assessments and interventions should be evidence based, monitored and evaluated.

The RACP supports these principles as useful guidance to paediatricians for the protection of children and considers them to be applicable to both Australia and New Zealand.

Much work to protect children in rural and regional areas is undertaken by primary health care workers (such as general practitioners, nurses, allied health care workers and where appropriate Aboriginal and Torres Strait Islander health workers), and regional paediatricians have an essential role in supporting their child protection work through acknowledgement and enhancement. Children in these areas are referred to tertiary centres where necessary.

Regional paediatricians, particularly, need support to continue their work protecting children. Ongoing education should be provided as needed to each paediatrician in the context in which they undertake this work. Tertiary level child protection units have a role in assisting through peer support and review.

There is a range of necessary skills relevant to paediatric practice that are required over the course of a paediatrician's career.

Primary and Secondary Child Protection and the concept of vulnerability/adversity

Primary level protection involves universal service provision by Government and non-Government services. Such services (e.g. universal health, welfare and education services and programs) support all children and families.

Secondary level protection involves the identification and provision of targeted services to vulnerable families early enough to change risky behaviours and adversity, and consequently avoid pathways to abuse. For example, vulnerable families with a new baby might be offered a Family Home Visiting Program.¹⁶

Specialist mental health, domestic violence and drug treatment services also have an important role in secondary level protection of children. The challenge for such service providers in these areas is to broaden their adult-focused role to encompass the wellbeing of the child as well as to work with the parents.

In Australia's *National Framework* primary and secondary protection is based on a broad social safety net and support for families in their parenting role. The goal of such services is to provide the conditions for optimal cultural, psychological and physical development of all children. Central to universal prevention efforts is mitigating adversity, the presence of which impinges on children's

capacity for *optimal* development. All health professionals involved with children have a role at the primary and secondary levels, as do other service providers such as education and social services. Paediatricians have a specific role in advocacy to local and national/state/territory government departments in support of the protection of children.

The presence of adversity or vulnerability in relation to children may be associated with harm already present or likely to occur. There may be a need to protect a child whenever there is a breakdown in parenting and a family is not functioning well. Adversity is identified through a comprehensive psychosocial evaluation of a child's circumstances within their family. Performing a psychosocial evaluation is part of the paediatrician's role.

All children are reliant on the adults responsible for their care to provide them with food, shelter, nurture and a safe environment in the appropriate cultural context. This dependence also makes them vulnerable when the level of parenting is inadequate.

When these needs are not met or are compromised, a child's development and wellbeing is endangered.

The adverse factors that pose a threat to a child's development and wellbeing might be intrinsic to the child, for example chronic ill health, disability, young age and temperament, or to their family environment.

External adverse factors include (but are not limited to):

- poor maternal health behaviours in pregnancy (for example smoking)
- poor maternal mental health¹⁷
- parental substance abuse¹⁸
- parental antisocial or criminal behaviour
- material hardship and economic difficulties^{19,20,21}
- poor-quality and unstable housing²²
- poor nutrition²³
- exposure to violence in the family²⁴
- recurrent maltreatment as a child.²⁵

Mitigating adversity is the goal of those services which appear in the second level of Australia's *National Framework* for protecting children. This level of intervention is characterised by targeted early interventions aimed at vulnerable children, to strengthen their families and communities before adversity leads to them being significantly harmed. Mitigating adversity is also a key role of the children's teams that are being established in New Zealand as part of the Children's Action Plan. From the perspective of paediatrics, community and general paediatricians play a significant role in

linking children and families to targeted services that will provide the necessary assistance to manage or reduce the level of adversity present. Such services do not necessarily have a child protection label or title, for example they might involve housing or employment support, or parenting skills workshops. Targeted programs for families and children with identified 'risk factors' (or family adversity/vulnerability) are aimed at addressing the vulnerabilities before the statutory child protection system needs to be engaged.

Tertiary Level Child Protection

Tertiary level protection is that which involves the statutory system. It includes the assessment, documentation and opinion formulation by paediatricians of suspected inflicted injury, sexual or emotional abuse, neglect, or fabricated or induced illness) and the preparation of a report for the police and the statutory welfare agency.

Children identified at this level need to be quickly assessed and provided with effective treatment for their abuse and trauma, and appropriate and secure placements made available to avoid further damage in situations where it is unsafe for children to remain at home.

Each State and Territory in Australia has child protection legislation which mandates paediatricians (and various other professionals) to report "suspicions of child abuse" or concerns of "high risk of child abuse". Individual state and territory legislation varies and paediatricians must be familiar with their jurisdictional obligations (see Appendix 2).

In New Zealand there is no specific mandatory reporting requirement, but the Children's Action Plan contains a range of initiatives that raise expectations on agencies and make it easier for frontline staff and the public to identify vulnerable children and report concerns to Child, Youth and Family. The Children, Young Persons, and Their Families Act 1989 also provides guidance and regional District Health Board policies support reporting by clinicians of children for whom abuse is suspected.

The General Medical Council in the UK has published a guideline²⁶ that outlines the duty of all doctors to act on any concerns they have about the safety or welfare of a child or young person.

The Council states that all individuals who work with children and young people must recognise signs that indicate the possibility that the child has been harmed. The Council recommends that possible harm be categorised according to tertiary level definitions (physical, sexual, emotional abuse or neglect, and induced or fabricated illness).

The National Institute for Health Care and Excellence (NICE) in the United Kingdom published 'When to suspect child maltreatment' in 2009, with modifications in 2013.²⁷ The guidance is relevant to both New Zealand and Australia and provides advice to health professionals, with recommendations to either "consider", "suspect" or "exclude" maltreatment.²⁸

Specifically, the NICE guidance provides advice in relation to physical features, clinical presentations, neglect (failure of provision and failure of supervision), emotional, behavioural, interpersonal and social functioning, and parent-child interactions.

In Australian and New Zealand jurisdictions the relevant child protection legislation defines the key terms relating to physical, sexual, emotional abuse and neglect. There is a similarity between the definitions used across the Australian States and Territories and New Zealand definitions.

Key terms are defined below:

- Physical abuse: any act or acts that result in inflicted injury to a child or young person. Such injury or injuries may be deliberately inflicted or the unintentional result of rage. Regardless of motivation, the result for the child or young person is physical abuse.
- Sexual abuse: any act or acts that result in the sexual exploitation of a child or young person.
- Emotional abuse: any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person. It includes such behaviours as rejection, deprivation, continued criticism, exposure to family violence, corruption of a child or young person, the negative impact of the mental condition of the caregiver, the negative impact of substance abuse by anyone living with the child or young person.
- Neglect: any act or omission that results in impaired physical functioning, injury and/or development of a child or young person. It includes physical neglect, neglect of supervision, medical neglect, abandonment, refusal to assume parental responsibility by not providing adequate care or control of a child or young person.
- Fabricated or induced illness: another form of harm that is not generally defined in Child Protection legislation. It occurs when a carer actively promotes the sick role in a child by exaggeration, non-treatment of real problems, fabrication (lying) or falsification of signs, and/or induction of illness. In addition to these severe cases, there are others where a child may present for medical attention with unusual or puzzling symptoms which are not attributable to any organic disease, and yet do not involve deliberate fabrication or deception, but are a manifestation of excessive and potentially harmful parental concern. Statutory intervention in such situations is generally based on the physical aspects of the harmful parental behaviour or on the identified psychological consequences.

Where one type of harm to a child is uncovered, others may also be present. It may compromise the child or young person further to fail to identify the presence of other forms of abuse, since this might result in other significant adverse factors not being identified, assessed and managed.

Emotional harm is a component of all forms of abuse. For example, it is important to consider that a child or young person who has been sexually abused may also have experienced neglect and/or physical or emotional abuse through such behaviours as physical assault, coercion, intimidation and isolation.

6. THE AUSTRALIAN AND NEW ZEALAND MODELS OF CHILD PROTECTION PRACTICE

In New Zealand the key documents are the White Paper for Vulnerable Children (volumes I, II, III)²⁹ and the Children’s Action Plan (released in 2012).³⁰ In Australia the Federal Government policy document is the National Child Protection Framework, 2009–2020.³¹ The framework adopts a “public health” approach to protecting children, with primary, secondary and tertiary components being emphasised. The Australian Framework was endorsed by the Council of Australian Governments.

Below are schematic representations of the principles identified in each of the policies. The principles form the foundation for the approaches to be used in the practice of protecting children.

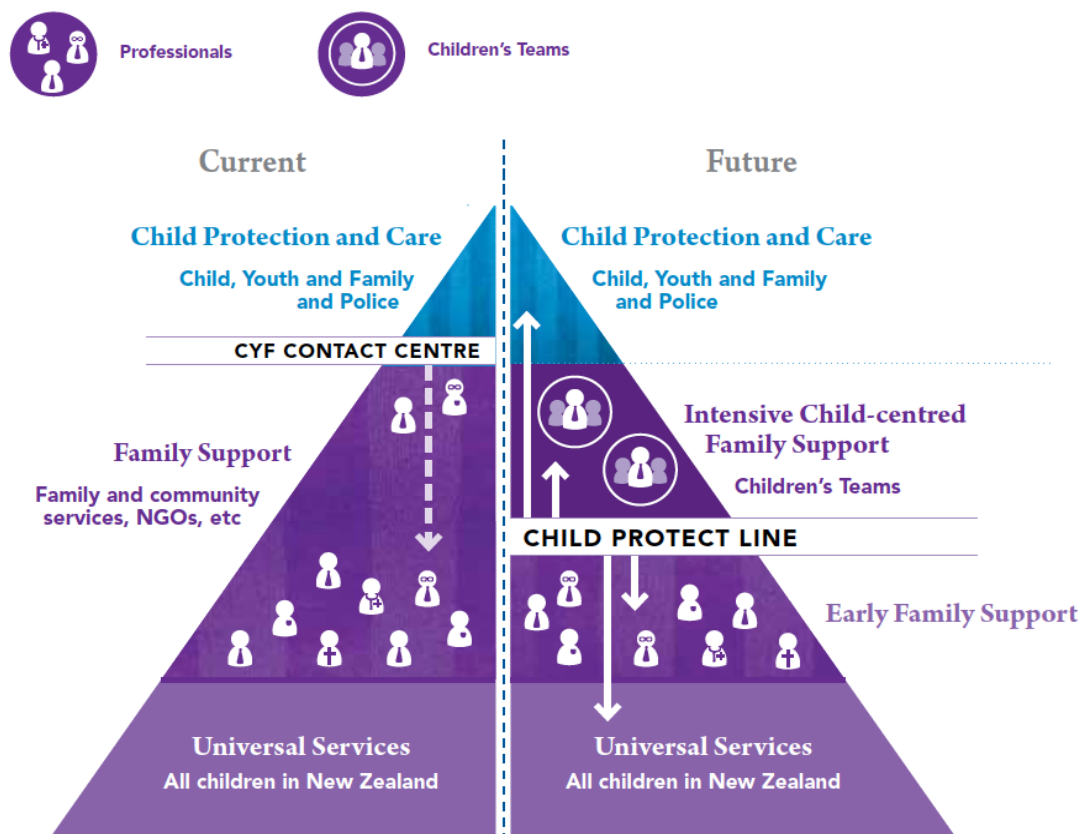


Figure 1 From the New Zealand White Paper for Vulnerable Children

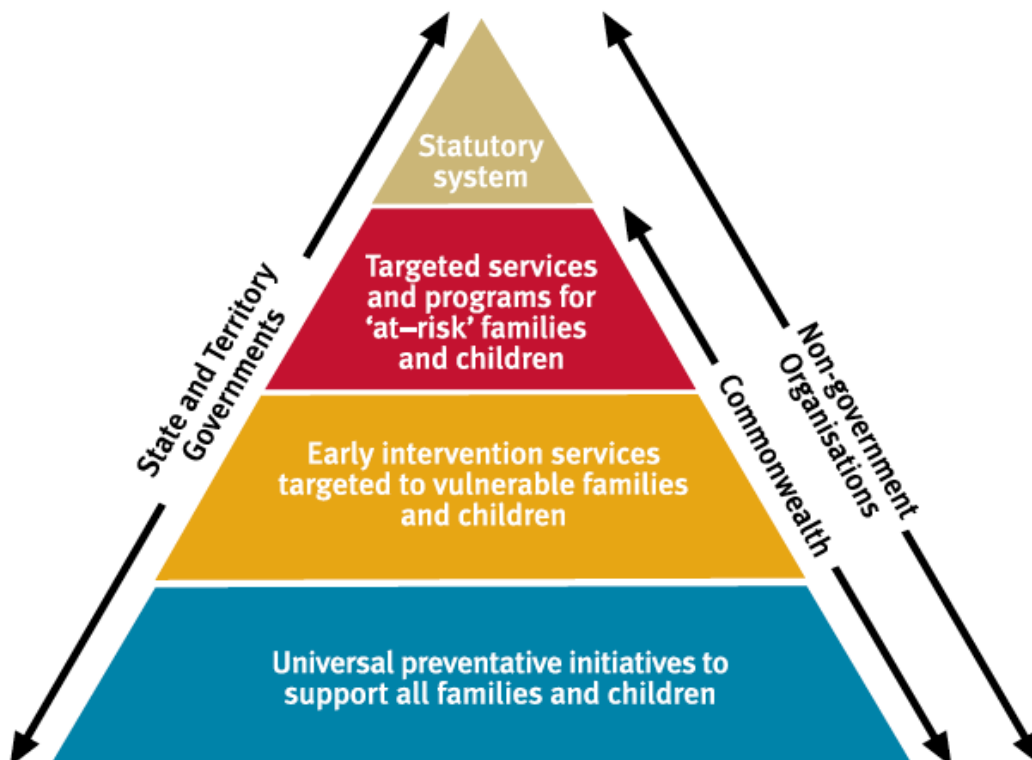


Figure 2 From Australia's National Framework for Protecting Children (2009–2020):

Primary (universal) → Secondary (targeted) → Tertiary interventions

Key elements of each model and their implications for paediatricians are below:

- A focus on protecting children at all levels of intervention.
- Paediatricians in both Australia (through mandatory reporting) and New Zealand (through Section 195A of the Crimes Act) are required to initiate child protection interventions when they believe that a child or young person may have been harmed. In some jurisdictions in Australia reporting is required when a child is considered to be at significant risk of harm.
- Emphasis on the importance of identifying and addressing factors that make children vulnerable before they become apparent or escalate to child abuse. These models are particularly relevant from the perspective of the RACP, as they draw attention to the role that all paediatricians could and should play across the protecting children spectrum, and to the importance of paediatricians collaborating with other health and social service professionals and agencies. Where concerns exist around the potential for harm to a child, more effective communication between paediatricians, statutory bodies and other health and welfare professionals could assist families in accessing relevant services.
- The New Zealand White Paper defines vulnerable children as “children who are at significant risk of harm to their wellbeing now and into the future as a consequence of the environment in which they are being raised and, in some cases, due to their own complex needs”.³²

- Insistence on a much higher level of interagency and interprofessional responsibility. This means that paediatricians who refer children and young people to statutory child protection agencies should receive feedback from the statutory agency's assessment and management decisions throughout the investigation and intervention phases.
- All health professionals and others (e.g. teachers and child care workers) whose work brings them into contact with children, young people and families have a similar level of primary and secondary responsibility. However, paediatricians, through their training in the assessment, observation and examination of children and young people, have the skills to advise and support other professionals in issues relating to protecting children. This is especially the case when it is necessary to determine whether a child or young person may have been harmed as opposed to experiencing the effects of an adverse environment. Likewise, paediatricians themselves will be better informed about the needs of the child through coordination and working together with the other professionals involved with the child

7. PAEDIATRICIANS' RELATIONSHIP WITH AND RESPONSIBILITY TO STATUTORY AGENCIES

Paediatricians working in Australia should be aware of their legal responsibility (known as mandatory reporting) by consulting the legislation of their particular State or Territory. There is no mandatory reporting in New Zealand; however, as part of the Children's Action Plan the New Zealand Government intends to introduce a range of initiatives that will raise expectations on agencies and make it easier for frontline staff and the public to identify vulnerable children and report concerns.³³ Section 195A of the Crimes Act (New Zealand) was amended in 2011 to make persons liable if they "fail to take reasonable steps to protect" a vulnerable child or other person known to be at risk.³⁴ Most District Health Boards in New Zealand have child protection policies in place requiring that clinicians concerned that a child "may have been abused" report their concerns to statutory authorities. This ensures that a full investigation of the child's situation can occur.

Useful guidance regarding reporting to statutory agencies is available on the NSW Department of Health website.³⁵

Some paediatricians may not have considered recognition of vulnerability or adversity in children and young people as an effective alternative approach to the prevention of harm, without the need for involvement of the statutory agency. Once vulnerability is recognised it may be reduced, and therefore harm prevented by referral to appropriate agencies.

It is important to note that attempts by paediatricians to involve child protection statutory agencies are not always successful because the paediatrician's concerns may be determined to have not reached the statutory agency threshold. In other situations the threshold may be reached but there may not be sufficient resources within the agency for the case to be allocated for an investigation. Consequently, the vulnerable families about which paediatricians are concerned do not receive a service response. It is important that relevant statutory bodies educate paediatricians and other health

professionals around reporting requirements and the capacity of statutory agencies to respond. Promoting the use of secondary measures to support children and their families, where appropriate, is important.

Of relevance are the data from the Australian Institute of Health and Welfare publication, *Child Protection Australia 2011–2012*. The total number of notifications for that year was 252,962 involving 173,502 children. Of these notifications, 116,528 were investigated and 48,420 (41.5 per cent) were substantiated.³⁶

Over the same 12 months in New Zealand there were 152,800 care and protection notifications made. In New Zealand in the year ending June 2013 there were 148,659 notifications to Child, Youth and Family, 61,877 required further action and abuse was substantiated for 22,984.³⁷

8. PSYCHOSOCIAL EVALUATION: IDENTIFICATION OF VULNERABILITY AND REFERRAL TO SERVICES

The Common Approach to Assessment, Referral and Support (CAARS) is a model developed under the Australian *National Framework* to identify strengths and needs (or adversity) across six domains of wellbeing.³⁸ It provides a framework within which service providers who work with children and families can easily identify adverse factors in relevant aspects of a child's life. It is useful both to identify adversity that can be a focus for intervention or support and to highlight strengths to build on.

The six wellbeing domains are:

- Physical health
- Mental health and emotional wellbeing
- Relationships
- Material wellbeing
- Learning and development
- Safety.

These domains encompass child, family and community factors. Within the child domain, factors that may indicate adversity include a disability (physical or cognitive), whether the child displays unsafe behaviours, or where development is delayed. Family factors may include parental attributes such as a physical disability or mental illness in one or more parents, the safety of the home environment, drug and alcohol abuse, or if there is either suspected or substantiated domestic violence.³⁹ Being in out-of-home care and living in poverty are other family factors that indicate adversity. Community factors that may mitigate adversity include the presence of trusted adults or other support outside the family, the availability of services in the local area, and the safety of the neighbourhood or school community.

Under the CAARS model, each of these factors can be highlighted by service providers as areas of need, providing focus for intervention and support. Any service provider who works with a child or

family can identify areas that need strengthening, as well as existing strengths on which to build. For example, a child with a disability and an unstable home life may have a trusted and supportive relative or friend in the local community and that relationship can be fostered and enhanced while concurrently seeking to ensure that the parents receive the required care and support services. All factors need to be considered in the context of children's developmental needs at different stages of life.

In New Zealand Whānau Ora is an inclusive interagency approach to providing health and social services to build the capacity of Māori families in need. It empowers whānau (the wider family) as a whole rather than focusing separately on individual family members and their issues. Some whānau will arrange support for themselves by working with the organisations available to them. Others will seek help from specialist Whānau Ora providers who offer services tailored to their needs.⁴⁰

9. SPECIFIC VULNERABLE POPULATIONS AND CULTURAL CONSIDERATIONS

In addition to considering the above factors, there are some particular population groups that may be more vulnerable to adversity.

Children of refugee or recent immigrant families are likely to experience more adversity. Their families are less likely to be economically stable, there may be a past or recent experience of trauma in the parents and/or children, the children's schooling may have been disrupted, they may not be comfortable speaking English, and their family may be fragmented.

In New Zealand Māori children and adults are more at risk of fatal abuse and intimate partner violence than Pākehā (New Zealand European) children (and adults). This is influenced by associations with deprivation and poverty, and attributable beyond that to ongoing loss of land, language and culture, and the impact of racist values and institutions.

“E kore e ngaro, he kakano i ruia mai i Rangiatea – the seed that was planted at Rangiatea will never be lost”

Māori cultural traditions are strongly pro-child, a fact attested to by early reports from New Zealand settlers:

“Their love and attachment to children was very great, and not merely to their own immediate offspring. They (Māori Adults) very commonly adopted children; indeed no man having a large family was ever allowed to bring them all up himself. Uncles, aunts and cousins claimed and took them, often whether the parents were willing or not. The father, or uncle, often carried or nursed his infant on his back or quietly to work with the little one there snugly ensconced.”⁴¹

In Australia children of Aboriginal and Torres Strait Islander origin are markedly overrepresented in mandatory reports of suspected child abuse and neglect.⁴² There is little knowledge of parenting

practices in pre-colonisation Aboriginal communities. Colonisation continues to be highly destructive of the social structure and function of Aboriginal communities. This was compounded further by the enduring impact of the 'Stolen Generation' in undermining parenting capacities.

Children of Aboriginal and Torres Strait Islander origin are also significantly overrepresented in the out-of-home care group. This group of children are more likely than the general population to experience adversity. In 2012 the rate for Aboriginal and Torres Strait Islander children to be in out-of-home care was 55.1 per 100,000 compared with a non-Aboriginal rate of 5.4 per 100,000.

Children who are in out-of-home-care are likely to have poorer physical, mental and developmental health compared to their peers.⁴³ Paediatricians who work with children in out-of-home-care should be alert to factors that may impact on the child's vulnerability. Availing themselves of information-sharing procedures in relation to the child and their family is often useful in establishing the presence and level of any adversity that may impact on or is already affecting the child's wellbeing.

Children with a disability are more likely to have higher levels of family adversity and therefore to be at an increased risk of harm. Families who have a child with a disability are likely to experience an economic impact from providing care for their child with a disability, and the parents' employment and/or housing situation may be compromised as a result.⁴⁴ The child's learning and development will depend on access to appropriate services. Family relationships and the emotional wellbeing of other family members as well as the child may also be impacted by the presence of a person with disability in the family. If it is a parent rather than a child who has a disability, then this is also a situation in which their child(ren) may be vulnerable. A parent with a disability, without external support and assistance, may be compromised in their ability to provide a stable home and appropriate care for their child(ren). The ability of the parent to secure and maintain employment may also impact on the child(ren).

10. HARM TO CHILDREN IN THE CONTEXT OF INTIMATE-PARTNER VIOLENCE

Intimate partner violence is defined in the recent WHO *World Report on Violence and Health* as:

"... any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Such behaviour includes:

- *Acts of physical aggression – such as slapping, hitting, kicking and beating*
- *Psychological abuse – such as intimidation, constant belittling and humiliating*
- *Forced intercourse and other forms of sexual coercion*
- *Various controlling behaviours – such as isolating a person from their family and friends, monitoring their movements, and restricting their access to information and assistance."*⁴⁵

Prevalence rates of intimate partner violence vary between studies because of the particular definitions used, the manner in which intimate partner violence questions are asked, the particular population being studied and the degree of privacy during the interview with the subject. A large population-based study of New Zealand women reported rates of intimate partner violence of 33 per cent in Auckland and 39 per cent in rural Waikato.⁴⁶ Another New Zealand study found that 21 per cent of women presenting for emergency department care in South Auckland screened positive for a history of intimate partner violence in the past year and 44 per cent reported partner violence at some time in their adulthood.⁴⁷

In Australia the Australian Bureau of Statistics' Social Trends Survey estimated that in 2005, 17 per cent (1.3 million) of women aged 18 years and over had experienced partner violence and 59 per cent of victims of partner violence reported that their children directly witnessed the violence.⁴⁸

Children are known to be present in 60 to 85 per cent of the Australian homes where partner violence is occurring (two-thirds being under the age of five).⁴⁹

Children living in homes with intimate partner violence are also at greater risk of physical and sexual harm; in 40 per cent of cases of sexual contact and in 55 per cent of physical assaults of children, partner violence was found to co-exist.⁵⁰

When a case of intimate partner abuse presents to health services, the co-occurrence of physical assault of children in the family must always be considered. Conversely, when physical assault presents in children, the co-occurrence of adult violence must be considered.

The presence of intimate partner violence in a family is a significant type of adversity and is often associated with children being physically and emotionally harmed. When police reports were the standard for the identification of intimate partner violence in pregnancy, there was a 3.5 times increase in neonatal death and a 3.7 times increase in preterm delivery, compared with pregnancies where intimate partner violence had not been reported.^{51,52}

11. ROLE OF PAEDIATRICIANS

Protecting children is a vital component of the work of paediatricians. Paediatricians have a role at each of the three levels of the spectrum, namely universal, primary and secondary prevention. The CAARS model provides a framework that health professionals in Australia can use to identify risk factors and protective factors that influence a child's potential vulnerability to abuse. In New Zealand the Children's Action Plan⁵³ aims to support vulnerable children to prevent them reaching the crisis point at which they need statutory intervention because of abuse and neglect.

12. INFORMATION-SHARING GUIDELINES

Due to the complex nature of child abuse and problems within families, effective prevention of child abuse and enhanced protection of children can only be achieved if the various professions and agencies work in partnership. Such agencies include Child Protection, child welfare, family support and community health.⁵⁴ Paediatricians must work with the various professional groups to find solutions to improve outcomes for vulnerable or abused children and their families.

An important strategy to facilitate working together in both Australia and New Zealand has been the development of information-sharing guidelines. Each Australian State and Territory⁵⁵ has a specific set of guidelines, and there are national guidelines in New Zealand.⁵⁶ Paediatricians should become familiar with the information-sharing guidelines relevant to their jurisdiction.

The guidelines provide a mechanism by which certain professionals can share information about vulnerable children and families. These provisions typically apply to children's service providers (family services and out-of-home care), disability service managers, medical practitioners, school teachers, nurses, psychologists, social workers, public servants and other relevant health professionals.

Information-sharing guidelines are important for health professionals such as paediatricians as they provide a valuable, available route to follow up on concerns about a child's vulnerability. If a child is identified as vulnerable or the health practitioner identifies significant adversity, information sharing is an avenue by which they can fill in more of the 'bigger picture' surrounding the child and their family. This may provide reassurance that the circumstances are not cause for significant concern, but may also support the initial concerns and indicate that the circumstances warrant further follow-up or reporting.

Paediatricians who identify risk factors or adversity in a child they assess should seek opportunities to communicate with other involved agencies – as facilitated by the relevant legislation – as a way of determining whether the adversity is part of a wider picture of concern. In each jurisdiction there are processes by which health professionals or other professionals can either request information from others who are or have been involved with the same child or family members, or can volunteer information to be shared with other professionals. In this way paediatricians and other professionals can ensure that all those involved with a child and their family are aware of any relevant known information; such information may assist in the identification of adversity or vulnerability.

13. CONCLUSION

All jurisdictions are obliged to take measures to protect children from all forms of abuse and neglect, and to ensure that all appropriate protective measures are in place to safeguard children. This document outlines the important role that paediatricians can have in providing this protection. Through their training and experience paediatricians gain expertise in the assessment and examination of children and young people for whom there are behavioural, developmental or physical health concerns. In turn, they are able to provide care across primary, secondary and tertiary child protection levels.

14. ACKNOWLEDGEMENTS

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The Working Group was chaired by Dr Terence Donald, and also included:

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APPENDIX 1 – TERTIARY LEVEL CHILD PROTECTION DEFINITIONS

In Australian and New Zealand jurisdictions, protecting children and young people who have been abused or neglected is grounded in relevant legislation. Key terms relating to physical, sexual, emotional abuse and neglect are defined in the legislation. There is a similarity between the definitions used across the Australian States and Territories and New Zealand definitions.

Key terms are defined below:⁵⁷

- **Physical abuse:** any act that results in inflicted injury to a child or young person. Such injury or injuries may be deliberately inflicted or the unintentional result of rage. Regardless of motivation, the result for the child or young person is physical abuse.
- **Sexual abuse:** any act or acts that result in the sexual exploitation of a child or young person.
- **Emotional abuse:** any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person. It includes such behaviours as rejection, deprivation, continued criticism, exposure to family

violence, corruption of a child or young person, the negative impact of the mental condition of the caregiver, the negative impact of substance abuse by anyone living with the child or young person.

- **Neglect:** any act or omission that results in impaired physical functioning, injury, and/or development of a child or a young person. It includes physical neglect, neglect of supervision, medical neglect, abandonment, refusal to assume parental responsibility by not providing adequate care or control of a child or young person.
- **Fabricated or induced illness:** another form of harm that is not generally defined in Child Protection legislation. It occurs when a carer actively promotes the sick role in a child by exaggeration, non-treatment of real problems, fabrication (lying) or falsification of signs, and/or induction of illness. In addition to these severe cases, there are others where a child may present for medical attention with unusual or puzzling symptoms which are not attributable to any organic disease, and yet do not involve deliberate fabrication or deception, but are a manifestation of excessive and potentially harmful parental concern. Statutory intervention in such situations is generally based on the physical aspects of the harmful parental behaviour or on the identified psychological consequences.

Where one type of harm to a child is uncovered, others may be present. It may compromise the child or young person further to identify only one form of abuse, since this might result in other factors not being identified, assessed and managed.

Emotional harm is a component of all forms of abuse. For example, it is important to consider that a child or young person who has been sexually abused may also have experienced neglect and/or physical or emotional abuse through such behaviours as physical assault, coercion, intimidation and isolation.

Paediatricians working in Australia should be aware of their legal responsibility (known as mandatory reporting) by consulting the legislation of their particular State or Territory. There is no mandatory reporting in New Zealand; however, as part of the Children's Action Plan the New Zealand Government intends to introduce a range of initiatives that will raise expectations on agencies and make it easier for frontline staff and the public to identify vulnerable children and report concerns.⁵⁸ Section 195A of the Crimes Act (New Zealand) was amended in 2011 to make persons liable if they "fail to take reasonable steps to protect" a vulnerable child or other person known to be at risk.⁵⁹ Most District Health Boards in New Zealand have child protection policies in place requiring that clinicians concerned that a child "may have been abused" report their concerns to statutory authorities. This ensures that a full investigation of the child's situation can occur.

APPENDIX 2 – STATUTORY REPORTING REQUIREMENTS IN RELEVANT JURISDICTIONS

Jurisdiction	State of mind	Extent of harm
New Zealand	No mandatory reporting in New Zealand	<p>There are no statutory reporting requirements but the New Zealand Children’s Action Plan contains a range of initiatives that raise expectations on agencies and make it easier for frontline staff and the public to identify vulnerable children and report concerns to Child, Youth and Family.</p> <p>The Children, Young Persons, and Their Families Act 1989 also provides guidance, and regional District Health Boards policies support reporting by clinicians of children for whom abuse is suspected. New Zealand (through Section 195A of the Crimes Act) is required to initiate child protection interventions when they believe that a child or young person may have been harmed.</p>
ACT	Belief on reasonable grounds	Not specified: “sexual abuse ... or non-accidental physical injury”
NSW	Suspects on reasonable grounds that a child is at risk of significant harm	A child or young person “is at risk of significant harm if current concerns exist for the safety, welfare or wellbeing of the child or young person because of the presence, to a significant extent, of ... basic physical or psychological needs are not being met ... physical or sexual abuse or ill-treatment ... serious psychological harm”.
NT	Belief on reasonable grounds	Any significant detrimental effect caused by any act, omission or circumstance on the physical, psychological or emotional wellbeing or development of the child
QLD	Becomes aware, or reasonably suspects	Significant detrimental effect on the child’s physical, psychological or emotional wellbeing
SA	Suspects on reasonable grounds	Any sexual abuse, physical or psychological abuse or neglect to the extent that the child “has suffered, or is likely to suffer, physical or psychological injury detrimental to the child’s wellbeing; or the child’s physical or psychological development is in jeopardy”
TAS	Believes, or suspects, on reasonable	Any sexual abuse, physical or emotional injury or other abuse, or neglect, to the extent that the child has suffered, or is likely to suffer, physical or psychological harm detrimental to the

	grounds, or knows	child's wellbeing; or the child's physical or psychological development is in jeopardy
VIC	Belief on reasonable grounds	Child has suffered, or is likely to suffer, significant harm as a result of physical injury or sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type
WA	Belief on reasonable grounds	Not specified: any sexual abuse
Australia	Suspects on reasonable grounds	Not specified: any assault or sexual assault; serious psychological harm; serious neglect

Adapted from relevant state and territory legislation⁶⁰

APPENDIX 3 – WEBSITES FOR STATUTORY BODIES BY JURISDICTION

New Zealand – Child, Youth and Family: <http://www.cyf.govt.nz/>

Australian Capital Territory – Office for Children, Youth and Family Support:
<http://www.communityservices.act.gov.au/ocyfs>

New South Wales – Department of Family and Community Services:
http://www.community.nsw.gov.au/docs_menu/preventing_child_abuse_and_neglect.html

Northern Territory – Department of Children and Families:
<http://childrenandfamilies.nt.gov.au/index.aspx>

Queensland – Department of Communities, Child Safety and Disability Services – Child Safety Services: <http://www.communities.qld.gov.au/childsafety>

South Australia – Department for Education and Child Development – Families SA:
<http://www.families.sa.gov.au/default.asp?navgrp=366>

Tasmania – Department of Health and Human Services – Child Protection Services:
http://www.dhhs.tas.gov.au/children/child_protection_services

Victoria – Department of Human Services – Children, Youth and Families:
<http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection>

Western Australia – Department for Child Protection and Family Support:
<http://www.dcp.wa.gov.au/Pages/Home.aspx>

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The Royal Australasian College of Physicians

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The RACP trains, educates and advocates on behalf of more than 14,600 physicians – often referred to as medical specialists – and 6,600 trainees, across Australia and New Zealand. The College represents more than 32 medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology and public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

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