Interviews with health professionals about the National Child Protection Alert System

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ABSTRACT

AIM: The New Zealand National Child Protection Alert System is administered by multidisciplinary teams in every district health board. The aim of this study was to investigate the factors that influence multidisciplinary child protection teams’ (MDTs’) decisions about whether to place a child protection alert.

METHOD: Members of the Child Protection Alert System teams were invited to participate in semi-structured interviews. Interview data were coded and grouped into themes using inductive thematic analysis.

RESULTS: Six themes were identified: the system works well; a wide range of factors are considered in multidisciplinary team decision-making; there are some difficulties with multidisciplinary team meetings; there are problems with the administration of the system across district health boards; there is concern about the potential for the Child Protection Alert System to stigmatise families or cause unjustified responses; improvements can be made to the system.

CONCLUSION: There is overall support for the National Child Protection Alert System and a consensus that the benefits outweigh any potential risks. There is a need for further improvements to the system, including consistent training, further standardisation and increased accessibility of the information to health professionals, including making information on the system available to primary healthcare.

New Zealand has a publicly funded healthcare system with services provided through 20 semi-autonomous district health boards (DHBs).1 All DHBs have policies requiring staff to notify child protection concerns to statutory child protective services (CPS). However, there is no nationally shared patient record system, and many families are highly mobile.2 As a result, a past history of child protection concerns is often invisible to health providers.

The potential consequences of this were tragically illustrated in the case of a child murdered in the Hawkes Bay in 1999 despite 40 contacts with health providers: four hospital emergency department visits, two admissions, one clinic, three face-to-face appointments with well-child nurses in the community and 30 visits to general practitioners at four practices. “Collectively the health sector had available a telling picture... [which] was never put together because of poor communication. Information was not passed on or was incomplete. Previous records within the same hospital or practice were not viewed and... social and medical histories were not sought or provided.”3 The failure of other agencies to share information with the health system was also important and was highlighted again in the death of two sisters in 2001.4 Similar issues occur repeatedly in reports into child-abuse deaths in other countries.5,6
There is one feature of the New Zealand healthcare system that makes it possible to share health information nationwide: the National Health Index number (NHI), “a unique identifier assigned to every person who uses health and disability support services.”

Linked to the NHI is the National Medical Warning System (NMWS), a simple database first designed in the 1960s to share information about risks such as anaphylactic medication reactions. The NHI and the NMWS are the only databases shared by all 20 DHBs, which otherwise use multiple information and clinical record systems, most of which cannot communicate with each other.

In response to these issues, the National Child Protection Alert System (NCPAS) was developed to use the NMWS to share information about child protection concerns. It is a collaboration between the Paediatric Society of New Zealand, the Ministry of Health and DHBs. Hawkes Bay DHB placed the first national child protection alert (CPA) in 2003 and was joined by the Auckland DHB in 2009. By 2011, a comprehensive framework was in place, incorporating national policy, a privacy impact assessment, governance, DHB policy templates, terms of reference for multidisciplinary child protection teams (MDTs) in each DHB, pro formas to document factors considered when placing CPAs, guidelines, training packages and regular auditing.

A CPA can only be placed where a DHB has notified CPS (or where CPS are already involved). It must be approved by the MDT and supported by comprehensive information. It remains until the eighteenth birthday but may be removed earlier by application to the MDT that approved it. CPAs can also be placed on siblings at risk and pregnant women who have been notified to CPS. Antenatal CPAs can be transferred to the baby after birth if concerns persist. Concerns leading to CPAs cover a wide range of issues, including emotional abuse, neglect, physical abuse, sexual abuse, mental-health or behavioural issues, poor engagement with services, family violence, parenting capacity, parental substance abuse, parental criminality or parental mental health. Many have multiple concerns. There are now 48,530 child protection alerts on the NCPAS.

When an individual presents to a DHB and their NHI is registered, the CPA is automatically downloaded from the NMWS and appears as follows: “Child protection concerns, contact X DHB,” where X is the name of the DHB that placed the CPA. Policies and training emphasise that the NCPAS is a flag to past concerns, not a child protection register (that is, it is not a database containing up-to-date information about a subset of children at a known level of risk). The health provider is expected to access those past concerns to inform a thorough assessment of the new presentation. A CPA does not necessarily indicate ongoing risk, and no CPA does not necessarily mean no risk.

Although the NCPAS is designed to enable information sharing, audits show a wide variation in the ratio between the number of CPS notifications submitted to each MDT for consideration of a CPA and the number of CPAs that each MDT agrees to place. Some MDTs place CPAs on 99% of children whom their DHB has notified to CPS, whereas others place CPAs on only 60%. Variation in this ratio (the ‘conversion rate’) was not eliminated in a study of inter-rater agreement where MDTs were presented with the same cases, so it appears there are factors other than case information alone that influence decisions to share child protection concerns.

The aim of this study was therefore to further investigate factors that may influence decision-making within NCPAS MDTs.

Method

Research approval was obtained from the Auckland DHB.

Every MDT member in all 20 DHBs was identified by direct contact with team coordinators, and all agreed to provide their email addresses to the study investigators. In December 2016 and January 2017, all were invited to participate in an online survey. The size, composition and frequency of MDT meetings nationwide, and the years of experience in child health of MDT
members, is described in detail in the results of that survey, published elsewhere. At the end of the survey, participants were asked if they would be willing to be interviewed. We aimed to recruit up to 25 interviewees, a number often sufficient to reach data saturation in qualitative studies. Data saturation occurs when there is no new information in the data. Using an online research randomiser, interviewees were randomly selected from those who said yes. The sample was checked to confirm that randomisation had achieved representation of multiple professional roles, multiple DHBs (eg, both small rural DHBs and large urban DHBs) and multiple perceptions of the NCPAS (ie, those selected included both those who rated the NCPAS highly in the online survey and those who rated it poorly).

In April and May 2017, telephone interviews were conducted by an Honours student in clinical psychology (MA) and the Starship Foundation Child Protection Research Fellow (CB). Interviews followed a semi-structured format (Figure 1). Prompts (in brackets) were used to seek clarification of initial responses. Interviews were recorded, transcribed and de-identified.

Thematic analysis followed the guidelines proposed by Braun and Clarke. Transcripts were read and re-read to gain familiarity with the data, then initial codes (features evident across the entire dataset) were generated and collated into themes. Each theme was reviewed in an iterative process to ensure that it worked in relation to the codes and the full dataset. Codes and themes were then reviewed by a third member of the research team (FS). Once data saturation had been reached, no further interviews took place. Because the interviews were semi-structured (ie, questions did not follow the same precise order and were not necessarily expressed in identical manner), the number of respondents for each theme are not reported, but descriptors such as ‘few’, ‘some’ and ‘many’ are used.

Results

Ninety-one of 160 MDT members (57%) completed the online survey, representing all 20 DHBs and a diverse range of professional groups and levels of experience. Of these, 61 (67%) volunteered for an interview, and 18 (29.5%) were interviewed. Thirteen were female and five were male. Sixteen were of European ethnicity, one was Māori and the ethnicity of one was unknown. Interviewees came from nine DHBs, with no more than two from any one DHB, and they represented the full range of perceptions of the NCPAS, from disapproval to approval, as expressed in the online survey.

There were six social workers, five doctors, three violence intervention programme coordinators, two nurses and two midwives. The professional mix reflected the national make-up of MDTs, as described in the 2016 study of inter-rater agreement and the online survey, but Māori health professionals (who are present in 44% of MDT meetings) were under-represented.

Six themes were identified (Figure 2).

Figure 1: Interview schedule.

Tell me how you feel the NCPAS is functioning at a national and local level? (Negative and positive)

What is the process you use when deciding whether to place an alert? (Factors that influence decision-making, personal threshold)

Do you have any concerns about NCPAS?

What else does the NCPAS need?

Is there anything else you would like to say about the NCPAS that we have not already talked about?
Theme 1: the system works well
Many supported the system and believed it was working well.

“...my feeling is that locally here for us it is functioning very well and effective. We’ve got a good strong group in that we’ve got very good buy in from a multi-professional group” (Participant 1)

“I think the process of identifying children and putting the alerts on is working pretty well” (Participant 5)

“I think it is making quite a significant difference to the safety of children and young people” (Participant 12)

Many commented on the strength and utility of MDT meetings.

“We do have some healthy discussions where, at times, maybe just one person in the group doesn’t agree, and so, we’ll continue to talk about that, to try and reach a consensus” (Participant 13)

Several stated that the NCPAS supported continuity of care.

“It’s good for professionals and for families because it... it can be a continuation, rather than a repeating, repeating over and over again of potential missing important information” (Participant 17)

Several described other advantages, including antenatal alerts and benefits in providing care for transient families.

Theme 2: a wide range of factors are considered
A wide range of factors are considered when MDTs are deciding whether to place a CPA. In addition to physical or sexual abuse or neglect, many mentioned the child's age, multiple presentations, parental mental health, family violence, substance abuse and gang affiliations. Some mentioned transience, truancy, concerns from multiple professionals and factors associated with parenting stress, such as being a solo mother or children from multiple fathers. Many said they took a common-sense approach and that some cases were obvious.

“We basically, we look at the parents and siblings, we look at all their presentations... I guess the more risk factors the more likelihood of harm. So, you know, engagement, mobility, mental health, maternal mental health, what the child presents with... alcohol, drug and the CPS history would probably be the biggest triple, the top trio... the other thing we look at would be the age of the children... intimate partner violence...” (Participant 11)

Figure 2: Themes.
Several mentioned factors that influenced them not to place an alert, such as engagement with services, presence of a safety plan, imminent plans for adoption or other changes in living circumstances and/or the child being an older adolescent.

“...if they were engaged with a number of services not just one... if mum or the partner were seeking help, seeking advice” (Participant 10)

A few placed great reliance on whether information had been substantiated by CPS, but others disagreed.

“I just think you should be basing it on... the information that you have in front of you. And if there's enough concern on that to warrant an alert... anything else you're actually gathering from other agencies is something that is not available in the health record” (Participant 14)

In summary, a wide range of factors were considered, but there was variation in understanding of how much information was needed before an alert was placed.

Theme 3: difficulties with MDT meetings

Although many commented positively on MDT meetings, some had concerns including the adequacy of the information presented, time required, staff turnover and challenges engaging doctors.

“There's some reluctance around paediatricians wanting to pick up child protection as part of a portfolio” (Participant 11)

A few expressed concerns about the impact of the work.

“I am worried about burnout... sometimes you just got to de-frag and try and leave that stuff here at work” (Participant 13)

One commented that it was difficult to get staff to attend meetings, as there was a feeling that the paediatrician overruled them.

“I know that has caused a few issues, for some... I've (heard) a couple of comments, ‘well, why do we bother if it's just the paediatrician making all the decisions’” (Participant 8)

Theme 4: concerns about potential negative impact

A few were concerned that alerts might cause unjustified or judgemental responses, or that they are not regularly reviewed.

“It has the potential to... skew the... approach that a subsequent clinician might have to that child towards child protection. And that's not necessarily a bad thing, but it... could lead to further investigations which are unnecessary and unwarranted, and also potentially removing a child, or another notification to CPS, which may or may not be necessary” (Participant 5)

“...my biggest concern would be that people may get judged by clinicians... I just worry that people might get treated differently” (Participant 11)

“...the fact that it hasn't been reviewed in 10 or 12 years. And so, you know this family or this child... has been treated in a way that actually is no longer relevant for them” (Participant 1)

Participants were specifically asked about stigmatisation. A few expressed concerns about the possibility but felt that it was outweighed by the need to ensure child safety. A few noted the information was helpful even when abuse was no longer a risk (eg, in adolescents presenting with later mental health concerns).

“Isn't it worthwhile us... having this information? And sharing it so that actually we can put better stuff around this mum... I don't think stigma is an issue at all, because if you're being professional. That's like saying... because she smokes there's a stigma around her, do you know what I mean, we're anti-smoke? And we know the damage smoking does” (Participant 6)

A few felt that there is misunderstanding about what an alert is (eg, a register of children at high risk, rather than simply a flag to past concerns that may or may not remain relevant).

“I think people get it into their head that... it's somehow marking a child and discriminating against them, and...
a family. And they don’t feel that’s okay, it’s certainly not what’s meant to happen, and shouldn’t be used that way because it is just alert information that’s held on the medical record that can be used for people to make decisions about the particular child” (Participant 14)

Another felt the name causes confusion. “I think the word ‘alert’ sometimes freaks people out, I don’t know what a better word would be, but the actual term alert, is in some ways already indicative of big concerns” (Participant 18)

Theme 5: problems with system administration

Electronic record systems are generally not shared between one DHB and another. Therefore, staff in one DHB who see a CPA that was entered on the NMWS by another DHB must contact the medical records department of that other DHB to access the information behind it. When the information does arrive, it may be of varying quality and may be presented in an unfamiliar way. Many interviewees struggle with these challenges.

“The system is clunky… every DHB has a different computing system… the only system… that every hospital has access to, is the national alert system. And it’s, you know built in the 70s… so it’s not the easiest way of sharing information. It would be nicer if you could have that information automatically come up” (Participant 14)

It is especially difficult after hours. A few felt that, even when accessed, the information was often not helpful

“...after hours, the alert system doesn’t work very well anyway, full stop… whether it’s a child protection issue or… penicillin allergy… the paediatrician I talked to had no idea where the alert was… there’s a lot of information that is irrelevant and there’s a lot of relevant information that isn’t there” (Participant 9)

A few commented that, because of these issues, staff were either not accessing information or using workarounds.

“...on our paediatric ward… this child’s been through a couple of times, and no one’s bothered to get this information” (Participant 8)

“What we’ve noticed a lot lately is that people are emailing each other instead of going through medical records” (Participant 11)

A few raised the issue of cost versus benefit. “...we don’t know whether it works or not, that would be my biggest concern. That we are spending heaps of money, and time, and energy, and doing all of this stuff, and we don’t really know whether it is making a difference to children and their families. And whether it’s making a positive difference, or a negative difference, and what the balance of outcomes is. And it’s really critical that we know that because otherwise it’s going to be hard to maintain its continued presence” (Participant 5)

Theme 6: improvements can be made

Many recommended a more cohesive system with greater standardisation of computer systems, documentation and MDT composition and more comprehensive guidelines. Many felt it should be accessible to primary health, including birthing centres.

“What I’d love to have is one health record… the national alert sitting on a health record… from birth to death. And that’s your spine, and then along the way we have all of these little branches that come of that are maternity services, well child providers, national immunisation register... nothing sitting in silos” (Participant 18)

A few discussed the content of notifications to CPS.

“...if you’ve got a really poor-quality notification it’s difficult to do anything with it. So, I think a lot of the education would be useful around what you put in... teaching people how to... add the right, correct information, may actually improve the alert system significantly. Because then your basis, your
information is better, so then your decision-making... is better”
(Participant 15)

A few highlighted the importance of training front-line staff.
“...there's a child protection alert... can you send a social worker. And so, the staff are not always trained to go oh, there's a child protection alert, I need to look at that information”
(Participant 17)

“I don’t think there's been a lot of education about how the system works” (Participant 9)

A few mentioned the need to improve alert visibility.
“...it should pop up and you should have to acknowledge the alert... I have to scroll down to see the alert... So technically you could go into this woman’s file and not see it”
(Participant 7)

A few noted the importance of cultural representation at MDT meetings.
“We don’t have any representative from... our Pasifika or Māori health team... We make those decisions, with the team that we have, and so, it could be better” (Participant 18)

Discussion

This study found a general perception that the National Child Protection Alert System (NCPAS) was functioning according to the purpose for which it was designed: to support information sharing. Our data are therefore consistent with the generally positive findings of the online survey but enable more intensive exploration of system strengths and weaknesses.

The fact that the NCPAS was regarded positively suggests that the information is genuinely useful to clinicians. This is consistent with international research, where computer-based alert systems have been shown to be useful in reducing prescription errors21 and (in one US emergency department) for identifying children who merit further evaluation for physical abuse.22 The closest parallel to the NCPAS is found in northern New South Wales, Australia, where clinicians who notify child protection services (CPS) have been required since 2015 to lodge a ‘Child-At-Risk’ alert in the electronic medical record.23 Those clinicians also regard their system positively,23 although there are no studies to date that investigate the ultimate question: are such systems effective in reducing the recurrence and/or morbidity of abuse?

However, despite the positive views, our data suggest that the information behind alerts is not always accessed and considered—consistent with both the online survey15 and implementation research into other clinical decision support systems.24 Issues include alert visibility, the understanding of front-line staff of an alert, ease of access to the information (especially after hours) and more consistent and embedded procedures for response to alerts.

Also, there was evidence of other issues that may contribute to inconsistency in implementation of the NCPAS and may go some way towards explaining the variation in conversion rate seen both in NCPAS audits and in the inter-rater agreement study.13

Many participants viewed the NCPAS simply as a flag to information that may or may not remain relevant (the concept to which the system is designed), but a few regarded it as a register for children at a certain level of risk,25 which highlights the issue of variation and gaps in multidisciplinary child protection team (MDT) members’ understanding of all aspects of the NCPAS. This issue was also identified in the online survey.15 The perception that the NCPAS is a register of ‘high-risk’ children leads naturally to a view that alerts should only be placed for high-risk cases (a notoriously complex issue to predict)26 to be reviewed regularly as circumstances change. However, when the NCPAS is used as intended, that view is less cogent. Even if the risk of recurrent abuse diminishes, the health impact of past abuse27 means that an alert may have enduring value for informing appropriate care while ensuring (as one participant put it) that children and families are not required endlessly to repeat accounts of their past experiences.

A view that alerts should be placed only in substantiated cases arises from the same perception. While it is tempting to view substantiated cases as ‘true’ abuse and unsubstantiated ones as ‘false,’28 the reality
is far more complex. The risk profiles and long-term outcomes are almost identical and some suggest that it is “time to leave substantiation behind.”

MDTs are incorporated in the NCPAS to support high-quality decision-making by drawing on a range of experience and expertise. Data in this study suggest that the factors they consider align with NCPAS policy and guidelines. However, quality is not determined simply by the information on the table. The dynamics may be complex and cohesion and shared goals are key to good decisions. This study confirms that many MDTs, but not all, function well. Further research into the functioning of MDTs is needed, including better assessment of the role of team dynamics.

MDTs are also there to reduce the risk of bias in decisions to place an alert. International literature is clear that bias plays a part in the notification of minorities and the poor to child protective services, possibly including notifications from child protection MDTs. In New Zealand, Māori and Pasifika children are far more likely to be notified to CPS. Such evidence supports the concern of some participants in this study that bias might affect decisions to place a CPA or actions taken in response to a CPA. That concern was also evident in the online survey, where a statement that “the NCPAS stigmatises families” received the agreement of 16% of MDT respondents and another 30% neither agreed nor disagreed. It is therefore important for MDTs to ensure that minority voices are well-represented and that all voices represented are heard.

Limitations

Varying familiarity with the NCPAS may have had some effect on responses. In some DHBs, the NCPAS had been in operation for more than a decade, and in others for less than a year. However, the most important limitation is that non-European MDT members were under-represented in our sample. This is a crucial limitation in an area of practice where Māori and Pasifika children are so greatly over-represented, and it raises the possibility that issues of equity and unconscious bias may not have been adequately investigated. We are attempting to address this deficit in our data in a current prospective multi-site mixed-methods study, where investigators observe MDT decision-making in multiple DHB meetings across New Zealand and interview individual team members afterwards.

Conclusion

The NCPAS is well-regarded by the MDT members that were involved in this study, but there are challenges to overcome. The technical challenges could be addressed by technical solutions, which would fit well with the recent proposals for DHB reform and a greater engagement with primary care. In addition, such solutions must be accompanied by thorough training in the conceptual framework of the NCPAS, how to complete a high-quality notification to CPS, how to access a CPA and what to do when one is seen.
Competing interests:
Miranda Ritchie is employed by contract to the Ministry of Health to audit implementation of the National Child Protection Alert System. Patrick Kelly is a member of the Clinical Reference Group of the Child Protection Special Interest Group of the Paediatric Society of New Zealand, which participates in the governance structure and quality assurance mechanisms of the National Child Protection Alert System. This position is unpaid.

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