

Child Protection ~ General Paediatricians

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General Paediatrics and Child Protection

This presentation will cover:

The spectrum of child protection

Issues of notification

General paediatricians & forensic medical assessments

Medical neglect

In the context of the presentation I'm referring to both metropolitan and regional/rural paediatricians

CHILD PROTECTION – Traditional approach

Suspicions of	M a n d a t o r y	Harm/Imminent Harm
		WHAT HAPPENS TO THESE TWO GROUPS? <u>Screened out</u> = not a child protection issue <u>In between</u> = Notifier Concern
Inflicted physical injury	N o t i f i c a t i o n	<u>Screened in</u> = investigation
Sexual molestation		statutory welfare agency
Psychological abuse		police
Neglect		tertiary health professionals

Notifications – AIHW 2005

Physical, Sexual, Psychological, Neglect

Table 2.3: Number of notifications, by state and territory, 1999–00 to 2004–05

Year	NSW ^(a)	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1999–00	30,398	36,805	19,057	2,645	15,181	422	1,189	1,437	107,134
2000–01	40,937	36,966	22,069	2,851	9,988 ^(b)	315	794	1,551	115,471
2001–02	55,208	37,976	27,592	3,045	11,203	508	801	1,605	137,938
2002–03	109,498	37,635	31,068	2,293 ^(c)	13,442	741	2,124 ^(d)	1,554	198,355
2003–04	115,541	36,956	35,023	2,417	14,917	7,248 ^(e)	5,325	1,957	219,384
2004–05	133,636	37,523	40,829	3,206	17,473	10,788	7,275	2,101	252,831

16%

33%

17%

Notifications – AIHW 2005

Physical, Sexual, Psychological, Neglect

Table 2.1: Notifications, by type of action and state and territory, 2004-05

Type of action	NSW	Vic	Qld	WA	SA	Tas	ACT	NT ^(a)
	Number							
Investigations finalised ^(b)	40,984	11,486	23,401	2,391	6,250	1,333	2,529	1,003
Investigations not finalised ^(c)	17,588	402	11,960	771	29	500	488	177
<i>Total investigations</i>	<i>58,572</i>	<i>11,888</i>	<i>35,361</i>	<i>3,162</i>	<i>6,279</i>	<i>1,833</i>	<i>3,017</i>	<i>1,180</i>
Dealt with by other means ^(d)	75,064	25,635	4,679	—	11,194	6,792	216	—
No investigation possible/no action ^(e)	—	—	789	44	—	2,163	4,042	921
Total notifications	133,636	37,523	40,829	3,206	17,473	10,788	7,275	2,101
	Per cent							
Investigations finalised ^(b)	31	31	57	75	36	12	35	48
Investigations not finalised ^(c)	13	1	29	24	0	5	7	8
<i>Total investigations</i>	44	32	87	99	36	17	41	56
Dealt with by other means ^(d)	56	68	11	—	64	63	3	—
No investigation possible/no action ^(e)	—	—	2	1	—	20	56	44

Notifications – AIHW 2005

Table 2.2: Outcomes of finalised investigations, by state and territory, 2004-05

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
	Number							
Substantiation	15,493	7,398	17,307	1,104	2,384	782	1,213	473
Not substantiated	25,491	4,088	6,094	1,287	3,866	551	1,316	530
Total finalised investigations	40,984	11,486	23,401	2,391	6,250	1,333	2,529	1,003
	Per cent							
Substantiation	38	64	74	46	38	59	48	47
Not substantiated	62	36	26	54	62	41	52	53

What conclusions can be drawn from the AIHW figures?

Notification rates are rising across Australia, but why?

Investigation rates of notifications are low \cong 30%

Notifications are dealt with by means other than investigation in \cong 60%

In SA .:

100 notifications	<u>LEADS TO</u>	36 investigations
	<u>LEADING TO</u>	14 substantiations.

∴ In 2004-2005 when **17,473 notifications** were made a total of **2,436 were substantiated**

What about the other 15,037 notifications?

The effects of the 'traditional system'

More and more resources directed towards the increasing notification rate

Emphasis on assessments with little capacity to provide a therapeutic response (current therapy levels in SA)

The belief seems to have been that the 'problem' will be resolved by improving how notifications are assessed and how interventions are made.

The question that must be asked is:

How many child protection concerns could be safely and properly managed in another way, not involving notification and therefore not involving the statutory agency?

What can we do as paediatricians in this regard?

Child Abuse ~ Child Protection – The Spectrum

Child abuse – a narrow concept - harm caused to a child by a parent/carer

Physical abuse

Sexual abuse

Psychological abuse

Neglect

Child protection – a broader concept – it is an issue that must arise whenever children living with any level of physical or psychosocial adversity are identified.

- **Child Protection is a spectrum with adversity the common denominator.**
- **The higher the level of adversity the more likely harm (harm = abuse) will occur**

Child Protection – a contemporary definition

Child Protection - a process that ensures children are either not exposed to or are buffered from adverse physical or psycho-social factors that are present or may be appear in their environment of care or are effectively identified and treated when affected by such adversity.

This statement incorporates the concepts of

- **prevention, early intervention**
- **reporting, investigation**
- **treatment of children who have been harmed (primary prevention of harm occurring in the next generation)**

The “New’ Child Protection Spectrum

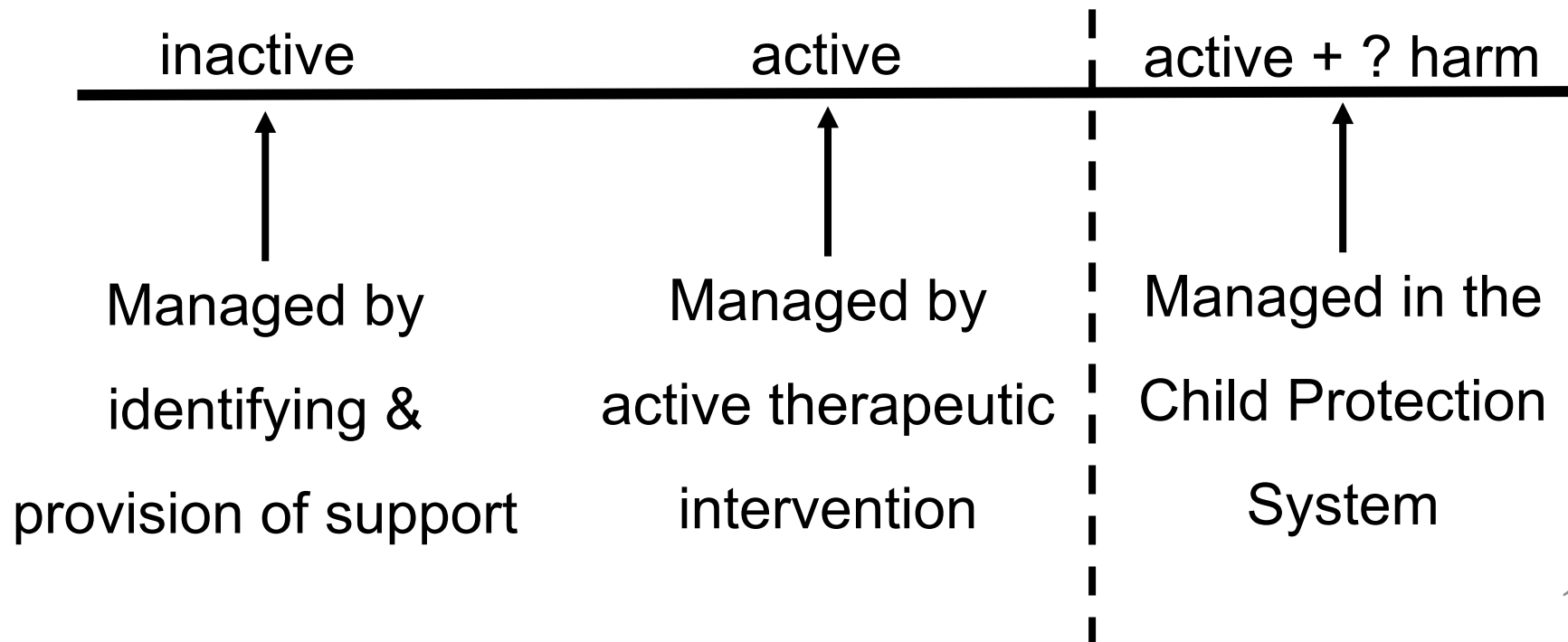
No Adversity	Psychosocial/physical Adversity	Harm/Imminent Harm
<p>Active management, primarily by Health, Education, community sector (Family Violence Services)</p>	<p>Poverty</p> <p>Young parental age</p> <p>Substance abuse</p> <p>Mental ill health</p> <p>Intellectual disability</p> <p>Interpersonal violence</p> <p>Social isolation</p>	<p style="writing-mode: vertical-rl; text-orientation: mixed;">M A N D A T O R Y R E P O R T I N G</p> <p>= VULNERABILITY</p> <p><u>Harm</u></p> <ul style="list-style-type: none"> • Physical • Psychological <p><u>Imminent Harm</u></p> <p>Infants in an actively adverse psychosocial environment</p>

Child protection spectrum - terminology

Vulnerability – children are vulnerable when their families are experiencing significant adversity (physical or psychosocial).

There is no cause-effect relationship between the presence of adversity and a child being abused (harmed by carers).

The spectrum of adversity :-



The Child Protection Spectrum – the agencies

NGOs

Early Childhood Services

Primary practitioners

Health – Primary Health Services e.g. GPs, Community nurses

Education – Early Childhood, Primary, Secondary

Secondary

Health – secondary level services e.g. paediatricians (public or private sector), mental health services (child, family, adult)

Education – counsellors, special units

Tertiary

Health – Child Protection Units, forensic practitioners

State statutory agencies – police, community services

The Current Challenges – across the Child Protection Spectrum 1

- Understanding the psychosocial bases of adversity
- Recognising adversity and assessing its effect on parenting
- Gathering further information (via **information sharing**) that allows the development of a child protection management plan
- Knowledgeable regarding referral to targeted services
- Ability to maintain involvement with families after referral

The Current Challenges– across the Child Protection Spectrum 2

- Recognising situations of harm or imminent harm in children and discussing such concerns with parents (when safe to do so)
- Being skilled in making reports to statutory agencies
- Ability to maintain involvement with families after notification
- Consult when necessary
 - Child Protection Units
 - Mental Health Services
 - Statutory agency reporting lines

Issues of Notification - 1

The concept of reasonable suspicion:-

These
situations
are straight
forward

Unexplained injury in young children

Injury patterns that have been inflicted (eg bites, blows from recognisable implements)

Allegations of inflicted injury, sexual molestation directly from a child/adolescent

What about reports from another on behalf of a child?

What about children with significant, chronic illness who are not being given recommended medical treatment?

Issues of Notification - 2

Do you tell the parent/carer of the notification?

Consider –

- Your knowledge of the individual
- Your safety
- Whether you think the child may be in danger
- Your on-going responsibility for and relationship with the family

Informing a family of an intention to notify is not always detrimental to the ongoing relationship between the family and the paediatrician

Forensic Medical Assessment

In tertiary centres done by child protection (forensic)
Paediatricians

Most population centres in Australia funnel significant clinical
child protection issues to tertiary centres.

For example

- suspected severe inflicted injury including head injury, burns and scalds, intraabdominal injury
- illness fabrication or symptom falsification

Forensic Medical Assessment – the General Paediatrician and the Two Hats Phenomenon

General & Community Paediatricians assume the role of Child Protection Paediatricians in Regional Centres

This means having a choice of two hats:-

The normal paediatric hat –

- referrals from GPs etc

- caring for inpatients

- conducting hospital & private follow-up

The child protection hat \equiv forensic paediatric hat

- should only involve referrals from statutory agencies (police, community services) – this should follow an agreed set of “Interagency Procedures”.

Forensic Medical Assessment – the General Paediatrician and the ‘Two Hats Phenomenon’

- Referring agents may attempt to by-pass the child protection notification requirement, if they are aware of the local paediatrician’s child protection role.
- Allowing this practice to occur can compromise the paediatrician's forensic responsibilities.
- Regional child protection paediatricians need to be confident in their knowledge of the local limitations in the availability of ‘special investigations’.
- For example the need for skeletal surveys, bone scans, optimal fundoscopy, cranial imaging may require transfer to a tertiary centre.

Forensic Medical Assessment – the General Paediatrician and the ‘Two Hats Phenomenon’

- Regional paediatricians should be supported by the RACP in their insisting on the availability of adequate equipment, infrastructure and support to be able to conduct forensic medical assessments
- Tertiary child protection paediatricians should actively support and advise regional paediatricians
- Tertiary child protection paediatricians should seek advice from regional paediatricians to ensure that proper support and advice is available to them; for example report writing, opinion formulation, expert witness training

The Issue of Medical Neglect

In this context referring to situations where children, usually but not always with chronic, serious disease fail to receive the medical treatment considered necessary by their paediatrician usually because of parental non-compliance.

The Issue of Medical Neglect

Several factors are considered necessary for the diagnosis of medical neglect:

1. a child is harmed or is at risk of harm because of lack of health care
2. the recommended health care offers significant net benefit to the child
3. the anticipated benefit of the treatment is significantly greater than its morbidity, so that reasonable caregivers would choose treatment over non-treatment
4. it can be demonstrated that access to health care is available and not used
5. the caregiver understands the medical advice given

The Issue of Medical Neglect

Additional issues to be considered

- When a procedure carries inherent danger or a drug has significant adverse effects, labelling a caregiver's reluctance to cooperate as neglect may be problematic.
- In some situations, health care professionals may evaluate risks and benefits of drugs or procedures differently than families
- Whenever the issues of medical neglect arises there is invariably a role for the patient ethics committee – adds a neutral voice one step removed from the conflict

The Issue of Medical Neglect – matters to be considered

Factors within family

Poverty or Economic Hardship

Family Chaos and Disorganization

Lack of Awareness, Knowledge, or Skills

Lack of Trust in Health Care Professionals

Impairment of Caregivers

Caregiver's Belief Systems

The Child's Attitudes and Behaviour

Each of these should be considered and their contribution understood- attention may improve the problem

The Issue of Medical Neglect

Factors within the paediatrician

(Patient care ethics groups are helpful in this regard)

Misunderstanding of Different Cultures – particularly in parenting practices

Communication impaired by parental literacy, lack of understanding – more so when medical instructions are complicated

A Response & Approach to Medical Neglect

- Understand the family's concerns – try and establish a partnership with the family
- Make sure counsel provided to family regarding the child's condition and the necessary treatment regimes
- Involve other carers from within the extended family
- Involve family in development of medical plan
- Consider the development of a medical treatment contract with the family (an agreed contract may assist with statutory agency involvement if this becomes necessary)
- Regular home visits to observe treatment regimes and assistance in implementation

When all prior has failed

Primary consideration is that child is being harmed or will be harmed because of lack of advised medical care (eg harm that will be associated with failure to comply with PKU regime)

View must be objective and well reasoned, rather than 'just an opinion'

Management Approach - 1

Refusal for 'one off' treatments – blood, platelets etc. in otherwise compliant family

- Consider applying for 'medical treatment order' rather than statutory services involvement

Children with chronic serious disease whose health is considered to have been harmed or whose health will be harmed without parental compliance

- Case conference (without parents) including doctors, allied health, nurses and child protection paediatrician
- Responsible paediatrician to prepare a comprehensive case study report highlighting the basis for harm &/or the effects of non-compliance (eg PKU child not given diet)

Management Approach - 2

Review of case study report and address the following

- Evidence parents understand the concern
- The level of contractual arrangements negotiated with the parents (has a contract been drawn up?)
- Be clear that the issue is one of child protection and not medical treatment
- Consider (with advice from child protection paediatrician)
 - The best time for notification
 - The best content of notification
 - The best method of notification

Management Approach - 3

It's not usual for statutory agencies to have priority access to services therefore their role in such situations (if they agree that the report requires a child protection response) is to

- Enforce parental compliance with child's medical management needs
- Consider statutory or voluntary removal of child into voluntary placement.

As a general principle the outcome for a child in such a situation tends to be better if the issue can be adequately addresses outside of the child protection system

Thank You