Duty to Report: Child Abuse and Neglect (Community)

Site Applicability

All VCH Community Programs who provide care to children, youth and families.

Practice Level

Basic Skill: All clinicians who provide care for children, youth and families in VCH community settings including but not limited to:

- Registered Nurse, Registered Psychiatric Nurse, Licensed Practical Nurse, Nurse Practitioner
- Registered Dietitian (RD)
- Social Work (SW)
- Dental Assistant, Certified Dental Assistant (CDA), Dental Hygienist (RDH), Dentist (DMD)
- Speech Language Pathologist (S-LP)
- Audiologist
- Physiotherapist (PT)
- Occupational Therapist (OT)
- Clinical Counsellor
- Spiritual Care Practitioner
- Health Support Worker

Education: See LearningHub VCH Duty to Report online Module

Policy Statement

All VCH community clinicians will complete the online VCH Duty to Report education during orientation and will review and follow this guidance document when concerns about suspected child abuse arise.

Need to Know

The purpose of this document is to guide clinicians in their Duty to Report child abuse and neglect through contact with Ministry of Children and Family Development (MCFD), Vancouver Aboriginal Child and Family Services Society (VACFSS) or other Delegated Aboriginal Agencies (DAA). The term client in this document may refer to individual children/youth, parents, guardians, or families.

The goals are to build clinician's confidence in their decision making about when and how to call MCFD/VACFSS/DAA through:

- Application of their knowledge from the *BC Handbook for Action on Child Abuse and Neglect Service Providers* and related Duty to Report education modules.
- Understanding their role in reporting to and advocating for MCFD/VACFSS/DAA supports for families and children.
- Familiarity with the VCH Ethical Decision Making framework – and availability of VCH Ethicists to provide support in the decision making process.
- Understanding the complexities of situations which require a Duty to Report and benefits of assessment and planning in partnership with families. When the client is a youth, it is important to base your plan of care on their developmental stage.
- To build clinician's skills in effectively collaborating with both the client and MCFD/VACFSS/DAA to promote optimal support for the family and minimize trauma.

Practice Guideline

Step 1: Build Therapeutic Relationship

- A therapeutic helping relationship is a relationship based on mutual trust and respect, the nurturing of hope, being sensitive to self and others and assisting with client's needs through your knowledge and skill.
- A therapeutic relationship can be established in the context of a long term client relationship or in shorter episodic care.
- Use a non-judgemental trauma informed approach, taking into consideration that clients and/or their families may have a history of trauma that can influence their accessing, navigating or transitioning to health care services.
- Clients can present differently and sometimes in unexpected ways, it is important to show respect, caring and open curiosity about their experiences and/or culture.
- Validate your understanding of client situations, behaviours, or phrases.
- Use open ended questions and reflection to avoid misunderstandings and assumptions.
- Utilize interpreters wherever possible to ensure accurate communication and assessments when language could be a barrier.
- Discuss with client whether engaging with culturally based resources, such as Aboriginal Elders, would be desired.
- Understanding a client's perspective provides information on client motivation, readiness to take action as well as identifying possible barriers to action.
- Recognize clients will discuss what they feel comfortable and capable of sharing. Understand their need for controlling the disclosure of personal information.

Step 2: Be Transparent

- Advise the client early on in your relationship that if you have any concerns about them/their child or situation you will talk about it with them. Discuss with the client your need to contact MCFD or VAFSS/DAA for their input and support if you are concerned about their safety or that of their child.
- Tell the client you will always try to let them know before you make a call to MCFD/VACFSS/DAA and you will encourage them to be involved in making the call whenever possible.
- Acknowledge the benefits of early support from MCFD/VACFSS/DAA and how this support can prevent issues before they occur.
- Consider asking them, "If for any reason you were unable to look after your child who could you call to help you out?" The earlier you can guide clients to seek support the better. An early support request allows for thoughtful calm planning rather than a crisis reaction.
- If you are in a long term client relationship, consider getting written consent from the client permitting MCFD/VACFS/DAA to share information with you. Although MCFD/VACFS/DAA can request any information from care providers with or without client consent, if they are concerned about a child's safety, they cannot disclose information to other care providers without client permission.

Step 3: Making the Decision to Call MCFD/VACFSS/DAA

- You do not need proof that a child has or likely is to be abused or neglected, neither do you have to be certain about it; if you have reasons to believe a child is at risk and the parent is unwilling or unable to protect the child, you must report. Refer to *BC Handbook for Action Child Abuse and Neglect Service Providers* handbook for additional information.
- It is the child protection worker's job to determine whether abuse or neglect has occurred or is likely to occur based on the information they may have gathered from a variety of sources. The clinician's assessment of the family and the situation is an important part of this assessment.

- When information is disclosed that indicates risk of immediate danger, a call to 911 (police) and/or MCFD/VACFSS/DAA must be made immediately.
- When you are unsure about your duty to report, seek to gain better understanding of the situation.
  a) Explore with the client/family their understanding, concerns or worries about themselves, their child or situation through the use of open ended questions and reflection. Seek to understand and strengthen their motivation and/or confidence to promote change.
  b) Explore with the client/family what other family or community connections can be accessed for support. These supports need to be willing and able if they are included in care planning.
  c) Consult with your team leader/educator/manager for support in moving yourself and the client toward appropriate action.
  d) Consider consulting with other involved service providers to gain a more complete picture of the situation.
  e) Consider making a consultation call to a MCFD/VACFSS/DAA social worker to determine the actions or supports that may be needed in the situation.
  f) Reference the VCH Ethical Decision Making Framework and/or call a VCH Ethicist to help guide your decision making process about when to call or in planning future care.
  g) *Note: These actions can occur during the decision making process, or following a call to MCFD/VACFSS/DAA.*
- Many clinicians are concerned if they contact the MCFD/VACFSS/DAA SW they will lose connection with the client and no further supports will be offered or accepted by the client/family. However, safety and well-being of children are the paramount consideration. Following the steps in this guideline and partnering with others including the family, may reduce potential discord in your relationship.
- **Always assess if there are safety implications for yourself if the client or partner were to be aware you are calling MCFD/VACFSS/DAA. If there are safety concerns, speak directly with your manager/lead and a call should be made to MCFD/VACFSS/DAA without the client's knowledge.**

Step 4: Preparing for the Call

- With the client, discuss why you are concerned and assess the client's understanding of why you are concerned.
- Assess whether the client/family has had involvement with the Ministry in the past and what they believe their partner's or family's response to the call might be. Acknowledge and validate any concerns.
- Ask what might make the client/family more comfortable engaging with MCFD/VACFSS/DAA this time?
- Message to the client/family that MCFD/VACFSS/DAA is part of a circle of care whose intention is to keep clients/families safe. The circle of care includes the family, clinicians, the Ministry and others working with the family. Speak about Ministry's mandate to support families and acknowledge the Ministry wants to keep children with their family wherever possible.
- If you anticipate ongoing contact with the client/family, tell them that you are prepared to work collaboratively with them through the MCFD/VACFSS/DAA process
- Assess whether the client needs a safety plan? (See safety plan resources in Related Documents section)
- Be empathetic and acknowledge when there is a difficult situation for the client/family. Ask the client/family what they think would make the situation better and how that could be accomplished. Having a plan they can share with MCFD/VACFSS/DAA can provide some sense of control but use caution and do not promise MCFD/VACFSS will agree to the plan.

- If the client is unsure of what to do or has limited ideas, offer suggestions that have supported others and ask how they think those supports would help them.
- Do not promise specific supports from MCFD/VACFSS/DAA as they may not be available.
- Discuss options with the client/family for how contact will be made with MCFD/VACFSS/DAA and allow choice when possible – The options presented to the client will need to consider client age, client capacity, urgency of the situation, client willingness to engage, client and/or clinician safety, and circumstances related to the specific situation such as location of disclosure.
  a) Client initiates the contact without the direct assistance of the clinician. Plan with the client specifically how and when this will be done. In addition, discuss how the clinician will validate the client was able to complete the plan and how the next steps will be communicated to the clinician.
  b) Clinician and the client make the call together.
  c) Clinician calls without the client/family present but client/family is aware. If client is not making the call with you, consider letting client know you will introduce yourself to the social worker as an advocate highlighting strengths, concerns and risk factors of the client's situation.

Step 5: Making the Call

- Act as an advocate for the client with MCFD/VACFSS/DAA – introduce yourself and explain your involvement with the client. Communicate to the social worker that you plan to work with the client/family to provide ongoing support (as appropriate).
- Be clear, concise and organized in the presentation of your information:
  a) Be prepared to provide client information such as legal names of parent(s) and child(ren), DOB, address and phone number
  b) Present concerns and related risk factors:
     - child(ren)'s basic needs not being provided for
     - child behavior that does not meet age expected physical or social emotional development
     - parental concerns about their ability to provide for their child(ren)'s needs or manage their behaviour
     - domestic violence - physical or emotional
     - social isolation
     - parental history of childhood abuse or neglect
     - substance use
     - parental mental health or cognitive issues
  c) Highlight client/family strengths that will be helpful in dealing with the situation, such as:
     - extended family support
     - willingness to take action
     - recognition or acknowledgement of the concern
     - ability to follow through on planned actions
     - strong attachment to child(ren)
  d) Present current plans you and/or client/family have in place to deal with the concern and what additional support you and/or the client are seeking.
  e) Ensure any safety concerns are effectively communicated to the Intake Social Worker and have been acknowledged and necessary protection/support has been arranged.
- Request to be informed about MCFD/VACFSS/DAA follow up; who will be involved and when.
- If you are in a long term relationship with the client/family, request a joint integrated case management meeting to ensure everyone involved, including the client, have an understanding of the situation and know the plan and their role.

Step 6: Following the Call

- Follow-up with the client/family re: the outcome of the MCFD/VACFSS/DAA report – reflect/acknowledge their feelings. Affirm positive outcomes or changes in their behaviour and link them to the longer term differences they will have. Be specific and individual if you can.
- If client/family is having difficulty acknowledging the reasons why MCFD/VACFSS/DAA is putting specific supports or conditions in place, or not seeing any positive outcomes from the involvement of MCFD, assist them to reframe the situation through the use of open ended questions like:
  a) "Why might the social worker think/do that?"
  b) "How could you help the social worker to feel more confident in your parenting?"
- If the client/family is struggling to see any positive aspects of their situation, you can help them shift focus by using open-ended questions to draw their attention to positives:
  a) "What is one thing you could do that would make your time with your child enjoyable for both of you? What would need to happen so you could do that?"
- Repeat calls to MCFD/VACFSS/DAA may be necessary to advocate for the type and amount of support you feel the client and/or child(ren) require.
- Repeat calls may be necessary over time with new incidences of concern, or particularly with concerns about escalating severity or frequency.
- If the services offered through the Ministry do not support the client/family to meet their needs and goals, discuss with your manager/lead/educator and advocate for involving MCFD/VACFSS/DAA leadership (team leads or otherwise) as necessary.
- If the call to MCFD/VCFASS/DAA has caused discord in your relationship:
  a) Don't give up.
  b) Acknowledge how the client might feel. Reflect they may feel hurt/angry/disappointed/betrayed.
  c) Ask the client/family why they think you called; offer that you called because you care about them.
  d) If they are not yet prepared to re-engage, leave the door open by letting them know should they feel like calling you in the future you would like to hear from them.
  e) It may be helpful to mention supports that have been useful to them.

Urgency scale for Child Abuse reporting

The goal is to work collaboratively with the client/family during the reporting process however there are times when the situation is more urgent and immediate action is required. This chart is designed to guide the clinician in determining whether there is time, if needed, to motivate the client to call MCFD/VACFASS/DAA collaboratively with the clinician or not.

Remember that the clinician's role is not to investigate abuse. MCFD/VACFSS /DAA often has additional information available to them that is not known to the clinician.

Level of Urgency	Type of abuse	Emotional state of parent	Supports	Access to financial/other resources	Client's readiness to take action
Lower	Neglect or potential for harm if behaviours continue/ change in frequency or intensity No behaviour changes in child	No indication mental health, substance use or cognitive impairment are compromising parent's ability to provide care	Extensive family, friend or service provider support	Family has access to finances and or other resources that they could utilize	Family acknowledges care needs to change and is willing to immediately work collaboratively on a plan
Moderate	Degree of neglect or inappropriate parental behaviour is increasing in frequency or intensity OR Child presenting with behaviour changes (see BC Child Abuse Handbook for more detail)	Mental health, substance use or cognitive impairment are present and may be compromising parent's ability to provide care	limited	Family has limited financial/other resources. Has access to resources through others but is unwilling or unable to request assistance	Family acknowledges the child's care needs to change but is unable to take the necessary steps
High	Sudden increase change in frequency or intensity of abuse Lack of ability to keep child safe Signs of physical harm esp. if they require medical attention Sexual abuse or exploitation by parent Child is in pain or emotional distress Severe neglect-lack of provision of basic needs	Family is unwilling or unable to provide for or protect the child	none	Parent has insufficient financial resources and/or access to other resources such as transportation, phone etc. to provide care	Family are unable or unwilling to make changes to their behaviour or choices

Urgency scale for IPV reporting

Intimate partner violence impacts the health and well-being of children/youth. Clinicians should consult the BC Handbook for Action on Child Abuse and Neglect for Service Providers and/or their lead/educator/manager to determine their duty to report. The goal is to work collaboratively with the client/family during the reporting process, however there are times when the situation is more urgent and immediate action is required. This chart is designed to guide the clinician in determining whether there is time, if needed, to motivate the client to call MCFD/VACFASS/DAA collaboratively with the clinician or not.

Remember that the clinician's role is not to investigate abuse. MCFD/VACFSS/DAA often has additional information available to them that is not known to the clinician.

Level of Urgency	Type of abuse	Emotional state	Supports	Dependence on partner for economic or other resources	Client's readiness to take action
Lower	Client has disclosed verbal/emotional abuse without changes in frequency or intensity	Client verbalizes no change in sense of safety or control over decisions she could make	Extensive family, friend or service provider support	Has access to finances and or other resources that she could utilize if needed	Client has a safety plan and the resources to put the plan into action
Moderate	Client has disclosed changes in type, frequency or intensity of abuse	Client is ambivalent- about sense of safety	limited	Has access to resources through others	Client has a safety plan and the resources to put the plan into action
High	Sudden increase/change in frequency or intensity of abuse Other risk factors as outlined in the BC Domestic Violence Teams Summary of Domestic Violence Risk factors (see link under Related Documents)	Client is fearful for her own or children's safety Client is experiencing increase or change in depressive or anxious feelings	none	No other source of income or access to other resources such as transportation, phone etc.	Client is preparing to take steps to leave the relationship or the client is unable or unwilling to consider leaving the relationship

Ministry Supported Services

The range of supports available varies significantly. MCFD/VACFSS/DAA assess and determine which services are offered to families. Clinicians play an important role in advocating for client supports but should be mindful that decisions re: resource allocation are made by Ministry Staff.

Supports may include:

a) One on one family preservation
b) Group family preservation classes
c) Postpartum Doula services
d) Counselling services
e) Funding for daycare
f) Funding for supplies (e.g. crib, diapers, compass cards)
g) Support connection and reunification with extended family
h) Youth Agreements

Documentation

Documentation of all client contacts in which a clinician-client relationship is established will be documented according to professional and program guidelines.

Health records may be used to help resolve legal issues, therefore, documentation should include relevant, objective, and specific factual observations and client statements. Document enough factual detail to demonstrate your decision-making. Document the specific actions you take.

Related Documents

1. BC Handbook for Action on Child Abuse and Neglect for Service Providers (June 2017)
2. BC Duty to Report pamphlet (not available online): Appendix A
3. BC Domestic Violence Team's Summary of Domestic Violence Risk Factors (see appendix)
4. Safety Plan Resources:
   - VCH/PHC: Leaving Domestic Violence: A Safety Planning Checklist
   - BC Provincial Domestic Violence Website
5. VCH Ethical Decision Making Framework & Ethics Consultation Services
6. BC Representative for Children & Youth – Key Reports
   a. BC Representative for Children & Youth Report: Honouring Kaitlynee, Max and Cordon
      Report followed Schoenborn murder of three children in which multiple systems were involved but had not connected with one another.
   b. BC Representative for Children & Youth Report: Paige's Story: Abuse, Indifference and a Young Life Discarded
      Report advocated for provincial review of duty to report training of service provider staff.
7. Trauma Informed Practice Guide: http://bccewh.bc.ca/2014/02/trauma-informed-practice-guide/
8. Early Childhood Exposure to Domestic Violence: You Can Help. A toolkit for individuals working with children between the ages of 0-5.
   https://earlyyearsbc.ca/wp-content/uploads/2017/10/domestic-violence-toolkit.pdf
9. Domestic Violence Resource Card (Catalogue No. CE.350.D66)

References

See *Related Documents*

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VCH: *(Regional SharePoint 2nd Reading)*
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Final Sign-off & Approval for Posting by

Vice President Professional Practice and Chief Clinical Information Officer, VCH

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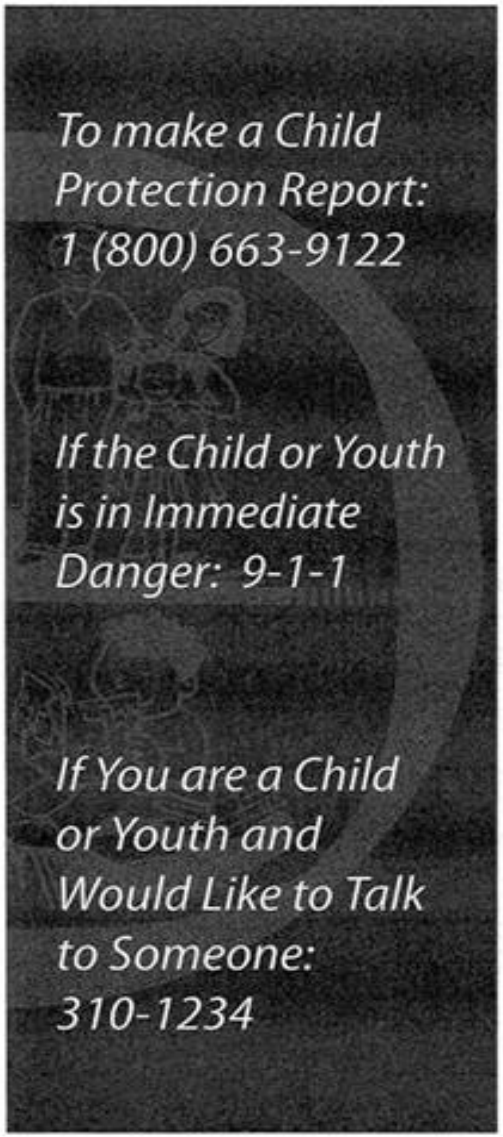
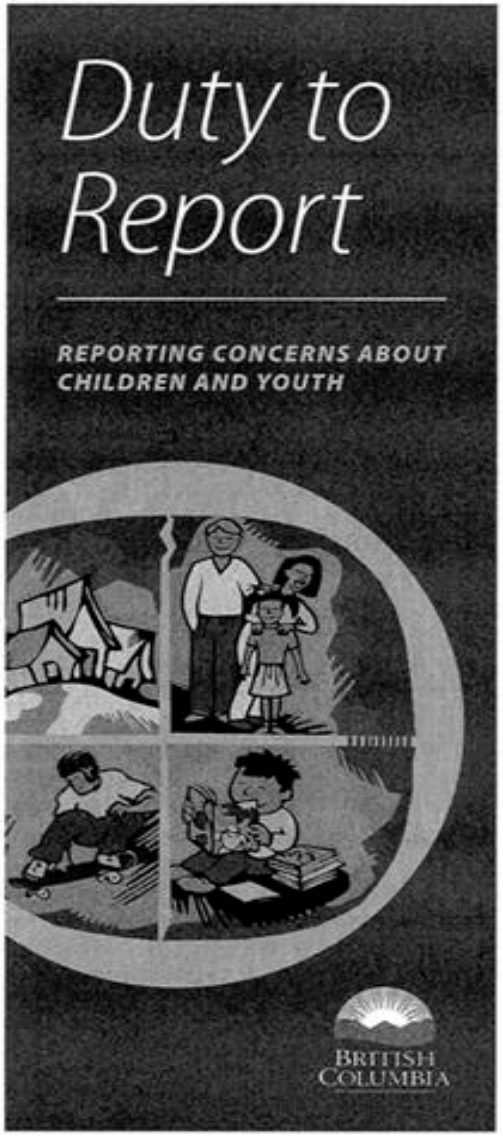
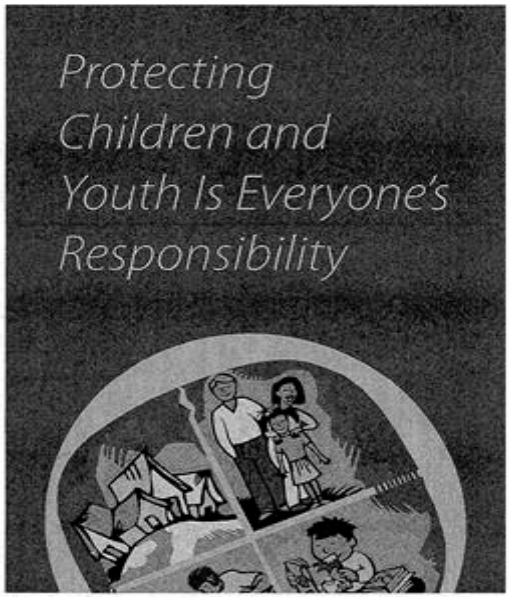
Appendix A: BC Duty to Report Pamphlet







WHO SHOULD REPORT?

In BC anyone who has reason to believe that a child or youth under 19 has been or is likely to be abused or neglected and that the parent is unwilling or unable to protect the child or youth, ***must*** report the suspected abuse or neglect to the Ministry of Children and Family Development.

Everyone in the community should be alert to signs of abuse or neglect in children and youth. Their safety, welfare and well-being are a community responsibility.

FOR MORE INFORMATION:

www.gov.bc.ca/reportchildabuse

WHEN MUST A REPORT BE MADE

A report to the Ministry of Children and Family Development ***must*** be made when you have reason to believe that a child or youth:

- Has been, or is likely to be, physically harmed, sexually abused or sexually exploited by a parent or another person and the parent is unwilling or unable to protect the child or youth;
- Has been or is likely to be physically harmed because of neglect by the child or youth's parent;
- Is emotionally harmed by the parent's conduct;
- Is or has been absent from home in circumstances that endanger the child or youth's safety or well-being;
- Has been abandoned and adequate provisions have not been made for the child or youth's care;
- Is living in a situation where there is domestic violence by or towards a person with whom the child or youth resides;
- Is likely to have seriously impaired development by a treatable condition and the child or youth's parent refuses to provide consent to treatment;
- Has a parent that is unable or unwilling to care for the child or youth and has not made adequate provisions for the child or youth's care; or
- Has a parent that is no longer alive and adequate provisions have not been made for the child or youth's care.

WHAT DOES "REASON TO BELIEVE" MEAN?

"Reason to believe" simply means that, based on what you have seen or information you have received, you believe a child or youth has been or is likely to be at risk. You do not need to be certain. It is the child protection worker's job to determine whether abuse or neglect has occurred or is likely to occur.

FAILURE TO REPORT

Failing to promptly report suspected abuse or neglect to the Ministry of Children and Family Development is a serious offence under the Child, Family and Community Service Act and carries a maximum penalty of a $10,000 fine, six months in jail, or both.

No action for damages may be brought against you for reporting information under the Child, Family and Community Service Act unless you knowingly report false information, or the report was not made in good faith.