Child Wellbeing and Child Protection Policies and Procedures for NSW Health

Summary The Child Wellbeing and Child Protection Policies and Procedures for NSW Health brings together in a single document the tools and guidance for Health workers to meet their legal and policy responsibilities within the NSW Government Child Protection System.

Every Health worker coming into contact with a child or young person has a responsibility to protect their health, safety, welfare and wellbeing.

Please note: This policy also replaces the following documents:
Prenatal Reporting Guidelines [GL2011_008]
Assumption of Care Order by Community Services on health premises [PD2011_065]
Recording by Community Services of Inbound Calls to the Child Protection Helpline [IB2012_002]

Related Link: NSW Kids and Families - Keep Them Safe Funded Services

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Personnel/Workforce - Learning and Development

Applies to Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, Community Health Centres, Dental Schools and Clinics, Government Medical Officers, NSW Ambulance Service, Ministry of Health, Public Health Units, Public Hospitals

Distributed to Public Health System, Government Medical Officers, Ministry of Health

Audience All staff

Secretary, NSW Health

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

POLICY STATEMENT

CHILD WELLBEING AND CHILD PROTECTION POLICIES AND PROCEDURES FOR NSW HEALTH

PURPOSE

This policy articulates the professional and legal responsibilities of all health workers to promote the health, safety, welfare and well-being of children and young people, working collaboratively with interagency partners in the shared system of child protection in NSW. These responsibilities apply whether workers are providing health care directly to children and young people or to adult clients who are parents / carers or are pregnant.

This policy informs Local Health Districts, Specialty Health Networks, other health services and health workers about the tools and resources available and the interagency arrangements in place to assist them to meet their responsibilities and provide a consistent NSW Health response to child protection and wellbeing.

MANDATORY REQUIREMENTS

Every health worker has a responsibility to protect the health, safety, welfare and wellbeing of children or young people with whom they have contact.

The legal responsibilities of health services and health workers are identified in the following legislation:

Children and Young Persons (Care and Protection) Act 1998

- Collaborate with interagency partners and comply with information exchange provisions to promote the safety, welfare and wellbeing of children and young people, including taking reasonable steps to coordinate the provision of services with other agencies;
- Meet requirements for mandatory reporting of children and reporting of young people (or classes/groups of children or young people) at suspected risk of significant harm (ROSH);
- Report unborn children where it is suspected they may be at ROSH after their birth;
- Respond to the needs of children and young people after making a report to Community Services or to the NSW Health Child Wellbeing Unit;
- Respond to Community Services' and Children's Court requests to provide health services and or Community Services and Police Force requests to provide medical examinations and treatment;
- Assist with Children's Court proceedings when required.

Commission for Children and Young People Act 1998 / *Child Protection (Working with Children) Act 2012*

- Meet requirements to ensure that only people with valid Working with Children Checks are engaged in child related work (where a child is under the age of 18 years).

Ombudsman Act 1974

- Maintain systems to prevent 'reportable conduct' by health workers and for reporting and responding to alleged reportable conduct involving NSW Health employees.

The policy responsibilities of health workers are to:

- Recognise and respond appropriately to the vulnerabilities, risks and needs of families, children and young people when providing any health service;
- Collaborate across NSW Health services and with interagency partners to support and strengthen families and promote child health, safety, welfare and wellbeing;
- Use the Mandatory Reporter Guide and seek assistance from the NSW Health Child Wellbeing Unit to help identify children or young people at suspected risk of significant harm (ROSH);
- Seek assistance from the NSW Health Child Wellbeing Unit and the Family Referral Services to help respond to vulnerable families, children and young people below the ROSH threshold;

- Actively seek feedback from Community Services after making a child protection report and continue to support the child, young person or family consistent with the health worker's roles and responsibilities;
- Follow the Child Wellbeing and Child Protection - NSW Interagency Guidelines and other agreed interagency procedures when working with children, young people and families, including in relation to information exchange, High Risk Birth Alerts, Prenatal Reporting, escalation of child protection concerns, assumption of care by Community Services and out of home care health assessments;
- Collaborate in joint investigation and response to matters involving alleged child sexual assault or serious child abuse or neglect leading to criminal proceedings; and
- Participate in mandatory and / or other child protection training for NSW Health workers.

IMPLEMENTATION

Chief Executives across the NSW public health system are responsible and accountable for:

1. Ensuring that this policy and the associated *Child Wellbeing and Child Protection Fact Sheet for NSW Health Workers* are understood and implemented by all health workers; and
2. Enabling frontline staff to operationalise this Policy Statement in accordance with the attached *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*.

REVISION HISTORY

Version	Approved by	Amendment notes
PD2013_007	Director-General	This policy directive replaces the following policy directives and guidelines: ▪ PD2005_299 Protecting Children and Young People (including *NSW Health Frontline Procedures for the Protection of Children and Young People* December 2000) ▪ PD2006_104 Child Protection Roles and responsibilities – Interagency ▪ PD2007_023 Prenatal Reports ▪ IB2010_005 Keep Them Safe – Making a Child Protection Report ▪ PD2011_057 Child Protection and Wellbeing - Information Exchange ▪ GL2011_008 Prenatal Reporting Guidelines ▪ PD2011_065 Assumption of Care Order by Community Services on health premises ▪ IB2012_002 Recording by Community Services of Inbound Calls to the Child Protection Helpline

ATTACHMENTS

1. *Child Wellbeing and Child Protection Fact Sheet for NSW Health Workers*
2. *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*

Child Wellbeing and Child Protection FACT SHEET for NSW Health Workers

What is the role of NSW Health workers in the NSW child protection system?

The role of all NSW Health workers is to promote the health, safety, welfare and wellbeing of children and young people in collaboration with interagency partners in a shared system of child wellbeing and child protection in NSW. This role applies when providing health care to children and young people and to parents / carers or pregnant women.

The continuum of NSW Health services across primary, secondary and tertiary care offers many opportunities to identify children and young people at risk and assist vulnerable parents / carers to access appropriate support to provide safe and nurturing environments for their children.

Working at the frontline of the public health system, health workers are uniquely placed to identify and respond to family risk factors for child abuse and neglect early in a child's early life and as a young person in order to reduce these risks and improve health outcomes. Health workers also have a key role to identify and report children and young people at risk of significant harm and in ameliorating the effects of child abuse and neglect when it does occur. The many resources to assist health workers in meeting their responsibilities are outlined in this Fact Sheet.

What are the legal responsibilities of NSW Health services and workers?

Children and Young Persons (Care and Protection) Act 1998

- Collaborate with interagency partners and comply with information exchange provisions to promote the safety, welfare and wellbeing of children and young people, including taking reasonable steps to coordinate the provision of services with other agencies;
- Meet requirements for mandatory reporting of children and reporting of young people (or classes/groups of children or young people) at suspected risk of significant harm (ROSH);
- Report unborn children where it is suspected they may be at ROSH after their birth;
- Respond to the needs of children and young people after making a report to Community Services or to the NSW Health Child Wellbeing Unit;
- Respond to Community Services' and Children's Court requests to provide health services and or Community Services and Police Force requests to provide medical examinations and treatment;
- Assist in Children's Court proceedings when required.

Commission for Children and Young People Act 1998* / *Child Protection (Working with Children) Act 2012

- Meet requirements for *Working with Children Checks*

Ombudsman Act 1974

Maintain systems to prevent 'reportable conduct' by health workers and for reporting and responding to alleged reportable conduct involving NSW Health employees

What are the professional responsibilities of NSW Health workers?

- Recognise and respond appropriately to the vulnerabilities, risks and needs of families, children and young people when providing any health service;
- Collaborate across NSW Health services and with interagency partners to support and strengthen families and promote child health, safety, welfare and wellbeing;
- Use the Mandatory Reporter Guide and seek assistance from the NSW Health Child Wellbeing Unit to help identify children or young people at suspected risk of significant harm (ROSH);
- seek assistance from the NSW Health Child Wellbeing Unit and the Family Referral Services to help respond to vulnerable families, children and young people below the ROSH threshold;

- Actively seek feedback from Community Services after making a child protection report and continue to support the child, young person or family consistent with the health worker's roles and responsibilities;
- Follow the Child Wellbeing and Child Protection - NSW Interagency Guidelines and other agreed interagency procedures when working with children, young people and families, including in relation to information exchange, High Risk Birth Alerts, Prenatal Reporting, escalation of child protection concerns, assumption of care by Community Services and out of home care health assessments;
- Collaborate in joint investigation and response to matters involving alleged child sexual assault or serious child abuse or neglect leading to criminal proceedings; and
- Participate in mandatory and / or other child protection training for NSW Health workers.

Child wellbeing and child protection resources

Child Wellbeing and Child Protection Policies and Procedures for NSW Health

Child Wellbeing and Child Protection - NSW Interagency Guidelines

Mandatory Reporter Guide (MRG) guides decision-making about the level of risk to a child young person or unborn child and what initial action to take. This includes whether or not a child protection report is required.

Community Services Child Protection Helpline call **133 627** (24 hours/7 days) to report a child or young person suspected to be at Risk of Significant Harm.

NSW Health Child Wellbeing Unit call **1300 480 420** for support and assistance in determining the level of risk of harm and responding to the needs of vulnerable children, young people, pregnant women and families. After hours leave a message or use After Hours Contact Form

Tertiary Child Protection Service in your Child Health Network **–** call for clinical advice (24 hours/7 days), if not available locally, for responding to any form of child maltreatment:

- *Greater Eastern and Southern Child Health Network* - call the Sydney Children's Hospitals Network Randwick Campus Child Protection Unit on 02 9382 1412 or after hours on 02 9382 1111;
- *Western Child Health Network* – call the Sydney Children's Hospitals Network Children's Westmead Campus Child Protection Unit on 02 9845 0000 and ask for the Intake Worker for Child Protection;
- *Northern Child Health Network* – call the John Hunter Children's Hospital, Newcastle on 02 4921 3000 and ask for the paediatrician on call for child protection.

Local Health District (LHD) Child Wellbeing and Child Protection Staff - Child Wellbeing Coordinators, child protection and or violence prevention coordinators , child protection trainers, information exchange central contact points /consultants, out of home care health co-ordinators, Child Protection Counselling Services, Sexual Assault Services, New Street Services and Under 10s Sexualised Behaviour Program (See the LHD intranet site or call the NSW Health Child Wellbeing Unit).

Family Referral Services (FRS). To contact a FRS to refer vulnerable children, young people and families see the Family Referral Services website or ask the NSW Health CWU. FRS provide information, assessment and referral to a range of support services in their local area.

Education Centre Against Violence for state-wide mainstream and specialist training, consultation and resource development for NSW Health and interagency workers.

Keep Them Safe a whole of government website with resources to inform mandatory reporters and the general public about the system of child protection in NSW

More Information

Contact: NSW Kids and Families, NSW Health, 73 Miller Street North Sydney 2060

Child Wellbeing and Child Protection

Policies and Procedures for NSW Health

NSW GOVERNMENT | Health

SHPN (PHCP) 130018

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SECTION 1

Foreword

NSW Health has a strong commitment to ensuring the health, safety, welfare and wellbeing of children and young people in this State. This commitment is reinforced by the establishment of NSW Kids & Families, a new entity within the NSW Health organisational structure focused on championing the health and wellbeing of children, young people and their families.

Working at the frontline in our public health system, Health workers are uniquely placed to identify and respond to the needs and vulnerabilities of families from the earliest stages of a child's life to their teenage years and beyond. Child wellbeing and child protection is core business for all Health workers whether they are working directly with children and young people or with adult clients who are parents/carers.

Child Wellbeing and Child Protection Policies and Procedures for NSW Health operationalise the responsibilities of NSW Health under the *NSW Children and Young Persons (Care and Protection) Act 1998* and the *Child Wellbeing and Child Protection – NSW Interagency Guidelines* (2011). They build on and incorporate existing good practice. All Health workers have a responsibility to recognise and respond to wellbeing concerns and where appropriate provide or facilitate access to services for children, young people and their families to address their needs. Health workers are also required to identify and report children in need of statutory care and protection.

The policies and procedures are intended to help embed in the public health system the reforms to the NSW Child Protection system arising from the Special Commission of Inquiry into Child Protection Services in NSW. The policies and procedures provide the opportunity to reaffirm and strengthen the role of Health Workers in child wellbeing and child protection. The reforms are set out in *Keep Them Safe: A shared approach to child wellbeing 2009 – 2014* and provide an important step towards an integrated system that is concerned with child protection and the promotion of child wellbeing.

Central to these reforms is the understanding that child wellbeing and child protection is a collective or shared responsibility. All stakeholders – government, non-government, community, families and parents/ carers are expected to work together to support vulnerable children and young people to ensure a co-ordinated and comprehensive response to their needs. No individual worker, agency, service, program or profession has the complete knowledge, skills or mandate to work unilaterally to ensure the safety, welfare and wellbeing of children and young people. An integrated system involves individual agencies and professionals working in collaboration with others in the service system to help identify and address the often complex needs of vulnerable children and young people and their families and carers.

These procedures reflect three years work of the Ministry of Health (including the former Maternity, Children and Young People's Health Branch now NSW Kids & Families), Local Health Districts / Specialty Networks, NSW Health workers and the Department of Family and Community Services, Community Services.

It is with great pleasure that I present the second edition of *Child Wellbeing and Child Protection Policies and Procedures for NSW Health*. I encourage active participation from all levels of the Health system in collaboration with other key partners to promote the safety, welfare and wellbeing of children, young people and their families in NSW.

Dr Mary Foley
Director General

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SECTION 2

Key Resources

2.1 Mandatory Reporter Guide (MRG)

Guides decision-making about whether or not a report to the Child Protection Helpline is appropriate applying the risk of significant harm (ROSH) reporting threshold. Mandatory Reporter Guide: http://sdm.community.nsw.gov.au/mrg/

2.2 Child Protection Helpline

Report a child or young person suspected to be at imminent Risk of Significant Harm .

Telephone: 133 627 (24 hours/7 days)

For all other matters where the MRG recommends 'Report to Community Services' an e-report can be made.

Register for first user access through the DoCS Connect portal.

e-report: through DoCS Connect portal: http://www.community.nsw.gov.au/welcome_to_docs_website.html

Fax: 02 9633 7666 **only if e-reporting is unavailable and after attempting a phone call and leaving a message advising that a faxed report will be made**.

Fax form: http://www.community.nsw.gov.au/preventing_child_abuse_and_neglect/resources_for_mandatory_reporters.html or see Appendix 8 for a copy.

2.3 NSW Health Child Wellbeing Unit (CWU)

Telephone for advice, support and assistance in determining the level of risk of harm and in responding to the needs of vulnerable children, young people, pregnant women and families.

Telephone: **1300 480 420.** 8:30 am and 5.30 pm Monday to Friday, excluding public holidays.

Out of hours leave a telephone message on 1300 480 420, or use the After Hours Contact Form http://www0.health.nsw.gov.au/resources/initiatives/kts/pdf/CWU-Notification-Form.pdf and send a fax or email to:

Northern Child Wellbeing Unit
Fax 02 4924 6208
Email: NCWU@hnehealth.nsw.gov.au

Southern Child Wellbeing Unit
Fax 02 4228 3507
Email: GESCWU@sesiahs.health.nsw.gov.au

Western Child Wellbeing Unit
Fax 02 6881 4112
Email: westernchildwellbeingunit@gwahs.health.nsw.gov.au

Locate your LHD Child Wellbeing Co-ordinator via http://www0.health.nsw.gov.au/initiatives/kts/area_coordinators.asp or ask the CWU.

Child Wellbeing Co-ordinators are a key link between CWUs and LHDs in determining Health responses and developing improved referral pathways where concerns have been identified about a child or young person's safety, welfare and wellbeing.

2.4 Tertiary Child Protection Services in the Child Health Networks

Telephone for clinical advice Telephone for clinical advice relating to any form of child maltreatment which is not available locally, including forensic medical examinations. Any child who has a suspected inflicted head injury should be referred to one of these services as should cases where there are concerns about factitious illness, on suspected non-accidental injuries, neglect and sexual assault.

The following Child Protection Services provide 24 hour consultation services:

For the Greater Eastern and Southern Child Health Network
The Sydney Children's Hospitals Network Randwick Campus Child Protection Unit may be contacted on 02 9382 1412 during office hours and after hours on 02 9382 1111.

For the Western Child Health Network
The Sydney Children's Hospitals Network Children's Westmead Campus Child Protection Unit may be contacted on 02 9845 0000 and ask for the Intake Worker for Child Protection.

For the Northern Child Health Network
The John Hunter Children's Hospital, Newcastle can be contacted on 02 4921 3000 and ask for the paediatrician on call for child protection.

2.5 Family Referral Services (FRS)

Refer vulnerable children, young people and families to a Family Referral Service for information, assessment and referral to a range of support services in their local area.
To contact a FRS see Fact Sheet:
http://www.dpc.nsw.gov.au/__data/assets/pdf_file/0009/83646/06_Family_Referral_Services.pdf
or ask the NSW Health CWU.

2.6 Information Exchange

Use the following web links to the *Child Wellbeing and Child Protection - NSW Interagency Guidelines* checklists or refer to Section 6 of this document for further information and Section 13.6 for links to the NSW Health bar-coded Information Exchange letter templates.

Providing Information under Chapter 16A
http://www.community.nsw.gov.au/kts/guidelines/documents/information_response_checklist.pdf

Requesting information under Chapter 16A
http://www.community.nsw.gov.au/kts/guidelines/documents/Information_request_checklist.pdf

Receiving information under Chapter 16A
http://www.community.nsw.gov.au/kts/guidelines/documents/informations_received_checklist.pdf

Exchanging information under Section 248
http://www.community.nsw.gov.au/kts/guidelines/info_exchange/section_248.htm

Health workers may also consult:

- the NSW Health Child Wellbeing Units or Child Wellbeing Coordinator;
- child protection unit or service staff;
- the Local Health District/Speciality Network privacy officer;
- the Local Health District/Speciality Network central contact point for section 248 requests; or
- the designated Chapter 16A Information Exchange consultant in their Local Health District / Specialty Network.

2.7 Child Protection Training

Local Health Districts/Specialty Networks are responsible for providing mandatory child protection training for Health workers. Most LHDs have child protection trainers who coordinate child protection training in their district.

The Education Centre Against Violence (ECAV) provides mainstream and specialist training, consultation and resource development to support workers to perform their tasks.

Further information is available from the ECAV website:
http://www.ecav.health.nsw.gov.au

3 Introduction

SECTION 3

Introduction

The *Child Wellbeing and Child Protection Policies and Procedures for NSW Health* operationalise NSW Health's commitment to continuously improve the way that Health services identify and respond to child wellbeing and protection concerns. Health service interventions aim to reduce the incidence of abuse and neglect, to prevent and ameliorate their effects and to assist all vulnerable children and young people to receive the health care and other services they require.

Every Health worker coming into contact with a child or young person has a responsibility to protect their health, safety, welfare and wellbeing. The NSW Health Service is a part of the system of shared responsibility for child wellbeing and child protection across the government and non-government sectors and the whole community. The reforms arising from the 2008 *Special Commission of Inquiry into Child Protection Services in NSW* reaffirmed much of the current work performed by Health workers in responding to those concerns. The reforms give added structure to that work with the establishment of the Child Wellbeing Units and the Family Referral Services. These facilities provide support for Health and other workers in following up concerns and linking with other services that may be required to support vulnerable children, young people and families.

The Policies and Procedures are intended to embed in the NSW Health system the reforms set out in *Keep Them Safe: A shared approach to child wellbeing 2009 – 2014* which is the whole of government response to the *Report of the Special Commission of Inquiry.*

It is important for all Health workers to be able to recognise child wellbeing and child protection concerns, and know what action to take to protect children and young people and to address concerns as early as possible before issues escalate. Health workers should be particularly alert to pregnant women who may require additional services to ensure the safety, welfare and wellbeing of their child when born. .

Health workers should also be alert to situations where chronic and complex health care needs of children or young people or their parents /carers are identified and require collaboration with other Health professionals and other agency workers to ensure appropriate service responses are provided.

These Policies and Procedures provide information to assist Health workers to recognise and respond to child wellbeing and child protection concerns by setting out the legislation and the interagency and Health policies that empower Health workers; the indicators, reporting requirements and the tools and response mechanisms for abuse and neglect. Useful links and resources to support health workers in their roles are also provided.

The Policies and Procedures are consistent with the *Child Wellbeing and Child Protection – NSW Interagency Guidelines* (2011) and represent a clear commitment on the part of NSW Health to work cooperatively with other agencies to maximise the safety, welfare and wellbeing of vulnerable children and young people and unborn children, when born.

These policies and procedures apply to all frontline Health professionals in the NSW Health Service (as defined in the *Health Services Act 1997*). They are relevant to Health workers who provide services for children and young people as well as to those who provide services to adult clients who may be parents or carers. They are also relevant to support staff who work in the NSW Health Service.

Non-government organisations funded by NSW Health, including those in Aboriginal Community Controlled Health Services, may be required through the *NSW Health Operational Guidelines – Non-government Organisation Grant Program* or funding and performance agreements to comply with these Policies and Procedures.

4 Legislation, Systems, Roles and Responsibilities

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SECTION 4

Legislation, Systems, Roles and Responsibilities

This section sets out the legal and policy context for the child protection system in NSW. It provides Health workers with guidance on the relevant legislation and their legal responsibilities for child wellbeing and child protection; the key principles for child protection intervention; the NSW Health governance structure for child wellbeing and child protection; and identifies the systems, policies and procedures to be established by local Health services. The key interagency partners with NSW Health in child wellbeing and child protection and the principles for interagency collaboration are also identified in this section.

4.1 The NSW Legal Framework

Child wellbeing and child protection is core business for NSW Health, with the authority for Health worker's roles and responsibilities identified in the following legislation:

- The *Health Services Act 1997* which establishes the statutory obligation of Local Health Districts / Specialty Networks to promote, protect and maintain the health of NSW residents.
- The *Children and Young Persons (Care and Protection Act) 1998* (hereafter referred to as the *Care Act*) which provides for the care and protection of, and the provision of services to, children and young persons. A key object of the *Care Act* is for all institutions, services and facilities responsible for the care and protection of children and young people to provide an environment for them that is free of violence and exploitation and provide services that foster their health, developmental needs, spirituality, self-respect and dignity.

The key legal responsibilities of Health services and Health workers include:

- mandatory reporting of children, reporting of young people at risk of significant harm (ROSH) and prenatal reporting; *Care Act* s27, s27A, s24, s25
- Maintaining confidentiality regarding the identity of a mandatory reporter, *Care Act*, s29
- Reporting homelessness of children and young people, *Care Act*, ss120-121
- Responding to the needs of children and young people after making a report to Community Service, *Care Act*, s29A
- Responding to Community Services and Children's Court requests to provide health services to a child or young person or to his or her family, *Care Act*, s17, s18, s74, s85
- Providing medical examinations of children and young people in need of care and protection when requested by Community Services or NSW Police Force, *Care Act*, s173; or upon order of the Children's Court, *Care Act*, s53
- Requirement to take reasonable steps to co-ordinate decision-making and the delivery of services regarding children and young people and to work collaboratively in a way that respects the functions and expertise of each organisation, *Care Act*, s245E, s245A
- Compliance with information exchange provisions to promote the safety, welfare and wellbeing of children and young people, *Care Act*, s248 and Chapter 16A
- Complying with relevant requirements to ensure that only persons with valid Working with Children Checks are engaged in child related work (where a child is under the age of 18 years) in accordance with the *Commission for Children and Young People Act 1998*, or the *Child Protection (Working with Children) Act 2012* when it commences in 2013.;
- Maintaining systems to prevent reportable conduct by Health workers and for reporting and responding to alleged reportable conduct, or alleged misconduct that may be reportable conduct, involving NSW Health employees, in accordance with local procedures and with Part 3A of the *Ombudsman Act 1974*. Reportable conduct, including charges and reportable convictions, includes any sexual offence or sexual misconduct committed against with or in the presence of a child (including a child pornography offence), any assault, ill treatment, neglect, or any behaviour causing psychological harm to a child (the definition of a child is a person under the age of 18 years of age)
- Involvement in Children's Court proceedings dealing with matters relating to the care and protection of children and young people Chapter 5 and 6 of the *Care Act*

- Involvement in joint investigation and review of matters which may lead to criminal proceedings (under s175 and Chapter 14 of the *Care Act* and the *Crimes Act 1900*)

4.2 Key Principles for Child Protection Intervention

Health workers should be aware of the key principles for child protection intervention set out in the *Child Wellbeing and Child Protection – NSW Interagency Guidelines* (2011). http://www.community.nsw.gov.au/kts/guidelines/info_exchange/introduction.htm

Table 1: Key Principles for Child Protection intervention

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 non-government 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 the 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.

4.3 NSW Health Code of Conduct

When working with vulnerable children, young people and their families and with pregnant women, all Health workers are obliged to follow the NSW Health Code of Conduct. http://www.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_018.pdf

The CORE values are: Collaboration, Openness, Respect and Empowerment. The core values underpin all Health workers' dealings with clients, other Health workers and professionals and are consistent with the child protection intervention principles outlined above.

4.3.1 Core Values in the Child Protection Context

The *Child Wellbeing and Child Protection – NSW Interagency Guidelines* (2011) provide information and guidance to a wide range of human service and justice agencies involved in the delivery of child protection services in NSW in both government and non-government sectors. They are intended to enhance consistency, support collaborative practice and promote coordination in service delivery to vulnerable children, young people, and families. The link to the section of the Interagency Guidelines related to exchanging information is: http://www.community.nsw.gov.au/kts/guidelines/info_exchange/info_index.htm

Transparency and openness with clients is also a key element of child protection practice. Transparency is promoted by informing parents/carers, and where appropriate, children and young people, at the beginning of their relationship with the NSW Health system, about the mandatory responsibilities of a Health worker for the wellbeing and protection of children, young people and unborn children. Transparency should be maintained throughout the working relationship, including where it is necessary to make a report of risk of significant harm, unless it would compromise the safety, welfare and wellbeing of a child or young person.

Being respectful towards clients is essential to building positive working relationships with them and helping them achieve sustainable change in their lives. In the child protection context, respect includes recognition of the central importance of family in the lives of children and young people and the importance of supporting parents so they can raise their own children. Trust, respect, reliability and honesty are essential components of effective helping.

The importance of interagency collaboration to promote child wellbeing and child protection is highlighted in the *Child Wellbeing and Child Protection – NSW Interagency Guidelines (2011)*. Compliance with the Interagency Guidelines is mandatory for all Health workers.

Work to promote child wellbeing and protection is provided optimally when the parents/carers of a child or young person feel empowered to work towards sustainable change in their own lives. Empowerment of children, young people and families is promoted through the recognition of family strengths as well as needs and the active engagement of families in decision-making, goal setting and case planning.

Table 2: Core values in the Child Protection Context – Key References

COLLABORATION

- Key principle 1: Child protection is the collective responsibility of the whole-of-government and the community.
- Co-ordination of services, s245E, *Care Act*.
- Keep Them Safe and interagency collaboration, *Child Wellbeing and Child Protection – NSW Interagency Guidelines* (2011) http://www.community.nsw.gov.au/kts/guidelines/collaboration/collaboration_index.htm

OPENNESS

- Engaging children, young people and families, *Child Wellbeing and Child Protection – NSW Interagency Guidelines* (2011) – principles of engagement http://www.community.nsw.gov.au/kts/guidelines/engaging/principles.htm
- Informing families of a report to Community Services, Making a Child Protection Report Section 9.4.1 of this document
- Privacy and Consent, Section 6.3 of this document, which includes information sharing details.

RESPECT

- Key principle 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 non-government sector.
- Key principle 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.
- Principles: Cultural understanding, NSW Health Aboriginal Family Health Strategy 2011-2016, page 16. The elements of the Aboriginal child placement principle concerning placement are addressed in s13(1)(a)-(d). Chapter 2, Part 2 of the Act concerns Aboriginal and Torres Strait Islander principles, with the self determination principle found in s11, and importantly, http://www.health.nsw.gov.au/pubs/2011/pdf/aboriginal_family_health_.pdf
- Working with CALD communities, Section 5.2 of this document
- Working with Aboriginal Communities, Section 5.1 of this document

EMPOWERMENT

- Key principle 4: Positive outcomes for children and families are achieved through development of a relationship with the family that recognises their strengths and their needs.
- Key principle 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.
- Principles – self determination, *NSW Health Aboriginal Family Health Strategy 2011-2016*, page 16. http://www.health.nsw.gov.au/pubs/2011/pdf/aboriginal_family_health_.pdf
- Engaging children, young people and families, *Child Wellbeing and Child Protection – NSW Interagency Guidelines* (2011) – principles of engagement. http://www.community.nsw.gov.au/kts/guidelines/engaging/principles.htm

4.4 NSW Health Model of Care to Promote Child Wellbeing and Protection

All children should have the best start in life and the NSW Health Service aims to support a healthy pregnancy and transition to parenthood, to build on family strengths and address any identified risks that may contribute to the development of problems in infancy, childhood and later life.

Every Health worker who comes in contact with a child or young person has a responsibility to protect their health, safety, welfare and wellbeing. This responsibility may include providing additional services and support to pregnant women whose unborn child may be at risk of significant harm when born.
The significant efforts already undertaken by many Health workers in this area are acknowledged.
The reforms arising from the Special Commission of Inquiry into Child Protection Services in NSW are an opportunity for the Health Service to renew and reaffirm these efforts.

NSW Health recognises both the immediate and longer-term consequences of all forms of child abuse and neglect on the emotional, psychological, social and physical health and wellbeing of children and young people.

NSW Health aims to reduce the need for statutory intervention by implementing strategies and programs for intervention with families with the aim of identifying and resolving problems early. Prevention, identification and early intervention approaches have been demonstrated to be effective in reducing child abuse and neglect. Specialist services to ameliorate the effects of abuse also form a critical part of the health system.

NSW Health's role in promoting child wellbeing and child protection occurs across the continuum of primary, secondary and tertiary health care services: see Appendix 2.

NSW Health's model of care for promoting child wellbeing and child protection has the following elements:

- Prevention and early intervention services for children, young people, families and victims of violence;
- Responding to the immediate and long-term needs of children and young people at risk of significant harm;
- Therapeutic interventions responding to and addressing the effects of violence, abuse and neglect when it has occurred. Assessments and interventions provided by paediatric and adult services are sensitive to the needs of parents and carers and the impact of family illness on children and young people.

Adult health services have a key role to play in identifying and responding to child wellbeing and child protection concerns because the cause of the abuse or neglect is frequently parental or carer illness behaviour, earlier life experience, or disadvantage or deprivation. In working with parents and carers to address the context of the lives of children within their families, NSW Health services focus in particular on those parental or carer factors that increase vulnerability including chronic and complex health needs, drug and alcohol abuse, mental illness, and the impact of historical trauma and disadvantage.

Work to promote child wellbeing and protection is provided optimally when the parents or carers of the child or young person are actively engaged in working towards sustainable change in their own lives and strengthening their parenting capability.

Where a child, young person or family member/carer has chronic or complex health needs, Health workers need to be aware of any safety, welfare and wellbeing issues that may arise for the child or young person. Children and young people with ongoing medical conditions such as diabetes or severe obesity may be at risk of significant harm if there is failure to adhere to their treatment regimes and/or there is educational neglect.

All adult health services and clinical staff treating childhood illness should:

- be alert to child protection and wellbeing concerns taking into account; indicators of neglect and abuse – see Section 7 of this document.
- communicate with other Health professionals and other agency workers involved with a family about whom they have concerns; and
- seek appropriate assistance from the Health Child Wellbeing Units or other child protection experts within the Health Service whenever necessary.

4.5 NSW Health Governance Structure for Child Wellbeing and Child Protection

Figure 1: Governance structure for child protection and wellbeing in NSW Health

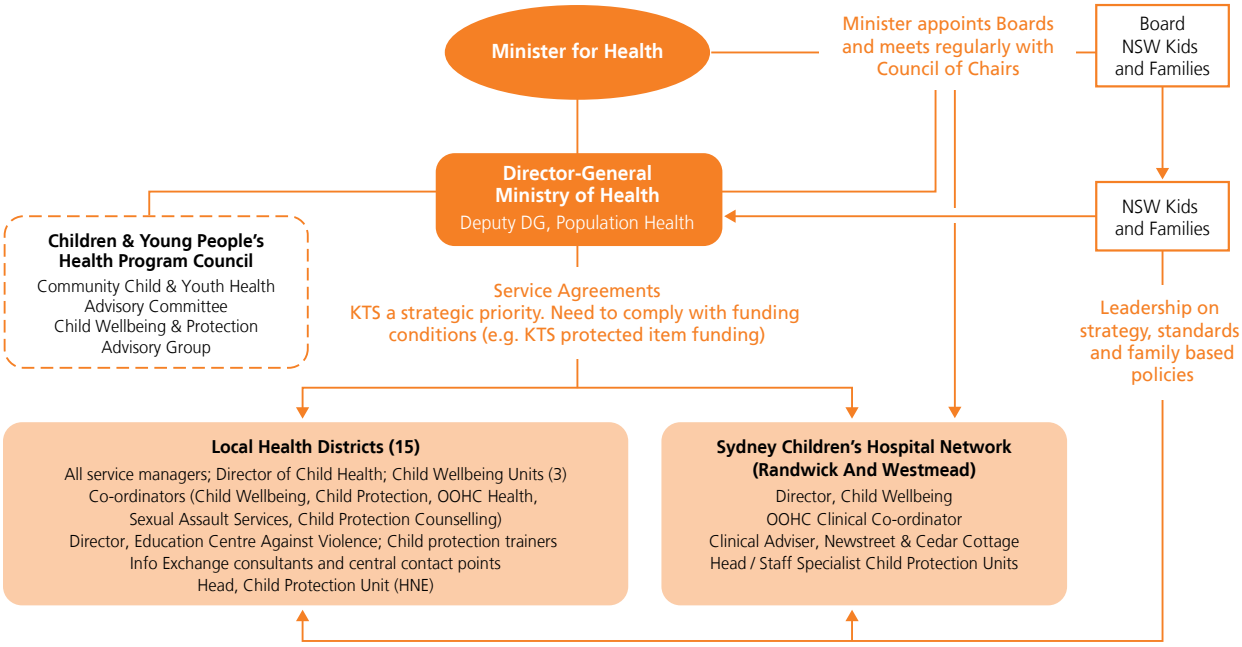

Table 3: Child protection and wellbeing and violence prevention responsibilities

Child Protection and Wellbeing and Violence Prevention Responsibilities		
NSW Kids and Families	**Local Health Districts**	**Sydney Children's Hospital Network (Randwick and Westmead) John Hunter Children's Hospital**
Statewide policy/procedure Represent Health at KTS SOG	Local policy/procedure Workforce development Service provision (primary, secondary, tertiary) Networking with other LHDs (e.g. the co-ordinators) KTS-funded services – quarterly acquittals	Specialist assessment and care Expert advice and program co-ordination

4.6 Systems, Policies and Procedures to be Established by Health Services

Health services are required to establish, implement and maintain local procedures, consistent with this policy to guide Health workers to meet their legal obligations and respond effectively to their child wellbeing and child protection responsibilities. Specifically local systems, policies and procedures are required as follows:

1. Intake and assessment procedures that:

- consider the safety, welfare and wellbeing of children and young people including those who are in the care of adult clients;
- prioritise service access (including for s173 medical examinations) for children and young people at risk of significant harm, particularly those referred by Community Services;
- prioritise service access for pregnant women who have been identified under SAFESTART as having significant vulnerabilities', and who are the subject of a High Risk Birth Alert;

- include the participation of Aboriginal and Torres Strait Islander children or young people in assessment and intervention decisions; and
- involve the child, young person, family or carers in the referral process where safe and appropriate to do so.

2. Mandatory and other child protection training for Health workers

Local Health Districts / Speciality Networks are responsible for providing mandatory child protection training for Health workers. Many LHDs have child protection trainers and/or child protection co-ordinators who co-ordinate child wellbeing and Child protection training for their LHD.

Each Local Health District /Speciality Network should have an ongoing training strategy that:

- Supports all Health workers receiving training about child protection that is relevant to their position;
- Facilitates the release of workers to attend designated mandatory training sessions; and
- Supports follow-up information or training sessions to be conducted for all health workers if there are significant changes in the child protection system.

Two hours training is a core training requirement for all health workers and should be provided as a part of induction processes for new Health workers. Core training should cover:

- early identification and response to safety, welfare and wellbeing concerns;
- responsibilities and procedures for reporting children and young people who are suspected to be at risk of significant harm; and
- identification of systems and structures for additional information and support.

Health workers working directly with children and young people (including maternity, child and youth health and paediatric services), or with adults who have children in their care and whose parenting capacity may be in question (for example, mental health and drug and alcohol services) require more detailed information and guidance on responding to vulnerable children and young people and their families. These Health workers should attend a minimum of one day face-to-face training by the Local Health District / Speciality Network Child Protection Trainer or accredited child protection facilitator in accordance with a local training strategy. This training should occur at orientation or as soon as possible thereafter.

Particular attention to the training needs of junior medical staff working in these services needs to be given.

Child Protection Facilitator training is provided by the Education Centre Against Violence (ECAV). As a minimum requirement, all Health staff who conduct child wellbeing and child protection training should attend this training. This training provides an accreditation process for experienced health workers to provide child protection training within Local Health Districts / Specialty Networks.

More comprehensive training (knowledge and skills based) on child protection, sexual assault and domestic violence for workers in mainstream, specialist and Aboriginal roles is also available through ECAV. Further information is available from the ECAV website: http://www.ecav.health.nsw.gov.au/

3. A centralised system to receive and respond to written section 248 and Chapter 16A (Care Act) requests for information

Each Local Health District / Speciality Network should have a centralised system, with a designated Central Contact Point Position(s), to respond to written requests for Information under section 248 and Chapter 16A.

Most information exchanged between prescribed bodies, including Community Services under **Chapter 16A** will be verbal between a worker in a prescribed agency and a Health worker with whom they have an existing professional relationship.

Requests for Information under **section 248** will always be in writing. Section 6 Information Sharing for *Information Exchange* provisions. The one exception to this is section 248 requests from the Joint Investigation Response Team (JIRT) which do not need to come through the Central Contact Point but may go directly to the health service from which the information is requested.

4. A policy and process to protect the identity of mandatory reporters under section 29

Section 29 of the *NSW Children and Young Persons (Care and Protection) Act 1998* affords protection of the identity of a reporter. Local Health records, responses to complaints, privacy and child protection policies and procedures should clearly state that Health services are not permitted to release information without the consent of the reporter to any person or agency that identifies or may identify the reporter except in very limited circumstances as provided by law.

Limited circumstances include requests from the NSW Ombudsman or the NSW Child Death Review Team. Requests for information from these organisations should be received in writing. Health workers should specifically ask whether the NSW Ombudsman or the Child Death Review Team requires information that identifies a reporter and/or the s29 report itself.

5. Monitoring 'best endeavours' requests for service

Community Services and the Children's Court may make referrals for clients to NSW Health services under section 17 and section 84(1) (c) respectively in order to gain access to services that will:

- Promote the safety, welfare and wellbeing of a child or young person; or
- Facilitate the restoration of a child or young person to his or her parents / carers.

Health Services must ensure that service providers use their best endeavours to respond to requests from Community Services and the Children's Court when these requests meet agreed criteria, and that demand and responses for these services are monitored by the Health Service.

6. Responding to s173 notices for medical examinations

Local procedures should be in place to guide medical practitioners working in the public health system to respond to s173 notices for the medical examination of a child or young person from Community Services or the NSW Police Force. This includes the requirement for medical reports under s173 to be countersigned by a medical consultant.

7. Development of referral pathways for clinicians to access specialist/forensic child protection expertise

Physical abuse and neglect
Clinicians with various levels of experience may be presented with cases where the identification of child abuse or neglect is uncertain or where the severity of the child's condition warrants consultation with a paediatrician at a Level 4 hospital or a paediatric child protection specialist at a Level 6 hospital.

Each LHD in conjunction with its rural and district hospital paediatricians and the Level 6 Child Protection service in its Child Health Network should develop a referral pathway that facilitates access to such advice and where required, the transfer of the patient.

This pathway should also cover the referral of children and young people presented by Community Services or the NSW Police Force for s173 examinations (see above).

Sexual abuse medical/forensic examinations
Each LHD has a responsibility to ensure that appropriate medical services are available to conduct medical and forensic examinations for children and young people who are thought to have been sexually abused. In some instances this will require referral to another LHD within their Child Health network.

Each LHD needs to develop a referral pathway for each of its facilities that identifies where children and young people presenting at that facility who require such examinations should be referred.

8. A centralised system for the receipt and processing of High Risk Birth Alerts (HRBAs)

Each Local Health District /Speciality Network should have a centralised system for the receipt and processing of High Risk Birth Alerts (HRBAs) to ensure that accurate, timely and targeted information is available to Health workers providing services to pregnant women. The system should ensure, however, that sensitive health information included in a HRBA is protected. All HRBAs are to be kept by the Health Service for 12 months from date of receipt due to the urgency of information requirements in high risk decision-making. The NSW Health *Prenatal Reporting Service Delivery Model* in included at Section 9.8 of this document.

9. A process for follow-up of Child Protection Helpline feedback

A local procedure is required for the receipt, response and follow up of Child Protection Helpline feedback letters, particularly where Health workers are on shift or move to other areas within Health in the course of their duties.

10. A process for the escalation of child protection concerns

A local pathway is required for Health workers to escalate, where appropriate, child protection and wellbeing concerns and differences of opinion with other Health workers or agencies. Concerns may include:

- a vulnerable child or young person in a high risk situation or their family is not receiving a particular service or level of service intensity the worker considers they need to mitigate risks;
- a child or young person is suspected by the health worker to be at ROSH but the health worker has serious concerns about the level of response by Community Services;

- It is alleged that reporter or identity has been disclosed in specific cases in breach of S29 of the *Care Act* either by someone within NSW Health or in another agency such as Community Services.

The suggested pathway would involve a Health worker(s) who has a serious concern or difference of opinion and/or their health service attempting in the first instance to resolve the matter locally. This would include clarifying the relevant legislative, policy or procedural requirement and raising their concerns with other party(s). If a matter cannot be resolved through discussion with the other party at local level, it should be raised at a more senior level within the organisation or organisations concerned

The suggested pathway should incorporate the agreed interagency processes for:

1. requesting reviews of Child Protection Helpline decisions through the Child Wellbeing Director as set out in Making a Report Section 9.7; and
2. resolving differences between agencies as set in the *Child Wellbeing and Child Protection – NSW Interagency Guidelines* (2011), *Keep Them Safe* and interagency collaboration. http://www.community.nsw.gov.au/kts/guidelines/collaboration/collaboration_index.htm#differences

The agreed escalation pathway with Community Services for resolving differences regarding ROSH matters operates from officer to officer as follows:

Table 4: Agreed Escalation Pathway with Community Services

NSW Health	Community Services
Health worker	Case Worker
Team Leader /Supervisor	Manager Case Work, CP Helpline
Health Service Manager	Manager Client Services
Director, or parallel (e.g. Community Health, Division or Unit)	Area Director Child and Family
Director of a child protection service or an Area Manager of a child protection service	Regional Director
Local Health District/Specialty Network Chief Executive	Deputy Chief Executive Operations
Director General Ministry of Health	Chief Executive, Community Services

Note: The above escalation pathway is not intended to inhibit existing local professional relationships which are relied on to resolve differences regarding ROSH matters.

11. A system for case management

A local policy is required for:

- appropriate case management and services to children and young people where child wellbeing concerns have been raised. The policy should cover situations where one Health service identifies a child protection concern and refers the child or young person to another Health service and when responding to children and young people with chronic and complex health care needs.
- reviewing the management of child abuse and neglect cases with Health workers.

Further information see Section 12 on case management and case work in this document.

12. A protocol for working with other agencies

A local protocol is required to support health workers working with other government and non-government agencies and private providers (including general practitioners) to plan and provide services for the safety, welfare and wellbeing of children and young people, and to strengthen and support families.

4.7 Roles and Responsibilities

4.7.1 Health Workers

Legal responsibilities

- Reporting Children and Young People at ROSH and unborn children who may be at ROSH suspected when born – Section 9.1.1 of this document.
- Maintaining confidentiality regarding the identity of a mandatory reporter – Section 9.1.2 of this document.
- Reporting homelessness – Section 9.1.1 of this document.
- Responding to the needs of children and young people after making a report to Community Services – Section 9.5 of this document.
- Reporting any allegation, charge or conviction of a child protection nature involving another NSW Health worker to their supervisor or to the designated person within their LHD/Specialty network as prescribed by local procedures, so that a decision may be made by the Chief Executive or their delegate regarding any requirements to manage the matter in accordance with the requirements of the Ombudsman Act.

- Making a written report to the chief executive of the LHD/Specialty Network if the Health worker is charged with having committed, or is convicted of, a serious sex or violence offence within 7 days of the charge being laid or conviction, in accordance with Section 117 of the *Health Services Act 1997*.
- Complying with information exchange provisions – Section 6 of this document.
- Collaborating in service provision to promote child safety, welfare and wellbeing – Section 8.2 of this document.
- Providing medical examination of children and young people in accordance with requests and orders under the *Care Act* – Section 9.10 of this document.
- Using best endeavours to respond to requests for service from Community Services and the Children's Court – Section 9.10.5 of this document.

Actions to assess and respond to vulnerable children and young people

- Assessing the level of risk to a child, young person or unborn child using the Standard Decision-Making ® Tool – Mandatory Reporter Guide.
- Conducting, documenting and acting appropriately on the outcomes of medical assessments of children and young people who present to health facilities with possible maltreatment.
- Contacting the Health Child Wellbeing Unit to discuss and seek advice regarding further action.
- Making reports to the Child Protection Helpline
- Receiving, responding and following up Child Protection Helpline feedback on child protection reports, particularly where Health workers are on shifts or move to other areas within Health in the course of their duties.
- Providing ongoing service provision to children and young people who are the subject of reports to Community Services
- Escalating risk of significant harm matters in accordance with this policy
- Responding to occasions of assumption of care of children and young people by Community Services on NSW Health premises.

Actions to collaborate with other service providers

- Share information with other service providers to facilitate decision-making, assessments, case management, service provision and investigations relating to the safety, welfare and wellbeing of children and young people
- Consider opportunities to collaborate with health professionals in private practice to promote child safety, welfare and wellbeing
- Participate in case coordination and case management interagency meetings and service responses consistent with the worker's professional roles and responsibilities.

Keeping Records

- Document reporting of children and young people suspected at risk of significant harm and associated information on the client Health record
- Flag client files where a High Risk Birth Alert or general alert from Community Services or the NSW Police Force has been received regarding a child or young person at risk of significant harm.

4.7.2 Health Service Managers

Assisting Health workers to access and comply with this document by:

- Providing online access; and/or
- Ensuring hard copies are available for Health staff without computer access.

Managing and supporting staff by:

- Providing staff with information about the role and location of the Head of the Level 4 or Level 6 Child Protection Service Sexual Assault Service Co-ordinator, Child Protection Co-ordinator, Child Protection Counselling Service Manager, Child Protection Trainer, Child Wellbeing Co-ordinator, JIRT Senior Clinician and Out-of-home-care Health Co-ordinator so they can provide consultation and advice about child wellbeing and child protection issues and training.
- Notifying staff of the designated paediatrician, paediatric social worker, or clinical nurse specialist who is available to provide support and guidance on child wellbeing and child protection concerns to community nursing and hospital staff, and ensure that on-call rosters are developed and that linkages with Level 4 and Level 6 Child Protection Units are adequately defined
- Supporting staff in their communication with other health or other agency workers regarding safety, welfare or wellbeing concerns of children and young people in accordance with Chapter 16A provisions of the *Care Act*. Highlight to staff that the objectives of such communication are to identify cumulative risk and co-ordinate services and supports for children, young people and families

- Supporting staff attendance at mandatory and other child protection training
- Providing and developing professional support, and debriefing and supervising staff working with children, young people and families where child wellbeing and protection concerns are identified. This includes recognising the risk of vicarious trauma and developing a mechanism to support staff exposed to traumatic material on a regular basis as part of their role
- Maintaining confidentiality regarding the identity of a mandatory reporter Section 9.1.2 of this document.
- Supporting the implementation of local procedures as outlined in Section 4.6 of this document regarding Health Service responsibilities.

4.8 Community Services

Community Services in the Department of Family and Community Services is the statutory child protection authority in NSW. In accordance with the *Care Act,* Community Services can take action to protect children and young people in NSW who are at risk of significant harm. The wide-ranging powers of the *Care Act* enable Community Services to carry out its responsibility on behalf of the community. Under the *Care Act,* Community Services has a mandate to promote partnerships, co-ordinate responses and to request other agencies to provide care and support to children, young people and their families as appropriate.

Section 29A of the *Care Act* provides the legal basis for Health workers to continue working with children and young people even if they have made a child protection report about them, in accordance with their usual professional obligations. This should be done in collaboration with Community Services so Health workers keep informed about whether Community Services is intervening in a matter involving their client(s) and relevant details regarding that intervention.

4.9 Other Government and non-Government Agencies

A **broad range of other government and non-government agencies** have a shared responsibility to identify, report and respond to safety, welfare and wellbeing concerns. It is important for Health workers to consider who else in another agency might be in contact with a vulnerable child or young person and/or their family.

For example, if Health workers have concerns about a child or young person who is school aged, they could take action to find out if the school shares similar concerns and/or has relevant information about the child or young person or their family.

With a diverse range of **non-government organisations (NGOs)** providing services to children, young people and their families, the non-government sector plays a key role in child wellbeing and child protection. This can vary from identifying and reporting or responding to and meeting the needs of children and young people across a continuum of vulnerability.

Detailed information on the roles, responsibilities and functions of key stakeholders (government and non-government) is contained in the *Child Wellbeing and Child Protection – NSW Interagency Guidelines* (2011), Roles and Responsibilities chapter at: http://www.community.nsw.gov.au/kts/guidelines/roles/roles_index.htm

As health care professionals, Health workers should consider opportunities to co-ordinate service provision with other health care providers to promote child safety, welfare and wellbeing including those in private practice and those in the non-government sector. Section 6 of this document includes guidance on how the information sharing provisions apply to General Practitioners and practice nurses and linkages provided through the Health Child Wellbeing Units are described below.

4.10 Key Mechanisms for Interagency Collaboration

4.10.1 Child Wellbeing Units (CWUs)

CWUs operate in the four government agencies responsible for the largest number of child protection reports: The NSW Police Force, the Department of Education and Communities the Department of Family and Community Services (Juvenile Justice, Housing and Ageing, Disability and Home Care) and NSW Health. CWUs help agency staff to collaborate in assessing the level of risk, detecting patterns of neglect and/or cumulative harm, intervening early before matters escalate, and building a case for statutory intervention when early intervention and prevention are no longer a safe option for a child or young person.

The Health Child Wellbeing Units (Tel: 1300 480 420) are available for use not only by workers employed by NSW Health but also by those from Aboriginal Community Controlled Health Services and those in affiliated health organisations.

As at 30 June 2012, opportunities for further collaboration were being explored through a trial of GP access to the Health Child Wellbeing Units in two regions.

'WellNet', is the CWUs shared information management system and provides staff from NSW Health, the NSW Police Force, the Department of Education and Communities and the Department of Family and Community Services with the ability to access limited information about other agencies' concerns for children and young people at risk. WellNet also interfaces with the Community Services' Child Protection Database (KiDS) and allows a CWU Assessment Officer to determine if Community Services is currently involved with a child or young person, or if an out-of-home-care (OOHC) non-government agency or Brighter Futures Program is involved with a child or young person. Information sharing helps to identify cumulative harm from a combination of factors and over time. See Section 8.4.1 of this document for further information about the Health Child Wellbeing Units

4.10.2 Joint Investigation Response Teams

Joint Investigation Response Teams (JIRTs) and the JIRT Review Unit have a unique role in protecting children and young people at risk of significant harm. Working collaboratively, the Department of Family and Community Services, NSW Police Force and NSW Health professionals undertake joint investigations of statutory child protection matters that require a criminal justice response. See Sections 10.2 and 10.3 of this document.

4.10.3 Family Referral Services

NSW Health is the lead agency on behalf of all NSW government agencies for the Family Referral Services which link vulnerable children and young people below the threshold for statutory child protection intervention and their families with a range of support services in their local areas. FRS are operated by non-government organisations who work as a professional network across different regions to share experience and best practice in servicing vulnerable families. They are a key resource for vulnerable families in regions. Health services are encouraged to develop strong partnerships with their FRS in order to promote integrated service provision in meeting both the health care and broader support needs of children, young people and families.

Fact Sheet: http://www.dpc.nsw.gov.au/__data/assets/pdf_file/0009/83646/06_Family_Referral_Services.pdf and see Section 8 on responding to non-ROSH concerns

4.10.4 Resolving Differences Between Agencies

Effective collaboration requires all partners to be committed to working together and being open to challenges and feedback received from interagency partners.

Different perspectives and competing priorities may occur from time to time. Where differences arise, these should be acknowledged and discussed as soon as possible so that each party can consider ways of resolving the issue that is in the best interests of the children or young people concerned and that may inform more effective practices and procedures. Where a fundamental difference is identified, an interagency review of the matter may be necessary. Effective collaboration requires that resolution is reached and agencies work together in the best interests of children and young people.

It is expected that Health Services will have clear policies and procedures on review and resolution of concerns raised by or in relation to agency partners.

Further information:

- *Child Wellbeing and Protection – NSW Interagency Guidelines* (2011), *Keep Them Safe* and interagency collaboration, *Model for Resolving Interagency Differences:* http://www.community.nsw.gov.au/kts/guidelines/collaboration/collaboration_index.htm#differences
- Guide to court processes involving children and young people: http://www.community.nsw.gov.au/kts/guidelines/court/index.htm

5

Responding to Children and Young People with Diverse Needs

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SECTION 5

Responding to Children and Young People with Diverse Needs

5.1 Working with Aboriginal Children and Families

5.1.1 Context

NSW Health is committed to improving the overall health and wellbeing of Aboriginal children, young people and families. This includes working with communities and other agencies to reduce the over-representation of Aboriginal children in the child protection system under *NSW Health's Aboriginal Family Health Strategy 2011-2016* http://www.health.nsw.gov.au/pubs/2011/pdf/aboriginal_family_health_.pdf
and the *Keep Them Safe* action plan.

The multi-faceted reasons for the over-representation of Aboriginal children in the child protection system include ongoing and generational effects of earlier laws, policies and practices which separated Aboriginal children from their families, as well as the cumulative effects of poor health, drug and alcohol abuse, unemployment, discrimination, poor education, community and family violence and gambling, housing and the disempowerment of parents and communities.

For child protection system trends including Aboriginal specific data see published Community Services statistical reports at http://www.community.nsw.gov.au/about_us/docs_data.html

5.1.2 Working with Aboriginal People and Communities

There are many strengths in Aboriginal communities, and a deep commitment to the care of children on the part of community members. Aboriginal family ties, loyalties and obligations are pivotal to Aboriginal culture. The extended notion of Aboriginal family provides the emotional strength and spirit for people who strive to maintain strong identity while adapting to changing, often difficult environments. Aboriginal families and communities are interlinked and one family or child cannot be treated in isolation from the community environment. These bonds provide a solid basis for Health workers and partner agencies to work with Aboriginal families and communities to ensure the care and protection of their children and young people remains a priority.

It is important to understand that the Health worker may sometimes be engaged with the individual client in the context of a close-knit community and that a client may wish to be supported in the context of their community. Workers must understand that relationships (including therapeutic relationships) will take time to develop and that this is often a necessary precursor to engaging in treatment and learning culturally appropriate ways of interacting with clients.

5.1.3 Health Service Responsibilities

Health services should ensure Health workers:

- offer culturally appropriate service responses for Aboriginal children and families. Workers should be empathetic and appreciate that there are many perspectives on situations that are influenced by culture;
- ask an Aboriginal 'family client' if they would like an appropriate Aboriginal health worker to be contacted to provide support and participate in consultation if required;
- with client consent, consult other health providers (including Aboriginal support services), and where appropriate and safe for the child or young person, with family and community members to determine the most appropriate course of action for the client;
- consider when developing case plans the need to incorporate the wider social and cultural context of the client. In the situation where an alleged perpetrator of abuse may have ongoing access to the child or young person, Health workers are to use their professional judgement regarding involvement of the child or young person's community where safe and appropriate;
- are sensitive when working with Aboriginal families, particularly if there may be issues relating to family violence and/or concerns about Aboriginal children and young people who may be at risk of significant harm that need to be reported to Community Services;
- are transparent about child wellbeing and child protection concerns, where this is appropriate and safe;
- are aware of the supports within the Child Wellbeing Units and Family Referral Services which have been put in place for assisting vulnerable Aboriginal children and young people below the statutory reporting threshold;

- establish and maintain ethical and supportive professional relationships when working with Aboriginal families and communities. Where an Aboriginal worker is also a community member, this includes ensuring safe client focussed boundaries and the management of secondary trauma are vital; and
- record the Aboriginal status of clients accurately and consistently in order to develop and improve, monitor and evaluate services providing care and protection for Aboriginal children and families. In general Aboriginal status is poorly recorded in health related data and consequently the utilisation of services by Aboriginal clients is under represented. This in turn contributes to insufficient culturally appropriate and accessible service provision.

Further information: http://www.health.nsw.gov.au/policies/pd/2005/PD2005_547.html

5.1.4 Best Practice Approaches

The following approaches that may contribute to better outcomes for Aboriginal children and young people and their families should be promoted by Health services and adopted by Health workers where possible:

- A holistic focus that aims to address the underlying causes of family violence should be considered as part of healing processes. Locating workers as part of well functioning multidisciplinary teams and partnerships can enhance holistic family centred approaches.
- Community consultation is essential to the success of any program. Actively engaging local communities is necessary to ensure that programs are community owned and responsive to local need. Examples include holding community forums and workshops, engaging local elders and community leaders.
- Interagency collaboration and integration of service provision between relevant government and Aboriginal Community Controlled Health Services (ACCHS) which includes integrated referral and assessment processes, streamlined information sharing processes and local interagency networks comprised of key services. Health workers should be proactive in establishing relationships with ACCHS and take responsibility for maintaining these relationships.
- The provision of Aboriginal-specific services as well as facilitating access to culturally competent mainstream services is vital to overcoming barriers to clients accessing services, for example New Street Services.. It is also important that approaches are flexible and adaptable to the needs of the community and individual clients.
- Clear, effective and culturally appropriate communication is an essential component in providing care to Aboriginal people. Health workers should consider sourcing culturally appropriate and sensitive material that supports advice or case plans involving the client or family.
- Approaches that employ a mixture of both individual and family support and community development strategies, with a focus on prevention and early intervention, and access to appropriate health and community support services.
- Workers need to be well supported to work in a stressful and demanding role. They should be provided with regular opportunities to meet, share experiences and exchange information, for peer support and to develop responses to common problems.

5.1.5 Aboriginal Family Health Workers

Aboriginal Family Health workers (AFHWs) are predominantly located in regional Aboriginal Community Controlled Health Services (ACCHSs) and some in Local Health Districts. These workers provide individual and family support focused activities to the Aboriginal community, including initial crisis support, advocacy and referral to other services.

Aboriginal Family Health Workers have an important role in supporting families experiencing family violence. This role includes short periods of intensive support in crisis situations to protect the safety of family members experiencing domestic violence, sexual assault, child abuse or abuse of older people, and less intensive support as clients gain knowledge and awareness of their options and rights. The role also comprises broader community development and education strategies, with a focus on prevention and early intervention. Aboriginal Family Health Workers provide a service that aims to respond to local needs and contexts, actively engage local communities, other services and relevant government agencies. Aboriginal Family Health Workers support activity related to the concept of 'healing' as a means of building the capacity and strength of individuals and communities to respond and recover from the trauma of family violence, sexual assault and child abuse.

Aboriginal Family Health Workers will liaise with a range of other agencies, both government and non-government to provide client/family support and community development.

The *Operational Guidelines for Aboriginal Family Health Workers* provides their roles and responsibilities and contact details:
http://www.health.nsw.gov.au/policies/gl/2009/GL2009_001.html

5.1.6 Culturally Appropriate Referral Pathways

Family Referral Services (FRS) and Health Child Wellbeing Units are required to ensure appropriate referral pathways are put in place to link Aboriginal children and their families with culturally responsive human and justice services and some FRS have an Aboriginal specific focus. Contact details for FRS and Health Child Wellbeing Units are in the key resources section of this document

5.1.7 Training for Health Workers

- Specialist Training pathways for Aboriginal Family Health workers are available through the Education Centre Against Violence. http://www.ecav.health.nsw.gov.au/
- This includes Certificate IV in Aboriginal Family Health (Family Violence, Sexual Assault, Child Protection) and Advanced Diploma of Aboriginal Specialist Trauma Counselling.
- Training for mainstream workers is available through Local Health District / Specialty Network Cultural Awareness training or the 'Competent Responses to Aboriginal Sexual and Family Violence' for non-Aboriginal workers through the Education Centre Against Violence. This course is a requirement for certain specific Health services, e.g. Sexual Assault Services.

5.1.8 Resources for Health Workers

In recognition of the need to establish additional health related services to support the Aboriginal community, NSW Health has invited ACCHSs to access Health Child Wellbeing Units (CWUs). Access to CWUs helps promote access to other services and further support for children and young people in Aboriginal communities. Health Child Wellbeing Unit assistance is set out in Section 8.4.1 of this document.

5.2 Working with Children, Young People and Families from Culturally Diverse Backgrounds

NSW is recognised internationally as one of the most culturally and ethnically diverse jurisdictions in the world. At the last Census, 1,623,600 people in NSW were born in a non-English speaking country and collectively they spoke over 150 different community languages.

Working sensitively with culturally and linguistically diverse communities, including refugees, is a core responsibility of all Health workers.

The NSW Health *Policy and implementation plan for healthy culturally diverse communities 2012-2016.* http://www.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_020.pdf sets out the following Multicultural Health Principles:

1. People from culturally, religiously and linguistically diverse backgrounds will have access to appropriate health information
2. People from culturally, religiously and linguistically diverse backgrounds will have access to quality health services that recognise and respect their linguistic, cultural and religious needs
3. Health policies, programs and services will respond in an appropriate way to the health needs of people from culturally, religiously and linguistically diverse backgrounds
4. People from culturally, religiously and linguistically diverse backgrounds will have an opportunity to contribute to decisions about health services that affect them
5. Multicultural health programs and services will be evidence-based and / or support best practice in the provision of health services in a culturally, religiously and linguistically diverse society

Child wellbeing and child protection within families from culturally and linguistically diverse communities is particularly complex and sensitive. Although there may be wide variation in parenting practice between cultural groups, child abuse or maltreatment is not condoned in any culture. Health workers should be aware that certain child rearing practices which are accepted in other cultures may infringe NSW laws or accepted practice. It is the role of the Health worker to acknowledge these differences with families where they are identified and support change.

Some forms of medical intervention are widely debated in the community and would not be included within the definition of necessary medical care. For example cultural or parental beliefs may lead a parent or caregiver to decide on a particular course of treatment for a condition. The deprivation of necessary medical care should be the basis for determining suspected Risk of Significant Harm rather than an action being taken by the parents that is not detrimental to the child or young person's health, safety, welfare and wellbeing. Further information is set out in Section 7 Recognising Child Abuse and Neglect.

Health personnel must communicate appropriately and effectively, through the use of a health care interpreter with patients who are not fluent in English when collecting personal details, health information and/or obtaining consent to conduct a medical procedure. NSW Health Policy provides the standard procedures for working with health care interpreters.
http://www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_053.pdf

Family Referral Services (FRS) offer culturally appropriate referral pathways into support for vulnerable children and young people who are subject of child wellbeing/non-statutory concerns and their families. The FRS in Sydney South West and South Eastern Sydney have a specific focus on servicing families from culturally and linguistically diverse communities.

Further Information:

There are many agencies and programs that Health workers may access for additional information or support, including:

- NSW Refugee Health Service
  http://www.sswahs.nsw.gov.au/sswahs/refugee/
- Transcultural mental health
  http://www.dhi.health.nsw.gov.au/tmhc/default.aspx
- Bilingual Community Educators/Workers
- Multicultural family workers
- NSW Education Program on Female Genital Mutilation
  http://www.dhi.health.nsw.gov.au/NSW-Education-Program-on-Female-Genital-Mutilation/NSW-Education-Program-on-Female-Genital-Mutilation/default.aspx
- NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)
  http://www.startts.org.au/
- Interpreter services http://internal.health.nsw.gov.au/health-public-affairs/interpreter/
  - Health Care Interpreter Service (HCIS)
  - Telephone Interpreter Service (TIS)
- Education Centre Against Violence
  www.ecav.health.nsw.gov.au provides:
  - Specialist Training for Interpreters and Bilingual Community Educators
  - Training for mainstream health workers working with refugee communities
  - Training for mainstream health workers: 'Working towards cultural competence'
  - Local Health District / Specialty Network Cultural Competence Training
- *Anti-Discrimination Act 1977*
  http://www.austlii.edu.au/au/legis/nsw/consol_act/aa1977204/
- Community Relations Commission and Principles of Multiculturalism

http://www.crc.nsw.gov.au/__data/assets/pdf_file/0004/16807/MulticulturalPlanning-AResourceForPractitioners.pdf#page=9

Further information on working with children and young people from culturally diverse communities may be found at
http://www.jkdiversityconsultants.com.au/Cultural_Diversity_&_Child_Protection_Kaur2012_A4.pdf

5.3 Working with Children and Young People with a Disability

There are many and varied situations that may arise for Health workers when responding to the health care needs of children and young people with a disability and in the context of child wellbeing and child protection. The issues arising in the protection of children and young people with a disability are that:

- Indicators of risk of significant harm may be 'overshadowed' by the child or young person's medical condition or disability
- For example, particular behaviours may be interpreted as related to the child's impairment and not as indicators of forms of abuse or neglect, or incidents can be interpreted as 'one-off incidents' without further consideration of abuse or neglect particularly regarding the parent's quality of care or parenting capacity.
- The child or young person with a disability can be vulnerable to particular risks, in particular the risks of abuse and neglect
- When providing any health service or assessment Health workers should be aware that issues of social exclusion, additional care stresses or interrupted bonding within families, bullying by peers and communication difficulties can create added risks for children and young people with a disability. Socioeconomic factors such as limited income, social isolation, poor carer health and parental concerns about the impact of the disability on other siblings, can tax family resources, time and skills.
- Specific indicators of abuse or neglect can sometimes be attributed to a child or young person's disability

- Assessing risk of harm for children and young people with a disability adds another level of complexity to the child wellbeing and child protection assessment process and requires expertise and accurate and detailed information about the person's disability, including type, level of support needs, communication abilities and behavioural support
- Children and young people with a disability are often involved in multiple care contexts, may have difficulty in getting away from abusers or in acquiring protective behaviours, and can lack oral and communication skills and therefore may be unable to communicate when abuse is occurring.
- Particular care is needed for a child or young person with a disability where it is possible that the parents or carers of such child or young person are not acting in their best interests in relation to the provision, or non-acceptance, of those services. Report of the Special Commission of Inquiry into Child Protection Services Vol 3 21.1-21-18

Further information:

- NSW Health Policy Directive Disability – People with a Disability: Responding to Needs During Hospitalisation http://www.health.nsw.gov.au/policies/pd/2008/pdf/PD2008_010.pdf
- The *Disability Services Act 1993* http://www.austlii.edu.au/au/legis/nsw/consol_act/dsa1993213/

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SECTION 6

Information Sharing

Key Actions

Use the following web links to the *Child Wellbeing and Child Protection - NSW Interagency Guidelines* checklists or read this section for further guidance for Health workers on sharing information.

Providing information under Chapter 16A

http://www.community.nsw.gov.au/kts/guidelines/documents/information_response_checklist.pdf
or see Section 6.9 *Health information that can be shared*

Requesting information under Chapter 16A

http://www.community.nsw.gov.au/kts/guidelines/documents/Information_request_checklist.pdf
or see Section 6.2

Receiving information under Chapter 16A

http://www.community.nsw.gov.au/kts/guidelines/documents/informations_received_checklist.pdf
or see Section 6.16

Declining a request for information under Chapter 16A

See Section 6.15

Exchanging information under Section 248

http://www.community.nsw.gov.au/kts/guidelines/info_exchange/section_248.htm
or see Section 6.17

Exchanging information about unborn children

See Section 6.11 Sharing information about unborn children

Interstate exchange of information

http://www.community.nsw.gov.au/kts/guidelines/info_exchange/responding.htm
scroll down to *Cross Border Information Exchange*
or see Section 6.7

Protecting a Reporter's identity

http://www.community.nsw.gov.au/kts/guidelines/info_exchange/reporter_identity.htm
or see 9.1.2

6.1 Introduction

This chapter provides guidance about how information can be shared in relation to the safety, welfare and wellbeing of a child or young person under the *Care Act*.

The care and protection of children and young people is dependent upon shared information. Access to accurate, relevant information will assist organisations working with children and young people to assess risks, make decisions and to identify and deliver appropriate services.

The legal framework for information exchange allows organisations to share information relating to the safety, welfare and wellbeing of children or young people without consent.

It takes precedence over the protection of confidentiality or of an individual's privacy because the safety, welfare and wellbeing of children and young people is considered to be paramount. However, while consent is not necessary, it should be sought where possible. Organisations should at a minimum advise children, young people and their families that information may be shared with other organisations.

6.2 Legislation

The *Children and Young Persons (Care and Protection) Act 1998* (*The Care Act)* allows agencies working with children and families to exchange information that promotes a child or young person's safety, welfare and/or wellbeing, whether or not the child or young person has been reported to the Child Protection Helpline. There are two schemes for the exchange of information about child wellbeing in the *Care Act:*

- **Chapter 16A** establishes a scheme for sharing information relating to the safety, welfare or wellbeing of children and young persons between prescribed bodies, being certain government agencies and non-government organisations (NGOs).
- **Section 248** governs the exchange of information relating to the safety, welfare and wellbeing of children and young people between the Director-General of the Department of Family and Community Services and prescribed bodies.

The provisions in Chapter 16A are facilitative in nature, whereas section 248 contains stronger powers of direction and discretion which are relevant to the statutory role of the Director-General of the Department of Family and Community Services (or delegate) in relation to child safety, welfare and wellbeing.

Health workers may provide, request and receive information under Chapter 16A and Section 248. It is particularly important from an interagency collaboration perspective that organisations should be able to provide information they believe is relevant to the safety, wellbeing or welfare of a child or young person without having received a request.

6.3 Privacy and Consent

Confidentiality is an important aspect of the relationship between Health professionals and their clients/patients and is protected under the State's privacy laws by provisions against the disclosure of personal information to third parties without the consent of the individual who is the subject of that information. Maintaining confidentiality serves the public interest by encouraging access to and use of services, and supporting open and trusting communication.

Consent is not however necessary for exchange of information under Chapter 16A or section 248 provided that the information exchanged relates to the safety, welfare and/or wellbeing of a child and fulfils the objects and principles of the legislation'. Chapter 16A recognises that the protection of confidentiality or of an individual's privacy must be balanced against another form of the public interest – ensuring the safety, welfare and/or wellbeing of vulnerable children and young people.

While consent is not necessary under the *Care Act*, it should be sought where possible, safe and appropriate. It is important for Health workers to know when and how information can be shared under Chapter 16A and when seeking the consent of a child or young person or their family is advisable.

Generally speaking Health workers should discuss concerns with a child, young person or their family before disclosing information about them under Chapter 16A. Exceptions include, if doing so places the child or young person at risk of abuse or neglect or it is not reasonable to seek the views of the child, young person or their family. Health workers should consider age and developmental factors in making the decision to discuss information exchange (e.g. Gillick Competency). Health workers should discuss the possibility of exchanging information under Chapter 16A at the earliest possible stage.

Agencies sharing personal information under Chapter 16A and section 248 are still expected to protect the confidentiality of the information, for example, by storing it securely and not disclosing it to others unless such disclosure is again intended to promote the safety, welfare and wellbeing of children or young people.

Further information:

Child Wellbeing & Child Protection – NSW Interagency Guidelines:
http://www.keepthemsafe.nsw.gov.au/reporting_concerns/interagency_guidelines

6.4 Chapter 16A – Objects and Principles

The object of Chapter 16A is to facilitate the provision of services to children or young persons by authorising or requiring the sharing of information between prescribed bodies and requiring those prescribed bodies to work collaboratively.

The principles underlying Chapter 16A include:

1. agencies that have responsibilities relating to the safety, welfare or well-being of children or young persons should be able to provide and receive information that promotes the safety, welfare or well-being of children or young persons,
2. those agencies should work collaboratively in a way that respects each other's functions and expertise,
3. each such agency should be able to communicate with each other agency so as to facilitate the provision of services to children and young persons and their families,
4. because the safety, welfare or wellbeing of children and young persons are paramount:

(a) the need to provide services relating to the care and protection of children and young persons, and
(b) the needs and interests of children and young persons, and of their families, in receiving those services, take precedence over the protection of confidentiality or of an individual's privacy.

This law takes precedence over other laws regulating the disclosure of personal information, such as the *Privacy and Personal Information Protection Act 1998* and the *Health Records and Information Privacy Act 2002*.

With the exception of the Federal courts and the Federal agencies listed below, in Prescribed Bodies, Chapter 16A requires prescribed bodies to take reasonable steps to co-ordinate the provision of services to children and young persons.

6.5 Chapter 16A – Coordination of Services

Within Chapter 16A, section 245 (E) refers to co-ordination of services and in order to effectively meet their responsibilities in relation to the safety, welfare or well-being of children and young people, requires prescribed bodies to take reasonable steps to co-ordinate decision-making and the delivery of services regarding children and young persons.

6.6 Prescribed Bodies

Only prescribed bodies may exchange information under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*. A 'prescribed body' is specified within this Act or is prescribed in the related regulations.

Table 5: Prescribed bodies for exchange of information

A prescribed body includes:

- the NSW Police Force;
- a NSW government department or NSW public authority, including the Department of Family and Community Services, Community Services;
- a NSW government school or a NSW registered non-government school;
- a NSW TAFE;
- a NSW public health organisation (PHO) or a NSW licensed private health facility;
- a FACS-accredited or FACS–registered out-of-home care agency;
- a FACS-accredited adoption service;
- the Family Court of Australia, the Federal Magistrate's Court of Australia, Commonwealth Department of Human Services and the Commonwealth Department of Immigration & Multicultural & Indigenous Affairs; and
- any other organisation which has direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly to children.

With the exception of the federal courts and Commonwealth agencies listed above, Chapter 16A does not provide a basis for information exchange with organisations and agencies in other jurisdictions. The operation of Chapter 16A is modified for the federal courts and Commonwealth agencies. Section 245I makes it clear that while these federal agencies Commonwealth agencies are authorised to exchange information under Chapter 16A, they are not required to do so.

Private sector organisations (e.g. non-government organisations, Aboriginal Community Controlled Health Services and incorporated medical practices) which qualify as 'any other organisation…' in accordance with the last criterion for 'prescribed bodies' as listed above are included under Chapter 16A. The *Children and Young Persons (Care and Protection) Act 1998* provides a lawful exception to the Australian *Privacy Act 1998* for those organisations. General practitioners and Practice Nurses who are not in an 'organisation' (e.g. because they operate as sole practitioners) are not included under Chapter 16A.

6.7 Inter-State Exchange of Information

Each State and Territory in Australia has its own child protection legislation. The provisions in the NSW *Care Act* which allow exchange of information about children and young people apply to those who ordinarily live in or who are present in NSW.

A Health worker who is concerned about or has information about the safety, welfare or wellbeing of a child or young person who resides in another State should notify Community Services. Community Services can exchange information with statutory bodies of other States or Territories (Section 231B). This is of particular relevance in border towns.

A Health worker who receives a request from another State or Territory for information about the safety, welfare or wellbeing of a child must refer the person making the request to Community Services (Tel: 02 9716 2222) as the statutory body with the authority to exchange information with another jurisdiction.

Similarly, a NSW Health worker who requires information about a child or young person that is held in another State or territory should contact Community Services to facilitate this process.

6.8 Community Services Participation in Chapter 16A

Under the NSW *Children and Young Persons (Care and Protection) Act 1998*, the Department of Family and Community Services, Community Services may operate as both a statutory child protection authority under section 248 and as a prescribed body under Chapter 16A for the purposes of information exchange.

Community Services primarily exchanges information under the provisions of Chapter 16A and only requests and provides information under section 248 in exceptional circumstances.

Requests under section 248 are directed to the Local Health District /Speciality Network Central Contact Point and come from the Director Child and Family, Family and Community Services (as a delegate of the Director-General of the Department of Family and Community Services).

6.9 Health Information that can be Shared

Only information that is already in existence is documented and relates to the safety, welfare or wellbeing of a child or young person may be exchanged under Chapter 16A.

Chapter 16A allows for information sharing in relation to children and young people who may be either above or below the statutory reporting threshold of risk of significant harm, and their families. A child where there is suspected risk below the statutory reporting threshold may need some form of assistance even though they do not need statutory intervention. There is no need for a child or young person to be reported to the Child Protection Helpline for the provisions to apply.

Sharing of information includes:

- Providing information in response to requests; or because the health worker believes it may assist another prescribed body: and
- Making a request for information from another prescribed body.

The *Child Protection & Child Wellbeing – Interagency Guidelines* (2011), Chapter on Exchanging information relating to children or young people in a child wellbeing and child protection context provides the following checklists:

- Checklist for providing information or responding to a Chapter 16A information request http://www.community.nsw.gov.au/kts/guidelines/documents/information_response_checklist.pdf
- Checklist for requesting information under Chapter 16A http://www.community.nsw.gov.au/kts/guidelines/documents/Information_request_checklist.pdf
- Checklist for receiving information under Chapter 16A http://www.community.nsw.gov.au/kts/guidelines/documents/informations_received_checklist.pdf

Health workers can share information relating to the safety, welfare or wellbeing of a child or young person if the health worker reasonably believes the information will assist in:

- making any decision, assessment or plan or to initiate or conduct any investigation, or to provide any service, relating to the safety, welfare or wellbeing of the child or young person or class of children or young people; or
- helping prescribed bodies manage any risk posed by an employee towards a child or young person (or class of children or young persons). (see Section 9.1.3 Alleged Perpetrator is NSW Health Worker)

Sharing of information between prescribed bodies could relate to:

- a child or young person's history or circumstances;
- a parent or other family member;
- people having a significant or relevant relationship with a child or young person;
- other agencies dealings with the child or young person, including past support or service arrangements.

Further information:

- NSW Health PD2006_025 Child Related Allegations, and Convictions Against Employees http://www0.health.nsw.gov.au/policies/pd/2006/PD2006_025.html; and
- NSW Health PD2006_026 Criminal Allegations, Charges and Convictions Against Employees. http://www.health.nsw.gov.au/policies/pd/2006/PD2006_025.html

6.10 De-Identifying Information

There may be circumstances where it is appropriate to de-identify references to third parties other than the child or young person, including Health workers, in particular to comply with the protection of reporter identity under section 29 of the *Care Act* – see Section 9 of this document.

Such circumstances might include de-identifying information which is not relevant to the safety, welfare or wellbeing of the child or young person and where disclosure raises potential issues of worker safety.

Generally, information identifying Health workers to another agency should occur where this would facilitate the provision of services to children and young persons and their families, consistent with the objects and principles of Chapter 16A. Where concerns exist, information could be provided to the other agency on the proviso that they do not on-disclose any information that identifies Health workers.

6.11 Sharing Information about Unborn Children

Health workers may only share information under Chapter 16A regarding an unborn child where a pre-natal report has been made to the Child Protection Helpline or to a Child Wellbeing Unit.

Before providing information about an unborn child Health workers should telephone the local Community Services Centre, Child Protection Helpline 13 36 27 or Health Child Wellbeing Unit 1300 480 420 to establish whether a pre-natal report has been made to Community Services. Contact details for all Community Services Centres can be found on the Community Services website www.community.nsw.gov.au.

Under Chapter 16A or section 248 Community Services can issue NSW Health services with an Unborn Child High Risk Birth Alert (HRBA) where a risk of significant harm to the child, when born, is identified. The HRBA will be issued to the Local Health District / Speciality Network Central Contact Point. Section 9.8 of this document provides prenatal reporting policy and a service delivery model.

6.12 Issues to Consider when Sharing Information

Chapter 16A requests can be made verbally or in writing depending on the clinical circumstance. Health workers should use their professional judgement to determine whether a form is the preferred method for exchanging information.

Health workers should be mindful that other parts of the Health Service may also hold relevant information including information about parents or other family members or people who have a significant relationship with the child or young person that may be relevant to their safety, welfare or wellbeing.

It is preferable that the Health worker exchanging verbal information has a relationship with, or knowledge of the person about whom the information is to be exchanged. This is to ensure the information provided is relevant and understood in the current context of the child, young person and their family.

Verbal information will most likely be sought when the request is straightforward or when it is needed urgently. A common example of verbal exchange would be at a case conference or telephone call about a shared client.

Information exchanged verbally should only be information already on file. On the occasion of a verbal request for urgent information, workers must verify the source of the request, determine appropriateness and discuss the timeframe for when the information is needed and when it can realistically be provided.

Written exchanges of information under Chapter 16A are encouraged where they occur outside the context of an existing professional relationship between agency representatives or where the information to be exchanged is complex.

Information exchange requests between Community Services and Health services outside the context of an existing relationship where the Health worker or service working with the subject of the request is unknown should be made in writing to the nominated Central Contact Point. This will ensure all appropriate information is made available to Community Services. Chapter 16A requests from prescribed agencies other than Community Services need not go through the Central Contact Point.

6.13 Information Requests from Children's Court Clinic

Where a letter of request for information is received under Chapter 16A from an authorised Children's Court Clinician it should:

- Be accompanied by a copy of the court order instructing that the Clinic perform the assessment in relation to the child. This will enable the Health worker who receives the request to ensure that the request is legitimate and that the details about the child are correct;
- Include a statement that the Children's Court Clinician is authorised by the Director of the Children's Court Clinic.

Health workers should ensure that any information provided in response to a request is only to be sent to the mailing address, fax number or email address of the Children's Court Clinic, or, in exceptional; circumstances, over the telephone. Information is not to be sent to a contract clinician's personal or business address.

6.14 Sexual Assault Communications Privilege

The *Criminal Procedure Act 1986* creates a sexual assault communications privilege for counselling communications which recognises that there is a public interest in preserving the confidentiality of counselling communications in sexual assault matters. As a result of this privilege, communications between a victim of sexual assault and her or his counsellor are inadmissible in court proceedings and cannot be compelled to be produced under subpoena.

The privilege does not apply to federal courts, for example the Family Court.

The object informing the sexual assault communications privilege is that the benefits of sexual assault counselling services to victims should not be compromised by the prospect that counselling communications will later be revealed to the accused or disclosed in court.

Health workers should not exchange information relating to sexual assault counselling communications under Chapter 16A except in cases where a child or young person would be at risk of significant harm if the information was not exchanged or the patient has consented. If information is exchanged under Chapter 16A the Health worker must inform the prescribed body that a sexual assault communications privilege may apply, including to any future third party claim for the information provided by NSW Health.

Further information:

- Health Policy Directive on Subpoenas http://www.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_065.pdf

6.15 Declining a Request for Information Under a Chapter 16A

A request for information from another prescribed body which meets the requirements of Chapter 16A for information exchange must be provided unless an exemption applies.

An agency is exempt from providing information if it believes that to do so would:

- Prejudice an investigation, or
- Prejudice a coronial inquest or inquiry, or
- Prejudice any care proceedings, or
- Contravene any legal professional or client legal privilege, or

- Enable the existence or identity of a confidential source of information in relation to the enforcement or administration of a law to be ascertained, or
- Endanger a person's life or physical safety, or
- Prejudice the effectiveness of a lawful method or procedure for preventing, detecting, investigating or dealing with a contravention of a law, or
- Is not in the public interest.

In deciding if there is a public interest, Health workers can and should factor into their considerations issues of privacy and confidentiality (See Section 6.3), but should also recognise that the objects clause in section 245A means greater weight should be placed on child safety and child protection issues. When there is a suspected risk to a child or young person's safety, welfare or wellbeing, this will take precedence over confidentiality issues

Where a Health worker believes information should not be provided, due to the objectives of Chapter 16A requests, the Health worker should consult with a Local Health District/Speciality Network senior manager.

Where the Health service decision is to decline to provide information, the Health service manager or Child Wellbeing Unit Co-ordinator must notify the requesting agency in writing on the form letter Declining a Chapter 16A request – Letter (Appendix 6). The grounds for refusing to release the information must be clearly stated within the letter. A copy of this letter is to be placed within the client health record.

6.16 Use of Shared Information by a Third Party Body

A prescribed body which receives information is expected to protect the confidentiality of that information. Information can only be shared with a third party body under Chapter 16A if the purpose is for the safety, welfare or wellbeing of the child the information relates to. As far as possible, the original provider of the information should be consulted and informed of what information has been provided and to whom, as new information may have come to hand.

This restriction applies except where the law may require or permit the information to be disclosed such as for court proceedings or legal investigation for example: NSW Ombudsman's proceedings or criminal investigations.

6.17 Exchange of Information under Section 248

Under Section 248 of the *Care Act*, the Director-General of the Department of Family and Community Services (or delegate) has the power to direct prescribed bodies to provide Community Services with information about the safety, welfare or wellbeing of a child or young person, or class of children or young persons.

Section 248 allows information relevant to the progress of investigations, assessments and case management to be shared between Community Services and prescribed bodies without the consent of an individual, where the information relates to the safety, welfare or wellbeing of a child or young person (or class of children or young persons).

Community Services will only request and provide information under section 248 in exceptional circumstances. In accordance with Community Services business rules, section 248 powers should only be used when:

- A prescribed body has declined to provide information under Chapter 16A citing one of the defined exclusions and the Director, Child and Family, Family and Community Services (as a delegate of the Director-General, Family and Community Services) is of the view that the exclusion does not apply;
- A prescribed body has declined to provide information, however Community Services has a compelling need for the information; and
- Discussions between senior staff in a prescribed body and Community Services have failed to arrive at a mutually acceptable solution.

Requests under section 248 will be directed to the Local Health District / Specialty Network Central Contact Point and come from the Director Child and Family, Family and Community Services (or delegate of the Director-General, Family and Community Services, Community Services).

6.17.1 Community Services Requests for Information Under Section 248

If frontline Health workers receive requests for information under section 248 directly from the Director-General of the Department of Family and Community Services (or delegate) they must immediately inform and consult with their service manager and the central contact point within their Local Health District / Specialty Network.

Health workers must provide information requested by the Director-General of the Department of Family and Community Services (or delegate) under section 248 of the *Care Act*. Information may also be sought in relation to a parent or carer of the child or young person, and services provided to them, provided that the information relates to the safety, welfare or wellbeing of a child or young person (or class of children or young persons).

Only information that is already in existence, is documented and relates to the safety, welfare or wellbeing of a child or young person may be exchanged under section 248. This section therefore does not permit the exchange of documents such as an entire Health file, which may contain information not relevant to the safety welfare or wellbeing of a child, or the creation of new documentation such as an assessment report.

The key factors of this provision are:

- The request must come from the Director-General of the Department of Family and Community Services (or delegate);
- The information requested can only be information relating to the safety, welfare or wellbeing of a particular child or young person or a class of children or young people;
- The request only applies to information already held by the Health Service; and
- The request cannot require Health Services to collect or obtain new information.
- By agreement with Community Services the request to the Health worker must be made using the *Section 248 Request from Community Services to prescribed bodies, including NSW Health form*.

Community Services may request information relating to the safety, welfare or wellbeing of a particular child or young person or a class of children or young people about:

- the child or young person's history, current circumstances and their views
- the parent or family
- other relationships
- the agency's role and relationship with the child, young person and family
- the capacity of the parent to adequately care for the child which could include information on domestic violence, drug and alcohol or mental health concerns.

When making a request for information under section 248 of the *Care Act*, Community Services will clearly outline:

- the subject of the information request and, their relationship to the child or young person;
- how the request for information relates to safety, welfare or wellbeing and risk issues;
- identifying information so Health workers can ensure they are requesting information about the appropriate person; and
- the timeframe for providing the information.

6.17.2 Requesting Information from Community Services Under Section 248

The legislation allows Health workers to request information from Community Services under either Chapter 16A or section 248 of the *Care Act*. Health workers are encouraged to rely on the provisions of Chapter 16A and it would only be in rare instances that a section 248 request would need to be made. Any requests made to Community Services under section 248 should come from the Director-General of NSW Health (or delegate).

6.17.3 Timeframes for Section 248

NSW Health and Community Services have agreed to timeframes for responding to section 248 requests for information. These timeframes apply to both Chapter 16A and section 248 requests and are outlined in Section 6.20 of this document. It is important that all Health workers comply with these timeframes when responding to requests for information.

6.18 Responding to Urgent Requests for Information

In urgent situations, a Local Health District / Specialty Network may provide information to Community Services by telephone. This information should then be confirmed in writing through the Central Contact Point using the *Agreeing to Chapter 16A* request letter (Appendix 5).

6.19 Legal Proceedings and Section 248 Information Requests

Arrangements have been made with the Department of Family and Community Services for them to inform a prescribed agency if it is intended to release information from that agency to the Children's Court for the purpose of any care and protection proceedings and give the agency the opportunity to consent to the release of the information.

Community Services will also inform the prescribed body providing the information that they may be subpoenaed to produce document(s) and to attend Court if the matter is heard in the Children's Court.

Where Community Services requires a document, such as a report or file, to be produced for the purpose of Court proceedings a subpoena should be issued. Where a prescribed body, such as a health service, receives a section 248 request from Community Services and believes that the information sought would be more appropriately sought by a subpoena, the relevant Health worker involved should contact Community Services or the Ministry of Health's Legal and Regulatory Services Branch. See also NSW Health policy directive on Subpoenas http://www.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_065.pdf

6.20 Timeframes for Requests for Information from Community Services to NSW Health

NSW Health and the Department of Family and Community Services have agreed to the following timeframes for responding to requests for information under section 248 and Chapter 16A exchanges. Health workers are to comply with these timeframes when responding to requests for information. Where Community Services and Health have an established relationship with the client who is the subject of the information request, or where the information is deemed critical, a more timely response should be provided.

6.20.1 Standard Requests

Local Health Districts/Specialty Networks should make efforts to provide the Department of Family and Community Services with the requested information within 5 and 10 working days.

If it is established that the nominated person has had contact with a Health Service the information that can reasonably be expected to be supplied within 72 hours includes:

- the name of the service;
- the last date of contact with the client; and
- the nature of the contact.

Where the identity of the Health Service that has had contact with the nominated person is not known, any information should be provided within 72 hours.

6.20.2 Urgent Requests

Due to the potentially serious nature of the information requested, a response to an urgent request should be made as soon as practicable but within 24 hours, particularly where the identity of the Health Service that has had contact with the nominated person is known.

Information that can reasonably be expected to be exchanged urgently includes:

- whether the client has made contact with a Health Service;
- the name of the service;
- the last date of contact with the client; and
- the nature of the contact.

Other information relevant to the request should also be provided where available.

6.20.3 After Hours and Weekend Requests

Local Health Districts/Specialty Networks may receive requests for information after business hours and on weekends. All reasonable efforts should be made to respond to after hours and weekend requests for information. The information that Health workers can be reasonably expected to provide after hours includes: whether a client has made contact with a Health Service, the name of the service, the last date of contact and nature of the contact.

6.21 Exchange of Information in Relation to Children in Out-of-home-care

A Memorandum of Understanding (MoU) has been agreed between NSW Health and the Department of Family and Community Services, Community Services to facilitate access to health services for children and young people in out-of-home-care including health screening, assessment, intervention and review.

The MoU contains a *Model Pathway* for the comprehensive health and developmental assessments for all children and young people entering out-of-home-care, which is a framework for interagency implementation. An information flow section has been included in the Pathway to capture issues regarding information exchange and legal guidelines.

Community Services, as legal guardian of children in their care, provides information to Health workers to enable children in out-of-home-care to receive health assessments and other services.

Community Services also provides consent for Health workers arranging or conducting assessments to liaise with the child's General Practitioners (GPs), specialists, Child Care Centres and others to obtain all necessary health and other information necessary to complete the assessment. It is not necessary for information to be requested or provided under section 248 or Chapter 16A. The information is given pursuant to statutory authority without any concern as to repercussions due to failure to seek the consent of the child's parent(s) or guardian(s).

6.22 Exchange of Information and Joint Investigation Response Teams (JIRT)

In accordance with Chapter 16A NSW Health has a responsibility to provide all information available that is relevant to the child and family to Community Services and the NSW Police Force in a timely manner for the purpose of JIRT investigations.

6.23 Ombudsman Requests for Information

Legislation providing for the Ombudsman to be the Convenor and the Co-ordinator of the Child Death Review Team came into effect on 9 February 2011.

Under the NSW *Care Act 1998* and section 38 of the NSW *Community Services (Complaints, Reviews and Monitoring) Act 1993*, there are provisions for the exchange of information about children and young people who have died. The Ombudsman can request full and unrestricted access to NSW Health records when investigating a reviewable death or a death reviewable by the Child Death Review Team.

The Ombudsman has more general powers to obtain information for the purpose of monitoring and/or investigating a 'community services complaint' within the meaning of Part 4 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. The Ombudsman has access to some information held by Child Wellbeing Units and is required to submit written requests to the Director General, Health (or delegate) for any other information.

NSW Health policy directive on *Records – Access by the Child Death Review Team*. http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_286.pdf provides information for Local Health District/Specialty Network response to requests for information from the Child Death Review Team.

6.24 Legal Protections

Health workers exchanging or requesting information are afforded protection under the *Care Act*. Health workers who exchange or disclose information under Chapter 16A are not subject to any legal liability in respect to the exchange or disclosure of the information, provided the information is shared in 'good faith' and is done in accordance with Chapter 16A or section 248 of the Act. The *Care Act* also provides that Health workers will not be subject to any civil or criminal liability and the exchange or disclosure of information cannot be held to constitute unprofessional conduct or a breach of professional etiquette or ethics.

Section 29 of the *Care Act* protects the identity of people who report concerns about children and young people to the Child Protection Helpline. The protection of a reporter's identity must be considered by Health workers when executing exchange of information requests, providing a response to a court subpoena or responding to requests for public access to government information. See section 9.1.2 in this document.

6.25 Information and Consultation

Health workers are expected to exercise professional judgment – that is to use their skills and knowledge as a Health professional – to guide their decisions. Health workers may also consult:

- the NSW Health Child Wellbeing Units or Child Wellbeing Coordinator;
- child protection unit or service staff;
- the Local Health District/Speciality Network privacy officer;
- the Local Health District/Speciality Network central contact point for section 248 requests; or
- the designated Chapter 16A Information Exchange consultant in their Local Health District / Specialty Network (Check the LHD intranet site and/or telephone the Health CWU on 1300 480 420 for details of the information exchange consultants in the NSW Health service).

6.26 Documentation

Health workers should use their professional judgement to determine whether a written request / form is required to exchange information.

Health workers must record any information exchange made under Chapter 16A or section 248 in the Client Health Record. This should include:

- information requested by another prescribed agency;
- information requested by Health from another prescribed agency; and
- information that Health has exchanged.

When a verbal request or response is made the details must be documented in the Client Health Record.

Chapter 16A information exchange forms are available on the NSW Kids and Families website http://www0.health.nsw.gov.au/nswkids/links.asp also available in the appendices of this document.

- Letter of request for information (Chapter 16A) http://www0.health.nsw.gov.au/resources/nswkids/pdf/form_requ_info_ch_16a_let.pdf

A copy of completed forms must be stored on the Client Health Record to ensure they are traceable and reviewable if required.

Health services are encouraged to establish local processes for the recording and filing of information exchanged. Copies of written requests to the Local Health District /Speciality Networks

Central Contact Points in Local Health Districts / Speciality Networks are to collate and store written requests for information. Local Health Districts / Specialty Networks are to ensure compliance with information exchange processes through regular documented file audit processes.

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SECTION 7

Recognising Child Abuse and Neglect

7.1 Indicators of Child Abuse andNeglect

7.1.1 Introduction

In the course of their work Health workers may see or hear something about a child, young person or adult client which raises concerns about the possible abuse or neglect of a child or young person.

The indicators in this chapter are a guide and do not provide a comprehensive list of all harms, behaviours or presentations that give rise to concerns or suspicions of child abuse or neglect. One indicator in isolation may or may not necessarily indicate abuse or neglect and each indicator needs to be considered in the context of the child or young person's personal circumstances.

The indicators in this chapter align with the indicators provided in the *Child Wellbeing and Child Protection – NSW Interagency Guidelines* (2011) and are grouped by type – physical, sexual and emotional abuse and neglect. They are described in terms of a child or young person's presentation and the behaviours of those who abuse and neglect children and young people.

When using these indicators Health workers need to consider whether for example risk of significant harm is likely to arise from a failure to arrange or comply with medical or dental care for an illness, condition or disability. For very young children, the risk of significant harm in not receiving medical attention may be particularly high. Conditions such as burns for example may be quite critical and, depending on severity, require medical attention.

There are a number of factors that Health workers should consider when deciding whether a child or young person is at risk of significant harm from abuse or neglect. These factors may include:

- the age, development, functioning and vulnerability of the child or young person
- the behaviour of the child or young person which suggests they may have been or are being harmed by another person
- the behaviour of another person that has had, or is having, a demonstrated negative impact on the healthy development, safety, welfare or wellbeing of the child or young person, for example drug and alcohol abuse or domestic violence
- contextual risk factors such as recent abuse or neglect of a sibling or a parent recently experiencing significant problems in managing the child or young person's behaviour
- indications that the child or young person's emotional, physical or psychological wellbeing are significantly affected as a result of abuse and neglect
- Contextual factors such as the presence of chronic or complex health issues in the family such as serious or terminal disease, obesity, diabetes, dialysis, problematic drug and alcohol use or mental health issues.
- The life circumstances of the child or young person such as:
  - history of previous harm to the child or young person
  - social or geographic isolation of the child, young person or family, including lack of access to extended family or supports
  - abuse or neglect of a sibling
  - family history of violence including injury to children and young people
  - domestic or dating violence

The evidence of harm may arise from:

- one event
- a series of events over time
- an accumulation of circumstances or behaviour causing concern (cumulative harm).

7.1.2 Physical Abuse

Physical abuse occurs if a child or young person sustains a non-accidental injury or is being treated in a way that may have or is likely to cause injury. The injury may be inflicted by a parent, carer, other adult or other child or young person.

Table 6: Potential Indicators of Physical Abuse

Potential indicators of physical abuse In children & young people	In parents or caregivers
Physical ■ bruising on the face, head or neck ■ other bruising or marks showing the shape of the object that caused it ■ lacerations and welts ■ adult bite marks and scratches ■ bone fractures or dislocations, especially in children under two years of age ■ disclosure by child or young person that injury occurred during an incident of domestic violence ■ burn marks or scalds ■ multiple injuries or bruises, maxilio-facial or dental injury, for example from force feeding ■ unspecified internal pains ■ explanation inconsistent with injury ■ head injuries where the child may be drowsy or vomiting, or have glassy eyes, fixed pupils or pooling of blood in the eyes suggesting the possibility of having been shaken ■ ingestion of poisonous substances, alcohol or drugs ■ behaves aggressively and violently towards others, particularly younger children ■ hypervigilance and cowering at sudden movements ■ physical indicators consistent with female genital mutilation such as: having a special operation associated with celebrations; difficulties with toileting or menstruation; anxiety about forthcoming school holidays or trip to a country which practises FGM or older siblings worried about their sisters visiting their country of origin	**Physical** ■ visits with child to health or other services with unexplained or suspicious injuries, swallowing of non-food substances or internal complaints ■ non-family member presents child to health services ■ presentation at a number of different medical centres/services over time ■ explanation of injury is not consistent with the visible injury ■ family history of violence ■ disclosed/apparent use of excessive discipline ■ aggressive behaviour displayed in the presence of the child or young person
Social /psychological ■ wears clothing, inappropriate to the weather conditions, to conceal injuries ■ direct or indirect disclosure of physical abuse ■ explosive temper out of proportion to precipitating event ■ fears going home or expresses a desire to live somewhere else ■ lacks empathy ■ general indicators consistent with female genital mutilation (e.g. having a 'special operation or ceremony') ■ constantly on guard around adults, cowers at sudden movements, unusually deferent to adults ■ aggression with peers and in play ■ hyper vigilance and cowering at sudden movements ■ age inappropriate behaviour	**Social/psychological** ■ history of their own maltreatment as a child ■ fears injuring their own child

7.1.3 Sexual Abuse

Sexual abuse is sexual activity or behaviour that is imposed, or is likely to be imposed, on a child or young person by another person. Sexual activity includes the following: sexual acts; exposure to sexually explicit material; inducing or coercing the child or young person to engage in, or assist any other person to engage in, sexually explicit conduct for any reason and exposing the child or young person to circumstances where there is risk that they may be sexually abused.

It is important to report sexual abuse that has happened to a child or young person in the past, particularly if the alleged perpetrator still has contact with children or young people, for example in a family setting or if the alleged perpetrator is a teacher or works with young people in a paid or unpaid capacity. Reporting such abuse enables follow up by employers if the alleged perpetrator still works with or cares for children and young people.

Health professionals should be aware that child sexual assault offenders are often known to and cultivate connections with the child and family. Sex offenders are skilled at tailoring their tactics of entrapment to the vulnerabilities of children, making any child a potential victim. Health workers need to be mindful that a priority of their intervention will be the child or young person in addition to the health issue with the adult client. There are tertiary services that may provide specialist responses to these issues.

Children and young people who have been abused may exhibit sexualised or sexually abusive behaviour. Whilst a child who is exhibiting such behaviour may be at risk of significant harm, such behaviour is often associated with the antecedents of other forms of disruptive, externalizing behaviour. In such cases, Health workers should consider the need to make a report after applying the MRG. This should occur even if a victim of the behaviour has not been identified.

Consensual peer sex

In the course of their duties Health workers may become aware of an adolescent who is engaging in sexual activity or is pregnant. Consensual peer sex is not of itself an indicator of sexual abuse. Health workers are however responsible for responding to the safety, welfare or wellbeing needs of adolescents engaging in consensual sexual activity, including considering whether the particular circumstances of the case give rise to a reasonable suspicion that an adolescent is at risk of significant harm. Health workers need to consider whether the sexual activity is with a peer and whether it is consensual, as well as any other indicators that may suggest the young person is at risk of significant harm (ROSH). In the context of this document, 'peers' are defined as individuals who are aged within two chronological years of each other.

Use of the MRG will guide a Health worker's decision on whether or not a case of peer consensual sex constitutes suspected risk of significant harm requiring a report to the Child Protection Helpline.

Although there is no requirement to make a child protection report for cases below this threshold, Health workers should consider any additional information and support that may be appropriate including referral to sexual health services.

See also Section 10 *Responding to Child Sexual Assault and Serious Abuse or Neglect* in this document.

Past sexual abuse

Research shows that children do not always manifest obvious current effects following serious abuse and disclosure of abuse is often delayed. Therefore a child or young person who has experienced past serious abuse, including sexual abuse, should be considered at possible risk of significant harm even if there do not appear to be obvious current concerns.

Table 7: Potential Indicators of sexual abuse

Potential Indicators of sexual abuse In victims	In non-offending parents or caregivers	In perpetrators
Physical ■ self mutilation ■ self destructive behaviour drug dependence, suicide attempts etc ■ eating disorders ■ pregnant and reluctant to identify father ■ diagnosed sexually transmitted infection ■ trauma to the genital region, including bruising, bleeding and tearing ■ trauma to the breasts, buttocks, lower abdomen or thighs including bite/burn marks ■ Hypervigilance and cowering at sudden movements	**Physical** nil	**Physical** nil
Social/psychological ■ direct or indirect disclosure of sexual abuse ■ contact with an alleged or known sex offender ■ describes or re-enacts sexual acts with age inappropriate knowledge ■ unexplained money or gifts ■ somatic or psychosomatic complaints ■ sexually provocative ■ risk taking behaviours, self harm, suicidal ideation and alcohol or drug use ■ poor self esteem ■ disturbed sleep and nightmares ■ marked changes in behaviour, for example a confident talkative child becoming suddenly introverted, or an introverted child becoming aggressive or not wanting to be alone ■ eating disorder ■ regresses in developmental achievements, child is excessively clingy or begins soiling and wetting when these were not formerly a problem ■ sexual themes in the child's artwork, stories or play ■ fears going home or expresses a desire to live elsewhere ■ persistently runs away from home ■ goes to bed fully clothed ■ wears baggy clothes in order to disguise gender, body shape, bruising or injuries ■ engages in, talks about sexual acts including violent sexual acts ■ knows about practices and locations usually associated with prostitution	**Social/psychological** ■ defers to partner ■ may minimise disclosure	**Social/psychological** ■ appears to encourage, tolerate sexualised behaviour ■ controlling attitude and behaviour to child, young person and/or partner ■ exposes child or young person to prostitution or pornography, or uses a child or young person for pornographic purposes ■ intentionally exposes child or ■ young person to the sexual behaviour of others ■ committed or has been suspected of child sexual abuse or child pornography ■ coerces child or young person to engage in sexual behaviour with other children and young people ■ minimises disclosure or defends against accusations of sexual abuse by claiming the child or young person is lying ■ inappropriately curtails development of child's age appropriate independence from the family ■ overly critical of adult partner ■ family denies pregnancy of child or young person ■ minimisation of the impact or seriousness of abuse ■ justification of abuse by blaming victim ■ grooming behaviour

7.1.4 Psychological Harm

The child or young person's psychological state has been, or is at risk of, being harmed, because of the parent or carer's behaviour or attitude. This could be due to domestic violence, mental health, drug and alcohol use, criminal or corrupting behaviour or deliberate exposure to traumatic events. Psychological harm involves the impairment of, disturbance or damage to a child or young person who experience or witness such violence.

There are varied manifestations of psychological harm which are affected by age, personality, length of exposure to incidents of domestic violence, nature of the incidents, and any remedial assistance given to the child or young person and their family for dealing with or ameliorating the harm. The *NSW Crimes (Domestic and Personal Violence) Act 2007* includes recognition that witnessing domestic violence can have a significant impact on the current and future physical, psychological and emotional well-being of a child.

Table 8: Potential Indicators of Psychological harm

Potential Indicators of psychological harm In children & young people	In parents or caregivers
Physical ■ self-harms, attempts suicide	**Physical** ■ uses inappropriate physical or social isolation as punishment ■ presence of domestic violence
Social/psychological ■ feels worthless, low self esteem, not confident ■ takes extreme risks, is markedly disruptive, is a bully, is aggressively violent ■ regresses in developmental achievements, child is excessively clingy or begins soiling and wetting when these were not formerly a problem ■ doesn't value others or show empathy ■ lacks trust in people ■ lacks age appropriate interpersonal skills ■ extreme attention seeking ■ impaired parental or caregiver attachment ■ depressed, anxious or other mental health indicators ■ avoids adults ■ obsessively flattering, submissive to adults ■ has difficulty maintaining long term significant relationships ■ highly self-critical ■ displays rocking, sucking, head-banging behaviour ■ somatic or psychosomatic complaints ■ hypervigilance and cowering at sudden movements	**Social/psychological** ■ constantly criticises, belittles, teases child/young person ■ ignores or withholds praise and affection ■ persistently hostile and verbally abusive, rejects and blames child unnecessarily ■ makes excessive or unreasonable demands ■ presence of domestic violence ■ unmanaged mental health condition ■ believes that a particular child or young person is bad or evil ■ isolates and/or prevents the child or young person from engaging in normal peer relationships ■ unable to respond to the psychological needs of the child or young person due to their own drug and/or alcohol use

7.1.5 Domestic and Family Violence

Domestic and family violence is any abusive behaviour used by a person in a relationship to gain and maintain control over their partner or ex-partner. It can include a broad range of behaviour that causes fear and physical and/or psychological harm. If a child or young person is living in a household where there have been incidents of domestic violence, then they may be at risk of serious physical and/or psychological harm.

Domestic violence toward a pregnant woman may cause injury to the foetus. A Health worker responding to domestic violence should record information received from a pregnant woman in their Health record.

Table 9: Potential Indicators of parent / carer domestic violence

Potential indicators of parent/carer domestic violence in children & young people	In adult victims	In perpetrators
Physical ■ preterm and low birth weight baby ■ low weight for age and/or fails to thrive and develop ■ unexplained physical injuries ■ uses or abuses alcohol or other drugs ■ eating disorders ■ somatic or psychosomatic complaints ■ aggressive or violent behaviour ■ regresses in developmental achievements, pre-school child is excessively clingy or begins soiling and wetting when these were not formerly a problem ■ wears concealing clothing, in order to hide bruising or injuries ■ hyper vigilance and cowering at sudden movements	**Physical** ■ explanation inconsistent with injury or offered in the context of duress ■ bruising and other injuries, especially if pregnant ■ minimises injuries and/or pain ■ wears concealing clothing, in order to hide bruising or injuries ■ unwanted pregnancy or sexually transmitted infection through coerced sex/refusal by sexual partner to use contraception ■ unexplained miscarriage or stillbirth ■ alcohol and/or drug abuse	**Physical** ■ physical signs of the victim fighting back, such as facial scratches and injuries to hands

Potential indicators of parent/carer domestic violence in children & young people	In adult victims	In perpetrators
Social/psychological ■ directly or indirectly discloses domestic violence ■ difficulties with sleeping, eating ■ over-protects mother or fears leaving mother at home ■ no or little emotion or fear when hurt or threatened ■ unusual fear of physical contact with adults ■ overly compliant, shy, withdrawn, passive and uncommunicative ■ poor sleeping patterns, fear of dark, nightmares ■ frequent school absenteeism, poor concentration ■ poor academic achiever ■ insecure attachment with parents ■ physically, verbally abusive towards siblings, parents and peers ■ abusive or dismissive attitude to a parent who is a victim ■ homeless or stays away from home for prolonged time ■ takes extreme risks ■ socially isolated ■ sadness and frequent crying ■ suicide attempts ■ hyper vigilance and cowering at sudden movements	**Social/psychological** ■ nutritional and sleep deprivation or disorders ■ feels anxious and depressed ■ low self-esteem ■ socially isolated ■ disclosure of suicidal thoughts and attempts ■ seldom or never makes decisions without referring to partner ■ frequent absences from work or studies ■ substantial delay before seeking medical treatment ■ repeat/after hours presentations at emergency departments ■ terror or reluctance to speak to those in authority ■ reference frequently made to a partner's anger or temper ■ financial problems ■ submissive and withdrawn	**Social/psychological** ■ directly or indirectly discloses domestic violence ■ presents as the victim ■ visible rough handling of victim, children, pets ■ threatens to commit acts of violence against family members or pets ■ is unable to control angry outbursts ■ always speaks for partner or children ■ describes partner as incompetent or stupid ■ holds rigidly to stereotypical gender roles ■ jealous of partner, lacks trust in them or anyone else ■ does not allow partner or child to access service providers alone ■ admits to some violence but minimises its frequency and severity ■ previous criminal convictions or apprehended violence orders imposed against them

7.1.6 Neglect

The child or young person's basic needs (e.g. supervision, medical care, nutrition, shelter and education) have not been met, or are at risk of not being met, to such an extent that it can reasonably be expected to have a significant adverse impact on the child or young person's safety, welfare or well-being. This lack of care could be constituted by a single act or omission or a pattern of acts or omissions such as failing to attend medical appointments or failing to ensure that a school age child attends school.

Medical neglect usually takes 1 of 2 forms: failure to heed obvious signs of serious illness or failure to follow a medical practitioner's instructions once medical advice has been sought. Either of these situations can place a child at risk of significant harm. Some parents with chronically ill children fail to keep multiple medical appointments. Depending on the seriousness of the child's illness, lack of medical care could place the child at risk of significant harm.

Table 10: Potential Indicators of Neglect

Potential indicators of neglect In children & young people	In parents or caregivers
Physical ■ low weight for age and/or fails to thrive and develop ■ inappropriate provision of nutrition leading to, for example, excessive weight for age ■ attains general developmental milestones late ■ poor primary health care, untreated sores, serious nappy rash, significant dental decay ■ failure to keep multiple health appointments when child has chronic and complex health care needs ■ standard of hygiene and self-care is poor ■ not adequately supervised for their age ■ loss of 'skin bloom'	**Physical** ■ may have poor standards of hygiene and self care ■ physical signs of injuries from domestic violence ■ prioritisation of work and adult interests to essential needs of child or young person ■ parental drug or alcohol use or dependence having a negative impact on the child's physical, social and psychological health
Social/psychological ■ scavenges or steals food, focus is on basic survival ■ longs for or indiscriminately seeks adult affection ■ poor school attendance ■ stays at the homes of friends and acquaintances for prolonged periods, rather than at own home ■ displays rocking, sucking, head-banging behaviour ■ overly passive, emotionless ■ somatic or psychosomatic complaints ■ Attending a parent or caregiver's appointment during school hours ■ Providing care to a parent/carer or other family member with chronic or complex health needs	**Social/psychological** ■ unable or unwilling to provide or arrange adequate food, shelter, clothing, education, medical attention or a safe home ■ leaves child without appropriate supervision ■ abandons child ■ withholds physical contact or stimulation for prolonged periods ■ minimal psychological nurturing, 'low-warmth' parenting ■ limited understanding of child's needs ■ unrealistic expectations of child ■ parent/carer appears unable to comprehend the severity of the child/young person's situation to the extent that parent/carer is unable to take actions necessary to provide needed intervention, care, and/or supervision.' ■ presence of an unmanaged mental health condition ■ treats one child differently to other siblings ■ presence of domestic violence in the family ■ presence of drug and alcohol misuse ■ homelessness or unstable housing arrangements

7.1.7 Prenatal Harm

Prenatal harm refers to a parent's circumstances or behaviours during pregnancy that may reasonably be expected to produce a substantial and demonstrably adverse impact on the child's safety, welfare or wellbeing when born.

Table 11: Potential Indicators of Prenatal Harm

Potential indicators of prenatal harm in parents or caregivers
Physical ■ pregnant woman misuses alcohol or drugs ■ pregnant woman is/has been victim of domestic violence ■ homelessness
Social/psychological ■ pregnant woman has an unmanaged mental health condition ■ pregnant woman is at risk of suicide ■ pregnant woman or caregivers have history of abuse or neglect of siblings of the unborn child ■ a previous child of the pregnant woman was removed or died ■ pregnant woman's partner had a previous child removed or die in suspicious circumstances ■ pregnant woman's significant others are misusing drugs, alcohol or have a mental illness ■ pregnant child or young person with limited social support, such as pregnant child/young person under parental responsibility to the Minister

7.2 Disclosures

7.2.1 Disclosures of Child Wellbeing Concerns and Abuse

When working with children, young people and their families Health workers may become aware of safety, welfare or wellbeing concerns. The following information provides Health workers with guidance on how to respond to disclosures of abuse and neglect. It is also useful in the context of recognising and responding to child wellbeing concerns.

Health workers may refer to chapters 8, 9 and 10 of this document for further information on determining and reporting risk of significant harm and on managing child wellbeing concerns that fall below the statutory child protection reporting threshold.

7.2.2 If a Child Discloses Abuse and/or Neglect to a Health Worker

If a child or young person discloses abuse and/or neglect to a Health worker, the Health worker should record the time and date of the conversation and, as far as possible, the exact words used. It is important for Health workers to try and gather enough information to determine whether the child or young person is at suspected risk of significant harm. This is the role of the mandatory reporter. This may require health workers to ask the child or young person to provide more information about disclosure. e.g. 'You said you were touched and it made you feel uncomfortable; can you tell me more about that?' OR 'How did you feel when your mother and father were fighting and throwing things at each other? What did you do?' Health workers should also attempt to ascertain whether the alleged perpetrator has access to the child or young person.

As the child or young person talks the Health worker should:

- react calmly to the information they provide and thank them for helping you to understand
- actively listen and be objective. Give the child or young person their full attention
- let the child or young person take his or her own time and use their own words
- if appropriate to the situation, reassure the child or young person that they have done the right thing to tell and that it is not their fault
- not ask leading questions (e.g. did he touch your vagina?)
- accept the child or young person will disclose only what is comfortable and recognise their bravery/ strength for talking about something that is so difficult
- let the child or young person know that they are not alone and you know that this has happened to other children and young people
- not make promises that may not be able to be kept, particularly around not telling anyone else about this information
- if it is appropriate and will not place the child or young person at risk, tell the child about the obligation to report and what you plan to do next
- if appropriate, reassure and support the caregivers present. In the situation where child sexual assault is suspected, Health workers should discretely keep the child or young person separate from the alleged perpetrator where possible. Health workers should not confront the perpetrator.
- Respond to any immediate medical/mental health needs e.g. threat to self harm.

7.2.3 If a Health Worker Becomes Aware of Abuse when Working with an Adult

Health workers may become concerned that a child, young person or class of children or young people is at risk of significant harm in ways other than the direct disclosure by a child or young person. These situations may include:

- an adult client disclosing abuse and or neglect of a child or young person
- the parent or caregiver of a child or young person disclosing abuse and or neglect of their child
- a Health worker working with an adult client who is a caregiver forming the view that the adult is not capable of caring for their child or children at that time due, for example, to physical or mental health problems or disorders, intoxication or distress
- a Health worker working with a pregnant woman forming the view that the woman may not be able to care for her child when born, and a report may reduce the likelihood of her baby being placed in out-of-home care
- an adult client disclosing that they were abused and or neglected when they were a child or young person by someone who remains in child related employment and/or has current access to children which would mean a class of children or young people are at risk.

If a Health worker has a concern that a child, young person or class of children or young people is at risk of significant harm, they should use the Mandatory Reporter Guide, to determine the next steps. The next steps will be to continue to provide a health service to the child or young person, or to consult the Health Child Wellbeing Unit or to make a report to Community Services by contacting the Child Protection Helpline.

7.2.4 Evidence of First Complaint

If a Health worker is the first person the child or young person tells about abuse and or neglect that constitutes a crime, the Health worker may be in due course called to court to give evidence. This is called evidence of first complaint. It is therefore important for Health workers to record information received from the child or young person accurately in their Health record.

In the course of performing their duties a Health worker may be required to give information and or statements to statutory or investigatory authorities. These authorities include, but are not limited to:

- The Department of Family and Community Services
- The NSW Police Force
- The Director of Public Prosecutions or delegate
- Federal or state courts or other state or federal tribunals or authorities
- The NSW Ombudsman

Any information, statement or evidence given by a Health worker should be in accordance with the NSW Health Code of Conduct and other relevant policies including the NSW Health Privacy Manual – NSW Health PD 2005_593, and relevant legislation. Health workers who are asked to give evidence, statements or attend court should consult with senior managers in the Local Health District or Specialty Network or relevant NSW Health legal representatives as approved by the Local Health District or Specialty Network.

7.2.5 Safety Issues in Relation to Disclosures

The safety of the child or young person and of the Health worker is paramount in all situations of disclosure of abuse, assault or neglect.

Health workers are to ensure that the child or young person disclosing assault or abuse is afforded appropriate support and care. Health workers are to facilitate access to appropriate services as soon as is possible and as appropriate to the situation. Health workers are to inform their line manager of any disclosure of assault or abuse in accordance with usual reporting procedures and to ensure they are alert to possible additional risk to the child, young person and worker.

A first complaint disclosure of any form of assault or abuse by a child or young person to a Health worker is not a common occurrence. Disclosure of abuse or assault is usually a difficult subject for the child or young person and in most instances indicates that the child or young person is in crisis.

Worker safety

Health workers are to inform their supervisor or manager, or discuss the case with a team member of the Level 4 or 6 Child Protection Service when they have received a disclosure from a child or young person, to confirm an appropriate action or to inform their manager after they have taken relevant steps to respond to the child or young person. Child protection issues are complex and may raise both professional and personal issues for Health workers.

Informing a supervisor or consulting a Child Protection Co-ordinator or Child Protection Counselling Service or Child Protection team member when issues arise helps them to be aware that a Health worker may need additional support, information or supervision. Health workers may also contact the Local Health District/ Specialty Network Staff Counsellor or Employee Assistance Program (EAP) for personal support. Health workers may also consult the designated Occupational Health and Safety Officer in their Local Health District /Network.

If a Health worker is threatened with or fears personal violence the threat should be reported to the NSW Police Force. The NSW Police Force may apply for, and pursue on behalf of the Health worker, an Apprehended Personal Violence Order (APVO). Individuals may also obtain an APVO by making an application to a Chamber Magistrate at a Local District Court.

7.2.6 Disclosure of Child Sexual Assault

The Health worker to whom the disclosure is made must not confront the alleged perpetrator as this may lead to further risk to the child or young person. Discussing the allegation with the alleged perpetrator is the role of Community Services or the NSW Police Force. If a child makes a disclosure and the alleged perpetrator is at the Health Service premises or due to pick up the child, relay the immediacy of need for intervention to Community Services and, if possible, keep the child separate from the alleged perpetrator. If a Community Services case worker is not expected to arrive for some time and it would be difficult to keep the child separate from the alleged perpetrator, the Health worker should ask Community Services for advice about how to handle the situation. If there are concerns about the immediate safety of the child or a worker, contact the NSW Police Force or Local Health District / Specialty Network Security staff.

Health workers may also contact their Local Health District/ Specialty Network Sexual Assault Service or Child Wellbeing Co-ordinator, JIRT Senior Health Clinician, Health Child Wellbeing Unit (Tel: 1300 480 420) or the Child Protection Units in the Sydney Children's Hospitals' Network – Randwick (Tel: 9382 1111) and Westmead (Tel: 9845 0000) or at John Hunter Children's Hospital (Tel: 4921 3000) for information, referral and support.

7.2.7 Disclosure or Indicators of Physical or Emotional Abuse or Neglect

Should the child or young person disclose abuse or neglect to the Health worker, or should the Health worker form the opinion that abuse or neglect may have occurred, the Health worker may need to ask questions of the family members or carers accompanying the child to help clarify the situation.

Clarifying questions should relate to the consistency of history given or to the reason for presentation at the Health service and should only be asked where doing so is unlikely to place the child or young person at further risk.

Concern that a child or young person may have been abused or neglected may also arise where another family member is the Health service client. A Health worker may have concerns that the child of an adult client may be at risk of significant harm where a parent who as a result of their own health issue is unable to provide appropriate care for their child/children.

Health workers may also contact their Local Health District Child Wellbeing Co-ordinator, Child Protection Co-ordinator, Child Protection Counselling Service or the Health Child Wellbeing Unit or Level 4 or 6 child protection team member for information, referral and support.

Further information:

Advice about responding appropriately to disclosures of child abuse or neglect is offered in child protection training within Local Health Districts or Specialty Networks and through the Education Centre Against Violence (ECAV).

7.3 Supports for Health Workers

7.3.1 Documentation

Specialist NSW Health policies and procedures have been developed for use by medical workers involved in assessing children or young people who have been or are suspected of being physically abused or neglected including:

- A Suspected Child Abuse and Neglect Medical Protocol form to document an assessment is being trialled in 2012. For further information telephone NSW Kids and Families on 93919693.
- A Sexual Assault Investigation Kit (SAIK) including an Adult Sexual Assault Protocol and a Child Sexual Assault Medical Protocol. For further information please contact the Local Health District / Specialty Network Sexual Assault Service.

7.3.2 Mandatory Reporter Guide (MRG)

The MRG is available at:
http://sdm.community.nsw.gov.au/mrg/

When a Health worker has concerns about the safety, welfare or wellbeing of a child or young person they are to use the MRG prior to reporting to the Child Protection Helpline. The MRG will assist Health mandatory reporters in making a decision about the level of risk and in deciding whether to report their concerns.

Table 12: Responding to Concerns

If the concern is **imminent** Health workers must:

- Call the Child Protection Helpline immediately when concerns constitute suspected risk of significant harm and the child protection concerns are about imminent risk.

If the concern is **not imminent** Health workers are to:

- Contact the Child Protection Helpline (Tel: 133 672) within 24 hours when concerns constitute suspected risk of significant harm
- Contact the Health Child Wellbeing Unit (Tel: 1300 480 420) when concerns about the child or young person's safety, welfare or wellbeing are identified through the application of the MRG as being below the statutory reporting threshold or if the Health worker is uncertain whether the concerns meet the statutory threshold
- Document their concerns in the client Health record and if appropriate continue working with the client/ patient when the concerns are not at a level which requires a Child Protection Helpline response or contact with a Child Wellbeing Unit.

7.3.3 Child Wellbeing Unit assistance

When considering making a report of suspected ROSH, Health workers should use their professional judgement. The MRG does not replace critical thinking or prohibit a mandatory reporter from a course of action he/she believes is appropriate. Where the Health worker reasonably suspects that their concerns in fact do constitute *risk of significant harm*, they should contact the Child Protection Helpline to report their concerns. In doing so they should indicate the full nature of their concerns which could go beyond those explored in the MRG.

A key role of the Health Child Wellbeing Unit is to receive information to develop a picture of cumulative risk and to assist in planning services and supports to prevent the risk escalating. When the MRG outcome/decision point is to contact the Child Wellbeing Unit (CWU), Health workers are to contact the Health CWU as soon as possible but no later than the next business day. The CWU will discuss and record the concerns, and will follow CWU protocol to assist in determining what actions might need to be taken. Health workers must contact the Health Child Wellbeing Unit if the MRG outcome is to contact the Health Child Wellbeing Unit to discuss and record their concerns, and for assistance in planning a Health Service response.

Where the MRG indicates that a risk of significant harm report is not required at that time, it may indicate that the Health worker is to contact the Health Child Wellbeing Unit to have the concern documented and to plan what other supports the child, young person or pregnant woman may require.

7.3.4 Using the MRG to assess Risk of Significant Harm

Health workers are expected to use the Mandatory Reporter Guide (MRG) to assist in determining whether concerns for the safety, welfare or wellbeing of a child or young person meet the threshold of suspected risk of significant harm.

The MRG is an agreed interagency Structured Decision-making® tool to assist in determining the level of risk to a child, young person or unborn child, and what action should be taken.

A number of 'decision trees' (sections such as physical abuse, neglect, psychological harm) which ask a series of questions to determine if there is suspected risk of significant harm. As the statutory child protection body, Community Services makes the determination about whether a risk meets the legislative threshold of risk of significant harm, and not all cases determined by the MRG to require a report to the Child Protection Helpline will be accepted as meeting this threshold at the Helpline.

The MRG encourages the reporter to focus on critical information to inform their decision-making. The MRG is intended to support professional judgment and facilitates consistent decision-making. It takes mandatory reporters through a series of questions to determine if their concerns meet the statutory threshold for a report to the Child Protection Helpline, or if not, what other action to take. This process may include contacting the Health Child Wellbeing Unit to discuss how to manage the assessed child welfare or wellbeing concern.

Health workers can access the MRG online via the *Keep Them Safe* Quick link on Health intranet sites, at the NSW Health KTS internet site as an online interactive document or as a PDF version or may be found at:
http://sdm.community.nsw.gov.au/mrg/

If a Health worker does not have access to the intranet or internet, a hard copy should be available at all workplaces or Health workers should consult, the Health Child Wellbeing Unit, Child Wellbeing Co-ordinator, Child Protection Co-ordinator or their supervisor. Further information is available from: http://www.keepthemsafe.nsw.gov.au/resources/factsheets

7.3.5 Guide to Making a Report

A flowchart of the reporting process to the Child Protection Helpline (telephone 13 36 27) is included in Section 9 of this document.

A fact sheet has been developed by Community Services to help reporters and mandated reporters decide whether to report a child or young person as suspected ROSH. The fact sheet includes information about the Mandatory Reporter Guide. The fact sheet can be accessed at: http://www.community.nsw.gov.au/kts/guidelines/documents/make_report_factsheet.pdf

7.3.6 Outcomes of the Mandatory Reporter Guide

The MRG may recommend one of three possible outcomes:

1. that the concern is identified as being suspected risk of significant harm,
2. that the concern is not identified as risk of significant harm but risks are present, or
3. that the concern is not identified as risk of significant harm and low risk is present.

1. The concern is identified as being suspected risk of significant harm (ROSH)

The MRG will advise the Health worker to report to the Child Protection Helpline. The guide will also provide advice as to whether the report should be made immediately.

Where the MRG outcome is that the concerns constitute suspected *risk of significant harm*, Health workers as mandatory reporters should contact the Child Protection Helpline to report the child, young person or unborn baby.

Where the MRG recommends a report to the Child Protection Helpline and the Health worker intends to make the professional decision not to report, the Health worker is to consult their manager about this decision in the first instance as well as the Health Child Wellbeing Unit. The Health Child Wellbeing Unit may have additional information that could add to the known level of risk.

The rationale for any decision to take a different course of action than the MRG outcome based on professional judgement, and consultation with the CWU or manager about this decision should be clearly documented in the Health record of the child, young person or pregnant woman or adult client who is a parent or carer of children or young people. The MRG issues a Decision report when the tool is completed. This is also to be printed, the client's name added, and filed in the Health record.

2. The concern is identified as not being suspected risk of significant harm but there are some risks to the child.

The MRG will advise the Health worker to contact the Health Child Wellbeing Unit to record the concerns and to discuss what additional assistance may be required for the child, young person or family members.

Health workers are required to contact the Health Child Wellbeing Unit to report and discuss concerns when reaching this outcome to ensure that the concerns are recorded on WellNet and acted upon. This is to occur when the concern does not constitute suspected risk of significant harm, but may still require action to ensure the safety, welfare or wellbeing of the child. The Child Wellbeing Unit may hold additional information about concerns for the child or young person which are unknown to others. On some occasions the CWU may contact the Helpline directly on behalf of the mandatory reporter. Examples include when the CWU has identified cumulative risk after identifying that more than one worker or agency has similar concerns.

In the situation where the outcome of the MRG is not to report, but the Health worker's professional judgement is that a report **is required** at that time, the Health workers should make a report or consult with the CWU.

The MRG outcome and any additional supports identified by the Health worker that may be required or to which the child, young person or family member is referred should be documented within the medical record. The MRG Decision Report is to be printed and filed within the Health record of the child, young person or pregnant woman.

3. The concern is identified as not being suspected risk of significant harm, and is of low risk.

The MRG outcome may be that a risk of significant harm report is not required at that time. The Health worker is responsible for considering what other supports or information the child, young person or pregnant woman may require, and for documenting this assessment in the appropriate Health record.

The Health worker should document the concerns and, where applicable, continue their working relationship with the child or young person and their family.

Where the MRG outcome is to document concerns and to continue work with the child, young person or family member, Health workers are to consider not only the service they are able to provide, but also any other supports or services that may be appropriate to offer to the child, young person or their family including other Health services or a Family Referral Service.

The MRG outcome and any additional supports identified by the Health worker that may be required or to which the child, young person or their family member is referred should be documented within the Health record.

Health workers responsibilities to respond to child wellbeing are outlined further in Section 4 of this document. Health workers should refer to Section 9.7 of this document in situations where the Health worker's opinion is that a report should still be made.

Health workers can also contact the Health Child Wellbeing Unit for further information and consult Sections 2 – *Key resources*, 4.10.1 *Roles and responsibilities*, and 8.4.1 *Responding to non-ROSH concerns* of this document.

7.3.7 Situations where a Health Worker Departs from the MRG Outcome

Where the MRG outcome is not to report, and the Health worker's professional opinion is to report

Where the outcome of the MRG is not to report to the Child Protection Helpline, but the Health worker's professional judgement is that a report is required, the Health worker should consult with the Health Child Wellbeing Unit (telephone 1300 480 420) to discuss the concern. This is unless, in their professional judgement, the child or young person is at suspected imminent ROSH. In this case the Health worker should make an immediate report, by telephone, to the Child Protection Helpline (telephone: 13 36 27). The Health Child Wellbeing Unit may also hold additional information about concerns for the child or young person which may impact on the level of risk or response required.

The MRG is intended to complement rather than replace critical thinking and does not prohibit a Health worker from any course of action they believe is appropriate. The MRG aims to help workers on the most critical pieces of information for the decision at hand and reflects the consensus of multiple government departments and non-government agencies concerning situations that are best served through statutory responses and those that are best served through alternative interventions.

The Health worker is to document the rationale behind their decision to report in the Health record of the child, young person or pregnant woman. This should include attaching the MRG Decision Report to the Health record.

Further information can be found in Section 8 *Responding to child wellbeing / non-statutory concerns (Non-ROSH)* in this document regarding procedures to request a review by Community Services of reports which have been assessed at the Child Protection Helpline as not meeting the threshold of ROSH.

7.3.8 Informing Children, Young People and Families of a Report to the Child Protection Helpline or the CWU

Children, young people and families who participate in decisions about their lives are more likely to support the decisions made. This participation may enable the child, young person or family to be involved in the process of making a report and will assist in making the process of reporting transparent. It is often helpful to assume that clients may wish to participate more actively in resolving difficulties that place their children at risk. In the situation where the Health worker assesses that informing the child, young person or their family may potentially place them or the worker at risk, they should not be informed.

Other family members who are not present when the concerns arise should not usually be approached about the need to make a report, particularly in the case of suspected domestic violence or sexual assault.

The dynamics of sexual assault and domestic violence in particular mean that it is important not to inform the alleged offender that a report will be made, as they may pressure the child or young person to retract their disclosure. The dynamics of physical abuse, psychological abuse and neglect may also mean that workers need to use their professional judgement in making decisions of whether to inform parents or carers about the need to make a report, as the safety of the child or young person should be the first priority and then, if possible, transparent and open discussions with parents/carers. The non-offending caregiver should be informed of a report and the reasons why a report has been or will be made where they have provided the information and the Health worker assesses it to be safe and appropriate. Health workers who are unsure about informing a child, young person or parent/caregiver of the decision to report should consult their Supervisor/Manager or the CWU.

8

Responding to Child Wellbeing /non-Statutory Concerns (non-ROSH)

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SECTION 8

Responding to Child Wellbeing / non-Statutory Concerns (non-ROSH)

8.1 Introduction

Consistent with NSW Health's model of care for child wellbeing and child protection, as well as legal responsibilities, Health workers are required to identify and respond to concerns about child safety, welfare or wellbeing no matter where the Health worker is employed. This includes workers in services where the parent or carer is the Health client.

This section provides guidance for Health workers in responding to cases where a Health worker identifies that a child or young person may be at risk of harm from abuse or neglect but the concerns do not meet the statutory threshold for making a child protection report. The Special Commission of Inquiry into Child Protection Services in NSW (2009), characterised this group of children, young people and families as those 'in need of support' to help mitigate concerns or risks, as distinct from those in need of statutory child protection intervention. Health services and individual workers are responsible for considering how to address both the health needs and other support needs of their clients in this 'non-ROSH' group.

Health workers should be aware that the distinction between families in need of support to help address concerns about a child's wellbeing and those whose children require statutory child protection intervention will not always be clear cut, with a family's need for services and the intensity of that need varying over time. This necessitates continual review of concerns and risks, as well as a family's strengths over time, if work with a client is ongoing.

8.2 Collaboration with other Service Providers

Consultation with the Health Child Wellbeing Unit (Tel: 1300 480 420) and collaboration with other professionals involved with the family (from within the NSW Health Service and from other agencies) is important when responding to the support needs of vulnerable children and young people and their families.

Talking with other professionals who know or have information on family members, in particular children and young people, can help ensure a worker has accurate information about the family and explore whether there are other strategies that could support them. For example, if a Health Worker has concerns about the safety, welfare or wellbeing of a young person who is of school age and is planning supports around the family, the child or young person's school can be contacted. Such consultation may help a worker plan how to talk to the family about concerns, promote referral options and ensure services to the family are co-ordinated. Refer to Section 6 of this document for additional information about the legal basis for Information sharing to co-ordinate services for children, young people and families.

Once other relevant agencies have been identified, it may be appropriate to negotiate a key person working with the child, young person or family, such as a Health worker, to provide case management. See Section 12 *Case Management and Case Work* of this document.

8.3 Making Referrals to other Services

In responding to the needs of vulnerable children, young people and families, Health workers must carefully consider, in collaboration with other relevant service providers:

- which services might be appropriate
- how they are planned and
- how they are offered to the family

Planning should recognise which issues may need to be addressed as a priority, because families can feel overwhelmed if they are offered referrals to multiple services all at once.

Prior consent is not a prerequisite to offering a service to a family, particularly when vulnerabilities have been identified. In some circumstances, Health workers can contact a family to offer a service following initial referral from another worker, knowing that the young person/family/carer is not aware their details have been provided.

Referrals to services should wherever possible be discussed with families, including children or young people. This allows clients to make an informed decision as to whether they agree to a referral and to optimise engagement. For further guidance on effective client engagement and coordinating services around a family's needs see the *Child Wellbeing and Child Protection – NSW Interagency Guidelines, Engaging children, young people and families* section at: http://www.community.nsw.gov.au/kts/guidelines/engaging/index.htm

8.4 Referral Advice

Sources of information about referral options to address the support needs of vulnerable families include:

- NSW Health Child Wellbeing Units
- Local Health District Child Wellbeing Co-ordinators
- Family Referral Services
- Hospital and community health based social workers,
- specialist Health Services (e.g. The NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services)

8.4.1 Child Wellbeing Units

When a Health worker identifies safety, welfare or wellbeing concerns for a child or young person, or potential concerns for an unborn child when born, they can contact the Health CWU (Tel: 1300 480 420) so that concerns can be discussed and recorded. This will assist in planning what follow up action the Health worker may need to take and in building a cumulative picture of risk of harm.

Health workers should contact the Child Wellbeing Unit:

- when the Mandatory Reporter Guide indicates that this should be done. This includes where the Mandatory Reporter Guide has been consulted and the worker remains unsure about what action to take
- to identify whether another agency or Health worker has concerns or is working with a particular child, young person, pregnant woman, or family and whether this information impacts on the level of risk or response required
- for advice and assistance in planning what supports or services may be offered to assist the child, young person, pregnant woman, and family
- to have child wellbeing concerns documented, to build up a Health record of any cumulative risk to a child or young person
- in response to a feedback letter from Community Services advising contact with the CWU, in order to discuss support needs, so that the concern can be recorded centrally by NSW Health, or to discuss a possible review of Helpline decision
- for advice around the conversations workers might have with families or when exchanging information with other service providers around safety, welfare or wellbeing concerns for a child or young person.

The CWU will record on *WellNet,* the secure Child Wellbeing database, details about:

- the contactor's name, workplace and position (Note the identity of Mandatory Reporters who report concerns to the CWU are subject to protection under NSW law)
- details of the concerns for the child, young person or unborn child
- details of the child or young person such as name, date of birth, address, indigenous status and primary cultural background
- details of the parent(s)/carer(s)/sibling(s)
- details about support needs for the child, young person or family, as well as information known about what services have been or are currently involved
- where known, information about court orders such as Apprehended Violence Orders.

Where appropriate, Child Wellbeing Unit Assessment Officers can inform Health workers about relevant information held on WellNet, to assist in planning and in the provision of services. For example, the CWU is able to conduct limited searches of the Community Services Child Protection database (KiDS) to determine if a child or young person is the subject of an open case at Community Services, with a Brighter Futures program or with an out-of-home care agency. The CWU is also able to view and share relevant information from other Child Wellbeing Unit agencies (Education and Communities, Family and Community Services and NSW Police) in relation to the safety, welfare or wellbeing of identified children.

CWU Assessment Officers work with the mandatory reporter to identify the level of risk and to plan next steps, including ways in which the child, young person and/or their family might be assisted. This may involve:

- determining actions the reporter can take and /or Child Wellbeing Unit actions
- exchanging information with other workers or agencies, including other CWUs and Community Services so as to make an assessment, co-ordinate decision-making or facilitate the provision of services
- progressing internal and/or external service referrals, and arranging such referrals with the consent of the family, if appropriate

- supporting mandatory reporters to seek culturally specific supports and services where appropriate, as well as providing information on available referral pathways for culturally and linguistically diverse populations and for Aboriginal children and families
- talking with Community Services if the child or young person has an open case with Community Services
- reporting to the Child Protection Helpline if concerns meet suspected risk of significant harm.

NSW Health CWUs can be contacted on 1300 480 420. Calls to the CWU may, be recorded for record keeping or quality assurance purposes. A recorded message at the beginning of the call will advise when a call may be recorded. Further contact details and how to contact the Health CWU out of hours are provided in Section 2 *Key resources* of this document.

8.4.2 Child Wellbeing Co-ordinators

Child Wellbeing Co-ordinators provide a coordination function in Local Health Districts/ Specialty Network to improve responses to children and young people where safety, welfare or wellbeing concerns are raised, either directly or via Child Wellbeing Units. The Co-ordinators are available to advise Health workers about the use of the Child Wellbeing Unit and have a detailed understanding of entry points into local health services.

Child Wellbeing Co-ordinators work in partnership with:

- Child Wellbeing Units (and have direct access to the CWU database WellNet);
- Child protection and violence prevention services in the LHD including child protection units/services;
- LHD Child Protection Trainers;
- Child and Family Health services;
- Aboriginal health services;
- Mental health services; and
- Drug and alcohol services

They are responsible or contributing to improving the coordination and alignment of Health Services so that children, young people and families for whom there are child protection or wellbeing concerns receive support as early as possible. This also involves working closely with other Government departments, as well as with local community agencies, including Family Referral Services, to provide advice about referral pathways within the Local Health District / Specialty Network.

Contact details for Child Wellbeing Co-ordinators are available at:
http://www.health.nsw.gov.au/Initiatives/kts/area_coordinators.asp
or by calling the CWU on 1300 480 420.

8.4.3 Family Referral Services

Family Referral Services (FRS) are intended to link vulnerable children, young people, and families with appropriate available support services in their local area.

Any worker (e.g. Health, other Government department, general practitioner) can refer families to FRS where circumstances do not warrant statutory intervention. Consistent with the voluntary nature of this service, some families may self-refer.

FRS can refer clients to a range of local support services such as case management, home visiting, family support, child care, housing, parenting education, supported play-group, youth support services, and respite care. Working in partnership with the Health Service, non-government operated FRS are a key resource for Health workers contributing to the holistic care of vulnerable children, young people and families in NSW.

Any Health worker may contact the FRS for assistance and information on community based support services and resources available in the local area. In this situation the FRS will not provide an ongoing direct service to a family or young person/, but will support the Health worker in continuing their work with the young person/family.

The FRS may also take referrals from Health workers to work directly, for up to six weeks, with a family or young person where they:

- Have complex or multiple support needs;
- Have previously engaged with services but not sustained engagement, that is, the young person/family has entered and exited services multiple times and/or for short periods of time; and/or
- Require a multi-agency approach as identified by the CWU or the MR and this is beyond the capacity of the MR.

See FRS referral protocol: http://www.health.nsw.gov.au/resources/initiatives/kts/pdf/referral_protocol_3006201.pdf

FRS will be available State-wide from April 2013.
Health workers should continue to use current referral pathways or access the Human Services Network (HSNET) *ServiceLink* to identify local support services. www.hsnet.nsw.gov.au

To contact a FRS see Fact Sheet:
http://www.dpc.nsw.gov.au/__data/assets/pdf_file/0009/83646/06_Family_Referral_Services.pdf
or ask the CWU.

8.4.4 Brighter Futures

Brighter Futures programs across NSW deliver targeted services and an average of 12 months of sustained case management support to eligible families with children aged under 9 years or who are expecting a child, where the child or children are at high risk of entering the statutory child protection system.

Health workers can arrange for a family to be considered for Brighter Futures by contacting their local non-government Brighter Futures Lead Agency. Health workers can also consult with the Health Child Wellbeing Unit or an AMIHS service for information about accessing Brighter Futures programs. See http://www.community.nsw.gov.au/for_agencies_that_work_with_us/early_intervention_services/brighter_futures.html

The Brighter Futures program is a voluntary program and once offered to a family, requires their consent to participate. Health workers should not refer to Brighter Futures if they also intend to make a suspected risk of significant harm report or pre-natal report to the Child Protection Helpline.

Families with children under three years, Aboriginal families, pregnant young women or young parents in OOHC are given priority access to Brighter Futures.

To participate in the Brighter Futures program, families must require at least two of the following core service options to improve the child's safety at home:

- Quality children's service;s
- Parenting programs (group based);
- Structured home visiting programs (including parenting programs delivered one-to-one); or
- Casework focussed on parent vulnerabilities

Parent(s) must also be experiencing at least one of the following vulnerabilities which impact adversely on their capacity to parent and/or the child's safety, welfare or wellbeing:

- Domestic violence – at least one parent is a victim or perpetrator of violence that represents a risk of significant abuse, neglect and/or psychological harm to their child or children;
- Drug or alcohol misuse – a parent's current drug or alcohol misuse interferes with his or her daily functioning and ability to ensure the safety of their child or children;
- Parental mental health issues – a parent has a mental health problem or diagnosed mental health illness that interferes with his/her daily functioning and ability to ensure the safety of their child or children;
- Lack of parenting skills or inadequate supervision – the parent's current lack of capacity and/or skills to consistently supervise or provide for their child's basic care places the child or children at risk of ongoing neglect;
- Parent(s) with significant learning difficulties or intellectual disability – the parent's learning difficulty or intellectual disability impairs his/her ability to manage their own life and/or their ability to provide adequate care and protection for an infant/child to the extent that there is a risk of abuse or neglect.

9

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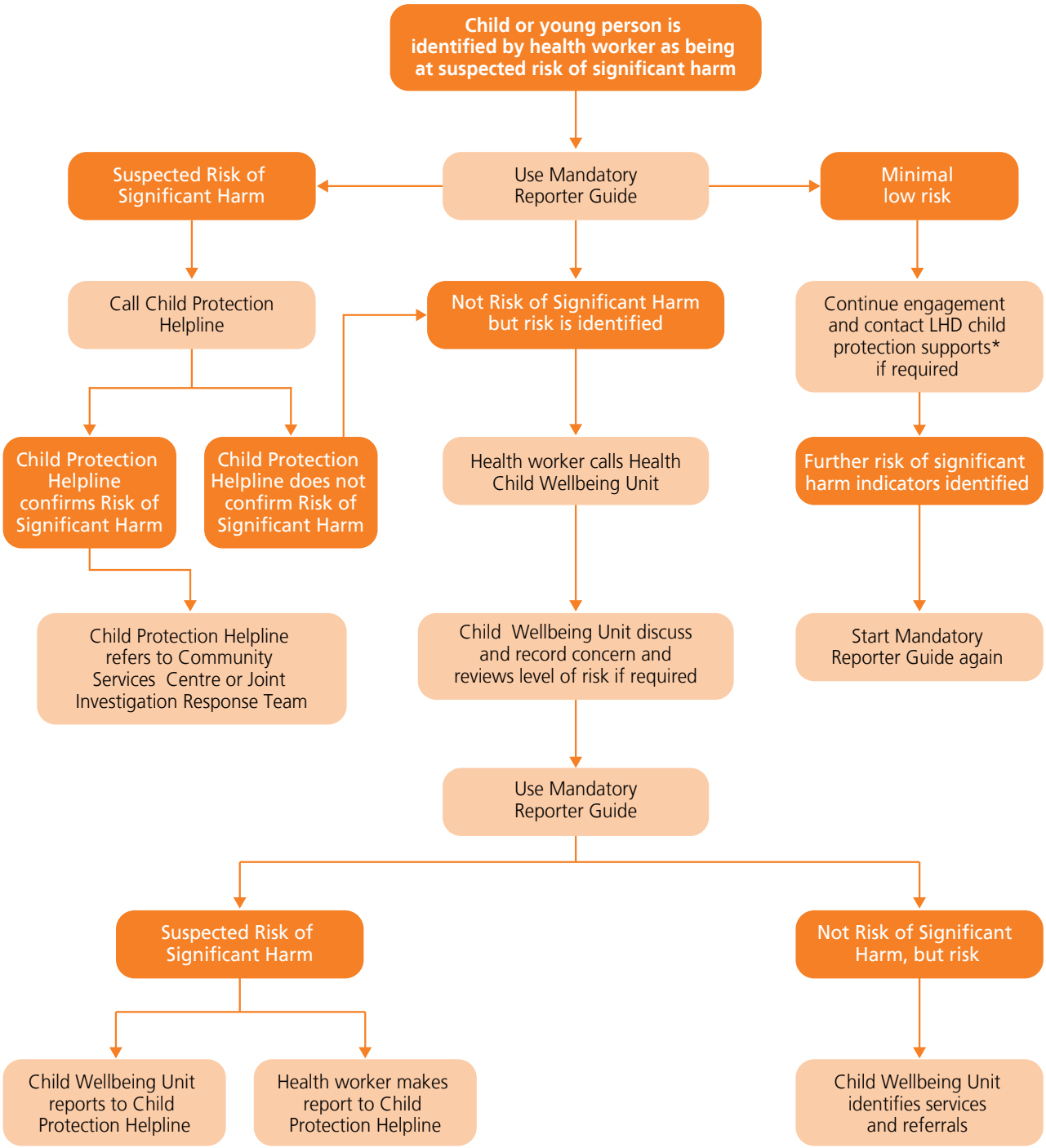
Responding to Children and Young People at Risk of Significant Harm (ROSH)

Figure 2: NSW Health Child Protection Reporting Process



* LHD Child Protection supports include specialist units such as Health Child Wellbeing Units, tertiary Child Protection Units, Child Protection Counselling Services, Sexual Assault Services and key Local Health District staff such as Child Protection Coordinators and Child Wellbeing Coordinators.

9.1 Making a Child Protection Report and Ongoing Health Worker Involvement

Table 13: Key Reporting Processes

Decide if child protection or prenatal report is required:
1. Complete Mandatory Reporter Guide at http://sdm.community.nsw.gov.au/mrg/
2. Follow MRG outcome

Report a child or young person suspected to be at *ROSH*:

1. Risk of significant harm is imminent
   Report immediately to the Child Protection Helpline by phoning **133 627** or contact the NSW Police Force by dialling 000.

2. Risk of significant harm but not imminent risk

- Telephone Child Protection Helpline: 133 627 (24 hours/7 days)
- e-report: through DoCS Connect portal:
  http://www.community.nsw.gov.au/welcome_to_docs_website.html
- Fax: 02 9633 7666 only after attempting a phone call and leaving a message advising that a faxed report will be made.
  Fax form:
  http://www.community.nsw.gov.au/preventing_child_abuse_and_neglect/resources_for_mandatory_reporters.html
  or see Appendix 8 for a copy.
  OR
- Call a Health Child Wellbeing Unit on 1300 480 420 to discuss making the report and ongoing health involvement

Note: As mandatory reporters Health workers should identify themselves by name, position and Local Health District/Specialty Network to the Child Protection Helpline officers.

Make a prenatal report if unborn child may be at ROSH when born

- Telephone the Child Protection Helpline or the Child Wellbeing Unit (see above)

Report a NSW Health worker who is an alleged perpetrator
Inform supervisor in accordance with local procedures.
Note: This requirement applies for all child-related allegations whether above or below ROSH.

9.1.1 What to Report to the Child Protection Helpline

Legal provisions

Health workers must make a child protection report about a child under 16 or class of children they suspect are at risk of significant harm (ROSH) (s27 of *Care Act* and see definition of ROSH below).

Health workers may make a prenatal report about an unborn child where they have reasonable grounds to suspect that the child may be at ROSH after his or her birth (section 25). See paragraph 9.8 below in this section.

Health workers may make a report about a young person aged 16-17, or class of young people they suspect are at ROSH (section 24 of the *Care Act*).

Health workers may make a report about the homelessness of a child (section 120) or may make a report about the homelessness of a young person with the consent of the young person (section 121).

A child or young person who is homeless is potentially at ROSH through neglect of their basic physical needs. In cases where a Health worker suspects that a homeless child is at ROSH, mandatory reporting is applicable under section 27 of the *Care Act*.

Reporting homeless young people aged 16 to 17 years is not mandatory and can only be done with the consent of the young person (s121 of *Care Act*) or if the young person is at ROSH under s24.

Policy considerations

The legal and policy definitions of 'risk of significant harm' (ROSH) are outlined in detail in the Definitions Appendix1 of this document. These reporting obligations apply to Health workers providing direct services to children, young people and those with adult clients who are parents or carers of children and young people. Health workers who provide services to adults should consider the parenting capacity of their adult clients in order to meet their obligations to identify and report risk of significant harm of a child or children in the care of the adult client.

Health workers should use the Mandatory Reporter Guide http://sdm.community.nsw.gov.au/mrg/ For support in determining if concerns about a child or young person meet the ROSH reporting threshold, and may call the Health Child Wellbeing Unit on 1300 480 420. Further information on MRG is found in section 7.3.2.

Health workers need to be aware that respecting the confidentiality of a client is not sufficient reason against reporting to the Child Protection Helpline. In making a report to the Child Protection Helpline, the protection of children and young people from abuse and neglect is deemed more important than an individual's right to privacy.

The *Care Act* gives mandatory reporters discretion in whether or not to make child protection reports about young people, Health workers are however required, as a matter of NSW Health policy, to report all young people identified as meeting the ROSH reporting threshold after the worker has applied the MRG. The young person should be involved in the decision to make the report and the process of reporting, unless there are exceptional reasons for excluding them. If the young person does not agree to the report being made, this information should be conveyed to Community Services, so they can consider the young person's wishes in any investigations and assessments.

Those working with young people should endeavour to reduce vulnerability to risk through the network of care and support services available. Health workers may consult with Health Child Wellbeing Units if they have concerns about the level of risk a young person is facing and are unsure if a report should be made.

Health workers who fail to comply with their reporting obligations under the *Care Act* and/or NSW Health Policy may be subject to disciplinary action.

9.1.2 Legal Protections for Reporters

Protection of reporter's identity

Legal provisions

Section 29 of the *Care Act* protects the identity of all people who report concerns about children and young people to the Child Protection Helpline or to a Child Wellbeing Unit. It also protects the identity of persons concerned in making the report or causing the report to be made.

It is generally prohibited under section 29 of the *Care Act* to disclose the reporter's identity as well as any information from which the reporter's identity might be deduced.

There are a number of legal exceptions to the protection of reporter identity:

- where the reporter gives consent;
- where non-disclosure would prevent the proper investigation of the report;
- where the court before which proceedings relating to the report (i.e. Children's Court or appeal court from the Children's Court) grants leave in certain limited circumstances;
- where the disclosure is made to a law enforcement agency (i.e. the NSW Police Force or Australian Federal Police) in connection with the investigation of a serious offence alleged to have been committed against a child or young person, subject to various restrictions set out in the section; and
- where the disclosure is to the NSW Ombudsman or the Convenor of the Child Death Review Team in response to a request made in accordance with the *NSW Community Services (Complaints, Review and Monitoring) Act 1993*.

Any request from the NSW Ombudsman including from the NSW Child Death Review Team should be in writing.

Policy considerations

The protection of a reporter's identity under section 29 of the *Care Act* must be considered by Local Health Districts / Speciality Networks when executing exchange of information requests, providing a response to a court subpoena or responding to requests for public access to government information.

Any disclosure of a reporter's identity without legal grounds to do so is a serious matter. Health worker concerns about any breach of section 29 of the *Care Act* should be raised with the worker's supervisor and escalated according to local and interagency escalation pathways.
See Section 4.6 (8) of this document.

When responding to a request for information from the Ombudsman or the Child Death Review Team the Health service or Health worker should specifically ask whether the information needs to include details of the reporter's identity and/or the ROSH report itself. If not, de-identified information should be provided.

Protection of content of reports

Reports to the Child Protection Helpline cannot be admitted in evidence in any court proceedings other than care proceedings in the Children's Court. A person cannot be compelled to produce a report to the Child Protection Helpline in any proceedings. The report of evidence of its contents can only be admitted to certain court proceedings, such as proceedings in the Children's Court or proceedings under the *Coroners Act*. Further information can be found in the Sharing Information Section 6.

Other protections

If the report is made in good faith the reporting or provision of information:

- does not constitute a breach of professional etiquette or ethics or a departure from acceptable standards of professional conduct;
- does not constitute grounds for liability for defamation; and
- does not constitute grounds for civil proceedings for malicious prosecution or conspiracy.

In addition, where a report is made in good faith, grievance proceedings within the Health Service shall not be initiated or allowed to progress against the person making the report in relation to that person's report.

In the situation where the Health worker makes a report to the Child Wellbeing Unit under section 27A of the *Care Act*, the same legal protections apply.

Client complaint to a Local Health District / Specialty Network or worker because a report has been made to Community Services

Local Health Districts / Speciality Networks should consider carefully any disclosure of information that confirms a child protection report has been made to the Child Protection Helpline or to a Child Wellbeing Unit, or provision of any information that may relate to the content of that report, taking into account the protection of reporter identity.

In responding to a client complaint about the making of a report, Local Health Districts / Speciality Networks should generally only recognise receipt of the complaint.

Agency complaint that a report has not been made to Community Services

Failure to make a report of suspected risk of significant harm in accordance with the *Care Act* and this policy is a breach of this policy and the Health worker may be subject to disciplinary action under the NSW Health Code of Conduct. http://www.health.nsw.gov.au/policies/pd/2012/PD2012_018.html

Where a complaint is made by another agency, prescribed or statutory body that a report has not been made by a Health worker or service, the complaining body should be directed to the Chief Executive of the relevant Health Service.

9.1.3 Alleged Perpetrator is NSW Health Worker

Legal Provisions

Part 3A of the *Ombudsman Act 1974* and the associated regulations require Chief Executives of Health Services to notify the Ombudsman of allegations (including charges) and convictions against employees that involve or may involve 'reportable conduct', that is, child-related allegations or convictions of conduct that may constitute:

- A sexual offence, or sexual misconduct, committed against, with or in the presence of a child (including a child pornography offence);
- Assault, ill treatment or neglect of a child; or
- Behaviour that causes psychological harm to a child.

The Health Services Act 1997 requires Chief Executives of Health Services to report to the appropriate professional council (or registration board) any conduct of a Health employee (Section 117A) or visiting practitioner (section 99A) that the CE suspects on reasonable grounds may constitute professional misconduct or unsatisfactory professional conduct.

The Health Services Act also requires NSW Health employees (section 117) or visiting practitioners (section 99) who are charged with having committed, or are convicted of, a serious sex or violence offence to report that fact in writing to the Chief Executive of the Health Service within 7 days of the charge being laid or conviction.

Further information: NSW Ombudsman, Child protection legislation: what employers and employees need to know at http://www.ombo.nsw.gov.au/__data/assets/pdf_file/0018/3663/FS_CP_03_What_you_need_to_know.pdf

Policy Considerations

Employees as defined in the Ombudsman Act 1974 (section 25A) who become aware of a child-related allegation, charge or conviction against another employee of their Health Service must report that matter to their supervisor or the designated person within their Health Service as prescribed by local procedures, so that a decision may be made by the Chief Executive or their delegate regarding any requirements to manage the matter in accordance with the requirements of the Ombudsman Act.

An 'employee' is defined as a person engaged in employment by or in connection with a Health Service.

The requirement to report an employee extends to allegations and convictions for conduct or alleged conduct that occurred outside the course of, or prior to, the employees' employment with NSW Health.

These reporting requirements apply to all child-related allegations which may be above or below the statutory reporting threshold of risk of significant harm.

In responding to allegations of reportable conduct or convictions involving such conduct, Health Services are required to

- Conduct an immediate risk assessment to determine whether there is any risk of further or ongoing harm to the child and whether the employee subject to the allegation or conviction requires relocation, supervision or suspension and report to the Ombudsman on the outcomes of their investigation;
- Notify NSW Police where an allegation involves possible criminal conduct;
- Take appropriate action to inform professional councils (or registration bodies) as required; and/or
- Report to the Child Protection Helpline where it is suspected that a child or young person (or class of such) is at ROSH.

Further Information: NSW Health Policy Directive, *Child Related Allegations, Charges and Convictions Against Employees*, PD2006_025 http://www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_025.pdf;

NSW Health Policy Directive, NSW Health Criminal Allegations, Charges and Convictions Against Employees, PD2006_026 at http://www.health.nsw.gov.au/policies/pd/2006/PD2006_025.html; and

NSW Health Policy Directive, Complaint or Concern About a Clinician – Principles for Action PD2006_007 at http://www0.health.nsw.gov.au/policies/pd/2006/PD2006_007.html

9.1.4 Interstate Reporting

Legal provisions

States and Territories in Australia operate under child protection legislation that pertains only to their particular State or Territory.

The provisions in the *Care Act*, including reporting obligations, apply to children and young people who ordinarily live in or who are present in NSW [Section 4(a) and (b)].

The provisions also apply to children and young people who are subject to an event or circumstances occurring in NSW which gives or give rise to a report [Section 4(c)].

At present, only Community Services can lawfully provide information about children and young people to other States and Territories if the disclosure is necessary to enable an interstate officer to exercise functions under a child welfare law or an interstate law (Section 231V).

Policy considerations

If a Health worker is concerned that a child or young person in another State who does not ordinarily live in NSW or is not present in NSW is at ROSH they should notify the Child Protection Helpline. Health workers may also notify the Helpline if they are concerned that the unborn child of a pregnant woman who is not normally a resident of NSW, may be at ROSH when born. Although Community Services is unable to intervene in these matters directly, they can refer the information on to the relevant interstate authority.

Interstate reporting is of particular relevance in border towns. Community Services' casework practice emphasises the need for Child Protection Helpline staff to obtain all relevant information from mandatory reporters who are situated close to borders and are reporting a child or young person suspected to be at ROSH from another State or Territory who is routinely attending their service. Helpline staff are expected to provide all relevant information to the counterpart statutory child protection agency in the other State or Territory on behalf of the mandatory reporter.

Further information:

For the processes regarding responding to requests for information from other States and Territories see Section 2 Information Sharing. See also The Child Wellbeing and Child Protection – NSW Interagency Guidelines http://www.community.nsw.gov.au/kts/guidelines/info_exchange/reporter_identity.htm

9.2 How to Make a Report to the Child Protection Helpline

9.2.1 Reporting by telephone

The Community Services Child Protection Helpline operates 24 hours a day and is a centralised intake, assessment and referral service. The Helpline telephone number for mandatory reporters is 133 627 and for the general public is 132 111

If a Child Protection Helpline Caseworker is not available to speak immediately to the Health worker making a report, options exist for Health workers to bypass the Child Protection Helpline queue (in urgent situations) or to leave a voice message on the Child Protection Helpline telephone system (in non-urgent situations).

Leaving a message does not enable adequate information for a risk assessment to be undertaken by Community Services about a child, unborn child or young person at risk of significant harm. If a message is left by a Health worker about a child at risk of significant harm, a faxed report should also be sent. Health workers leaving a telephone message at the Helpline should indicate in the message if they intend to fax a report at that time. Health workers should use the *Risk of Significant Harm Report Recording and Fax Form*, to fax a report to the Child Protection Helpline. See Appendix 8.

When leaving a message on the Child Protection Helpline message system, Health workers should:

- provide clear information about the urgency and seriousness of the matter so the call back team at the Helpline can prioritise calls appropriately.
- provide the name of the child, young person or pregnant woman about whom the report is being made.
- if possible, provide a Health (agency) reference number, such as a Health file or Medical Record Number.
- provide clear details of how to contact the Health worker, when the Health worker is available, or the contact details of another Health worker able to provide the information to the Child Protection Helpline if you will not be available.
- advise in the message that a fax is also to be sent.

9.2.2 e-Reporting – non-Imminent Risk of Significant Harm

e-Reporting is a secure and convenient means for reporting non-imminent suspected risk of significant harm reports to Community Services by mandatory reporters over the internet. If the risk is imminent, the Health worker should always call the Child Protection Helpline or NSW Police Force.

The Mandatory Reporter Guide should be applied to determine whether the risk is imminent.

eReports are made via a secure website, the Community Services Connect Portal, which can be accessed in one of two ways:

1. via the Community Services website: http://www.community.nsw.gov.au www.community.nsw.gov.au click on the DoCS Connect button at the top of the Home Page

2. via the Mandatory Reporter Guide when the recommended action is to eReport

The information entered into the eReport template is similar to the information that a mandatory reporter provides when making a report by phone to the Child Protection Helpline. The Child Protection Helpline actions all eReports within 24 hours of receipt.

eReporters are required to register for user access to the Community Services Connect Portal prior to making their first eReport, by faxing or emailing the Community Services Connect eReporting User Access Form to the Community Services Connect Service Desk. See http://www.community.nsw.gov.au and click on the DoCS Connect button.

The Community Services Connect Portal provides a range of assistance for eReporters, including

- Hover-over help, in the form of additional information that 'pops up' as the eReporter hovers over fields in the eReport
- Fact Sheets and Frequently Asked Questions
- Detailed information about eReporting

Technical assistance is available for eReporters from the Service Desk ICT specialists. The Service Desk operates Monday to Friday (except public holidays) from 7am to 7pm on 1300 740 641 (or fax 1300 760 863).

9.2.3 Reporting by Facsimile (Fax)

If e-reporting is unavailable, Health workers who have been unsuccessful in speaking with a caseworker at the Child Protection Helpline and have left a telephone message may fax the Helpline. The telephone message should indicate that a faxed report will also be sent. This procedure may be used if the wait time exceeds five minutes or where operational commitments prevent Health workers from making a telephone report.

Reports should only be made by fax (02 9633 7666) when the concerns are not about imminent risk of significant harm. If the risk is imminent, the Health worker should always call the Child Protection Helpline or the NSW Police Force.

A faxed report is made using the *Risk of Significant Harm Report Fax Form* at Appendix 8. Where the MRG has been used, a copy of the *Online MRG Decision Report* should also be attached. The form and any relevant additional pages of information should be faxed to the Helpline on fax: 02 9633 7666.

The form should include:

- detailed information in order for Community Services to determine if the level of risk meets risk of significant harm (ROSH). This should include primary and other concerns held.
- the number of attached pages of the faxed report
- the urgency of the matter to assist the Child Protection Helpline prioritise the initial urgency of response

To assist in the legibility of faxed forms Health workers should clearly print in black pen or, where possible, type the form.

All forms and information faxed to the Child Protection Helpline must be placed in the client Health record and will constitute documentation of the report. Any fax confirmation sheets generated by faxing the report should also be placed in the client Health file.

Reports should be made in one form only, i.e. either by phone, e-report or fax. **Duplicating or confirming a report in writing is unnecessary.**

9.2.4 Requirement to Provide Name to the Child Protection Helpline

NSW Health workers are mandatory reporters and are required by this policy to provide their name and contact details when making a report to Community Services.

Section 26 of the *Care Act* allows other persons to make an anonymous report to Community Services.

Health workers making a report are required to give their contact details to the Child Protection Helpline unless extenuating circumstances apply, such as the safety of the Health worker or child or young person. The professional judgement and experience of the Health mandatory reporter cannot be considered by the Community Services when assessing the Report if the Health worker has not identified themselves.

9.2.5 Differing Opinions About Whether to Make a Report

Individual Health workers, regardless of professional status, are able to report suspected risk of significant harm to the Child Protection Helpline or the Health Child Wellbeing Unit whether or not this view is held by any or all Health workers involved with the child, young person or family.

9.2.6 Information that Community Services may Require When Reporting

The detail and quality of the information provided to the Child Protection Helpline by the reporter is critical to the quality of the decision-making that follows. It is important to provide all relevant information when making a child protection report.

Health workers should prepare for making a report to the Child Protection Helpline by gathering the most crucial pieces of information together. Even where only a little information is known by the Health worker, the Mandatory Reporter Guide (MRG) may indicate that the matter meets the statutory reporting threshold of suspected risk of significant harm requiring a report to be made.

The Child Protection Helpline needs to obtain the information giving rise to the suspicion of risk of significant harm, as prompted by the Mandatory Reporter Guide, as well as information about the child or young person, the family, the reporter, and the context of the report, as follows:

- the name, date of birth, known aliases or description of the child or young person, or class of children or young people;
- where possible a Health record number (such as the child's Medical Record Number or a Unique Patient Identifier);
- the current whereabouts of the child or young person;
- the outcome of using the Mandatory Reporter Guide;
- when the child was last seen – Note: the Health worker does not need to sight the child to act;
- the name and address, if known, of the person suspected of abusing or neglecting the child or young person and, if possible, their occupation;
- cultural background of child or young person, language(s) spoken, religion and other cultural factors;
- whether a language or sign interpreter may be needed, or support required for a person with a disability;
- whether the child or young person and their parents, family or carers identifies as Aboriginal or Torres Strait Islander or both;
- the reasons for concern about risk of significant harm;

- all available information relating to the safety, welfare or wellbeing of the child or young person;
- information about other services, agencies and supports that are in place;
- the child or young person's views about the report, if known;
- events, conversations and observations that have led to concern – these should be recorded and available for reference;
- information about the child or young person's history, current circumstances and their views;
- information about the parent, family or caregivers;
- information about relationships within the family;
- information about the agency's role and relationship with the child, young person and their family;
- whether risk of significant harm is related to a staff member of an organisation;
- whether the child/young person is subject of an Apprehended Personal Violence Order or any other order such as a Family Law Order;
- whether the child or young person is under the care of the Minister or residing in out-of-home care;
- Information about parental risk factors and how they impact on the child, young person or unborn baby such as:
  - domestic violence
  - alcohol or other drug misuse
  - unmanaged mental illness
  - intellectual or other disability
  - teenage pregnancy
  - homelessness

- the name and contact details of an adult who has disclosed they were abused when they were a child or young person by someone who remains in child related employment and/or has access to children which would mean a class of children or young people are at risk.

Once a report is made to the Child Protection Helpline no further report needs to be made to the Helpline unless new information comes to hand.

Additional information given to the Child Protection Helpline or to Community Services officers in any subsequent contact about the initial report should be exchanged within the provisions of Chapter 16A or section 248 of the *Care Act*. Information exchanged outside of the context of a report is not subject to the protections afforded to mandatory reporters in s29 of the *Care Act*

If any new information is identified as suspected risk of significant harm then Health workers should make an additional report to the Child Protection Helpline. As a new report of risk of significant harm, the identity protection provisions of section 29 of the *Care Act* would apply.

9.2.7 Child Protection Helpline Assessment of Report

When the Child Protection Helpline receives a report, they assess the level of risk using a *Structured* Decision-making® *(SDM)* tool to determine if the concerns meet Community Services' threshold for establishing if a child or young person is at risk of significant harm. This threshold is at a different level to the Mandatory Reporter Guide (MRG) (which helps workers determine suspected risk of significant harm) due to the ability of Family and Community Services to draw on other information.

The *SDM® screening* tool guides caseworkers through a structured analysis of all information available to them about a child or young person (including any family history that may be recorded on KiDS, the Department of Family and Community Services database, to determine whether a matter meets the threshold for statutory child protection intervention.

Where a matter is screened in as ROSH by the Child Protection Helpline, the *SDM® response priority* tool is used to determine the response priority that should be allocated to the reported matter. There are three response priorities: 24 hours, less than 72 hours or less than 10 days.

If a report does not meet the statutory threshold it may still be forwarded within Community Services, for example, if it relates to information already known (multiple reports) or Community Services is working with the family under an existing open case plan.

In these instances the mandatory reporter will receive written feedback advising that the report has been forwarded within Community Services and provided with relevant contact details.

9.2.8 Call Recording of Reports Made to the Child Protection Helpline

Community Services applies the following recording procedures to all calls to the Child Protection Helpline (telephone 13 36 27):

A Call Recording Queue Announcement will be heard by callers to the Child Protection Helpline as follows:

> *'Community Services advises that your call will be recorded for record-keeping, security, accountability and quality assurance purposes. Please be aware that the identity of any person who makes a report is confidential and generally protected under law.'*

System for recording information by the Child Protection Helpline

The program that will record voice calls is known as Verint. The Verint Program records all inbound calls to the general Helpline telephone queue and captures the time, date, phone numbers for the call and everything which is said during the call.

Access to recorded information

Access to recorded calls is limited and requires a secure ID and login PIN by authorised Helpline staff. This is for the purposes of evaluation and coaching only.

An audio recording could be subject to an application under *Government Information (Public Access) Act 2009* (GIPA). However, if the audio recording is a report under section 29 of the *Care Act* then it would not have to be produced under GIPA. All reports received at the Helpline, even if they are subsequently determined to not meet the risk of significant harm threshold, are considered reports under the *Care Act* and cannot be subject to an application under GIPA.

Options for reporters who do not want their call recorded

It is not a legal requirement that the caller consents to being recorded. Mandated reporters have the option of e-Reporting (for non-imminent RoSH) or faxing a report if they do not wish to be recorded.

9.3 Child Protection Helpline Outcomes and Feedback

Table 14: Child Protection Helpline Outcomes

Child Protection Helpline OUTCOME	DESCRIPTION
Risk of significant harm	The reported matter meets the threshold of risk of significant harm (ROSH) according to SDM screening tool and requires a response by Community Services. The response times/priorities are: < 24 hours < 72 hours < 10 days
Non-risk of significant harm – declined by Helpline	The reported matter does not meet the threshold of ROSH and the child children and/or young person(s) do not have an open case plan at any Community Services Business Unit.
Non-risk of Significant Harm – close	The reported matter does not meet ROSH. However, there is the potential for a Brighter Futures referral.
Reports that do not require screening but do require a Community Services response in line with relevant policy	Child abduction (Hague) Youth Protocol (Commonwealth Government) Disaster Welfare Request for assistance
Other reports that may require an additional response by Community Services	Allegation involves Community Services employee or authorised carer Sibling safety following a child death Joint Investigation Response Team referral required Unauthorised carer Family Court matter Case management issues for child/young person in care of Director-General or under parental responsibility of the Minister Case management issues for open and allocated child protection cases Crisis Response Team action required Critical incident/allegation report
Non-ROSH – Contact Forward	The reported matter does not meet risk of significant harm AND the child or children or young person(s) has an open Community Services case plan and this includes multiple reports (that is, the information is already known).

9.3.1 Child Protection HelplineFeedback

The mandatory reporter will receive written feedback from Community Services advising whether or not the concerns reported met the threshold of risk of significant harm and if so, to which Community Services Business Unit (i.e. Community Services Centre or Joint Investigation Response Team) the report has been transferred.

This feedback will assist Health workers in knowing:

- who to contact to discuss the case;
- whether they should contact the Health Child Wellbeing Unit;
- whether additional referral is required for the child, young person or family for support or other services;
- whether additional information should be sought under the information exchange protocols or
- to continue their involvement with the family.

This feedback is a prompt for mandatory reporters to carry out other necessary tasks to help promote the safety, welfare or wellbeing of a child or young person such as consulting with another professional, contacting their Child Wellbeing Unit (if applicable), referring directly to local services, offering alternate support services, seeking additional information under the interagency information exchange legislation or continuing their involvement with the family.

This approach ensures concerns about children and young people, whether these are above or below the statutory threshold, receive an appropriate response from Health workers.

The mandatory reporter may receive written feedback advising that the report has been forwarded within Community Services and provided with relevant contact details.

Feedback letters are sent to the mandatory reporter, rather than to a Health workplace, as they aim to protect the privacy of the report. As a result there is minimal information about the patient/client in the letter. It is advisable to quote the child or parent's Health record number when a report is made in order to ensure the letter can be acted upon when it is received by the mandatory reporter.

Where the feedback letter states that the report has not met the ROSH threshold the Health worker will be advised to contact the Health Child Wellbeing Unit (CWU).

The Health CWU will:

- Advise of any action the Health worker may need to undertake in light of the fact the CS will not be conducting a child protection assessment on the report;
- Discuss the reason for the report and the decision made by the Helpline, particularly where the Health worker believes that a review of the Helpline decision should be sought; or
- Record the concerns on WellNet for the purposes of cumulative risk information.

Local Health Districts / Specialty Networks and Health Service Managers are responsible for developing procedures for the receipt, response and follow up of Child Protection Helpline feedback letters, particularly where Health workers are on shift or move to other areas within Health in the course of their duties.

9.4 Documentation of Reports of Risk of Significant Harm

A report made to the Child Protection Helpline must be documented in the Client Health Record. Documentation is to be:

- written within the clinical notes of the Client Health Record including adult clients where carer concerns , or disclosure of abuse' after the word 'concerns have prompted the report; or
- completed by using the form entitled R*isk of Significant Harm Recording and Fax Form* at Appendix 8. The MRG outcome sheet should be attached to the fax form and placed in the Client Health Record; and
- placed, when completed, in an Alerts section on the Health record, if available.

Documentation of a report should be made as a separate entry and not as a part of any other clinical assessment or documentation. Whether recording information directly in the health file or on the *Risk of Significant Harm Recording and Fax Form* documentation should include:

- the date and time contact was made with the Child Protection Helpline;
- the name of the Child Protection Helpline officer spoken to;
- the nature of concerns reported;
- whether the report was made by phone, fax or email if e-reporting;
- full and accurate details of the information provided to Community Services (including the client's details, nature of the concerns reported);
- the MRG outcome;

- the faxed report;
- an e-Report ;
- the Child Protection Helpline Contact Reference Number (CRN); and
- the response from Community Services if known.

Health reporters should continue to update the Client Health Record with any subsequent information provided to the Child Protection Helpline, a CSC or JIRT officer following the initial report to the Helpline.

The Community Services feedback letter to mandatory reporters should be placed in the Alerts section, if available, of the Health record by the mandatory reporter who made the report.

9.4.1 Informing Families of a Report to Community Services

It is good practice in some instances to make the report to the Child Protection Helpline in conjunction with the child, young person, their family or carer(s).

Next best practice is for the Health worker to inform the child or young person and their family/carer(s) the specific nature of their concerns and the need to make a report to the Child Protection Helpline.

On occasions a Health worker's professional judgement may determine not to inform the child or young person, family or carer, for example, where a Health worker has concerns for their personal safety or that informing the family may increase the risk to the child or young person.

The dynamics of sexual assault, physical abuse, psychological abuse and domestic and family violence in particular can mean it is important not to inform the alleged offender that a report will be made. Informing the alleged offender may expose the child, young person or other family members to additional risk, cause pressure to be placed to retract the disclosure or compromise criminal or statutory investigation.

9.5 Ongoing Support to Children and Young People After a Report

Section 29A of the *Care Act* provides that making a report to Community Services does not prevent Health workers from providing other services or interventions to assist the child or young person. When a Health worker makes a child protection report, they also need to consider other opportunities to support the child or family.

This may include continuing to provide a service, referral to another service or the involvement of other specialist services. Further information regarding referral to other service providers and Health worker involvement in case discussions and case management may be found in Sections 12 *Case Management and Case Work* of this document.

When a referral is made to another Health Service or agency when risk of significant harm is suspected or identified, Health workers need to ensure that all information relevant to the case, including any concerns held relating to that child or young person, is contained within the referral to the Health Service or other agency. It is critical that Health workers communicate appropriately with regard to children, young people and their families where risk has been identified.

9.6 Follow up Where a ROSH Report has Been Accepted by Community Services

Where a Health worker has made a report to the Child Protection Helpline which met the threshold of risk of significant harm, Health workers should endeavour to speak directly with Community Services to facilitate open communication.

The Health worker should speak with the relevant Community Service Centre or JIRT office to:

- determine the status of the case e.g. allocated to a case worker, unallocated or closed;
- determine whether Community Services are seeking any further information to assist them in making decisions about Community Services intervention; and
- determine what level of support the Health worker may offer the family, such as continuing to provide a service or making referrals to other Health Services or agencies.

Community Services may, under Chapter 16A, ring Health workers for additional information after the initial report has been made. In such circumstances full documentation of the content of the exchange should be recorded contemporaneously in the medical record.

The nature and extent of the Health worker's role with the family will determine the level of follow up they should provide.

Further information is available in Section 12 *Case Management and Case Work* of this document. The Health Child Wellbeing Unit can also provide advice about contact with Community Services on open cases.

Follow up with Community Services where there is an open and active case.

Where a Health worker is aware that Community Services are involved with a family who are subject of an open and active case, Health workers are encouraged to maintain open communication with Community Services.

The Health worker should speak with the relevant Community Service Centre or Joint Investigative Response Team (JIRT) office to:

- determine whether Community Services are seeking any further information; and
- determine what level of support the Health worker may offer the family, such as continuing to provide a service or making referrals to other Health Services or agencies.

In conversations with Community Services subsequent to making a child protection report, Health workers should be aware that their identity is not protected under section 29. A worker's identity is only protected in the process of making a report to the Child Protection Helpline or the Child Wellbeing Unit. Health workers should consider the good practice principles of open disclosure with clients about their discussions with Community Services, except in the situation where client or worker safety is of concern. A Health worker may consider re-contacting the Child Protection Helpline to give the information as a new report or utilising exchange of information provisions under Chapter 16A of the legislation.

Further information on worker and client safety, and protection of reporter's identity may be found in Sections 6.10 *De-identifying information* and 7.2.5 *Safety issues in relation to disclosures* of this document.

9.7 Request to the Child Protection Helpline to Review a Screening Decision

In a situation where a Health worker has reported a child to be at suspected risk of significant harm to the Child Protection Helpline and the Helpline has subsequently assessed/ screened out the information as not constituting risk of significant harm, the Health worker should discuss their concern and the Helpline decision with the NSW Health Child Wellbeing Unit or with a manager/supervisor who has child protection expertise e.g. Hospital Child Protection Unit or Service or LHD Child Protection Co-ordinator.

Where it is identified by a Health worker, in consultation with a manager/supervisor who has child protection expertise, that a review of the Helpline assessment should be sought the NSW Health Child Wellbeing Unit Manager can formally request that the Child Protection Helpline review their original screening decision using an agreed protocol.

In a situation where a Health worker's professional judgement is that a child or young person is at an imminent or urgent risk of significant harm but the Child Protection Helpline decision is that an urgent response is not required, the Health worker should contact:

- the Manager of a Health Child Wellbeing Unit (Tel: 1300 480 420) if in business hours); or
- the senior clinician on duty at their closest Level 6 Hospital Child Protection Unit/Team. The State's CPUs/Teams are located in the Sydney Children's Hospitals' Network at Randwick (Tel: 02 9382 1111) and Westmead (Tel: 02 9845 0000) and at the John Hunter Children's Hospital (Tel: 02 4921 3000); or
- or the NSW Police Force (Tel: 000) where the matter is urgent and the child or young person may be the victim of an urgent or significant threat and requires Police intervention.

9.8 Pre-Natal Reporting

9.8.1 Introduction

NSW Health workers are uniquely positioned to identify vulnerabilities in pregnant women so that health services and other supports can be put in place with the aim of prevent the unborn child from being at risk of significant harm when born.

Health workers should be aware of the following principles and procedures for engaging vulnerable pregnant women in the NSW Health system and identifying cases where an unborn child may be at risk of significant harm after his or her birth. These procedures are to be referenced by Local Health Districts / Specialty Networks when developing local response mechanisms.

These procedures describe the role and processes for NSW Health workers to respond when:

- They identify that additional services and support are needed for a vulnerable pregnant woman
- A pregnant woman presents at a NSW Health Service and a Health worker suspects the unborn child may be at risk of significant harm when born;
- a Health worker receives a request from a prescribed body for information about a pregnant woman under Chapter 16A; and
- the Local Health District / Specialty Network Central Contact Point receives from Community Services an Unborn Child High Risk Birth Alert (HRBA) or written request for information about a pregnant woman under Chapter 16A or under Section 248.

9.8.2 Key Principles

- NSW Health has the primary role to ensure the health related needs of vulnerable pregnant women and unborn children are met through the provision of antenatal and specialist Health services such as drug and alcohol and mental health treatment services and other support programs following the SAFE START model. For further information see: PD2010_016 SAFE START Strategic Policy and GL2010_004 SAFE START Guidelines: Improving Mental Health Outcomes for Parents & Infants"
- NSW Health collaborates with the Department of Family and Community Services, Community Services (Community Services) to maximise preventative and early intervention strategies to reduce risk of harm to a child when born.
- Local Health Districts / Specialty Networks should plan their prenatal response mechanisms using these procedures. The Prenatal Service Delivery Model (outlined below) may need to be adapted to local systems.

9.8.3 Making a Prenatal Report

Pre-natal reports are not mandatory under the *Care Act* and Health workers should make every effort to engage vulnerable pregnant women in health services and other supports to address their needs. If there are sufficient grounds for making a prenatal report, however, the Mandatory Reporter Guide will prompt the worker to do so.

Health workers may make a prenatal report about an unborn child under section 25 of the *Care Act* to help facilitate assistance and support to the pregnant woman and reduce the likelihood that her child, when born, will need to be placed in out-of-home care.

A prenatal report may be made to the Child Wellbeing Unit 1300 480 420 or to the Child Protection Helpline 133 627. Reporting may occur where a worker has reasonable grounds to suspect that the child may be at risk of significant harm after his or her birth. See Section 9.1 and 9.2 above regarding making a report to the Child Protection Helpline.

Pre-natal reporting can be a valuable process for the provision of early assistance to mothers and their babies.

By alerting Community Services to potential risks, NSW Health and Community Services are able to work collaboratively to ensure that all available preventative and early intervention strategies are in place to reduce the risk of harm to a child when born.

Prenatal reporting may be particularly helpful in situations where the pregnant woman is in a domestic violence situation, or where there are unmanaged or ongoing mental health concerns for a member of the household or hazardous drug and/or alcohol misuse and these situations are likely to continue after the birth of the child. It is also appropriate to make a prenatal report where a parent has previously demonstrated significant harm to other children.

9.8.4 High Risk Birth Alerts (HRBA)

A High Risk Birth Alert (HRBA) is a procedure which may follow a prenatal report to the Child Protection Helpline. HRBAs are issued by Community Services to NSW Health and/or other agencies where it is determined that there may be a risk of significant harm after the child's birth.

The Prenatal Reporting Service Delivery Model outlined in this section aims to ensure that Health Services attempt to engage a pregnant woman who is the subject of a HRBA in support services regardless of where the woman presents in the Health system before the birth.

9.8.5 Making a Child Protection Report after the Birth of a Child

Under Section 23 (1)(f) and Section 25 of the *Care Act,* past prenatal reports act as an extra risk factor that must be taken into account when Health workers are considering whether or not a child is at suspected risk of significant harm upon birth.

Children could be at risk of significant harm if they were the subject of a prenatal report under section 25 of the *Care Act* and their birth mother has not engaged with support services to eliminate or minimise the risk that gave rise to the report.

Table 15: Prenatal Service Delivery Model

STARTING POINT 1

Pregnant woman presents at Local Health District/ Specialty Network and ROSH to unborn child after his or her birth is suspected.

SUSPECTED ROSH TO UNBORN CHILD AFTER BIRTH

High Risk Indicators (from Community Services Unborn Child HRBA Form):

- A pregnant child or young person who is under the parental responsibility of the Minister
- History of abuse or neglect of siblings of the unborn child
- A sibling of the unborn child has been removed or has died in circumstances reviewable by the Ombudsman
- Serious and persistent substance abuse by pregnant woman
- Unmanaged mental illness of pregnant woman
- Pregnant woman is at risk of suicide (either threatened or attempted)
- Pregnant woman is the victim of domestic violence involving serious injury to her, or injury requiring hospitalisation/treatment or involving use of a weapon

Other risk factors (from MRG Unborn Child Decision Tree)

Other circumstances that suggest that *either* parent/carer will be unable to care for the baby upon birth due to:

- suicidal tendencies
- serious and persistent substance abuse
- unmanaged mental illness
- domestic violence
- unmanaged intellectual disability
- unmanaged medical condition/physical disability
- homelessness
- inadequate preparations for birth.

Note:

In all cases the Health worker should continue to provide Health services to the pregnant woman and unborn child, and refer to other services as appropriate.

HEALTH RESPONSE

Use Mandatory Reporter Guide (MRG)

The MRG was developed to assist mandatory reporters with the decision about what they should do when they are concerned about a child, young person or unborn child. However, it should not override the Health workers' professional judgement. While reports relating to an unborn child are not mandatory, Health workers with mandatory reporting responsibility should consider the potential benefits of making a report to enable Community Services, NSW Health and other agencies to mobilise services for the benefit of the child and the mother. MRG: http://sdm.community.nsw.gov.au/mrg/

Mandatory reporters may make pre-natal reports to the child Wellbeing Unit instead of directly to the Child Protection Helpline.

Child Protection Helpline number 13 36 27. Child Wellbeing Unit number 1300 480 420.

MRG outcome is to report to the Child Protection Helpline:

- The Child Protection Helpline assesses whether the prenatal report meets the risk of significant harm threshold and checks any previous history about the pregnant woman, including aliases for the mother and siblings of the unborn child.
- If there is ROSH, the Child Protection Helpline refers the matter to the local Community Services Centre who works with NSW Health to maximise preventative and early intervention strategies to reduce risk of significant harm to the child when born.
- The local Community Services Centre forwards an Unborn Child High Risk Birth Alert (HRBA) to the Local Health District / Specialty Network Central Contact Point (CCP) where there is a high risk for the unborn child and at least one of three circumstances is present, i.e. the pregnant woman is: unable to be engaged with services; not accepting of support intervention; transient.

OR

MRG outcome is to contact the Health Child Wellbeing Unit (CWU):

- CWU will check WellNet database (including aliases and siblings) and for any past recorded concerns. CWU will identify whether there is an open or active case with Community Services, including Unborn Child HRBAs that may have been issued.
- CWU may recommend that the Health worker contacts the local Community Services Centre to discuss their current concerns for cases that are already open or active within Community Services.
- Where previous concerns are recorded the CWU will conduct a cumulative risk appraisal to determine if all known information meets suspected risk of significant harm. If so, the CWU will discuss with the Health reporter and either the Health mandatory reporter or CWU Assessment Officer will make a report to the Community Services. This will be negotiated based on who has the most relevant, direct information and is best placed to have the reporting conversation with the Child Protection Helpline.
- The Health worker should discuss with CWU follow up action required by Health including possible referral to appropriate service(s).
- The health worker should refer each case in accordance with their local Health District's case management process for child protection cases. SAFESTART Multidisciplinary Case Discussion Meetings may have a role to play.
- SAFE START Multidisciplinary Case Discussion meetings should occur in all settings where SAFESTART Assessment and Screening is implemented and provide a venue for clinicians from the LHD to discuss identified risk issues for any pregnant woman who is engaged with (or known to) the LHD services

SAFE START Assessment and Screening is a universal comprehensive psychosocial assessment and depression screen using the *Edinburgh Perinatal Scale* which is articulated in NSW Health's Families NSW, Supporting Families Early (SFE) Package. The SFE Package promotes an integrated approach to the care of women, their unborn children, infants and families in the perinatal period, and includes the SAFE START Strategic Policy. SAFE START Assessment and Screening may be conducted at any time in the perinatal period for all women. It is recommended that the first assessment/screen is included. All pregnant women should be encouraged and supported to book in for routine antenatal care, and thus access the SAFE START process. The SAFESTART Consultation Liaison Worker role may be of assistance in these processes.

OR

MRG outcome is to document and continue relationship:
Continue care of pregnant woman and unborn child. The Health worker may also contact the Health Child Wellbeing Unit to discuss and record concerns or to ascertain if there are previous concerns by another Health worker recorded.

STARTING POINT 2

A. Health worker receives a request for information about a pregnant woman , who is the subject of a prenatal report; or
B. The Local Health District / Central Contact Point receives an Unborn Child High Risk Birth Alert (HRBA) from Community Services or information under Chapter 16A or Section 248.

Notes:
The *Care Act* provides for information exchange between prescribed bodies under Chapter 16A, and between Community Services and prescribed bodies under section 248. In all cases the Health worker should continue to provide Health services to the pregnant woman and refer to other services as appropriate, with the consent of the pregnant woman.

Local Health District resources

- One Central Contact Point (CCP) officer and backup officer identified at Local Health District to receive and action HRBAs and written requests for information issued under Chapter 16A or under Section 248.
- One officer and backup officer identified at each service to receive HRBA and written requests for information from the CCP and action.

HEALTH RESPONSE

The Health worker responds to the request for information under Chapter 16A in accordance with Local Health District / Specialty Network Information Exchange procedures. Information under Chapter 16A can only be exchanged if the unborn child is the subject of a prenatal report to the Child Protection Helpline or to a Child Wellbeing Unit.

The Central Contact Point:

- reviews and discusses with Community Services the Unborn Child High Risk Birth Alert or
- discusses the information request with Community Services or the prescribed body to clarify details as needed.

The Central Contact Point should use a spreadsheet to record the Unborn Child High Risk Birth Alert, to track notices and to collect data. The suggested data fields are:

- Date received by Central Contact Point
- Date sent to Health services and name of health services
- Unborn child family name(s)
- Expected date of delivery
- Mother's name and date of birth
- Alias
- Father's/partner's name and date of birth
- Identifying information clearly specified? Yes/No and any comment
- Hospital likely to deliver child
- Previous hospitals attended
- Instructions/comments
- Risk of Significant Harm (ROSH) clearly specified and any concerns noted and report made
- Other children known in family removed
- Service(s) able to engage with pregnant woman? Yes/No
- Pregnant woman accepting of support intervention? Yes/No
- Pregnant woman transient? Yes/No
- High risk indicators selected?
- Any safety issues relevant to staff? Yes/No and any comment
- Consultation with Community Services? Yes/No and any comment
- General Alert received from NSW Police Force or Community Services sent to Health services
- Location of birth was at expected hospital? Yes/No
- Child Protection Helpline informed of birth? Yes/No, date and worker's service
- Information provided to Community Services by Health re clinical response and from which service
- Name of Community Services officer/ and Community Services Centre reference

The Central Contact Point distributes (Local Health District /Speciality Network to identify process) the Unborn Child High Risk Birth Alert or prenatal report information to all relevant services/departments based on information provided by Community Services e.g. Birthing Unit/ Maternity, Aboriginal Maternal and Infant Health Service (AMIHS), Emergency Department, Social Work, Child Protection Counselling Service (CPCS), Sexual Assault Service (SAS), Drug & Alcohol, Mental Health, Early Childhood, Child & Family, Sexual Health. Information is also to be distributed to antenatal clinics to enable early intervention. Where CS has subsequently cancelled a HRBA the Central Contact Point advises the cancellation to all units previously contacted.

The identified officer in each service/department receives and files an Unborn Child High Risk Birth Alert (HRBA) on the file of the expectant mother or where there is no file for the expectant mother, stores securely on a designated an HRBA file held by the service and checks this file when a pregnant woman presents at the service. The service holds an HRBA for 12 months.
The HRBA should be recorded and accessible at all times to appropriate maternity staff, including administration staff.
Local Health District / Specialty Network processes are in place to ensure HRBAs or prenatal information is recorded in the free text alert section on FirstNet where the pregnant woman is registered in the system. The NSW Health Child Wellbeing Unit (CWU) records information on the CWU WellNet database as an Event so that any Health worker who subsequently contacts the CWU about their concerns for pregnant woman is made aware of the Unborn Child High Risk Birth Alert.

Woman presents at hospital to deliver, or has already delivered:

- Midwifery services; or
- Emergency Department

Woman presents who has already delivered:

- Drug & Alcohol; Child & Family Health; Mental Health services, AMIHS, Child Protection Counselling Service, and Sexual Assault Services.

Where a service has been notified of an Unborn Child High Risk Birth Alert and the woman births:

- In accordance with Chapter 16A, the service *informs* the Community Services Centre who had issued the High Risk Birth Alert.
- The service *reports* the birth to the Child Protection Helpline (13 36 27) if the support services did not engage successfully with the birth mother and the risk factors that gave rise to the report were not minimised to the lowest level reasonably practical.
- The service notifies the Central Contact Point of action(s) taken.

Discussing the Prenatal Report with a client

Health workers should consider whether it is safe and appropriate to disclose to the client that they have received a request for information under Chapter 16A or Section 248; made a Prenatal Report; or received an Unborn Child High Risk Birth Alert, as part of their engagement and therapeutic relationship with the pregnant woman.

9.9 Assumption of Care Responsibility of a Child or Young Person by Community Services on Health Premises

9.9.1 Introduction

There are times when Community Services or the Police have to remove a child or young person from their parents or carers. This step is taken when:

- there are reasons to suspect that the child or young person is at immediate risk of serious harm; and
- an Apprehended Violence Order will not be sufficient to protect the child or young person from harm.

If the child or young person is at risk of serious harm, but currently safe (for example in a hospital) their care might be assumed by the Director-General of FACS without the need for them to be physically removed from where they are.

Health workers have no legal authority to detain a child or young person. Community Services does have the statutory authority to assume care responsibility of a child or young person in hospital or any other premises under an order issued pursuant to section 44 of the *Care Act*. This section applies where Community Services suspects on reasonable grounds that a child (including a newborn child) or young person is at risk of serious harm and is satisfied that it is not in the best interests of the child or young person to be removed from the hospital or other premises.

If a child or young person is removed or assumed into care without a Court Order, Community Services must advise the Children's Court within three working days.

NSW Health and Community Services have negotiated a protocol to be followed by Health workers when the Director General, Community Services assumes care responsibility of a child or young person on NSW Health premises. The protocol is the basis of the following procedures.

9.9.2 Mandatory Requirements

The NSW Health staff member in charge of the premises or with the appropriate delegation will:

1. Make preparations to ensure that Assumption of Care Orders are served in an environment that maximises safety for the child or young person, parent(s)/ carer(s) and staff. This may include if available and appropriate moving to a more secure location within the Health premises. It is not the responsibility of Health workers to remove the child or young person to a location outside the Health premises or to facilitate the removal of a child or young person.
2. Provide a safe and secure environment for the child or young person, parent(s)/ carer(s) and staff in accordance with the NSW Health Policy Manual, *Protecting People/Property: NSW Health Policy/ Guidelines* for Security Risk Management in Health Facilities *(*Policy Directive *PD2005_339)* and Local Health District security procedures.
3. Provide ongoing health care and treatment for the child or young person, as necessary, from the time the Assumption of Care Order takes effect until Community Services removes the child or young person from the Health premises or the order lapses.

NSW Health recognises that it may take some time for Community Services to arrange alternate care for the child or young person. The need for a period longer than 3 days is to be negotiated between the senior staff of Health and Community Services.

Health workers have no legal authority to detain a child or young person. Community Services does have the statutory authority to assume care responsibility and protection of a child or young person in hospital or any other premises under an order issued pursuant to section 44 of the *Children and Young Persons (Care and Protection) Act 1998*.

9.9.3 Assumption of Care Order

An Assumption of Care Order:

1. Must be served in writing on the person whom the Director General of Community Services or his/her delegate (usually a caseworker) determines to be in charge of the NSW Health premises at the time the order will be served (e.g. health premises manager/ after hours manager/nursing unit manager);
2. Must specify the child or young person for whom the order is made; and
3. Must specify the premises on which the child or young person is located at the time of serving the order.

The following conditions apply once an Assumption of Care Order has been served:

1. Legal care responsibility for the child or young person is removed from his or her parent(s)/ carer(s) and given to Community Services pending care proceedings in the Children's Court;
2. It is unlawful for the parent(s)/carer(s) to remove the child or young person from the premises specified in the order without the consent of Community Services. Any attempt to remove the child or young person from the premises may constitute an offence under section 229 of the *Care Act*.

9.9.4 NSW Health Roles and Responsibilities

The factors leading to a decision by Community Services to assume care responsibility of a child (including a newborn child) or young person are most often complex. A range of reactions can be expected from the child or young person and/or the child or young person's parent(s)/ carer(s) to an impending or served Assumption of Care Order. Safety and security of children, young people, carers and health workers are paramount in all situations.

Children and Adolescents – *Safety and Security in NSW Acute Health Facilities PD2010_033* http://www.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_033.pdf also provides policy direction to assist the development of local protocol for Health staff when assumption of care by Community Services occurs on health premises.

Role of the Person in charge of the Health premises

The Person in charge of the Health premises or with the appropriate delegation will:

- Accept all reasonable direction by Community Services in relation to the care of the child or young person and/or contact between the child or young person and his or her parent(s)/carer(s). Resources permitting, this may include a direction from Community Services that the parent(s)/carer(s) are to have limited or no contact for an interim period until the matter is brought before a magistrate and interim orders are obtained. Contact by the parent(s)/carer(s) is dependent on Community Services being satisfied that issues of safety, welfare or wellbeing are adequately addressed.
- Have local procedures in place to address how the Health premises will comply with Assumption of Care Orders. These should take into account the specific circumstances of the case such as the child or young person, their state of health, age, breastfeeding/feeding arrangements for a newborn child, attitude of parent(s)/carer(s), other family members, nature of the premises, its isolation and staffing levels and levels of risk arising in the case.
- Provide procedures for appropriate cultural responses for the protection and safety of Aboriginal children where assumption of care responsibility involves Aboriginal children and parent(s)/carer(s). In the absence of an Aboriginal Health Unit in the Local Health District /Specialty Network, contact should be made with the Centre for Aboriginal Health at the Ministry of Health for advice on development of procedures.
- Provide procedures for appropriate cultural responses for the protection and safety of Culturally and Linguistically Diverse (CALD) children, young people and their families. Provide access, if required, to a Multicultural Care Interpreter in accordance with *PD2006_053 Interpreters – Standard Procedures for Working with Health Care Interpreters*.
- Involve Local Health District / Specialty Network security staff, where available and appropriate, to ensure the protection of Health staff. Security staff are to be guided by existing Local Health District / Specialty Network security policies and procedures.
- Place a copy of the Assumption of Care Order in the child or young person's Health Record and document information identified at 9.9.7 of this section.

In tertiary and non-tertiary urban hospitals a Social Worker is often the primary health worker undertaking the role and responsibilities related to assumption of care on health premises.

9.9.5 Prior to the Assumption of Care Order Being Served

Prior to the Assumption of Care Order being served Health staff will:

- Make preparations to ensure that the Assumption of Care Order may be served in an environment that maximises the safety, welfare and wellbeing of the child or young person, parent(s)/carer(s) and staff. This may include arranging a private location within the Health premises for Community Services to serve the order on the parent(s)/ carer(s); arranging for Health staff such as a social worker, Aboriginal health worker or multi-cultural care interpreter to be present where appropriate and possible; and organising appropriate security procedures if required.
- Make all reasonable efforts to retain a child or young person on the Health premises prior to Community Services arrival to serve the Assumption of Care Order.
- Contact Community Services immediately in cases where a parent plans/attempts to remove the child or young person from the Health premises. If a Community Services officer is not expected to arrive for some time and it would be difficult to keep the child or young person on the Health premises, Health

staff should ask the Community Services officer for advice about managing the situation. If there are concerns about the immediate safety of the child or young person or a Health worker / Specialty Network security procedures are to be applied.

- Immediately report the child or young person to the Child Protection Helpline Number (13 36 27) and as a 'Missing Person' to the NSW Police Force in cases where a parent/carer removes the child or young person from the Health premises. Health staff cannot prevent parent(s)/carer(s) from removing the child or young person from the Health premises even if this is contrary to medical advice.
- Immediately inform the Child Protection Helpline Number (13 36 27) and also contact the NSW Police Force in cases where the child or young person leaves the Health premises voluntarily or otherwise, in accordance with Local Health District / Specialty Network procedures regarding absconding children and young people.
- Provide ongoing health care and treatment for the child or young person, as may be necessary, from the time an Assumption of Care Order takes effect until Community Services removes the child or young person to other premises.
- Provide ongoing health care and treatment to the parent(s)/carer(s) and/or other family members, if appropriate.

9.9.6 Following the Serving of an Assumption of Care Order

Following the Assumption of Care order being served Health staff will:

- Maintain a child or young person on Health premises, and provide a safe environment for the child or young person, parent(s)/carer(s) and staff. This may include, if available and appropriate, moving to a more secure location within the NSW Health premises.
- At all times exchange information with Community Services as necessary to ensure proper actions and compliance in relation to the Assumption of Care Order given the circumstances of each case, including known risks of harm or the need for an interpreter.

NSW Health ***does not*** have responsibility to:

- Remove the child or young person to a location outside the NSW Health premises.
- Retain in hospital, without clinical justification, a child or young person as a patient for a lengthy period of time.
- The periods of time should not exceed:
  - 24 hours for Community Services to serve an Assumption of Care Order; and
  - Three days following the serving of the order to allow Community Services to arrange alternate care.

Subject to medical treatment needs, retaining a child or young person, who is the subject of an assumption of care order beyond three days should be negotiated between the Health premises manager and a senior staff member of Community Services.

Community Services Process for serving Assumption of Care Orders

Community Services will determine if a child or young person is at risk of serious harm and whether or not it is in the best interests of the child or young person to be removed from the Health premises in which he or she is currently located.

Community Services will inform the person in charge of the NSW Health premises by telephone that a Community Services worker will attend the facility to assume the care responsibility of the child or young person, and the time and place that the Community Services worker will serve the Assumption of Care Order including:

- The decision to assume responsibility and the reasons for this decision;
- The effects of the order;
- The time and place for serving the Assumption of Care Order;
- Any special provisions relating to contact between the parent(s)/carer and the child or young person;
- Any safety issues for the child or young person, hospital staff and/or other patients; and
- Name and contact numbers of Community Services staff who can provide information to the parent(s)/carer(s) and health staff. (In some cases the person who calls to notify of the intention to serve an Assumption of Care Order may be different to the person who will have continued carriage of the matter. For example, the Child Protection Helpline may arrange assumption of care responsibility but the Community Services Centre may be responsible for follow-up actions.)

The person in charge of the Health premises will advise Community Services of any arrangements the Health facility will make to ensure the safety, welfare and wellbeing of the child or young person, their parent(s) and staff during the assumption of care responsibility, such as the provision if available and appropriate, of a private location on health premises and appropriate staff.

The Community Services Caseworker will attend the Health facility at the agreed time to serve the signed Assumption of Care Order in person on the person in charge of the Health premises, and:

- Provide a copy of the order to the parent(s)/carer(s) and the child (if 10 years or over) or young person;
- Inform all parties including the person in charge of the Health premises, parent(s)/carer(s) and child or young person of the effects of the order. The information presented to the child or young person must be in a manner appropriate for their age and developmental capacity, particularly where the child is aged under 10 years;
- Provide all parties with their contact details and information sheets. *'Information for parents and carers: When your child is removed from your care to parent(s') and 'Information for children and young people: When you can't stay with your parents'* to the child (if aged 10 years or over) or young person. Information Sheets are available at www.community.nsw.gov.au
- Advise the parent(s)/carer(s) and the child (if aged 10 years or over) or young person of the right to apply to the Director General of Community Services for the discharge of the child or young person from the Director General's care;
- Advise the child (if aged 10 years or over) or young person that he or she may choose to contact any person and ensure that he or she is given a reasonable opportunity and appropriate assistance to do so.
- Assume care responsibility for the child or young person in accordance with an Assumption of Care Order pending care proceedings in the Children's Court.
- Attempt to locate the child or young person's parent(s)/carer(s) as soon as practicable if they are not present at the time the order is served.
- Advise the child or young person's parent(s)/carer(s) or the child or young person if they are of an age where this is appropriate, that an Assumption of Care Order has been served on the Health premises and explain to the parent(s)/carer(s)/child or young person, that the child or young person is under the care responsibility of the Director General Community Services, the effects of this order; and advise the person in charge of the Health premises that this has occurred.
- Make any decision in regard to the child or young person that can be classified as an everyday decision, such as removing the child or young person to another premises or consenting to medical or dental treatment. (Note that consent is not required for medical or dental treatment if a medical practitioner or dentist is of the opinion that the child or young person requires the treatment as a matter of urgency in order to save the child/young persons's life or prevent serious damage to the child's or young person's health.)

Community Services must apply to the Children's Court within 3 working days after assumption of care responsibility for one or more of the following:

- An emergency care and protection order,
- An assessment order (within the meaning of Division 6 of this Part),
- Any other care order.

If no care application is made, Community Services must explain the reason to the Children's Court at the first available opportunity.

9.9.7 Documentation in Health Record

The person in charge of the Health premises or delegate will place a copy of the Assumption of Care Order in the child or young person's Health Record, and document the following information:

- That the Assumption of Care Order was served, the time and date this was done and by whom (include the Community Services worker's name and Community Services office);
- The contact name and details for any further action or issue in relation the matter;
- That the parent(s)/carer(s) and child or young person have been informed of the order and its effects, the time and date this was done and by whom;
- If interpreter services were organised;
- That protocols regarding the care and treatment of Aboriginal children and young people were followed;
- Any special provisions or instructions from Community Services, such as conditions regarding parental/carer contact with the child or young person;
- Any observations, including remarks made by the parent(s)/carer(s), that give them cause to be concerned for the safety, welfare and wellbeing of the child or young person. This information must also be provided immediately to Community Services; and
- The manager of a maternity unit must also document the above information in the mother's Health Record.

9.10 Orders and Requests for Health Services

Table 16: Requests for Health Services

Notices for Medical Examination
Child or young person, deemed to be in need of care and protection, may be presented for medical examination under notice issued by Community Services or Police. Medical practitioner must prepare written report of the examination for DG of FACS (s173)

Children's Court Orders
Children's Court Clinic and other expert clinicians may receive orders to assess:

- a child or young person's physical, psychological, psychiatric or other medical needs (s53)
- a person's capacity for parental responsibility (s 54);
- and provide assessment reports to the Court (s58)

Health services, by consent, may receive order to provide support services for child and young person for up to 12 months (s 74)

In cases where a child has exhibited sexually abusive behaviours, Health Services may be involved in providing therapeutic programs or treatment programs which a child under 14 is ordered to attend or a parent of a child or young person is ordered to attend (s75)

'Best Endeavours' Requests for Service
Health Services obliged to use ' best endeavours' when responding to:

- Community Services' requests for services to be provided to child, young person or family to promote child or young person's safety, welfare and wellbeing (in ROSH cases) (ss17-18)
- Children's Court requests for services to be provided to child, young person or family to facilitate restoration of child or young person to his or her parents (s84(1)(c), s85).

9.10.1 Introduction

Health Services have an important role under the *Care Act* in providing support services to children and young people in need of care and protection and their families.

Requests and orders for the provision of Health Services from Community Services, Police and/or the Children's Court may be made under several sections of the *Care Act.* Such requests and orders for services will generally involve prior consultation with the Health Service involved and agreement that the service is both appropriate and available.

Health workers may also be asked to assist in the development of care plans for children and young people under the *Care Act* by attending case conferences or case meetings. A care plan is a document that sets out, among other things, the services that need to be provided to the child or young person and the allocation of parental responsibility for a child or young person who has been removed from the care of his or her parents. Health workers should attend these meetings if asked, especially if a Health Service is proposed to be a component of the care plan. Health workers should document attendance at such meetings and outcomes in accordance with usual NSW Health documentation procedures. See Section 13 of this document.

If a Health service is approached to provide services that may become part of a court order, the service should negotiate the terms of the order and period for which the order is to be made with Community Services.

Health services will also need to negotiate the appropriate steps to take if an order has been made and either the child or family discontinue contact with the service or where a service is unable to be provided or continued.

9.10.2 Notices for Medical Examinations (Section 173)

If Community Services investigates a ROSH report and determines that a child or young person is in need of care and protection, they might take action to seek a medical examination of the child or young person.

As well as providing important information about the type and extent of any injuries, any diagnosed illness and/or necessary treatment(s), medical examinations can assist in the assessment and investigation of alleged abuse and or neglect.

If a parent or carer is unable or unwilling to consent to a medical examination in this context, the following provisions may apply.

Legal Provisions

Under section 173 of the *Care Act,* Community Services or the NSW Police Force may serve a notice on a parent/carer of a child or young person deemed to be in need of care and protection requiring them to present the child or young person for a medical examination. The notice will specify the medical practitioner to whom the child or young person must be presented and the timeframe for this to occur (up to 72 hours).

If the person fails to comply with this notice, the child may be presented by Community Services or by the Police to a hospital or other place for a medical examination. The Director-General of Community Services is deemed to be the parent for consent purposes.

A medical practitioner receiving a notice under section 173 may carry out or cause to be carried out such medical examination of the child as the medical practitioner thinks fit, including examination at a hospital or place not specified in the notice. A medical practitioner conducting a section 173 examination must provide a written report of the examination.

A medical practitioner who transmits a report prepared under these circumstances is protected under the Act from legal action in relation to allegations of professional misconduct and defamation.

Policy Considerations

Before Community Services refer a family for a medical examination of a child deemed in need of care and protection, they will contact the medical practitioner, hospital, or in the case of sexual assault, a Sexual Assault Service and arrange the time and place for the medical examination. Reports made under section 173 are to be provided without charge by Health workers.

Consent to a medical examination, including the taking and analysis of samples and the use of any machine or device that enables or assists in the examination, is taken to have been given when Community Services or a police officer requires the child to be medically examined under Section 173.

In the public health system, a medical examination under section 173 should only be conducted in hospitals that employ paediatricians (generally Level 4 or Level 6 hospitals) and should be provided by a paediatrician or a doctor (such as a trainee) working under the direct supervision of a paediatrician.

Where a child cannot be transferred to a Level 4 facility the Visiting Medical Officer, General Practitioner or Consultant Medical Officer at that hospital should perform that examination in consultation before and after the examination with a paediatrician at the nearest Level 4 hospital. As an outcome of that consultation it may be determined that the child needs to be transferred to the Level 4 hospital or Level 6 hospital for x-rays or bone scans or other investigations.

SCAN protocols should be used for recording the results of s173 medical examinations.

The child or young person should be admitted to hospital if he / she is considered at risk of significant harm and CS cannot provide a place of safety immediately. This may require CS to assume care of the child or young person. Section 173 permits admission up to 72 hours under the parental responsibility of the Director General Department of Family and Community Services (CS)

Community Services (CS) or the NSW Police Force are required to provide the hospital with the Section 173 notice prior to the release of medical documentation. On completion of a Section 173 medical examination the examining doctor is required to provide a written report to the Director General CS. This report should be countersigned by a Medical Consultant.

A photocopy of the completed S.173 form (request for examination by CS) should be obtained and placed in the child's or young person's health record.

9.10.3 Medical Examination and Assessment Orders (Sections 53-54)

Legal Provisions

The Children's Court may make orders for expert clinical assessments of:

- a child or young person's physical, psychological, psychiatric or other medical needs (section 53)
- a person's capacity for parental responsibility (section 54).

When considering whether to make an assessment order, the Court will take into account whether the proposed examination or assessment is necessary, whether the information sought can be obtained elsewhere, and whether the assessment will produce any unnecessary distress to the child or young person.

A child or young person of sufficient understanding to make an informed decision, may refuse to submit to medical examination or an assessment under these provisions.

Assessments are usually done by the Children's Court Clinic (a service within Sydney Children's Hospitals Network) under section 58 of the *Care Act.* The Court will appoint another person to complete the assessment when the Clinic has indicated it is unable to prepare the assessment report, or is of the opinion that it is more appropriate for the assessment report to be prepared by another person.

In circumstances where the clinic is unable to provide the assessment sought, an affidavit must indicate to the court that the clinic is unable to carry out this assessment, include details of an appropriate person to carry out the assessment and indicate that agreement was reached between the parties about the proposed person to carry out the assessment.

Policy Considerations

These assessments assist the Children's Court in making its decisions including whether there are grounds to make care order as set out in section 71.

The Children's Court Clinic employs and contracts a number of experienced psychiatrists, psychologists and social workers as Authorised Clinicians to undertake independent assessments and provide reports for the Children's Court.

The Children's Court Clinic does not undertake physical, medical or emergency assessments. It is considered that these assessments are best done by specialist medical practitioners. Appointments of other medical practitioners not within the Children's Court Clinic are required to be made by the Court with the agreement of the parties as far as possible.

For further information see Children's Court Clinic
http://www.lawlink.nsw.gov.au/lawlink/ccc/ll_ccc.nsf/pages/CCC_index.
and Children's Court Practice Note 6
http://www.lawlink.nsw.gov.au/childrenscourt

9.10.4 Children's Court Orders for Provision of Support Services (s74)

Under section 74, the Children's Court may order a person or organisation to provide support services for a child or young person for up to 12 months.

These orders are by consent of the person or organisation required to provide the support services and the views of the child or young person must have been taken into account.

The parents of a child or young person cannot be compelled to accept the provision of support services, particularly if the services relate to the parents rather than to the child or young person.

Orders to Attend Therapeutic or Treatment Program Orders (child exhibiting sexually abusive behaviour) (s75)

Legal Provisions

If a child has exhibited sexually abusive behaviour, the Children's Court may make orders for:

- A child under 14 to attend a therapeutic program relating to sexually abusive behaviours (section 75(1))
- A parent of a child or young person to attend a therapeutic program relating to sexually abusive behaviours or any other kind of therapeutic or treatment program (section 75(1B))

Policy Considerations

These orders can be made to facilitate appropriate therapy and intervention where a child under the age of 14 years has displayed sexually abusive behavior.

If the child is aged ten or above, a referral may be made to designated Health programs such as New Street Services.

Where a child is under ten and is also a victim of sexual assault, Local Health Districts / Specialty Networks are responsible for ensuring that these services are available through Sexual Assault Services. Where a child is under ten and is not a victim of sexual assault, therapeutic services for children exhibiting sexualised or sexually abusive behaviours are provided by trained counsellors in Child and Family teams or Child and Adolescent Mental Health Services.

9.10.5 'Best Endeavours' Requests for Service (ss17-18, s84(1)(c), s85)

Legal Provisions

Under section 17 of the *Care Act,* Community Services may request Health services (including funded non-government organisations) to provide services to a child, young person or their family to promote the child or young person's safety, welfare and wellbeing.

Under section 84(1)(c), the Children's Court may request Health services (including funded non-government organisations) to provide a service to a child, young person or their family in order to facilitate restoration of a child or young person to his or her parents.

Under section 18 and section 85 of the *Care Act*, Local Health Districts and Networks must use their 'best endeavours' in responding to requests for a service under sections 17 and 84(1)(c) of the *Care Act*.

Requests for Service to Promote Restoration

If a child is removed from the care of their parents and restoration is likely, Community Services must develop a restoration plan outlining what steps the parents must take before the child can safely be returned. Child Protection Counselling Services, drug and alcohol or mental health programs are examples of elements of a restoration plan that Health Services may be asked to provide.

Health workers should give high priority to Children's Court requests under section 84(1)(c) and in responding to these requests should follow the same procedures that apply for section 17 requests.

Elements of Community Services' requests

By agreement with Community Services, the following elements will be present for best endeavours requests for services for children from Community Services under section 17:

- Community Services has assessed that a child or young person is at ROSH and may be in need of care and protection.
- Community Services is in the process of, or has undertaken, assessment of the matter.
- A case plan has been developed which is provided with the written request to the Health Service.
- Community Services is involved in follow up and monitoring.

By agreement with Community Services, the Child Protection Helpline is able to make best endeavours requests in limited situations which require:

- urgent mental health assessment or intervention
- forensic medical examination
- emergency medical treatment
- other crisis or trauma intervention (i.e. where there has been a critical incident such as a major accident and a crisis mental health response is needed).

Requests from the Child Protection Helpline may not require ongoing follow up by Community Services, but will be limited to cases where a child or young person is assessed to be at risk of significant harm and a written request is made accompanied by a case plan. For these purposes, a 'crisis or trauma intervention' is a situation; where there has been a critical incident such as a major accident and a crisis mental health response is needed.

'Best endeavours' requests for service are not intended to replace existing effective referral mechanisms between Community Services and NSW Health.

Obligation to co-operate

In the context of sections 18 and 85, 'best endeavours' means to exercise a genuine and considered effort to respond to a request for service to promote and safeguard the safety, welfare and wellbeing of a child or young person.

Local Health Districts and Networks are not expected to provide services that are not within their responsibility or expertise, or if doing so would place an undue burden on a service's ability to carry out its core functions. Community Services will make a request for service only if that organisation considers a child or young person needs the service, and that the Local Health District or Speciality Network approached is best placed to provide the service.

Requests may involve clients who in the first instance do not attend, or who appear reluctant to attend services. In such cases best endeavours would include practitioners making efforts to follow up the person referred and encourage their attendance.

In using best endeavours Health services should:

- manage services flexibly to deal with high demand so that a child or young person's safety, welfare or wellbeing is not compromised
- have documented intake procedures for children, young people and families that prioritise those who are vulnerable
- consider risk of significant harm issues in prioritising the request for a service
- deliver accessible services
- use active attempts to engage families and assist families to make use of services offered.

Processing 'best endeavours' requests

Best endeavours requests are sent by Community Services on the Community Services section 17 Request for Service form. The requests include a case plan and are sent to the Local Health District/ Speciality Network Central Contact Point for forwarding to the Manager of the Health Service from which the service is sought. When a request is received a copy of the Community Services request must be immediately sent to the central register.

The Health Service Manager will then provide information to the Community Services Centre (CSC) within 2 working days on whether or not the service can be provided, and the time frame for the provision of the service using the *NSW Health Response Form for Best Endeavours Request for Service from the Department of Family and Community Services*.

If the Health Service is able to provide the service, the Community Services Centre will then notify the family or individual and arrange for the necessary planning meetings to agree on the goals of the intervention.

Each Local Health District or Speciality Network is required to record information on all section 17 and 84(1) (c) requests for service. A senior officer of the Local Health District /Speciality Network is responsible for monitoring any unmet requests and resolving service provision issues for Health services.

'Best endeavours' requests from the Child Protection Helpline

'Best endeavours' requests from the Child Protection Helpline will be directed to the Health service from which the service is sought. Verbal and written confirmation is to be given to the Child Protection Helpline on whether or not a service can be provided. The Health Service Manager is to fax a written response to the Child Protection Helpline within 24 hours using the *NSW Health Update to Best Endeavours Request for Service Form.*

Criteria for accepting 'best endeavours' requests

A Health Service must provide the services requested under section 17 and 84(1) (c) of the *Care Act* unless:

- the service requested is not currently provided by the service;
- the service requested is not consistent with the service's responsibilities; or
- providing the service would prejudice the discharge of the service functions.

If a service is at capacity, priority should be given to section 17 or section 84(1)(c) requests on any waiting list unless there are demonstrable acute clinical reasons for other referrals to take precedence.

Concerns about the appropriateness of a request or the lack of information provided are not sufficient grounds to refuse to provide a service. If there are such concerns, the Service Manager should consult with the appropriate Community Services Manager to discuss and resolve these issues.

Concerns that providing a service as requested may place Health workers at risk should also be discussed internally and with the appropriate Community Services Manager to find out if a safe alternative means of providing the service is available.

Agreement to the provision of a service should not be made if it is considered that the safety of a Health worker will be placed at risk. Community Services should be advised that provision of the service would be inconsistent with the Local Health District's / Specialty Network's Occupational Health and Safety obligations. This reason for refusal to provide a service is likely to be rare and may mean that another agency may need to provide assist in providing a service.

Health workers should also consider whether the service could be provided from an alternative agency or site within the Local Health District / Specialty Network if this will meet the needs of the client. This can be negotiated between the managers of the Health Service in question. The service originally approached to provide the request retains responsibility for informing Community Services of the outcome of the request.

Local Health Districts / Speciality Networks need to establish procedures for senior staff to resolve differences in relation to responsibility to accept section 17 and 84(1) (c) best endeavours requests. The responsibility for these requests lies with the Local Health District /Speciality Network, not just with individual services.

Declining 'best endeavours' requests

If a Health service cannot accept a request for service, the Health Service Manager must inform Community Services of the reasons using the *NSW Health Response Form for Best Endeavours Request for Service from Family and Community Services.* These referrals must be resolved promptly to enable Community Services to identify alternative agencies that can deliver the requested service.

In the event that the service may be provided by another unit or agency of the Health Service, the Health Service Manager should assist in the facilitation of the request to that Health Service.

The Health Service Manager should also communicate the availability of this service to the issuing Community Services Centre.

10 Responding to Child Sexual Abuse and Serious Abuse or Neglect

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SECTION 10

Responding to Child Sexual Abuse and Serious Abuse or Neglect

10.1 Introduction

Sexual abuse is sexual activity or behaviour that is imposed, or is likely to be imposed, on a child or young person by another person. Child sexual abuse is a crime. It is also grounds for making a child protection report whether or not a parent/carer is protective of the child or young person. See Section 7 Recognising Child Abuse and Neglect in this document.

Child abuse and neglect are offences under the *Care Act* and may also constitute a crime under the *Crimes Act 1900*. They are also grounds for making a child protection report.

10.2 Joint Investigation Response Teams (JIRT)

Joint Investigation Response Teams (JIRTs) have a unique role in responding when children and young people are at risk of significant harm. Working collaboratively, Community Services, NSW Police Force and NSW Health JIRT Senior Health Clinicians undertake joint investigations of statutory child protection matters that require a criminal justice response. Referrals to JIRT can only be made through the Child Protection Helpline or a Community Services Centre (CRC). http://www.community.nsw.gov.au/docs_menu/about_us/contact_us/community_services_centres.html

The JIRT response links the responsibilities of the three agencies and aims to reduce the emotional trauma for child victims through more effective investigative interviews, co-ordinated investigations, timely delivery of services to respond to the needs of victims and improved interagency collaboration. It also requires the management and co-ordination of three distinct and quite different elements of government:

1. Criminality – NSW Police Force
2. Care and protection – Family and Community Services
3. Emotional, psychological and physical health and wellbeing – NSW Health
4. Provision of medical and forensic examinations – NSW Health

The JIRT Health response is supported by NSW Health specialist forensic medical and counselling services offered by Sexual Assault Services, Child Protection Units, Child Protection Counselling Services, Whole of Family Teams, Child and Adolescent Mental Health Services, and Newstreet Services, Youth Health, Aboriginal Family Health Workers and Drug and Alcohol Services. Paediatric services, including specialist medical, forensic and social work services in each Local Health District / Specialty Network are also available. Health workers provide medical examination, acute crisis intervention, counselling and therapeutic services to children or young people and their non-offending parents or carers, when required.

NSW Health is a full partner with Community Services and the NSW Police Force in JIRT. In accordance with the NSW Children and Young Persons (Care and Protection) Act 1998, NSW Health has a responsibility to provide information to Community Services and the NSW Police Force for the purpose of assisting JIRT investigations. At times this requires JIRT Health Senior Clinicians to seek information from other parts of the Health system about children and young people at risk of significant harm.

There are exemptions regarding information release and protections regarding pieces of information that may be contained within Health records. Additional information regarding exchange of information provisions and protections in the legislation may be found in Section 6 Information Sharing of this document and should be considered prior to the release of information.

10.3 JIRT Referral Unit (JRU)

The JRU provides a centralised decision-making process for accepting and investigating JIRT referrals. All JIRT reports go through the Child Protection Helpline to the Joint Referral Unit (JRU). The JRU accepts referrals that require criminal investigation, such as cases of sexual assault and serious physical abuse and neglect. The JRU is staffed by JIRT agency partners and the procedure of decision making is conducted jointly by JRU Managers representing NSW Police Force, NSW Health and Community Services.

The JRU Health team is responsible for initiating a Health response at the point the matter is received by the JRU. The JRU Health team will initiate a request for a health service for all accepted JIRT matters to the JIRT Senior Health Clinicians, Sexual Assault Services, Child Protection Units and Child Protection Counselling Services. The JRU Health team will also initiate a request for a health service for those matters not accepted for JIRT investigation to general health services considered appropriate for the child and family for information, acute crisis support, follow up and ongoing care. eg Whole of Family Teams, Child and Adolescent Mental Health Services, and Newstreet Services, Youth Health, Aboriginal Family Health Workers and Drug and Alcohol Services.

10.4 Forensic and Medical Examinations

Forensic and medical examinations are critical to the crisis response required on presentation of: a victim of sexual assault, including a child victim, to a Sexual Assault Service or emergency department; or a child with suspected physical abuse or neglect to a doctor, emergency department, or other health service.

Medical services for victims of sexual assault and child abuse and neglect focus on an examination to identify and respond to treatment needs, the provision of medical information, support and reassurance, and coordination of appropriate referrals for ongoing physical and psychological wellbeing.

A forensic examination is an examination specifically for the purpose of gathering evidence for use in a court of law.

10.5 Sexual Assault Forensic and Medical Examinations

Sexual assault of a child or young person is extremely traumatic for both the child and their parent or caregiver. NSW Health's role is to provide a general medical examination, a sexual assault forensic medical examination if indicated, psychosocial assessment, crisis intervention and counselling. The medical and psychosocial needs of the child or young person are a priority and need to be responded to in accordance with the child's or young person's health needs. If a child presents to an Emergency Department and sexual assault is suspected, consultation with the local Sexual Assault Service or Child Protection Unit is to occur immediately.

NSW Health services assess, support and treat children and families and respond to the crisis resulting from disclosure of sexual abuse. It is the role of Police and CS in JIRT to investigate complaints of sexual assault. Joint Investigation and Response Teams undertake investigations of statutory child protection matters that require a criminal justice response. Health workers contribute to the JIRT response by sharing information obtained from the medical and psychosocial assessments to assist in the investigative process. Health workers are trained to conduct these assessments while maintaining the requirements of the criminal justice response. The Health response is not reliant on JIRT interview or substantiation as a criterion to proceed. Further information on Joint Investigation and Response Teams (JIRT) can be found in sections 10.2 and 10.3 of this document.

NSW Health Sexual Assault Services are responsible for the overall coordination of medical and forensic services to victims of child sexual assault. Sexual Assault Services will offer and provide medical consultation for every child and young person who has experienced sexual abuse involving physical trauma (NSW Department of Community Services, NSW Health and NSW Police Service (2001), *Joint Investigation Response Team Policy and Procedures*, NSW Government (specialist manual)). Sexual Assault Services should liaise with their designated medical practitioner to ensure there is minimal delay in initial contact with the child/ young person who has been sexually assaulted.

A joint response by the medical practitioner and counsellor from the Sexual Assault Service or Child Protection Unit provides the professional response required in these situations. Completing a medical assessment at the time of presentation will assist the doctor to assess whether a sexual assault forensic medical examination is urgently required so forensic evidence is not lost. It is also an opportunity for the social and emotional needs of the child to be assessed by the Sexual Assault Service counsellor. The collection of forensic evidence may not be necessary or appropriate for investigative purposes, but a medical examination may be necessary for the child's health and wellbeing.

Any new child protection concerns or information resulting from this assessment process must be communicated to the Child Protection Helpline as a further report. Health will communicate their plan for intervention to the on call JIRT as an agency partner.

Sexual assault medical and forensic medical examinations are provided by appropriately trained Health professionals (medical practitioners or Sexual Assault Nurse Examiners (SANEs)) from the medical service employed by a Sexual Assault Service or level 6 (Tertiary) hospital Child Protection Unit. In cases where the victim is a 14-16 year old adolescent who has experienced sexual assault by someone who is not a caregiver or relative and who wishes to attend a NSW Health Adult Sexual Assault Service, a medical and forensic examination may be conducted by a Sexual Assault Nurse Examiner. Sexual assault medical examinations of children and young people are to be recorded in the NSW Health (2003), *Sexual Assault Investigation Kit (SAIK)*: *Child and Adult Sexual Assault Protocols (specialist medical record and manuals) and forensic evidence collection kit*, NSW Government by the doctor attending the medical examination.

The Child Sexual Assault Medical Protocol clearly defines the consent required prior to carrying out a sexual assault forensic medical examination and must be used for all forensic medicals.

The NSW Health Sexual Assault Identification Kit (SAIK) - Adult Sexual Assault Protocol may be used where an eligible young person has attended an adult Sexual Assault Service (i.e. a young person aged 14-16 years who was not assaulted by a caregiver or relative or aged 16 years and over).

An urgent sexual assault forensic medical examination may be required in circumstances including:

- the child or young person was sexually assaulted within the previous 5 days;
- any symptoms or signs of acute injury as assessed by the medical practitioner

Counselling may be provided by Sexual Assault Services and Child Protection Units to non-offending parents, caregivers and children and young people 14 years and over whether or not a sexual assault forensic medical examination is undertaken at the time of the presentation of a child or young person.

Sexual Assault Nurse Examiners (SANEs) may only provide a sexual assault forensic medical examination to children or young people who are able to attend an adult Sexual Assault Service (i.e. children aged 14-16 years who were not assaulted by a caregiver or a relative, or young people aged 16 years and over).

10.6 Adolescent Peer Consensual Sex

NSW Health workers should consider whether an adolescent engaging in sexual activity with a peer is at risk of significant harm. Under the *Crimes Act (1900)* sexual activity by or with a person under the age of 16 years is a crime, however only cases of apparent consensual adolescent peer sex that meet the ROSH threshold because of other indicators must be reported to the Child Protection Helpline.

JIRT will investigate all matters of peer sex with a complaint about or disclosure of sexual assault.

A JRU decision to reject a referral alleging adolescent peer sexual activity where one or more party is under the age of consent necessitates a 'Police Only' response as per internal Police Standard Operating Procedures relating to sections 66C and 66D of *Crimes Act 1900.* A 'Police Only' response means that the Police will investigate the matter by interviewing the adolescent in the presence of a parent or guardian. If, in the course of investigating under age sex, JIRT Police have reasonable grounds to form a view that one or more parties may be at *risk of significant harm* (*ROSH*), JIRT Police will make a report/s to the Child Protection Helpline as standard practice.

Where both parties have impaired intellectual functioning but there is an absence of complaint, The JRU will conduct further inquiries to establish:

- evidence of complaint
- relevant child protection history
- relevant criminal history

If there is

- any evidence of complaint and/or
- relevant child protection history and/or
- relevant criminal history

the referral will be **accepted** for a JIRT intervention.

If there is

- **no evidence** of complaint and
- **no relevant** child protection history and
- **no relevant** criminal history

the referral will be **rejected** for a JIRT intervention.

Rejected referrals will be forwarded as follows:

- For CS: to the relevant Community Services Centre
- For Police: to the relevant JIRT Unit for a *'Police Only'* response
- For Health: to the relevant Health service where required.

Sexually Transmitted Infections (STIs)

A STI diagnosis is a potential indicator of sexual abuse and may or may not give rise to a reasonable suspicion that a child or young person is at risk of significant harm.

Clinicians should also be mindful that the *Public Health Act 2010* has mandatory notification requirements, including STI diagnoses in any person (including a child) to a NSW Health Public Health Unit.

When a STI diagnosis has been confirmed in a child or young person, the NSW Health Infectious Diseases Control Guidelines provide guidance regarding public health responses and mandatory child protection reporting requirements for the treating doctor and Public Health Unit Staff.

Disease notification

http://www.health.nsw.gov.au/publichealth/infectious/notification.asp

Infectious Diseases Control Guidelines

http://www.health.nsw.gov.au/infectious/control_guideline/pages/default.aspx

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SECTION 11

Health Assessments and Care for Children and Young People in Out-of-Home-Care

11.1 Introduction

Children and young people in out-of-home-care (OOHC) are more likely to have significant, often unrecognised and unmet, acute and chronic health needs than those in the general population. Data from Australia and overseas, including studies from NSW, indicates that children and young people entering OOHC tend to have poor physical and mental health, increased rates of developmental difficulties and are less likely to access preventative health services such as immunisation compared to the general population.

The NSW Children's Guardian regularly conducts audits of both government and NGO providers of out of home care. This audit includes a review of the documentation on file relating to health services provided to children and young people entering care, the nature of any identified problems, and whether a health plan exists.

11.2 Health Assessments and Health Management Plans

NSW Health provides health assessments for all children and young people entering statutory OOHC who are expected to remain in care for longer than 90 days. Health assessment services are provided through Local Health Districts / Specialty Networks upon referral from Community Services.

OOHC Co-ordinators have been appointed in Local Health Districts across NSW to enhance best practice in the provision of health assessments to children and young people entering statutory OOHC. OOHC Co-ordinators and Community Services Interagency Pathway Co-ordinators work together to support the timely provision of primary health assessments. The aim is to commence assessments within 30 days of the child or young person entering statutory out-of-home-care.

Referrals for assessment are initiated by Community Services and are provided in accordance with the NSW Health and Department of Family and Community Services, Community Services *Memorandum of Understanding on Health Screening, Assessment Intervention and Review for Children and Young People in Out-of-home-care*. The MoU contains an interagency framework '*Model Pathway for the Comprehensive Health and Developmental Assessments for All Children and Young People Entering Out-of-Home Care*' for conducting and coordinating health screening, assessment and intervention for children and young people in statutory OOHC.

Based on the findings of the primary health assessment a child or young person may receive a comprehensive multidisciplinary health assessment.

A health management plan is developed for each child or young person.

Access to health services for children and young people in statutory OOHC is based on clinical need.

11.3 Consent to Medical and Dental Treatment

For children and young people in out-of-home-care, section 157 of the *Care Act* authorises foster carers to consent to medical and dental treatment:

1. not involving surgery, on the advice of a medical practitioner or dentist; or
2. involving surgery that a medical practitioner or dentist certifies in writing needs to be carried out as a matter of urgency in the best interests of the child or young person.

Treatment involving non-emergency surgery generally needs to be notified to the child or young person's caseworker and authorised by the designated agency providing their out-of-home-care.

Minor dental surgery (on the advice of a dentist) can be consented to by a foster carer. Minor dental surgery is tooth extraction, filling of a decayed tooth, root canal or repair to a broken or chipped tooth.

In a particular case a foster carer may have been given the authority to exercise the power to give consent involving non-emergency surgery if that authority has been specifically delegated to that foster carer. This can only be done by a person at the level of a Community Services Field Manager (Manager Casework) or above.

The consent arrangements outlined above do not replace the legal right of children and young people aged between 14 and 18 years to consent to their own medical or dental treatment if they have developed the capacity to do so.

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SECTION 12

Case Management and Case Work

12.1 Introduction

The *NSW Children and Young Persons (Care and Protection) Act 1998* (the *Care Act*) provides the legislative framework for partnership and shared responsibility in order to maximise appropriate responses and assistance to families for the safety, welfare and wellbeing of children and young people. Section 245E of the *Care Act* requires government and non-government agencies, in order to effectively meet their responsibilities in relation to the safety, welfare or well-being of children and young persons, to take reasonable steps to co-ordinate decision-making and the delivery of services regarding children and young persons. Section 245A includes as a guiding principle that those agencies should work collaboratively in a way that respects each other's functions and expertise.

12.2 Case Management Continuum

NSW Health workers perform a variety of functions with other Health, government and non-government agencies to support child wellbeing and child protection through case work and case management.

Depending on their role, Health workers have involvement at any point in the continuum of child protection intervention. Health workers may be responsible for direct case management of a child or family's needs, or for providing brief or longer term case work services.

At one end of the continuum a Health worker may have minimal contact or a single occasion of service with a child, young person or family. An example is a Health worker (doctor or nurse) who identifies indicators suspicious of abuse, consults a paediatrician, child protection team member (where available) or social worker and makes a report of risk of significant harm to the Helpline, as well as arranging any necessary follow-up with a paediatrician or social worker.

In the middle of the continuum, a Child and Family Health nurse provides services for both a parent and a child, has more ongoing contact, facilitates appropriate referrals and may be involved in case meetings, planning and reviews.

Alternatively, a Mental Health or Drug and Alcohol worker might have a high degree of contact with an adult client and less frequently have contact with the client's children. They may provide support and advocacy on behalf of their adult client, while actively being involved in case meetings, planning, intervention, and review of any child protection and parenting concerns such as the potential impact of the parent's health issues on their capacity to parent and care for their children.

At the far end of the continuum, child protection workers, including doctors and nurses, social workers and psychologists, may provide a range of practical and therapeutic services. This service provision would include a high degree of contact with other agencies, including Community Services, and a high level of involvement with the child, young person or family/carers around assessments, planning, monitoring and reviews. Regardless of the level of involvement, where there is a concern about safety, welfare or wellbeing, Health workers should respond to concerns. The Health worker should:

- ensure that support processes are in place within the scope of their expected professional duties;
- follow up action to ensure an appropriate service response is in place;
- actively refer to another service as required;
- co-ordinate a case meeting with any new service and the client;
- facilitate a case handover to another Health professional.

12.3 Case Management

Case management aims to strengthen outcomes for families, children and young people through integrated and co-ordinated service delivery between Health services and interagency partners to their clients. Case management is particularly important for clients with complex and multiple service needs.

Case management co-ordinates individual client care and aims to improve service access and provision. This includes collaboration between those working primarily with adults who are parents and those working with children, young people, or the whole family.

Case management within Health services and between inter-agency partners should aim to maximise communication between the professionals and agencies involved in the care of the child, young person or family and minimise duplication or omission of services.

In the context of child protection, case management is seen as an inter- and intra-agency process. Community Services retains case management where there is risk of significant harm and there is an open and active child protection case with Community Services. Where appropriate to their role, Health workers should attend case meetings to discuss the safety, welfare and wellbeing of a child or young person when requested by Community Services.

Where the concerns are below ROSH, the services or agencies involved should negotiate a key person working with the child, young person or family, such as a Health worker, to provide case management.

Health workers should be aware that clients may move between levels of risk during the time they are working with the client. Case management plans will require adjustment in response to the needs of the client.

Case management is an interactive and dynamic process, and includes ongoing analysis, decision-making and record keeping. Health workers should ensure that the case management process remains child centred and family focussed and that the family has the capacity to participate in the services provided.

Further information: *Child Wellbeing & Child Protection – NSW Interagency Guidelines*
http://www.keepthemsafe.nsw.gov.au/reporting_concerns/interagency_guidelines

12.3.1 Case Management Responsibilities

Health workers may be asked to participate in case management meetings with Community Services, other Health services or agencies. Health workers may also fulfil a case management role for a child, young person, family member/carer and/or for a family.

Health workers' case management role may include to:

- communicate with inter- and intra-agency partners, keeping involved agencies informed of progress;
- call and convene case meetings and ensure that meetings are documented and minutes are distributed as appropriate;
- document, monitor and review case plans;
- co-ordinate the participation of children, young people and their families in the case management process where appropriate;
- receive relevant feedback from other agencies on the progress of the child, young person and family;
- inform relevant agencies, children, young people and families of changes of case manager, and, as appropriate, of a plan for case closure.

12.3.2 Case Management Where There is Risk of Significant Harm

Community Services, as lead agency in child protection cases, may involve Health workers in interagency case coordination and discussion where services offered by the public health system may be required.

When continuing to provide services to the child, young person and/or family/carer, Health workers are to consider not only the services that they are able to provide, but also any other supports or services that may be appropriate to offer to the child, young person or family. Health workers should communicate these recommendations with Community Services as the lead agency. Health workers should utilise all areas of consultation and support available, for example the Child Wellbeing Unit, Child Protection Co-ordinators and trainers and the Family Referral Services in selecting appropriate services for children and young people at risk of significant harm.

The safety, welfare and wellbeing of the child or young person is of paramount consideration. Health workers should be aware that the level of risk may vary during the time they are involved with a client, and that further reports to the Child Protection Helpline or changes in service needs or delivery may be required.

12.3.3 Case Management Where the Current Concerns are Below Community Services Risk of Significant Harm but There are Risks to the Family Identified by the Health Worker

Where reports to the Child Protection Helpline are not accepted as risk of significant harm by Community Services, but where the Health worker identifies that concerns are still current, Health workers may:

- consult with the Health Child Wellbeing Unit for further support and referral resources;
- request the Health Child Wellbeing Unit seek a review of the matter; or
- request that the CWU Manager or Local Health District child protection co-ordinator apply to the Child Protection Helpline to review the decision using the Request to Review Screening Decision form.

Health workers should continue current service provision with the child, young person or family/carer and consider any additional support or referrals that may be appropriate. This may include a referral to a Family Referral Service.

12.3.4 Case Management Below the Statutory Threshold for Risk of Significant Harm

Where a matter is assessed as below risk of significant harm (ROSH), or where concerns have been sufficiently resolved, and other agencies continue to provide services to a family, any agency can negotiate to assume the role of case manager. Where necessary, information can be exchanged between agencies under the provisions of Chapter 16A as part of the case management process.

12.4 Out-Of-Home-Care

Responsibility for case management for children or young people who are under a care Order and/or living in out-of-home care (OOHC) can be with Community Services or a designated agency; or can be a joint responsibility between agencies.

12.4.1 Health Screening Assessments Intervention and Review

NSW Health provides primary health and, where required, comprehensive health assessments, reviews and interventions for children and young people in statutory out-of-home-care (OOHC) in accordance with the *Memorandum of Understanding between Department of Family and Community Services, Community Services Division and NSW Health on Health Screening Assessment, Intervention and Review for Children and Young People in Statutory OOHC*.

The assessments, reviews and interventions are provided for children and young people entering statutory OOHC who are expected to remain for 90 days or more and for children and young people already in care in some circumstances. Health assessment services are co-ordinated by OOHC Co-ordinators in Local Health Districts. Case management for children and young people remains with Community Services or a designated agency.

OOHC Co-ordinators are available for each Local Health District and Specialty Network. Contact details are available from:
http://www.health.nsw.gov.au/initiatives/kts/contact.asp

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SECTION 13

Documentation

13.1 Introduction

A Health record is a documented account, whether in hard or electronic form, of a clients/patient's health, illness and treatment during each visit or stay at a health service (and includes a medical record).

Health records must be kept confidential, current, complete and readily available for patient care. All documentation should be in line with NSW Health PD2012_069 *NSW Health Care Records - Documentation and Management*. http://www0.health.nsw.gov.au/policies/pd/2012/pdf/PD2012_069.pdf

Health records can be used as evidence in court.

Documentation requirements have been written throughout these Policies and Procedures and are summarised in this chapter.

13.2 Child Protection Reports

A report made to the Child Protection Helpline must be documented in the health record of the child, young person or adult client who is a parent / carer. Documentation should include:

- the date and time the report was made;
- the name of the caseworker spoken to at the Child Protection Helpline;
- the nature of concerns reported;
- how the report was made, for example by phone, e-Report or fax;
- the Child Protection Helpline Contact Reference Number (CRN) allocated by the Child Protection Helpline; and
- the feedback letter from the Child Protection Helpline/ Community Services.

Documentation can be in the form of:

- a print-out of the summary page or the decision report from the online Mandatory Reporter Guide;
- A printout of the full eReport;
- a faxed report and any fax confirmation sheets generated by faxing the report;
- Information written within the clinical notes of the client health record in accordance with the direction below.

The Community Services feedback letter which will be sent to mandatory reporters should also be placed on the Health record by the mandatory reporter who made the report or anyone else who has received the feedback letter by prior arrangement with the reporter who has given consent for this.

13.3 Child Wellbeing Concerns

Health workers should document all child wellbeing concerns in the client health record. This includes all information relating to child wellbeing and protection concerns that have not been reported to the Child Protection Helpline due to the concerns not meeting the risk of significant harm statutory threshold.

In considering child wellbeing concerns Health workers may have consulted a number of sources including:

- the MRG;
- Health Child Wellbeing Unit;
- Manager;
- LHD Child Wellbeing Co-ordinators;
- LHD Child Protection Services;
- LHD Sexual Assault Services; and
- Other workers (prescribed bodies) involved with the family through Chapter 16A information exchange provisions in the NSW *Children and Young Persons (Care and Protection) Act 1998*.

This contact should be documented in the client health record.

Health workers are also required to document the action they have taken to identify and respond to child wellbeing concerns. Documentation should include:

- the identified risk factors for the child or young person;
- the identified preventative factors that mitigate against risk;
- whether the CWU or another service was contacted;
- the date and time the contact was made;
- the name of the worker spoken to at the CWU or other service;
- the nature of concerns reported;
- any reference number given by the CWU;
- the response of the worker spoken to;
- the outcomes from this discussion; and
- any future actions required i.e. referrals.

Where a report was also made, Health workers should also document in accordance with Section 9.2.8, Recording of Reports to the Helpline, of this document.

13.4 Prenatal Reports

A prenatal report is to be documented in the health record of a pregnant woman. Further information on prenatal reporting requirements see Section 9.8, Prenatal Reporting, of this document.

13.5 Requests for Written Reports

Health workers who receive a request for a written report from Community Services or a court, must document in the client health record the source of the request and the means of receiving the request, and place the original request in the client health record. A copy of any report given to Community Services or to the court must also be placed in the client health record.

Additional information about the procedures for providing information requested under Chapter 16A or section 248 of the *Care Act* may be found in Section 2 of this document.

If a written report is provided as a result of a section 173 medical examination order, the names of the children to be examined, and any reasons given by the parents for refusing to consent to a medical examination which caused the s173 to be issued. NSW Health does not charge for providing reports requested by Community Services.

13.6 Section 248 and Chapter 16A Exchange of Information Requests

Health workers must record any information exchange made under Chapter 16A or section 248 in the client health record. This should include:

- any information requested by another agency;
- any information requested by Health; and
- the information that Health has exchanged.

Chapter 16A requests can be made verbally or in writing depending on the clinical circumstance.

When the exchange is requested or responded to verbally details of the request and the response must be documented in the client health record. When a form is used to exchange information, a copy must be stored on the client health record to ensure it is traceable and reviewable if required.

Under Chapter 16A if a Health service declines to provide information to a requesting agency, after approval and counter signature by a senior manager, the Health service must notify the requesting agency in writing of the refusal and the reasons for the refusal on the form letter *Response to Chapter 16A Request–decline* at Appendix 6 or at http://www0.health.nsw.gov.au/resources/nswkids/pdf/form_declining_chapter_16.pdf

A copy of the letter should be kept on the client health record.

13.7 Information Sharing Using Chapter 16A and Section 248 of the *Care Act*

Health workers must record any information exchange made under Chapter 16A in the Client Health Record. This should include:

- information requested by another prescribed agency;
- information requested by Health from another prescribed agency; and
- information that Health has exchanged.

When a verbal request or response is made the details must be documented in the Client Health Record.

Chapter 16A and section 248 information exchange forms are available on the NSW Kids and Families website. These forms have been adapted for use by Health staff and are accessible at http://www0.health.nsw.gov.au/nswkids/links.asp or see Appendices 3-6 in this document.

NSW Health workers are to use the forms contained on the NSW Kids and Families website. The common forms for interagency use on which the Health forms are based are also provided within the *Child Wellbeing and Child Protection – NSW Interagency Guidelines* located on the Department of Family and Community Services website at: http://www.community.nsw.gov.au/kts/guidelines/info_exchange/info_index.htm.

- Response to Chapter 16A request – Agree http://www0.health.nsw.gov.au/resources/nswkids/pdf/form_agree_ch_16a_requ_le.pdf
- Response to Chapter 16A request – decline http://www0.health.nsw.gov.au/resources/nswkids/pdf/form_declining_chapter_16.pdf

A standardised form is also available to make a Chapter 16A request to another prescribed body.

- Letter of request for information (Chapter 16A) http://www0.health.nsw.gov.au/resources/nswkids/pdf/form_requ_info_ch_16a_let.pdf

When used, a copy of these information exchange forms must be stored on the client health record to ensure they are traceable and reviewable if required.

Health services are encouraged to establish local processes for the recording and filing of information exchanged. Copies of written requests to the Local Health District / Speciality Network

Central Contact Points in Local Health Districts / Speciality Networks are to collate and store written requests for information. Local Health Districts / Specialty Networks are to ensure compliance with information exchange processes through regular documented file audit processes.

13.8 Contact with the Health Child Wellbeing Unit

Contact with a Health Child Wellbeing Unit to report or discuss any level of child wellbeing or child protection concern must be documented in the client Health record. Documentation is to be:

- written within the clinical notes of the client health record as a separate entry;
- placed when completed in an Alerts section on the client health record, if available.

The Health Child Wellbeing Unit will document the contact on the WellNet database.

The relevant policies seem to be: PD 2005_127 and Patient Matters Manual at http://www.health.nsw.gov.au/resources/policies/manuals/pdf/pmm_9.pdf

13.9 Access to Health Records by Children, Young People and their Families

The Health Records and Information Privacy Act 2002 stipulates that an organisation that holds health information must, at the request of the individual to whom the information relates and without excessive delay or expense, provide the individual with access to the information. Access to health information held by public sector agencies may also be available under the *Government Information (Public Access) Act 2009* (GIPA) or the *State Records Act 1998*.

An important lawful exception to the requirement to provide access to client health records, relates to the protection of reporter identity under section 29 of the *Children and Young Persons (Care and Protection) Act 1998*.

The protection of reporter's identity under section 29 must be considered by Local Health Districts / Specialty Networks when responding to requests for public access to government information including client health records. It is prohibited under this section to disclose the reporter's identity without their consent as well as any information from which the reporter's identity might be deduced. Health workers should be aware that information pertaining to a report or the identity of a reporter may be contained within any adult or child health record.

13.10 Medical Documentation of Physical and Emotional Abuse and Neglect of Children and Young People

As core business for NSW Health, medical practitioners and staff provide acute and non-acute medical assessment and treatment for children and young people where physical and emotional abuse and/or neglect is suspected or has occurred. In accordance with NSW Health Policies and procedures, Health workers undertaking medical assessment must make sure that all information is accurately recorded in the client health record including:

- time of presentation;
- languages spoken and need for interpreter;
- physical injury, size, colour, shape of markings, type etc – use body maps;

- history given by child in the course of a medical examination;
- clinical observations and whether these are consistent with the history given by the child and family;
- social, emotional, developmental and nutritional assessment of child and family;
- all treatment given, for example drugs prescribed, referral for x-ray, admission and reason, blood tests; and
- growth percentiles.

Further information on the provision and documentation of medical assessment and treatment can be found in Section 9.10 of this document.

13.11 Child Sexual Assault

Health workers need to ensure that all relevant medical information about child sexual assault is recorded on the *Child Sexual Assault Medical Protocol* by appropriate medical practitioners and in the client health record and clinical notes by other staff members.

The *Child Sexual Assault Medical Protocol* is used for children up to 14 years old. The *Adult Sexual Assault Medical Protocol* is used for young people aged 14 ayears and over.

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APPENDIX 1

Definitions

This section is set out as follows:

A. Terminology related to defining risk of significant harm; and
B. Other commonly found terms in this document (listed in alphabetical order).

A. Risk of Significant Harm

Legal Definition Section 23 of the *Care Act:*

1. For the purposes of this Part and Part 3, a child or young person is 'at risk of significant harm' if current concerns exist for the safety, welfare or well-being of the child or young person because of the presence, to a significant extent, of any one or more of the following circumstances:
   (a) the child's or young person's basic physical or psychological needs are not being met or are at risk of not being met,
   (b) the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care,
   (b1) in the case of a child or young person who is required to attend school in accordance with the *Education Act 1990* – the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive an education in accordance with that Act,
   (c) the child or young person has been, or is at risk of being, physically or sexually abused or ill-treated,
   (d) the child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm,
   (e) a parent or other caregiver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm,
   (f) the child was the subject of a pre-natal report under section 25 and the birth mother of the child did not engage successfully with support services to eliminate, or minimise to the lowest level reasonably practical, the risk factors that gave rise to the report.

Note: Physical or sexual abuse may include an assault and can exist despite the fact that consent has been given.

2. Any such circumstances may relate to a single act or omission or to a series of acts or omissions.

Policy Definitions

Risk of Significant Harm (ROSH) The likelihood that a child or young person may suffer physical, psychological or emotional harm as a result of what is done (physical, sexual or emotional abuse) or not done (neglect) to the child or young person by another person, often an adult responsible for their care.

Risk of significant harm can also refer to young people who may suffer physical, psychological, sexual or emotional harm as a result of environmental factors (for example homelessness) or self-harming behaviours.

'Current Concerns': Significant harm arising from abuse or neglect is recent or likely in the foreseeable future should circumstances continue unchanged. Current concerns may also arise from a child or young person having contact with someone who is known to be responsible for causing harm to a child in the past. The abuse or neglect of the child or young person may also have occurred some time in the past but continue to have an impact on the child or young person's safety, welfare or wellbeing.

'Significant' as in Significant Harm: A child or young person is at risk of significant harm if the circumstances that are causing concern for the safety, welfare or well-being of the child or young person are present to a significant extent.

What is meant by 'significant' in the phrase 'to a significant extent' is that which is sufficiently serious to warrant a response by a statutory authority irrespective of a family's consent.

What is significant is not minor or trivial and may reasonably be expected to produce a substantial and demonstrably adverse impact on the child or young person's safety, welfare or wellbeing.

In the case of an unborn child, what is significant is not minor or trivial and may reasonably be expected to produce a substantial and demonstrably adverse impact on the child after the child's birth.

Significance can result from a single act or omission or an accumulation of these.

Neglect (section 23 (1) a) – the failure to provide the basic physical and emotional necessities of life. Neglect may be an ongoing situation.

Neglect of basic physical needs section 23 (1) a) – Occurs when a parent or caregiver fails to provide the basic staples of life to an adequate degree. These include food, physical support and hygiene. It also includes safety from harm which may include providing appropriate and adequate adult supervision.

Neglect of basic psychological needs section 23 (1) a) – Occurs when a child or young person does not receive sufficient or appropriate interaction, encouragement, nurturing or stimulation from their parent or caregiver. Neglect also refers to the persistent ignoring of a child's signals of distress such as pleas for help, attention, comfort, reassurance, encouragement and acceptance. In young people this may include disinterest in all aspects of a young person's life by the parent or caregiver.

Neglect of medical care (section 23 (1) b) **–** occurs when the parents or caregivers have not arranged and are unable or unwilling to arrange for a child or young person to receive necessary medical or dental care or they may have attended a clinical practice or hospital initially but have then failed to comply with necessary treatment provided insufficient care or inappropriate care in response to the condition or disability, or attend follow up appointments which is likely to have an adverse effect on the child or young person's health.

Educational Neglect section 23 (1) b1) **–** occurs when the parents or caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive an education in accordance with Part 5 Section 22B of the *Education Act 1990*. Under amendments to the minimum leaving school age which commenced in January 2010, that Act includes a requirement for children and young people in this State to be engaged in school, training or work until 17 years of age.

Physical abuse or ill-treatment section 23 (1) c) – Physical abuse or ill-treatment is assault, non-accidental injury or physical harm to a child or young person by a parent, caregiver, other person responsible for the child or young person, or a sibling or other child or young person in the household. It includes injuries or harm which are caused by excessive discipline, beating or shaking, bruising, lacerations or welts, burns, fractures or dislocation, female genital mutilation, attempted suffocation or strangulation. All of these may result in the death of a child or young person.

Physical abuse may constitute criminal assault. The circumstances of the victim, including the vulnerability of the child or young person, and the likelihood of them sustaining a serious or permanent injury, means that assault charges may be warranted in cases of physical abuse.

Physical abuse includes female genital mutilation.

Sexual abuse or ill treatment section 23 (1) c) – Sexual abuse or ill-treatment may cover a range of activities against a child or young person, such as sexual acts against a child or young person by a family member or other adult and the use of threats or coercion to gain a young person's cooperation to participate in sexual acts. Adults, adolescents or older children who sexually abuse children or young people exploit their dependency and immaturity.

Coercion, which may be physical or psychological, threats and force is intrinsic to child sexual assault and differentiates it from consensual sex with a peer. Generally, sexual activity by consenting teenagers with peers within a 2 year chronological age difference will not constitute sexual abuse or ill-treatment.

However careful consideration is necessary because although a child or young person may perceive sexual activity as consensual because of the way the other person involved has promoted it, the situation may be one of sexual abuse and exploitation. The apparent consent of a child or young person does not necessarily mean that abuse did not occur.

Domestic violence section 23 (1) d) – violent, abusive or intimidating behaviour carried out by an adult against a partner or former partner to control and dominate that person. Domestic violence includes violence in same sex relationships.

Domestic violence causes fear, physical and/or psychological harm. It is most often violent, abusive or intimidating behaviour by a man against a woman. Short term or longer term exposure to domestic violence has a profound effect upon children including very young children and young people and may constitute a form of child abuse.

Domestic violence includes physical abuse; sexual abuse; psychological, emotional and verbal abuse; social abuse; economic abuse; and harassment and stalking. These various forms of abuse often occur simultaneously as a form of systematic abuse with the effect of coercing and controlling a partner.

Many forms of domestic violence are offences under the *NSW Crimes Act 1900*. A domestic violence offence is a personal violence offence committed by a person against another person with whom the person has or has had a 'domestic relationship'.

Source: The *NSW Health Policy and Procedures for Identifying and Responding to Domestic Violence*. http://www0.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_084.pdf

Domestic relationship – Section 5 of the *NSW Crimes (Domestic and family Violence) Act 2007*

A person has a 'domestic relationship' with another person if the person:

(a) is or has been married to the other person, or
(b) is or has been a de facto partner of that other person, or
(c) has or has had an intimate personal relationship with the other person, whether or not the intimate relationship involves or has involved a relationship of a sexual nature, or
(d) is living or has lived in the same household as the other person, or
(e) is living or has lived as a long-term resident in the same residential facility as the other person and at the same time as the other person (not being a facility that is a correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999* or a detention centre within the meaning of the *Children (Detention Centres) Act 1987*), or
(f) has or has had a relationship involving his or her dependence on the ongoing paid or unpaid care of the other person, or
(g) is or has been a relative of the other person, or
(h) in the case of an Aboriginal person or a Torres Strait Islander, is or has been part of the extended family or kin of the other person according to the Indigenous kinship system of the person's culture.

Psychological harm section 23 (1) e) – damage to the emotional or intellectual development of a child (Section 227 of the *Children and Young Peoples (Care and Protection) Act* 1998.

Psychological harm is behaviour by a parent, caregiver, older child or other person that damages the confidence and self-esteem of a child or young person resulting in serious emotional deprivation or trauma. Psychological harm is also experienced by a child or young person when living in a situation of domestic violence.

Serious psychological harm should be assumed in the presence of any of the following factors:

- the repetition or an escalation in frequency or severity of violence in the household;
- whether a child or young person has been physically harmed;
- if the victim has required medical attention as a result of the violence;
- where weapons have been used;
- apprehended violence orders have been issued and/or breached; and
- threats to take or harm children.

Serious psychological harm may also arise in circumstances where:

- the parent or caregiver is unable to protect the safety, welfare and well-being of the child or young person due to the level of victimisation;
- domestic violence exists with one or more factors such as the hazardous use of alcohol or other drugs; and
- there are other factors that may increase the vulnerability of the child or young person such as the presence of a mental health problem or a disability.

Prenatal report section 23 (1) f) A report made to the Child Protection Helpline under section 25 of t*he Care Act* by a person who has reasonable grounds to suspect, before the birth of a child, that the child may be at risk of significant harm after his or her birth.

B. Other Commonly Used Terms

NSW *Children and Young Persons (Care and Protection) Act 1998* – the key legislative framework for the safety, welfare and wellbeing of children and young people. Referred to in this document as the *Care Act*.

Aboriginal Family Violence – Aboriginal family violence describes all forms of violence (including physical, emotional, sexual, sociological, economic and spiritual) in intimate, family and other relationships of mutual obligation and support (*Aboriginal Child Sexual Assault Taskforce 2006*). In Aboriginal communities family violence encapsulates the extended nature of Aboriginal families and takes account of the diversity and complexity of kinship ties in Aboriginal communities. It recognises that Aboriginal family violence impacts on a wide range of kin and community members.

Adolescent – a person between the ages of 13 and 18 years of age.

'Best endeavours' means to exercise a genuine and considered effort to respond to a request under S17 of the *Children and Young Persons (Care and Protection) Act 1998* for service to promote and safeguard the safety, welfare and wellbeing of a child or young person.

Care Responsibility – Authority to exercise the functions specified in section 157 of the *Care Act.*

Carer – A person who:

- has responsibility for a child or young person at any time; or
- is responsible for attending to the needs of a child or young person

Case Management – A direct client service in which Health workers, agencies and families collaborate in comprehensive assessment, individual and family care planning, service facilitation and implementation, outcome monitoring and advocacy.

Child – a person who is under the age of 16 years, as per section 3 of the *Care Act*. This includes a newborn child.

Health workers should be aware that under other NSW legislation, a child is defined differently:

The *NSW Crimes Act 1900* alters classification of the age range of a child in different sections of the Act.

The *NSW Commission for Children and Young People Act 1998* and the *NSW Ombudsman Act 1974* define children as persons under 18 years. There is no distinction between the responsibilities to a person under 16 years and a person under 18 years in relation to employee conduct.

Child abuse – a term commonly used to refer to different types of maltreatment inflicted on a child or young person. It includes physical harm, assault (including sexual assault), ill treatment and exposing the child or young person to behaviour that might cause psychological harm. Child abuse is an offence under Section 227 of the *Children and Young Persons (Care and Protection) Act 1998*.

Child Health Networks (CHN) – indicates the three existing geographically defined networks in NSW that have been developed for the provision of paediatric and child Health Services utilising the expertise of clinicians throughout the Network. The CHNs endeavour to provide the highest quality care services in the most appropriate locations. The networks include: Western CHN, Northern CHN and Greater Eastern & Southern CHN.

Child Protection Helpline – operated by Community Services providing a 24 hour 7 days per week telephone service for reporting children and young people suspected to be at being of risk of significant harm (previously known as the DoCS Helpline).

Child Wellbeing Unit (CWU) – agency service set up to support staff in NSW Health, the Department of Education and Communities, NSW Police Force and the Department of Family and Community Services (Juvenile Justice, Housing and Ageing, Disability and Home Care) with alternate reporting arrangements under section 27A of the *Care Act.* A CWU operates in each of the four agencies. All the CWUs share a common database.

Community Services, (CS) – a division of the Department of Family and Community Services, Community Services is the NSW statutory child protection service.

Class of children or young people – more than one child or young person who may be at risk of significant harm from abuse because of a person or situation. An example may be the children in a school or recreational group where a person in charge is suspected of abuse or known to have abused a child**.**

Emotional Abuse – See Psychological Harm

Female Genital Mutilation – Female genital mutilation is a crime under the NSW *Crimes Act 1900*. The NSW *Crimes (Female Genital Mutilation) Act 1995* states that anyone who is found guilty of practising female genital mutilation or who aids, abets, counsels or procures someone else to practise female genital mutilation on another person is liable to a prison sentence of up to seven years. It is also illegal for female genital mutilation to be carried out overseas on any person who is normally a resident in New South Wales.

Health Premises – Any public hospital or non-inpatient public health facility in NSW such as Accident and Emergency Departments, Mental Health Centres and Community Health Centres.

Health Service – (as defined in the *Health Services Act 1997*) means any of the following:

- any hospital service,
- any medical service,
- any paramedical service,
- any community health service,
- any environmental health service,

- the supply or fitting of any prosthesis or therapeutic device,
- any other service (including any service of a class or description prescribed by the regulations) relating to the maintenance or improvement of the health, or the restoration to health, of persons or the prevention of disease in or injury to persons.

Health Service Manager – In the context of this document the term Health Service Manager applies to an authorised officer in accordance with the *Health Services Act 1997*

Health worker/staff – includes all staff of the NSW public health system: those employed or engaged by Local Health Districts, Speciality Network Governed Statutory Health Corporations, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Affiliated Health Organisations (Declared and Undeclared), Public Health System Support Division, Community Health Centres, Dental Schools and Clinics, NSW Ambulance Service, Ministry of Health, Public Health Units, Public Hospitals regardless of the position held.

Impaired cognitive functioning – In the context of this document impaired cognitive functioning is any condition which impairs an individual's cognitive capacity irrespective of the cause or duration of that condition (for example intellectual disability, under the influence of a substance, brain injury, mental health episode or disorder, and others).

Mandatory reporter – a person who, in the course of his or her professional work or other paid employment delivers health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly, to children. This also includes managers of these services. NSW Health policy directs Health workers to report children, young people and unborn babies at risk of significant harm to the Child Protection Helpline or where appropriate to the Health Child Wellbeing Unit.

Mandatory Reporter Guide (MRG) – a Structured Decision-Making® tool developed by a wide range of NSW interagency partners, in conjunction with the US-based Children's Research Center. It helps gauge suspected risk of significant harm and guides mandatory reporters to report to the Child Protection Helpline, or indicates whether other actions are appropriate'. The MRG can be used online at: http://sdm.community.nsw.gov.au/mrg/

NSW Health – means public health organisations, the Ministry of Health, the Ambulance Service of NSW, and all other organisations under the control and direction of the Minister for Health or the Director-General of Health.

Parent – a person who has parental responsibility for a child or young person.

Parental Responsibility – all duties, powers, responsibilities and authority that parents have by law in relation to their children.

Peer – individuals who are aged within two chronological years of each other.

Person in Charge of NSW Health Premises – The person designated by the Local Health District or Speciality Network to be in charge of a Health service, or their delegate.

People with disability – The term, people with disability, as used in this document, refers to people who face social, architectural, environmental and/or attitudinal barriers restricting their full participation in society due to the impairments covered by the Commonwealth *Disability Discrimination Act 1992* (DDA).

Prenatal/Unborn child – Prenatal/unborn in the context of this policy refers to the period between conception and the birth of a baby. The term antenatal is also used with the same meaning.

Public Health Organisation and Public Health System – For the purpose of these policies and procedures the terms are used in accordance with section 7 of the Health Services Act (1997). Under this Act, Local Health Districts, Specialty Networks and affiliated health organisations in respect of its recognised establishments and recognised services (such as Tresillian and other 3rd schedule establishments) are called 'Public Health Organisations' (PHOs). All Public Health Organisations have a responsibility to ensure implementation of this Policies and Procedures within their area of responsibility.

Statutory reporting threshold – Risk of Significant Harm is the legislative threshold for child protection reporting in NSW.

The *Care Act- NSW Children and Young Persons (Care and Protection) Act 1998* – the key legislative framework for the safety, welfare and wellbeing of children and young people.

Wellbeing – 'Wellbeing' describes the quality of childhoods as they are lived. Wellbeing draws in the many different factors which affect children's lives: including material conditions; housing and neighbourhoods; how children feel and do at school; their health; exposure to dangerous risks; and the quality of family and classmate relationships children develop'.
Source: Child Poverty Action Group 2009.

The vulnerabilities of a family that could impact on the 'wellbeing' of a child include but are not limited to:

- parental mental health issues
- parental substance issues
- domestic violence
- economic disadvantage
- social isolation
- child developmental and behavioural issues
- poor parent-child interaction
- homelessness
- disability
- low parental education levels
- stressful life events
- parental unemployment
- sudden or chronic illness
- refugee or newly arrived families.

When identified and appropriately supported, these vulnerabilities can be addressed to reduce risk and prevent escalation into abuse and neglect.

A focus on child wellbeing acknowledges the possibility of reducing risk by increasing protective factors. Factors that may help reduce risk and provide protection include nurturing, affectionate and securely attached relationships with at least one parent or another adult, building resilience and capacity in vulnerable children and young people, positive school environments, pro-social peer groups, and positive personal achievements.

WellNet database – the database used by CWUs to record concerns about children and young people.

Young person – a person who is aged 16 years or above but who is under the age of 18 years, as per section 3 of the *Care Act*.

APPENDIX 2

Primary, Secondary and Tertiary NSW Health Services and Programs Relevant to Child Health, Wellbeing and Protection

Health services are provided at primary (universal), secondary (targeted) and tertiary (specialist) levels according to a model of care for promoting child wellbeing and protection that has the following elements:

- Prevention and early intervention services for children, young people, families and victims of violence;
- Responding to the immediate and long-term needs of children and young people at risk of significant harm.
- Specialist services which provide therapeutic interventions responding to and addressing the effects of violence, abuse and neglect when it has occurred.

PRIMARY – Universal Health Programs and Services

Universal services are those which are available to the whole community. The focus of these services is to enhance the health, welfare and wellbeing of children, young people and their families. Services have a role in the identification, early intervention and prevention of abuse of children and young people.

Universal maternity and child health services offer support to families at the early stage of the parent-child relationship. This universal platform of care, delivered by Health professionals whose roles are viewed by families as acceptable and non-stigmatising, facilitates the engagement of families into targeted services where needed.

Maternity Services

Maternity services are provided in more than 80 maternity units in public hospitals across NSW. These services assist with the majority of births in NSW. A range of services are offered to pregnant women including antenatal care, Early Pregnancy Assessment Services for those women experiencing problems in early pregnancy, birthing services, homebirth and post natal care. Services are offered through a variety of models of care, including continuity of care and more specialised care for those women identified as moderate or high risk. Information is also freely available to pregnant women, for example the *'Having a Baby'* book is available free of charge to women booking in to a public facility, *'Thinking of Having a Baby'* is a pamphlet available to women from a number of outlets, including GP surgeries and pharmacies.

Aboriginal Maternal and Infant Health Service (AMIHS)

The Aboriginal Maternal and Infant Health Service was established in 2001 to improve the health of Aboriginal women during pregnancy and decrease perinatal morbidity and mortality for Aboriginal babies. The Service is delivered through a continuity-of-care model, where midwives and Aboriginal Health Workers collaborate to provide a high quality maternity service that is culturally sensitive, women centred, based on primary health-care principles and provided in partnership with Aboriginal people. An evaluation of the Service found that the program is achieving its goals in relation to the provision of antenatal and postnatal care and has demonstrated improvements in perinatal morbidity and mortality rates.

AMIHS is a culturally appropriate maternity service; its philosophy is based on cultural respect, social justice, participation, equality, access, learning and collaboration. The guiding principles that make the Service unique include taking a broad social view of health, forming effective partnerships with Aboriginal communities, working within a primary health-care framework and providing women-centred care.

AMIHS midwives and Aboriginal Health Workers provide antenatal and postnatal care, from as early as possible after conception up to 8 weeks postpartum. The care is provided in the community but is linked into mainstream maternity services to ensure that risk management and education are available to AMIHS teams.

Statewide Infant Screening – Hearing Program (SWISH)

NSW Health provides universal newborn hearing screening in NSW with the Statewide Infant Screening-Hearing Program (SWISH). Under this initiative all babies across NSW are offered a hearing test within the first few days of being born. This enables the early identification of newborns with significant bilateral hearing impairment and the opportunity for early treatment. Since the beginning of the program, over 45,000 babies have been screened across NSW.

Universal Health Home Visiting

Universal Home Visiting
http://www.health.nsw.gov.au/publichealth/surveys/hsc/0506/toc/4_serv_07_homevisiting.asp

Within the context of NSW Health's child and family health service system, includes the offer and provision of at least one universal contact in the family's home within two weeks of birth by a child and family health nurse. The aim of UHHV is to engage all families with newborns and to provide support to parents with young children. The UHHV is based on universality of access, assessment and intervention in the context of the family's own environment and the development of partnerships.

Parent education and support are significant components of the universal early childhood Health Services. Early Childhood Health Centres are staffed by registered nurses usually with specialised qualifications and experience in child and family health nursing. They work in multidisciplinary teams to identify developmental and health issues, provide early intervention when concerns are found and support vulnerable families to engage in the wider Families NSW network of care.

Families First
http://www.health.nsw.gov.au/PublicHealth/mch/family_first.asp

This is a whole-of-Government initiative involving the five human service agencies of Health, Family and Community Services, Education and Training, Ageing Disability and Home Care, and Housing.

Early Childhood Health Service

A range of early childhood health services are provided to children in the 0-5 year age group and their families including: advice and information on a wide range of parenting and child health matters; assessment of growth and developmental progress of children; support to parents and families to provide a warm and nurturing environment for their child; dealing with behaviour and developmental issues; early identification of child abuse and post natal depression; health promotion including child safety; parenting groups and referral to community and specialised services. Services are offered on a one to one basis either drop-in or appointment, in group situations, by home visiting or by telephone.

Building Strong Foundations for Aboriginal Children Families and Communities

Provides early childhood Health Services in Taree, Tamworth, Newcastle; Gosford including Bateau Bay, Long Jetty and The Entrance; Penrith/Cranebrook; Menai and Nowra.

These services have strong links to Aboriginal mothers and babies programs such as AMIHS and the Commonwealth funded program *New Directions for Mothers and Babies* as well as to mainstream maternity and child and family Health Services. The programs have been implemented after significant consultation with Aboriginal families and stakeholders.

Statewide Eyesight Preschooler Screening (StEPS program)

A population based free vision screening program for all four year old children in NSW. The StEPS program builds on regular eye health surveillance checks as recommended in the Personal Health Record and is designed to identify childhood vision problems early so that treatment outcomes can be optimised.

Child and family health multidisciplinary teams

Based in community health centres, these teams provide assessment and management of children and families referred for a range of developmental, emotional, behavioural and family relationship problems. Parents may be provided with information, support and counselling to assist with the management of their children. These teams may also provide a range of early intervention and health promotion programs for children, families and the community. Partnerships are established with other departments and agencies for the assessment and care of children and for developing and conducting programs are important aspects of child and family teams in community health.

A range of professionals contribute to the child and family multidisciplinary teams and may include nurses, social workers, psychologists, speech pathologists, physiotherapists, occupational therapists, audiometrists, medical officers, paediatricians and psychiatrists.

Through the Supporting Families Early initiative and the implementation of SAFE START, child and family health nurses are in a good position to identify mothers who may be at risk or who are suffering from post-natal depression or domestic violence which may put their children at risk of harm from abuse or neglect.

Specialist Children's Hospitals

The majority of hospitals in the NSW Health system have a children's ward catering for their local population. There are NSW Health guidelines for care of children and adolescents in acute care settings.
http://www.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_034.pdf

There are three tertiary level children's hospitals in NSW. Two are in the Sydney Children's Hospitals Network (The Children's Hospital at Westmead and the Sydney Children's Hospital Randwick). The third is the John Hunter Children's Hospital, Newcastle.

A range of services are provided by the specialist children's hospitals including: emergency services, specialised inpatient, ambulatory care and rehabilitation services for children with acute illness, chronic illness and disability; and services to support parents caring for chronically ill and hospitalised children such as the provision of accommodation for parents to enable them to remain with their child while in hospital, care by parent units, education and information services for parents.

The specialist Children's Hospitals also provide tertiary child protection services through a Child Protection Unit located in each Hospital.

Education and Support Initiatives for Parents

In addition to the preceding network of services there are a number of other initiatives developed by NSW Health which provide information, education and support to parents with children. These include:

- All parents are provided with a copy of the Personal Health Record by maternity units following the birth of a baby. This Personal Health Record contains parenting information and is a record of the child's major health events. In addition to being an important health record, it is significant because it acknowledges that parents are the main providers of health care for children, and the best observers of their child's development.
- 24 hour Parent Help Lines, provided by Tresillian and Karitane, offering practical parenting advice and support on a wide range of issues concerning babies and children and referral to appropriate community services Toll free numbers are available for country parents.
- Child Health Information Services have extensive collections of resource material on all aspects of child health and are located at the Children's Hospital Westmead and Sydney Children's Hospital. There are parent information sheets and other information available from www.chw.edu.au

General Practice

NSW Health aims to enhance the provision of primary health care for the whole community including families through the promotion of more effective partnerships and integration between community health services and general practice, hospitals, NGOs, other private health service providers, other NSW Government services and local government. The aim is to ensure local/regionally responsive primary health care services that identify, prioritise and meet the health care needs of local communities. Child and family health services are a core component of this approach.

The Commonwealth Government's commissioning of primary health care organisations – Medicare Locals – complements the strategy of local governance for health services and further encourages participation and ownership by local communities. The delivery of integrated patient care increasingly requires effective linkages of Local Health Districts / Specialty Networks with Medicare Locals and other local healthcare providers.

Health Care interpreters

Health Care interpreters are available and many centres arrange specific clinics for women from nonEnglish speaking backgrounds. There are some specific services provided for Aboriginal communities staffed by Aboriginal Health workers.

Drug and Alcohol treatment services

Provide treatment and /or withdrawal programs for people who have drug and alcohol dependency. Programs are offered in residential settings or day clinics, and include substitution treatment via a range of pharmacotherapies, withdrawal management, psycho-social counselling, case management etc. Services are provided in the public and private sector non-government organisations funded services, some general practitioners and community pharmacies.

ADIS (Alcohol and Drug Information Services)

24 hours telephone service
(02) 9361 8000 or 1800 422 599 (outside Sydney)

DASA (Drug and Alcohol Specialist Advisory Services)

24 hours telephone service
Sydney callers (02) 9936 18006 and
Country callers 1800 023 687 appropriate treatment.

SECONDARY – Targeted Health Programs

Secondary services target specific sections of the population with identified vulnerabilities or predictive risk factors which could place their children at risk of abuse or neglect, and specific sections of the adult population whose vulnerabilities, such as mental health issues, may increase the risk of abusing children or young people in their care.

The early identification of children and young people who may be at risk through assessment at critical entry points into the Health system is crucial in preventing or ameliorating the effects of abuse and neglect.

Family Care Centres

Secondary level of service and support the services provided by Early Childhood Health Services. These services are designed to address more complex parenting problems involving a mix of both physical and psychosocial issues which require expertise and extra professional time. These centres may be staffed by early childhood health nurses, mothercraft nurses, social workers and psychologists who provide more intensive support, education and advice to families with children 0-5 years of age. The centres deal with management problems such as feeding, sleeping and settling, behaviour problems, psychosocial problems and parenting adjustment issues. The centres provide assessment and intensive short term intervention and management. There is access to paediatricians, allied health and mental health practitioners where required. Parents may be referred by general practitioners, early childhood health nurses, social workers, hospitals. Problems not able to be resolved at this level may be referred to the next level of service Residential Family Care Services.

There are four Residential Family Care Services in NSW provided by Tresillian and Karitane that provide intensive specialist support and care for complex parenting problems. A referral from a Health professional is required for admission to a Residential Family Care Unit, which are staffed by specially trained registered nurses, mothercraft nurses, social workers, and psychologists, and are supported by paediatricians and psychiatrists. Parents live in for up to a week for problems such as unsettled babies, crying babies, feeding problems, behavioural problems, depression and complex psychosocial problems. There are also special units for toddler management and advice. Tresillian and Karitane are Affiliated Health Organisations who also offer a range of services including day stay services, outreach services, parent group programs, home visiting, 24 hour crisis telephone services and professional education programs.

Family Referral Services

NSW Health is lead agency for the whole of government program of Family Referral Services (FRS). The FRS are operated by non-government organisations funded through NSW Health and aim to link vulnerable children and young people who are below the threshold for statutory child protection intervention and their families to a broad range of support services available in their local area.

Working in partnership with the Health Service, FRS are a key resource for Health workers and other mandatory reporters contributing to the holistic care of vulnerable children, young people and families in this State.

FRS provide information and assist entry into a broad range of services that may assist children young people and families with current issues promote child well being, prevent escalation to crisis, and foster the development of supportive, protective and nurturing environments for children and young people. Those service include Commonwealth, State and local government and non-government services such as case management, home visiting, family support, child care, housing, parenting education, supported play-group, youth support services, and respite care.

For further information :

- Fact Sheet: http://www.dpc.nsw.gov.au/__data/assets/pdf_file/0009/83646/06_Family_Referral_Services.pdf
- Section 4.10.3 Family Referral Services in this document.

Sustaining NSW Families

The Sustaining NSW Families program is being rolled out across NSW to support vulnerable infants, young children and families. The program aims to improve developmental outcomes for children, through engaging specialist child and family health teams to work intensively with high needs families in pregnancy and in the first 2 years of a child's life. The intention is to improve social and emotional developmental outcomes for children through fostering the development of:

- parental self-efficacy
- the early attachment relationship and
- awareness of the developmental needs of the infant.

Families identified as vulnerable using the SAFESTART assessment will be offered intensive structured home visiting. Services will be provided by the same child and family health nurse. The family will also be supported by a social worker and have access to other appropriate early childhood, family and specialist services as required.

The services are targeted at mothers with or at risk of post-natal depression: young, first time, isolated or vulnerable mothers.

SAFESTART

SAFESTART consultation and liaison positions have been funded across NSW, and provide essential mental health consultation and liaison functions across mental health,

drug & alcohol, maternity, child and family, general practitioner and other services for families with multiple and complex needs during the peri-natal period.

State wide Outreach Service for mental health (SwOPS-mh).

Based out of Westmead Hospital, Sydney the service is aimed at improving access to specialist peri-natal mental health expertise throughout NSW, prioritising rural, remote and regional women and their families.

Substance Use in Pregnancy Services

Specific substance use in pregnancy services operate in many Local Health Districts (including Mid North Coast, Northern, South Eastern Sydney, Illawarra Shoalhaven, Sydney and Western Sydney). These services provide families with support, linkages to antenatal services and discharge planning for continuing care. In the remaining LHD a broad based collaborative model operates with maternity services taking the lead with support from drug and alcohol services.

Supports for parents with mental illness

Carer drug and alcohol and mental health issues have been a significant factor in child protection reports to the Child Protection Helpline. Mental Health and Drug and Alcohol Services are expected to play a role in identifying adult clients with parenting or care responsibilities and in protecting children.

The NSW Children of Parents with Mental Illness (COPMI) Framework for Mental Health Services 2010-2015 assists Local Health District Mental Health Services to continue collaborative approaches to working with families in which adults with mental illness have responsibility for, live with or have contact with dependent children. Contact numbers for 24-hour mental health telephone access can be found at: www.health.nsw.gov.au/mhdao/contact_service.asp.

Child and Adolescent Mental Health Services (CAMHS)

CAMHS provide mental health services for young people aged 0-17yrs (inclusive), their families, carers and communities. CAMHS provide specialist mental health services and cover the spectrum of promotion, prevention, early intervention and treatment. CAMH service settings include community based, day programs, non acute inpatient, acute inpatient and intensive family interventions. Common problems that bring infants, children, adolescents and their families to CAMHS include psychological and emotional problems, behaviour problems, relationship problems (eg: school, peers, family), school related problems (eg: learning, performance, school refusal), eating problems, suicidal thoughts and self-harm.

Getting on Track in Time (Got It)

Getting on Track in Time (Got It) is a school-based early intervention program for children with disruptive behaviours. Got It! aims to prevent the development of severe behavioural disturbance and conduct related disorders in young children and a range of mental health and behavioural disorders in later life. The target group is children in Kindergarten to Year 2, their parents/ carers and related primary schools staff. Got It! is a pilot program, funded through the Keep Them Safe initiative until June 2014 and has been established in three locations, Dubbo, Newcastle and Mt Druitt.

Led by NSW Health in partnership with the NSW Department of Education and Communities the program includes training for primary school staff, screening, targeted assessment and group treatment for identified children. It provides evidence based parenting interventions and linkages with local community Child and Adolescent Mental Health Services.

NSW School Link

School Link is a collaborative initiative between the NSW Ministry of Health and the NSW Department of Education and Communities to improve the mental health of children and young people in NSW. School-Link has three main areas of focus: (1) Assist in strengthening links between mental health services, schools and TAFE colleges, (2) Provide training programs for mental health workers and school and TAFE counsellors to enhance the knowledge and skills of clinicians in the understanding and management of mental health problems in children and young people and (3) Support the implementation of programs in schools for the prevention of or early intervention in mental health problems.

Adult Drug and Alcohol Services

Whilst Drug and Alcohol services focus on adults, they have a role to play in the assessment and identification of children and young people who may be at risk of harm as a result of their parents' or carers' substance abuse problems. Such services also have a responsibility to intervene to protect and ensure the safety of children and young people. Drug and Alcohol Services may also play an ongoing role with respect to support and assistance to families where needed.

These services are provided both in the public and private sectors: either by LHDs, non-government organisations or drug and alcohol specialists and GPs. Services include drug withdrawal management, psycho social counselling, opioid pharmacotherapy programs, cannabis clinics, stimulants treatment programs, case management.

Adult Drug and Alcohol Services include:

- **Adult Drug Court**

The Adult Drug Court is a specialised court, operating under the *Drug Court Act 1998* with the aim of breaking the cycle of drug dependency, criminal activity and imprisonment. The Court targets drug-dependent adult offenders who are facing a custodial sentence and offers the option of drug treatment while on parole or probation. The system works with close cooperation between the Department of Health, Justice Health, two Area Health Services and a range of Non-Government Organisations which assist in providing drug treatment including residential rehab.

- **Cannabis Clinics**

Dedicated cannabis clinics are located at Parramatta, the Central Coast, Bathurst/Orange, Sutherland http://www.sesiahs.health.nsw.gov.au/Cannabis_Clinic/ Newcastle and the North Coast. The clinics have been set up to stand apart from the mainstream drug and alcohol treatment services and provide intensive clinical interventions and treatment to dependent cannabis users with complex needs, including clients with mental health issues.

Further aims of the clinics are to reduce the health, social and legal problems and risk of harm associated with cannabis use, and to assist people using cannabis who want to become abstinent.

- **Drug and Alcohol Consultation Liaison Services (DA CLS)**

DA CLS facilitate access to specialist support and advice for the treatment and management of patients who present to or have been admitted to hospital with drug and alcohol issues and support their referral to appropriate services.

Most hospitals in NSW provide DA CLS as part of their core DA service. Some LHS are funded to operate enhanced services at Royal Prince Alfred, Concord, Liverpool, Campbelltown, Newcastle (John Hunter), Albury, Wagga Wagga, Goulburn, Bathurst, Orange, and Dubbo hospitals).

DA CLS:

- assist the early identification of D&A related health issues in patients;
- Improve pathways to treatment;
- Improve generalist staff knowledge of DA issues and capacity to provide appropriate patient intervention; and
- Provide a long term cost-efficient means of reducing the impact of DA presentations and hospital admissions on hospital staff and resources

DA CLS are well placed to assist the early identification of Child protection concerns in patients presenting or being admitted to hospitals with DA related issues and who have children in their care.

- **Non-Government Organisation based Drug and Alcohol Services**

The non-government sector is a significant provider of drug and alcohol services in NSW. NGOs provide a variety of services including: counselling, outreach, co-morbidity services, education, group and family support and life skills training. Residential rehabilitation services in NSW are predominantly provided by NGOs and range from large therapeutic community style programs to short stay residential rehabilitation services.

- **MERIT**

The MERIT program is a court based diversion program that allows arrested defendants with illicit drug use problems to be assessed for suitability to undertake treatment and rehabilitation under bail conditions. As a result of that assessment, Magistrates can bail defendants to attend dedicated drug treatment services created through specific MERIT program funding.

As of 2008, MERIT is now available in 61 local courts across all eight Area Health Services.

To date, over 11,000 adult offenders have entered the program since 2000, and over 6,100 have successfully graduated from the program.

- **Stimulant Treatment Clinics**

NSW Health funds a stimulant treatment program on a trial basis at two clinics. One clinic is located at the Wesley Mission in Newcastle West and the other is at St Vincent's Hospital, Darlinghurst.

The clinics provide a range of services to stimulant users within a stepped care framework to match the special needs of each patient. An evaluation is being conducted, based on extensive interviews before, during and after the treatment.

The clinics operate from 8am to 4.30pm Monday to Friday. Contact phone numbers for both clinics are: (02) 9361 8088 (metro) 1800 101 188 (regional/rural).

Opioid Treatment Program (OTP)

The NSW Opioid Treatment Program (OTP) seeks to reduce the social, economic and health harms associated with opioid use. The OTP delivers pharmacotherapy and associated services to opioid dependent patients in NSW through the public sector (including Justice Health), and private sector (private clinics, general practitioners, psychiatrists and pharmacies). There are currently 3 types of opioid treatment pharmacotherapy available in NSW: methadone, buprenorphine and buprenorphine-naloxone.

NSW Health has conducted a Child Safety Campaign targeted at individuals on the Opioid Treatment Program who have children in their care. A wallet sized leaflet was developed by the Ministry of Health and Department of Family and Community Services and aims to reduce the risk of methadone poisoning in children by educating those with children in their care on the dangers of child ingestion of methadone, correct methadone storage methods and safe settling and sleeping techniques for young babies.

The *Joint Information Sharing Protocol* is designed to improve information sharing between NSW Health opioid treatment prescribers and Community Services in assessing the risk of harm to children that may arise from a child being in the care of an adult on opioid treatment.

A new campaign is under development (2012) to include child safety risks associated with buprenorphine.

National Partnership Agreement Indigenous Early Childhood Development (NPA IECD) Element 2 – Mental Health and Drug & Alcohol.

As part of the NPA IECD, funding has been approved until 30th June 2014 for the provision of state wide prevention and early intervention mental health and drug & alcohol services through 9 LHDs with MH and D&A positions co-located at 11 Aboriginal Maternal Infant Health Services (AMIHS).

Nursing Outreach Services in schools

Nurses providing outreach services in schools concentrate on the general wellbeing of children. They contribute to school health through screening, immunisation and the education of teachers and parents. In some schools, NSW Health nurses and allied Health workers provide health care services to students with disabilities or chronic illness.

Public Oral Health Services

Preschool children and children and young people up to 18 years old may receive public oral health care. This may include oral health education and an oral health assessment in school as well as clinical care in public clinics.

Public clinics are located in school grounds, public hospitals, community health centres and other sites. Clinical care may be provided by dental therapists or by dentists.

TERTIARY – Specialist Health Programs

Specialist services provide therapeutic interventions for children, young people and their families or carers where abuse or neglect has occurred with the aim of stopping further abuse, as well as ameliorating the effects of the abuse and neglect and preventing the development of longer-term difficulties.

Child Protection Counselling Services (CPCS)

CPCS (also known as Physical Abuse and Neglect of Children (PANOC) services) provide specialist counselling and casework services to children and young people and their families referred by Community Services, the Joint Investigation Response Team or the Children's Court, where abuse and neglect, including exposure to domestic violence has occurred to ameliorate the impact of abuse. This usually involves medium to long-term intervention.

Child Protection Counselling Services work with individual children and young people and their families/carers. This work is complex because the person responsible for abuse is most commonly the child or young person's parent/carer. Their participation in interventions is often integral to stopping the abuse and preventing further abuse of the child or other children within the family, particularly where the child or young person remains with their family of origin or it is planned to restore the child or young person to their family of origin. The aim is to work towards safety and healing for the child or young person, whether this occurs in the family home or in out-of-home-care.

Children and families receive an individualised service provided in close collaboration with the Community Services as well as other relevant government or non-government agencies, which includes assistance to ensure a family is able to access other appropriate support and services.

Child Protection Counselling Services also provide education and are a source of consultation in relation to child protection issues for Health workers and assist in the development of child protection services within Local Health Districts.

Child Protection Counselling Services based in each Local Health District /Specialty Network provide a range of therapeutic, counselling and casework services to children, young people and their families when physical abuse, emotional abuse, neglect or exposure to domestic violence has occurred within the family. Intervention is specialised and complex because the perpetrator is most commonly the child or young person's caregiver and the goal is to maintain the child or young person in their family where possible. Current approaches to treatment emphasise the need to try to establish open, respectful partnerships with parents to increase their competency and confidence as parents. CPCS may also work with the perpetrator of domestic violence around child protection issues.

Referrals for children, young people and their families to specialist Child Protection Counselling Services can only be made by Community Services or the Joint Investigation Response Teams. Where appropriate, referrals can also be accepted from some courts. Children need to be at risk of significant harm to be referred to CPCS. Priority is given to families in which there is:

- a previous child death in the family from suspicious injury;
- a previous assumption of care or removal of the child or other siblings in the family;
- serious physical or psychological injury as a result of physical abuse or domestic violence, particularly where a weapon has been used;
- a child under five years where physical abuse or neglect has occurred;
- multiple child protection reports about a child;
- a parent or carer who has a poly-substance abuse problem;
- a parent or carer who has a disability or mental illness;
- a parent or carer who has a mental illness and substance abuse problem; and
- a child who has high needs, for example, disability or chronic or serious illness.

CPCS also provide consultation and support for Health workers on child protection issues and concerns, as well as education and training about child protection issues.

Child Protection Units/Team

The Sydney Children's Hospitals Network has a Child Protection Unit at Westmead and at Randwick. The John Hunter Children's Hospital at Newcastle has a child protection team. The Units and the Team provide specialist paediatric and child protection services for NSW. These tertiary child protection services (Level 6 delineation) provide comprehensive paediatric medical, forensic and psychosocial assessments with access to intensive care, surgery and other subspecialties. Medical officers and paediatric sub-specialists are available for medical consultation and second opinions to staff across NSW.

The Child Protection Units/Team provide 24-hour crisis counselling and medical service, specialist psychosocial and medical assessment, forensic medical assessment, ongoing therapeutic and counselling services for victims of sexual assault and their non-offending family members, medical treatment, advocacy and case management, court support and expert testimony in court. They also provide state-wide 24-hour specialist consultation and support to Community Services and Health workers.

Referrals can be made by individuals, health professionals, Family and Community Services, the NSW Police Force and the Joint Investigation Response Team (JIRT).

The Child Protection Units at Randwick and Westmead incorporate a Sexual Assault Service and provide counselling services for children under 10 years with sexualised behaviours.

Child Protection Units work within a NSW Government interagency framework with the Department of Family and Community Services, the NSW Police Force and the NSW Department of Attorney General and Justice.

Children's Court Clinic

The Children's Court Clinic is part of NSW Health and is located within the Sydney Children's Hospitals Network (Randwick and Westmead). The Children's Court Clinic is established under section 15B of the *Children's Court Act 1987*.

Pursuant to its function under sections 52-59 of the *Care Act*, the Clinic assists the Children's Court and higher courts in care and protection matters, by providing independent expert clinical assessments of:

- a child or young person's psychological or psychiatric needs; and/or
- the capacity of parents and others to carry out parental responsibility.

The Children's Court Clinic employs and contracts a number of experienced psychiatrists, psychologists and social workers as 'Authorised Clinicians' to undertake these assessments and provide reports for the Children's Court.

For further information on the Children's Court Clinic see: http://www.schn.health.nsw.gov.au/about/facilities.php

Joint Investigation Response Team (JIRT)

The JIRT program is an interagency service delivery model consisting of three government agencies; Family and Community Services (FACS), NSW Police Force and NSW Health, and was implemented across NSW in 1997. It was designed to provide a collaborative response to serious child abuse reports, where the concerns reported may constitute a criminal offence.

The JIRT response to children and young people requires the co-ordination of three distinct and different functions of government:

- criminality;
- care and protection; and
- emotional/psychological and physical health and wellbeing

The JIRT service delivery model has staff of the NSW Police Force, Family and Community Services and NSW Local Health Districts co-located in some areas. In others, the NSW Police Force, Family and Community Services and NSW Local Health Districts work in joint responses to child abuse allegation although they are not co-located. The JIRT model reduces the number of investigative interviews required to be conducted by staff attempting to determine if Criminal or Care and Protection offences have occurred.

The role of NSW Police Force is to detect and investigate alleged child abuse and neglect. Where appropriate they initiate legal proceedings against identified offenders. The role of Community Services is to receive and assess reports of risk of significant harm to children and young people. Community Services also ensure the safety of children and their ongoing care.

Where appropriate JIRT will initiate Children's Court proceedings. The role of Health is to gather information for the JIRT Referral Unit and JIRT Units, prepare court reports, provide medical/forensic interventions, treatment, crisis as well as a range of ongoing counselling and therapeutic interventions to the child or young person and their non-offending parents.

Keep Them Safe – Whole Family Teams (KTS-WFTs)

In 2009, as part of the NSW Keep them Safe Implementation Plan, NSW Health was allocated funding to establish and evaluate four new mental health and drug & alcohol multidisciplinary teams – Keep Them Safe – Whole Family Teams (KTS-WFTs) located in Nowra, Lismore, Gosford and Newcastle.

The KTS-WFTs Pilot (2009-2014) aims to address the needs of families where carers have mental health and/or drug and alcohol problems and parenting difficulties in the context of child protection concerns. KTS-WFT services have been in operation since December 2010.

NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors is an affiliated Health service which addresses the needs of traumatized refugees, particularly those who have been tortured as part of their ordeal. Services include torture and trauma counselling to individuals and families, health assessments and referrals, group work for young people and adults and adjuncts to therapy such as limited employment and training assistance. Other services provided include community education and awareness raising about the health and psychosocial issues affecting torture and trauma survivors; training for service providers to develop their skills to work with traumatised refugees; and consultation with organisations to enhance the appropriateness and effectiveness of their services for refugee communities.

Services for children under 10 years exhibiting inappropriate sexualised or sexually abusive behaviours

Each Local Health District provides services to children under the age of 10 years who display problematic or harmful sexual behaviour. Where these children have also been victims of sexual assault, services are provided by Sexual Assault Services. Trained child and family health and child and adolescent mental Health workers provide services for children who are not themselves victims of sexual assault but who exhibit these inappropriately sexualised or sexually abusive behaviours. These services are available across NSW through a range of locations.

New Street Services

NSW Health provides specialist services through the New Street Services to young people who have engaged in sexually harmful behaviours towards others. New Street Services are located in Western Sydney, Hunter New England and Western New South Wales Local Health Districts.

New Street Services provide therapeutic services to children and young people aged 10-17 years who have engaged in sexually harmful behaviours towards others, and are not eligible for programs provided by Juvenile Justice. Referrals can be made by any member of the community. Eligibility for the program includes that the sexually harmful behaviour is confirmed by JIRT or FaCS.

The program run by the Western Sydney Local Health District, 'New Street Sydney', is a Sydney and Central Coast service for NSW Health. The office is located in North Parramatta and an outreach service is provided to the Central Coast.

The programs run by Hunter New England Local Health District and Western New South Wales Local Health District are 'Rural New Street Services' which provide services to the regions of their respective local health districts from offices located in Newcastle and Tamworth (Rural New Street HNE) and Dubbo (Rural New Street Western).

New Street Services work in partnership with Government and non Government agencies to ensure an holistic and coordinated approach for young people and their families. Services focus on:

- Safety for children and young people
- Young people taking responsibility for their actions, and the harm those actions have caused others
- Working at the differing and appropriate developmental levels of young people
- Working with young people's families, carers and important domains of their lives (e.g. school)
- Positive, and therefore safe and secure connection with family and community, which is considered essential
- Restorative processes, which part of the therapeutic intervention, for young people and their families. This includes processes of restoration towards those harmed and restoration of young people within family and community relationships

Referral Process

Any member of the community can make a referral to the New Street Services, and referrals can be made at any time. The most common referrers are: family members, health workers, Joint Investigation Response Teams (JIRT) and Family and Community Services.

If a report to the Child Protection Helpline has not been made at the time of referral, as may be the case when a family member refers, the New Street staff will assist to ensure this step is taken and the referral is not diverted or delayed. Time may be needed for the appropriate interagency investigation to be undertaken.

Partner agencies may also contact New Street Services to request training and advice.

NSW Pre-Trial Diversion of Offenders Program

The NSW Pre-Trial Diversion of Offenders Program, known as Cedar Cottage, is a specialist statewide two to three year program which provides treatment to adults who have sexually assaulted their own or their partner's children. The Program is located in Western Sydney Local Health District. Entry into the Program is contingent on the offending parent being assessed as suitable, pleading guilty to the offence(s) and entering an Undertaking at the District Court to participate in the Program and to be subject to its conditions.

The primary focus of the NSW Pre-Trial Diversion of Offenders Program is child protection through prevention of further child sexual assault and attending to the effects of child sexual assault. Assessment of suitability for the Program includes whether the offending parent, in addition to pleading guilty, accepts responsibility for their actions and whether their participation in the Program will be in the best interests of the child/ren concerned. There are a number of Program conditions, which include no contact with their children, or other children, without the written permission of the Program Director, while participating in the Program. Should an offending parent breach Program conditions, such as these, they are suspended from the Program and returned to the criminal justice system.

It is recognised that the dynamics and effects of child sexual assault may severely harm a child or young person's relationship with their non-offending parent, and other family members. The program has an integrated family and interagency approach, working closely with Sexual Assault Services, and other Government and Non-Government agencies as well as close and extended family members.

Referral process

A person seeking referral does not need to enter pleas of guilt prior to referral or to have made admissions. If the person has denied all or part of the offences they are not precluded from seeking referral. The criteria is that the person has been charged with a relevant child sexual offence or offences. The matter of admissions and acknowledgements is a focus of the assessment for suitability for the Program. If assessed as suitable the person must then enter pleas of guilt to all charges to enter the Program.

The NSW Police Force is required to provide potential applicants printed information on Program, as required by the *Pre-Trial Diversion of Offenders Act 1985*.

The Program welcomes enquiries from family members and support persons of potential applicants and from potential applicants directly, at any time.

Sexual Assault Services

NSW Health has a network of 52 Sexual Assault Services, 49 of which are for children, young people and adults and three of which are for young people over the age of 14 years and adults. Sexual Assault Services deliver services to children, young people and their non-offending siblings, caregivers, and other supports. The services include forensic and medical examinations and treatment, crisis and ongoing counselling, information and advocacy, and court preparation and support. They also undertake a range of prevention activities including community education, consultation to other professionals, professional education, and resource development and information provision.

The priorities for client allocation for services that see both adults and children are:

1. children and adults, where the sexual assault has occurred within the past seven days
2. any disclosure of sexual assault by a child or young person under the age of 16
3. any disclosure of sexual assault by a young person aged 16–18
4. adult victims sexually assaulted in the last year
5. any sexual assault victim requiring court preparation and support or cases where the assault is the subject of some investigation which does not fit into categories one to four
6. adults who have been sexually assaulted as adults more than one year ago
7. adults who have been sexually assaulted as a child.

Adult referrals to SAS may come from the victim directly or from a third party such as Police, a local hospital, or Community Health. Children are referred to SAS by the Joint Investigation Response Team (JIRT) Referral Unit (JRU).

Specialist sexual assault counsellors are experienced in working with the multiple agencies which intervene in cases of child sexual assault. A variety of treatment modalities are offered including individual, family, group, and non-offending parent-child counselling. The aim of the treatment is to address the impact of the abuse on the child and non-offending family members so that long term emotional and social difficulties are less likely to develop.

This includes addressing the emotional impacts (such as fear and shame), interpersonal impacts (such as isolation and stigmatisation), and ensuring that responsibility is attributed to the offender. This helps to reduce self-blame and rebuild relationships with non-offending family members.

If sexual assault has not been positively identified but a Health Service is considered appropriate to assist a child or parent, referral may be made to an appropriate Local Health District Child and Family Health Service.

Aboriginal child sexual assault positions are located in Hunter New England, Illawarra Shoalhaven and Western Sydney Local Health Districts.

Specialist Services for Children and Young People in Out-Of-Home Care

OOHC Co-ordinator positions have been appointed in all LHDs across NSW. Out-of-Home Care Co-ordinators facilitate the coordination and delivery of health assessments for children and young people entering out-of-home-care.

A joint Alternate Care Clinic is provided by Redbank House (a specialist child and adolescent mental Health Service at Westmead Hospital) and The Children's Hospital Westmead, in partnership with Community Services. The Clinic assists carers in understanding and addressing the mental health needs of young people in out-of-home care. The clinic accepts referrals from Community Services Metro West and the Metro Intensive Support Service.

Youth Health Services

Youth Health Services provide a range of services for young people aged between 12 and 24 years. These services may include counselling and casework services, health promotion, nursing and medical services, drug and alcohol counselling, counselling for children and young people who are at risk of significant harm or where abuse has been identified, counselling for children and young people where sexual assault has not been positively identified, outreach services and needle exchange services.

Some Youth Health Services target children and young people who are homeless or who are at risk of homelessness and provide counselling for children, young people and their families.

APPENDIX 3

Requesting Information Under Chapter 16A

SMR020501

Requesting Information under Chapter 16A - Letter

(To be used by prescribed bodies seeking information under Chapter 16A)

Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998 provides for the exchange of information regarding the safety, welfare or wellbeing of a particular child or young person or class of children or young persons.

To:

At:

From:

At:

Ref:

Date:

This request is made in regard to:

Date of Birth: Gender:

Information is also sought regarding the following persons:

Name	Gender	Relationship to child/young person	DOB	Other identifying information

This information is sought in relation to the following issues of concern held for the above mentioned child/young person or class of children or young persons:

This information is sought because it relates to the safety, welfare or wellbeing of the child or young person (or class of children or young persons) and will assist with:

- making a decision, assessment or plan
- initiating or conducting an investigation
- providing a service and/or
- managing a risk, to a child or young person that might arise in this agency's capacity as an employer or designated agency.

Specific information is requested in regard to:

- relevant current and/or historical concerns about safety, welfare or wellbeing of the child, young person or family
- current and/or past history of involvement with the child, young person and/or their family
- family/ relationship dynamics (if known)
- attitude of the child, young person and/ or family to agency/service involvement
- other details required

Please provide the requested information

- by phone
- by email
- by fax*
- by mail.

** Care should be taken in providing sensitive information via fax. This procedure must be negotiated with and agreed to by the organisation providing the information.*

The information is required by

Consent should be sought in regard to the exchange of information, where appropriate, and the person should be given adequate information in a manner and language they can understand. However, the Act authorises the exchange of information under Chapter 16A without consent.

☑ The child/ young person/ family has consented to the release of information requested in this form by mail.
OR
☐ The child/ young person/ family has not consented to the release of information requested in this form by mail. The reason for this is:

☑ The child/ young person/ family has been informed of this request for information.
OR
☐ The child/ young person/ family has not been informed of this request for information. The reason for this is:

Contact details of the person making the request:

Name:

Title:

Organisation:

Phone:

Fax:

E-mail:

Mailing Address:

APPENDIX 4

Providing Information Under Chapter 16A – Letter

Providing Information under Chapter 16A - Letter

NSW GOVERNMENT Health

SMR020503

Our ref:
Date:

Dear

Re: Provision of information under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*

Section 245C of the Act allows a prescribed body to provide information of their own accord to another prescribed body that relates to the safety, welfare or wellbeing of a particular unborn child, child, young person or class of children or young persons.

is providing the information enclosed with this letter on the basis that there is a lawful reason to do so, in accordance with the provisions of Chapter 16A.

The information provided is in regard to:

Date of Birth: Gender:

Information is also provided regarding the following persons:

Name	Gender	Relationship to child/young person	DOB	Other identifying information

This information is provided in relation to the following issues of concern held for the above mentioned child/young person or class of children or young persons:

This information is provided because the believes it relates to the safety, welfare or wellbeing of the child or young person (or class of children or young persons) and would assist you with:

- making a decision, assessment or plan
- initiating or conducting an investigation
- providing a service and/or
- managing a risk to a child or young person that might arise in your capacity as an employer or designated agency.

Should you decide, in accordance with Chapter 16A, to provide some or all of this information, either on your own motion or in response to a request from a prescribed body, the information can only be shared on a confidential basis in accordance with the processes and principles of Chapter 16A.

If the information is sought from you for any purpose other than those described in Chapter 16A, you should refer the requesting organisation to the original owner of the information.

Any information provided herewith is not to be used in any court or tribunal proceedings. Should the matter proceed to court, the information should be subpoenaed or summonsed.

If you require further information or wish to discuss the matter, please contact on during business hours, quoting the reference number above.

Yours sincerely

Enclosed: Information

APPENDIX 5

Agreeing to Chapter 16A Request – Letter

Agreeing to a Chapter 16A Request - Letter

NSW GOVERNMENT Health

SMR020502

Our ref:
Your ref:
Date:

Dear

Re: Request for release of information under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*

I refer to your letter/fax/email dated in which you sought information from under Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998 (the Act) relating to the and .

Section 245C of the Act allows a prescribed body to request another prescribed body to provide information they hold that relates to the safety, welfare or wellbeing of a particular unborn child, child, young person or class of children or young persons.

is releasing the information enclosed with this letter on the basis that there is a lawful reason to do so, in accordance with the provisions of Chapter 16A.

The information has been released to you in good faith to assist you to promote the safety, welfare or well-being of the relevant child/ren.

Should you decide, in accordance with Chapter 16A, to provide some or all of this information, either on your own motion or in response to a request, the information can only be shared in accordance with the processes and principles of Chapter 16A.

If the information is sought from you for any purpose other than those described in Chapter 16A, you should refer the organisation or individual making the report to the original owner of the information.

Any information provided herewith are not to be used in any court or tribunal proceedings. Should the matter proceed to court, the information should be subpoenaed or summonsed.

If you require further information or wish to discuss the matter, please contact on during business hours, quoting the reference number above.

I trust this information will be of assistance.

Yours sincerely

Enclosed: Requested information

Declining a Chapter 16A Request – Letter

Declining a Chapter 16A Request - Letter

NSW GOVERNMENT Health

SMR020504

Our ref:
Your ref:

Dear

Re: Request for release of information under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*

I refer to your letter/fax/email dated in which you sought information from under Chapter 16A of the Children and Young Persons (Care and Protection) Act 1998 (the Act) relating to the and .

Sections 245D (4) and (5) allow a prescribed body to refuse to provide information in certain circumstances, with the reasons for the refusal to be given in writing.

In this instance, has decided to withhold information for the following reason/s:

I trust you will accept decision. However, if you wish to discuss this matter further, please contact on during business hours, quoting the reference number above.

Yours sincerely

Documenting Information Provided – Form

NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	

NO ADDRESS TO BE RELEASED

COMPLETE ALL DETAILS

SMR805500

EXCHANGE OF INFORMATION CHAPTER 16A

Children and Young Person's (Care and Protection) Act 1998

Form to be completed to document the exchange of information under Chapter 16A Children and Young Person's (Care and Proctection) Act 1998.

Provision of information must be to a representative of a Prescribed Body

Central Contact Point Reference Number: (where applicable)

Date of Request for Information: _____

Name of Prescribed Body (eg. Name of School, Police Station): _____

Name of Representative from Prescribed Body (eg. Teacher's name, Police Officer's name): _____

Information provided: [ ] verbally [ ] written [ ] NA [ ] Copies of Medical record documentation

Date of information exchange? _____ Is client/patient aware of information exchange? [ ] Yes [ ] No

[ ] This information has been extracted directly from the health care record

Information Exchanged:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

This information has been released in good faith to assist and promote the safety, welfare and wellbeing of the subject child

Health Worker/ Service Name:_____ Date: _____

Signature: _____ Pager No: _____ Phone No: _____

Designation: _____ Facility/CH Centre: _____

NO WRITING

Page 1 of 2

SAMPLE - DO NOT PRINT

Holes punched as per AS2828-1999

BINDING MARGIN - NO WRITING

NH606593 150312

EXCHANGE OF INFORMATION CHAPTER 16A SMR805.500

Children and Young Person's (Care and Protection) Act 1998

NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	
NO ADDRESS TO BE RELEASED	
COMPLETE ALL DETAILS	

EXCHANGE OF INFORMATION
CHAPTER 16A
Children and Young Person's (Care and Protection) Act 1998

Responding to Chapter 16A requests
CHECKLIST

- ❑ Have you clarified the name, position and organisation of the caller? (if request comes by telephone)
- ❑ Have you identified whether the letter, fax or call is from a 'prescribed body'?
  Note: For details of prescribed bodies please see PD2011_057 Child Protection and Wellbeing - Information Exchange.
- ❑ Has the request come from Community Services (CS)?
  Note: Unless you are currently working with CS to provide a service to this client and know the CS worker involved, all requests from CS must go though the LHD Central Contact Point.
- ❑ Does the request relate to the safety, welfare or wellbeing of a child or young person?
  Note: Information cannot be exchanged with another agency unless it relates to the safety, welfare or wellbeing of a child/young person.
- ❑ Is there any other reason to decline this request?
  Note: information is not required to be exchanged if it will: (a) prejudice the investigation of a contravention (or possible contravention) of a law in any particular case, or (b) prejudice a coronial inquest or inquiry, or (c) prejudice any care proceedings, or (d) contravene any legal professional or client legal privilege, or (e) enable the existence or identify of a confidential source of information in relation to the enforcement or administration of a law to be ascertained, or (f) endanger a person's life or physical safety
- ❑ If you do not know the worker from the prescribed body that is contacting you for information, have you undertaken a call-back process?
  Note: If exchanging information over the telephone it is important to confirm their identity and ensure you are exchanging information with someone from a prescribed body.
- ❑ If you are currently working with the child, young person or family, have you asked the caller, or ascertained otherwise, if the family, child or young person are aware of the information exchange?
  Note: It may not be appropriate to inform the child young person or family if there is a current police/ JIRT investigation. While it is not necessary for a family, child or young person to be made aware of the information exchange, it is considered best practice to discuss the information request with the family, child or young person unless this would place them, or their workers, at risk of harm.
- ❑ Have you ensured there is no identification label also known as sticky label on the Chapter 16A response form?
  Note: The sticky label contains information that may not be relevant to the prescribed body e.g. Medicare number and address
- ❑ Have you ensured that the response contains no identifying information about a reporter?
  Note: The identity of the person who made the report, or information from which the identity of that person could be deduced, must not be disclosed by any person or body.
- ❑ If sending a written response, have you completed an 'agree letter' to accompany this response?
  Note: A standard 'agree' letter can be found on the Keep Them Safe website and the NSW Kids website.
- ❑ If you are declining the information request, a written response must be provided and placed in the health care record.
  Note: A standard 'decline' letter can be found on the Keep Them Safe website and the NSW Kids website.
- ❑ Have you placed/scanned a copy of this form and the 'agree' or 'decline' letter into the health care record?

For further information or advice contact your local Information Exchange consultants

SAMPLE - DO NOT PRINT

Holes punched as per AS2828-1999
BINDING MARGIN - NO WRITING

SMR805500

NO WRITING

ROSH Record of Report and Fax Form

NSW GOVERNMENT Health

Facility: _____

Risk of Significant Harm (ROSH) Record of Report and Fax

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR805510

PLEASE TYPE OR PRINT CLEARLY

Please make sure all pages are sent

1. YOUR DETAILS

Reporter's name		**Position**	
Service / Agency			
Contact phone no.		**Fax no.**	
Business Address			
Was a message left on the Child Protection Helpline telephone system?	☐ No ☐ Yes	If yes ➔	**Date** / **Time**
COPS Event No. (Police only)			
Is the parent / carer / alleged offender on the NSW Child Protection Register? (Police only - tick if applicable)	☐ Yes	**In relation to this report, are you an Opioid treatment prescriber?** (Health only)	☐ Yes

2. DETAILS ABOUT THE CHILD OR YOUNG PERSON

Child or young person's name				
Date of birth (or expected date)		Age or approximate age	☐ Unborn	
Gender	☐ Male	☐ Female	☐ Not known	
Tick if applicable	☐ Aboriginal	☐ Torres Strait Islander	☐ Both	☐ Unknown
Cultural background				
School / Pre-School attended or other child care (Family Day Care / nanny arrangements etc)				
Child or young person's name				
Date of birth (or expected date)		Age or approximate age	☐ Unborn	
Gender	☐ Male	☐ Female	☐ Not known	
Tick if applicable	☐ Aboriginal	☐ Torres Strait Islander	☐ Both	☐ Unknown
Cultural background				
School / Pre-School attended or other child care (Family Day Care / nanny arrangements etc)				

Page 1 of 4

Risk of Significant Harm (ROSH) Record of Report and Fax

SMR805.510

NSW GOVERNMENT Health

Facility: _____

Risk of Significant Harm (ROSH) Record of Report and Fax

FAMILY NAME			MRN
GIVEN NAME			☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____		M.O.	
ADDRESS			
LOCATION			
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE			

Child or young person's name				
Date of birth (or expected date)		Age or approximate age	☐ Unborn	
Gender	☐ Male	☐ Female	☐ Not known	
Tick if applicable	☐ Aboriginal	☐ Torres Strait Islander	☐ Both	☐ Unknown
Cultural background				
School / Pre-School attended or other child care (Family Day Care / nanny arrangements etc)				
Child or young person's name				
Date of birth (or expected date)		Age or approximate age	☐ Unborn	
Gender	☐ Male	☐ Female	☐ Not known	
Tick if applicable	☐ Aboriginal	☐ Torres Strait Islander	☐ Both	☐ Unknown
Cultural background				
School / Pre-School attended or other child care (Family Day Care / nanny arrangements etc)				

3. FAMILY DETAILS

Family's address			
Suburb		Postcode	
Home phone			
Interpreter required	☐ No ☐ Yes ➔	Please identify language spoken	
Disability issues			
Current whereabouts of child / young person			

4. NAME OF PARENTS/ CARERS & THEIR RELATIONSHIP TO THE CHILD OR YOUNG PERSON

Name	
Address (if different from above)	
Phone (if different from above)	
Relationship	
Name	
Address (if different from above)	
Phone (if different from above)	
Relationship	
Significant others close to the child and/or family (eg. grandparents/ aunts/ uncles	

NSW GOVERNMENT Health

Facility: _____

Risk of Significant Harm (ROSH) Record of Report and Fax

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

5. SAFETY CONCERNS

Known relevant criminal history of parents/carers			
Current Apprehended Violence Order (AVO)	☐ Yes ↓	☐ No	☐ Not known
Who is the AVO against?			
Who is protected by the AVO?			
Family Law Court Orders (please provide details)			
Any known worker safety issues	☐ No	☐ Yes (please provide details)	

AS PER THE ACT, A CHILD IS DEFINED AS A PERSON WHO IS UNDER THE AGE OF 16 YEARS, AND A YOUNG PERSON IS DEFINED AS 16 YEARS AND ABOVE, BUT IS UNDER THE AGE OF 18 YEARS.

What is the reason for reporting under the Children and Young Persons (Care and Protection) Act 1998?	☐ Request for Assistance (Sect 21/113) ☐ Risk of Significant Harm (Sect 23/24)	☐ Prenatal (Sect 25) ☐ Homelessness (Sect 120/121/122)

Please provide details of your ROSH concern for the safety and/or welfare of the child/ren and/or young persons. Also include any concerns you may have in regards to: • **issues of domestic violence** • **carer's alcohol or other drug misuse** • **carer's mental health issues**	
What have you noticed about the child/ren and/or young person's appearance and behaviour?	

NSW GOVERNMENT Health

Facility: _____

Risk of Significant Harm (ROSH) Record of Report and Fax

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Did this incident result in a physical injury to a Child/ Young Person?	☐ Yes ☐ No If yes, please provide details:
Did this incident result in a physical injury to another person?	☐ Yes ☐ No If yes, please provide details:
Did this incident result in medical attention/ treatment?	☐ Yes ☐ No If yes, please provide details:
What is the nature of your ongoing professional role, if any, with the child/ren, young person/s and their parents/carers, and the frequency, duration and type (if applicable)?	
What other services or supports are currently in place to support the child/ ren, young person/s and their parents/carers (if known)?	

Is the family, child or young person aware that this report has been made? ☐ Yes ☐ No

Do you consent for your identifying information to be provided to JIRT (NSW Police and NSW Health) or NSW Police (LAC) and/or NSW Health in the event that JIRT does not accept the report for action? ☐ Yes ☐ No

If the report is referred to NSW Police, the same protections and confidentiality relating to your identity will continue to apply as per Section 29 of the *Children and Young Persons (Care and Protection) Act 1998.*

Reporter's name (please print clearly)	
Signature	
Date and time	
Child Protection Helpline Reference Number	

Page 4 of 4

APPENDIX 9

Key Government and non-Goverment Child Wellbeing and Child Protection Support Mechanisms and Services Relevant to NSW Health Workers

	Universal / Primary Services: aimed at enhancing the health, welfare and wellbeing of children, young people and their families	Secondary Services: aimed at those considered potentially 'at risk' of harm or 'at risk' of abusing)	Tertiary Services: services for children, young people and their families where abuse or neglect has occurred to ameliorate its effects and prevent further harm	Continuing Care: ongoing / long term / intensive intervention – multi-agency and / or multidisciplinary intervention
ASSESSING LEVEL OF RISK OF HARM				
Worker Support	**Mandatory Reporters Guide: suspected Risk of Significant Harm (ROSH)** tool to guide decision-making about whether or not a matter should be reported to the Child Protection Helpline for further investigation (inter-agency – Community Services led)			
Worker Support	**Child Wellbeing Units (CWUs)** were established in NSW Health, NSW Police Force & Department of Education and Communities, Department of Family and Community Services (for Juvenile Justice, Housing and Aging Disability and Home Care) as an alternative intake and consultation process for child wellbeing and child protection concerns that do not meet the threshold for ROSH; to assist mandatory reporters formulate appropriate service responses; assist mandatory reporters identify whether a concern meets the ***suspected ROSH*** threshold; conduct cumulative risk of harm appraisals; facilitate inter-agency collaboration. **NSW Health CWU Telephone: 1300 480 420. Or via fax or email after hours: See page 80**			
Worker Support	**Structured Decision Making (Child Protection Helpline 133 627) determination of ROSH** comprehensive decision-making tool to help determine whether a report meets the threshold for a statutory response) (structured analysis of all information available to caseworker/s, including family history that may be recorded on the Community Services Database (KiDS). (Community Services)			
Worker Support	**Education Centre Against Violence (ECAV)** provides mainstream and specialist training, consultation and resource development to support workers to perform their tasks.			
SUPPORT FOR CHILDREN / YOUNG PEOPLE / FAMILIES (Non-ROSH)				
Agency support services	**Family Referral Services** have been established to support the needs of children, young people and their families, where there is a child protection concern that is below the threshold for statutory intervention; link them to appropriate support services available in their local area/s. (Provided by NGOs funded by NSW Health)			
Agency support services	**Home School Liaison Officers / Aboriginal School Liaison Officers** expand services x25 HSLO and x15 ASLO – to support children attending school			
Agency support services	**Schools as Community Centres:** family centres based in primary schools conducting early intervention programs to support families with young children using a community capacity building and inter-agency approach (Education & Communities)			
Agency support services		**Getting on Track in Time (Got It)** Health CAMHS in partnership with DET: school based early intervention for children with disruptive behaviours		
Agency support services	**Parenting programs, for example Hey Dad! Indigenous Dads, Uncles & Pops Program**; Triple P. (Provided by NGOs funded Community Services)			
Agency support services		**Brighter Futures Program (BFP)** targeted support tailored to meet the needs of vulnerable families with children <9 years or families expecting a child. BFP focuses on families with children who are at risk of harm rather than risk of significant harm .(Provided by NGOs funded by Community Services)		
Agency support services		**Family Case Management (FCM)** is an integrated case management response to families who frequently come into contact with multiple agencies. FCM focuses on families with child or young person at risk of harm rather than risk of significant harm. That is they fall below the threshold for statutory child protection intervention. (Provided by NGOs funded by Community Services)		

	Universal / Primary Services: aimed at enhancing the health, welfare and wellbeing of children, young people and their families	Secondary Services: aimed at those considered potentially 'at risk' of harm or 'at risk' of abusing)	Tertiary Services: services for children, young people and their families where abuse or neglect has occurred to ameliorate its effects and prevent further harm	Continuing Care: ongoing / long term / intensive intervention – multi-agency and / or multidisciplinary intervention
SUPPORT FOR CHILDREN / YOUNG PEOPLE / FAMILIES (ROSH)				
Agency support services				**Out-of-home care (OOHC) Co-ordinators** ensure children and young people in OOHC receive comprehensive multidisciplinary health and development assessments and individual education plans (NSW Health & Department of Education & Communities)
			Family Preservation / Restoration Service. A pilot program to provide intensive casework services and support for a period of up to 18 months to families. (Community Services)	
			Alternate Dispute Resolution aims to empower children and their families in decision-making processes and reduce adversarial outcomes in child protection cases that go through the court system. (Department of Attorney General and Justice)	
			Joint Investigation Response Team Referral Unit (JIRT) is an inter-agency service delivery approach consisting of three government agencies – Community Services, NSW Police Service and NSW Health – and is designed to provide a collaborative response to serious child abuse reports, where the concerns reported may constitute a criminal offence. Referrals are processed through the JRU (Joint Referral Unit) received from the CP Helpline. (Community Services, NSW Police Force, NSW Health) NSW Health has a JIRT workforce of 17 positions located in LHDs across the state.	
			Intensive Aboriginal Family Based Services – intensive, home-based programs for Aboriginal families whose children are at risk of entering care or those currently in care who are to be restored to their families. (Provided by NGOs funded by Community Services)	
	Alternate Care Clinic program delivering mental health services to high-needs children. The project provides services for children and young people from 0-18 years in long-term OOHC who have high level complex needs. (Community Services, NSW Health)			
	Safe Families Program aims to tackle Aboriginal child sexual assault through an integrated community development, child protection, early intervention and prevention and risk reduction strategy. (Inter-agency – Aboriginal Affairs led)			
			Keep Them Safe – Whole Families Team (KTS-WFT) is a multidisciplinary team that addresses the needs of the whole family where parents/carers have mental health / drug & alcohol problems that affect their parenting capacity and children and young people have been identified at risk of significant harm. (NSW Health)	
			New Street is an early intervention program for young people aged 10-17 who have sexually abused. (NSW Health). A Clinical Advisor New Streets & Cedar Cottage Services is based at Westmead	
		Sustaining NSW Families: Families is a multi-disciplinary team approach delivering an evidenced based early intervention structured parenting and child development program to vulnerable families commencing antenatally and continuing to the child's 2nd birthday		
		JIRT Senior Health Technicians	**Bail Hotline** 24 hour hotline co-ordinating information, advice and support, mainly for NSW Police, regarding juveniles (<18 years) being held by police to reduce the number of young people remanded in custody. This is part of 'Before Court' support. The service gives Police access to Juvenile Justice staff seven days a week, 24 hours a day, who will assist in finding accommodation and services for young people eligible for bail. (NSW Police Force & Juvenile Justice)	

	Universal / Primary Services: aimed at enhancing the health, welfare and wellbeing of children, young people and their families	Secondary Services: aimed at those considered potentially 'at risk' of harm or 'at risk' of abusing)	Tertiary Services: services for children, young people and their families where abuse or neglect has occurred to ameliorate its effects and prevent further harm	Continuing Care: ongoing / long term / intensive intervention – multi-agency and / or multidisciplinary intervention
SUPPORT FOR CHILDREN/YOUNG PEOPLE / FAMILIES – TARGETED SERVICES				
Hospital Services	**Children's Hospitals and Wards** provide a range of services for children, including emergency services, specialised inpatient, ambulatory care and rehabilitation services. There are three tertiary level children's services in NSW: located at Westmead, Randwick and Newcastle			
	Maternity Services including antenatal care, Early Pregnancy Assessment Services, birthing services, homebirth and postnatal care. Routine screening for drug & alcohol consumption during pregnancy as part of initial maternity 'Booking in visit' (NSW Health)		**Child Protection Units (CPUs):** The Sydney Children's Hospitals Network (Westmead and Randwick) and John Hunter Hospital provide specialist paediatric and child protection services for NSW. These tertiary child protection services (Level 6 delineation) provide comprehensive paediatric medical, forensic and psychosocial assessments with access to intensive care, surgery and other sub-specialties. Medical officers and paediatric sub-specialists are available for medical consultation and second opinions to staff across NSW.	
	Ambulance services (emergency and ambulatory care)			
Maternity and Early Childhood	**Safe Start** is a program provided in maternity and child and family health services. It is a comprehensive assessment including psychosocial domains using the Edinburgh depression Scale. Safe Start assists in identifying and supporting women with a range of psychosocial issues in pregnancy and after the birth of the baby, including post natal depression and the relationship between mental health and the parenting role.(NSW Health)			
	Aboriginal Maternal and Infant Health Service (AMIHS) improve health outcomes for Aboriginal women and babies during pregnancy and up to 8 weeks postnatally. As part of the Indigenous Early Childhood Development National Partnership Agreement. Mental Health and Drug and Alcohol Secondary services are co-located at selected AMIHS sites.			
	Early Childhood Health Centres identify development and health issues; provide early intervention.	**Family Care Centres** designed to address more complex parenting problems involving a mix of both physical and psychosocial issues.		
		Residential Family Care Services: Tresillian and Karitane: provide intensive specialist support and care for complex parenting problems.		
	Universal Health Home Visiting offer and provision of at least one universal contact in the family's home within two weeks of birth of child.	**Sustained NSW Families** is a multi-disciplinary team approach delivering an evidenced based early intervention structured parenting and child development program to vulnerable families commencing antenatally and continuing to the child's 2nd birthday.		
	Education Centre Against Violence (ECAV) provides mainstream and specialist training in the areas of child protection, sexual assault and domestic violence, consultation and resource development to enhance and improve the work across secondary services. E.g.Drug & Alcohol, mental health, early childhood, and specialist services E.g. Child Protection Counselling Services, sexual assault, Child Protection Units and Aboriginal Family Health Workers.			
	Youth health services provide a range of services for young people aged between 12 and 24 years. These services may include counselling and casework services, health promotion, nursing and medical services, drug and alcohol counselling, counselling for children and young people who are at risk of significant harm or where abuse has been identified, counselling for children and young people where sexual assault has not been positively identified, outreach services and needle exchange services. Some youth Health Services target children and young people who are homeless or who are at risk of homelessness and provide counselling for children, young people and their families.			

	Universal / Primary Services: aimed at enhancing the health, welfare and wellbeing of children, young people and their families	Secondary Services: aimed at those considered potentially 'at risk' of harm or 'at risk' of abusing)	Tertiary Services: services for children, young people and their families where abuse or neglect has occurred to ameliorate its effects and prevent further harm	Continuing Care: ongoing / long term / intensive intervention – multi-agency and / or multidisciplinary intervention
Child Development / Allied health	**Families NSW: Parentline 1300 1300 52** – 24 hour service to assist with parenting information. (Provided by NGOs funded by Community Services)			
			Child Protection Counselling Services (also known as PANOC) provide specialist therapeutic counselling and casework services to children, young people and their families where abuse and neglect has been substantiated by Community Services and/or Joint Investigative Response Teams (JIRT) and the Children's Court. Services also provide consultative and education services. (NSW Health)	
	Statewide Eyesight Preschooler Screen (StEPS) vision screening program for all 4 year olds: designed to identify childhood vision problems early on.	**Diagnostic & Assessment Teams (DASS)** comprehensive/multidisciplinary assessment of children who may have an intellectual disability and/or autism. The service can provide developmental and psychometric assessments, medical diagnosis, clinic based reviews and guidance regarding the implementation of recommendations.		
	Statewide Infant Screening – Hearing (SWISH) offers all babies across NSW a hearing test within the first few days of being born: early identification of significant bi-lateral hearing impairment. (NSW Health)			
	The NSW School-Based Immunisation Program Vaccinations offers a range of vaccinations to eligible students in secondary/high school. (NSW Health)	**Child & Family Multidisciplinary Teams** provide assessment and management of children and families referred to a range of developmental, emotional, behavioural and family relationship problems) (including Speech Therapy, Audiology, Occupational Health, Physiotherapy, Psychological Services (NSW Health).		**OOHC Co-ordinator in Health and Education** ensure children and young people in OOHC receive primary health assessments and where indicated comprehensive multi-disciplinary health and development assessments and individual education plans
	Oral Health: 'Lift the Lip' children 0-5 years to check for signs of dental disease/teeth decay (NSW Health)			
Social Work	**Social Work Services** assist patients and their families/carers cope with and adjust to their circumstances; co-ordinate a safe patient discharge; facilitate support services on discharge; provide education, support and counselling to patients, families/carers). Social workers provide services in both hospital and community health settings (including early childhood, child protection services, mental health, DV and drug and alcohol).			
Sexual Assault/Health Services			**Pre-trial Diversion of Offenders Program (child sexual assault)** is a specialised statewide program which provides treatment to adults who have sexually assaulted their own or their partner's child/ren; the program is 2 years in duration. (NSW Health)	
		Sexual Health Centres: confidential and comprehensive services that provides screening, vaccination and management of sexually transmissible infections. (NSW Health)	**Sexual Assault Services** delivers services to children and young people who have been victims of sexual assault, their non-offending siblings and caregivers; provide medical examination, forensic assessment and treatment and ongoing counselling, and court preparation and support, advocacy and crisis intervention. They also undertake a range of prevention activities including community education with families and communities. (NSW Health)	
		Children Under 10s Sexualised Behaviour Program Therapeutic case management intervention for children under ten displaying problematic or harmful sexualised behaviour. (NSW Health)	**New Street** is an early intervention program for young people aged 10-17 who have sexually abused (NSW Health)	

	Universal / Primary Services: aimed at enhancing the health, welfare and wellbeing of children, young people and their families	Secondary Services: aimed at those considered potentially 'at risk' of harm or 'at risk' of abusing)	Tertiary Services: services for children, young people and their families where abuse or neglect has occurred to ameliorate its effects and prevent further harm	Continuing Care: ongoing / long term / intensive intervention – multi-agency and / or multidisciplinary intervention
Drug & Alcohol	ADIS (Alcohol and Drug Information Services) 24 hours telephone service Sydney callers (02) 9361 8000 and country callers 1800 422 599			
	DASA (Drug and Alcohol Specialist Advisory Services) 24 hours telephone services – Sydney callers (02) 99361 8006 and country callers 1800 023 687			
		Drug & Alcohol Counselling Youth Team (DACYT) specialist clinical service for young people (12-24 years) and their families/carers who are concerned about their own or someone else's drug & alcohol use. (NSW Health)		**Residential Drug & Alcohol Units** provide multidisciplinary treatment in a residential setting
		The Child Safety Campaign aims to reduce the risk of methadone poisoning in children by educating those with children in their care. A new campaign is under development to include child safety risks associated with buprenorphine. **(NSW Health)**		**Specialised Treatment Program** e.g. methadone, opioid, stimulant, cannabis. Provide pharmacotherapy and associated services to dependent patients in NSW. (NSW Health)
		Drug & Alcohol Counselling Adult Team (DACAT) (specialised clinical services to adults with drug & alcohol dependence).		
	Drug and Alcohol treatment services provide treatment and/or withdrawal programs for people who have drug and alcohol dependency. Programs are offered in residential settings or day clinics, and include substitution treatment via a range of pharmacotherapies, withdrawal management, psycho-social counselling, case management etc. Services are provided in the public and private sector non-government organisations funded services, some general practitioners and community pharmacies.	**Needle & Syringe Exchange Program** aims to protect the community from the spread of infections such as HIV and Hepatitis C among people who inject drugs. (NSW Health)		
		SUPs/CUPs (Substance/Chemical Use in Pregnancy provide pregnant women who use drug and alcohol with support and referrals to drug and alcohol treatment options, as appropriate, and antenatal care to improve the health outcomes of their unborn child; and plan for discharge to ensure continuity of care after birth and address any issues related to parental drug and alcohol use that may impact on the newborn child. (NSW Health)		
			MERIT (Magistrate Early Referral into Treatment) is a special program based in local courts that provides the opportunity for adult defendants with drug problems to work, on a voluntary basis, towards rehabilitation as part of the bail process. (Department of Attorney General and Justice and NSW Health)	
			Keep them Safe – Whole Family Team (WFT) (KTS- WFT) are multi-disciplinary teams that address the needs of the whole family where parents/carers have mental health/ drug & alcohol problems that affect their parenting capacity and children and young people have been identified at risk of significant harm. (NSW Health)	

	Universal / Primary Services: aimed at enhancing the health, welfare and wellbeing of children, young people and their families	Secondary Services: aimed at those considered potentially 'at risk' of harm or 'at risk' of abusing)	Tertiary Services: services for children, young people and their families where abuse or neglect has occurred to ameliorate its effects and prevent further harm	Continuing Care: ongoing / long term / intensive intervention – multi-agency and / or multidisciplinary intervention
Mental Health	**Kids Helpline: 1800 55 1800**			
	Suicide Prevention and Crisis Intervention: 1300 363 622			
	Community Mental Health Teams – case management, mental health care, treatment and support for adults with mental disorders.			
	Children of Parents with Mental Illness (COPMI) collaborative approach to working with families in which adults with mental illness have responsibility for, live with or have contact with dependent children.			
		Youth Mental Health (provide early intervention to young people aged 14 to 24 years (and their carers) with a suspected emerging mental illness.		**Child & Adolescent Day Programs** provide specialised therapeutic and educational group program developed to address the psychological, social and behavioural needs of clients
		School Link Program joint initiative of NSW Health and NSW Department of Education to improve the mental health of young people; early identification and collaborative treatment of mental health disorders.	**Early Psychosis Program** evidence shows that preventing and intervening early for young people who are developing psychosis can dramatically improve outcomes.	
			Youth Mental Health Rehabilitation Teams Mental Health Rehabilitation Clinician is to provide rehabilitation and recovery focused interventions for young people aged 14-24.	
			Child & Adolescent Mental Health Services (CAMHS) provide specialist assessment and treatment services for children and adolescents with mental health problems/disorders and their families.	
			Whole of Families Team (WOFT) is a multidisciplinary team that addresses the needs of the whole family where parents/carers have mental health/drug & alcohol problems, and parenting difficulties. WOFT focuses on families where there are current child protection concerns.	
			Mental Health Inpatient Units for children/young people (up to 18 years) with a mental health illness who need to stay in hospital.	
			Acute Care Team crisis management and offers emergency mental health assessment in the community.	
Domestic Violence	**Domestic Violence Helpline: 1800 65 64 63**			
	Domestic Violence Liaison Officer are experienced in police/legal issues around DV and available for consultation in most police stations.			
	Domestic Violence Counselling Services: NSW Health provides counselling for victims, families and children; including specific targeted services and outreach services.			
	Domestic Violence Screening: routine of DV which is aimed at preventing DV by providing information to 'at-risk' populations as well as providing a strategy for early intervention; target group all women attending antenatal and early childhood health services and women aged >16 years presenting to drug/alcohol and mental health services.			
			Acute Inpatient Services provided to patients who are hospitalised.	

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