

Privacy Commissioner John Edwards' presentation to the Paediatric Society Child Protection Special Interest Group

24 November 2015, at Te Papa, Wellington

Addressing the scenario

It's more helpful to address the systems behind this scenario than to focus on the microscopic detail of the scenario itself.

When a teenager arrives at an ED at 2am, drunk and with a head injury, she needs to arrive at an ED where everyone knows who can access what information, and what they can do with it.

The same principle applies to Shaniyah's assessment in the morning.

If there is a clear set of guidelines as to who can access the information about her mum's mental health records, and what they can do with that information, there's no need to spend time trying to make these decisions on the fly on the day.

These guidelines need to be built around proportionality.

Clinical staff, social workers and other professionals are trusted to share the information they need to share to do their jobs – and no more.

They are trusted by the institutions and society they work for.

They are trusted by their patients.

Establishing the proportional limits of information sharing ahead of time spares healthcare workers the headache of trying to determine them at 2am, and lets them get on with doing their jobs.

Family violence screening is a related example. DHBs have clear guidelines around which patients they ask about family violence (almost all of them). By setting up these guidelines beforehand, it has become easier to collect this information in a safe, consented way rather than having to make assumptions further down the track when someone shows up at an ED as a possible victim of family violence.

The same principle – of building a culture and systems beforehand – should be followed when dealing with patients' personal information.

2am at scale

The bigger challenges to reveal themselves when you try to apply the 2am thinking at a large scale. How do you share information at a large scale without breaching the trust between professionals and their patients?

Experienced professionals know when to share information.

They also know that the amount of information and type of information required varies widely depending on the specific circumstance.

We trust these professionals to make the right decision.

In order to achieve this same outcome at a large-scale, institutional level, you need to create a set of standards that 'copy' the ward-level 2am standards judgement to an institutional level.

In order to do that, you need to simplify that judgement – and all the human complexity that drives it.

Take a 100 km/hr speed limit, for example. In some situations, you could probably safely drive at 110. And in other situations, you wouldn't want to go much faster than 90.

But a speed limit sign can't address the day-to-day differences in road conditions and driver competence, so it simplifies to one number.

The same concept applies when it comes to information sharing in a healthcare setting.

To enable information sharing at an institutional level, you need to create standards that simplify the day-to-day decision making that clinicians are already doing.

These standards need to be sufficiently thought-out to address the complexity of the problems they are trying to solve.

It's not sufficient to just 'open the records' and let anyone access any information.'

Rather, information sharing standards should follow the same process that a clinician follows when making decisions on the ground.

Like the clinician's decision, institutional information sharing should have a clear purpose, clear limits and only deliver information required to solve the problem at hand.

Clinicians do not develop the judgement to do this overnight. By that same token, it's not reasonable to expect institutions to develop this judgement overnight.

Rather, we need to change institutions one step at a time.

Otherwise we run the risk of sharing information disproportionately and breaking the trust that exists between patients and clinicians.

Information sharing in child protection

So this is the approach we're taking with information sharing in child protection.

The Vulnerable Children's Approved Information Sharing Agreement is now in place in the Vulnerable Children's Hub in Hamilton.

The agreement – or AISA – is a step towards 'scaling up' that 2am decision-making

It provides clarity and certainty around what information government agencies can share about vulnerable children, who they can share it with and when they can do so.

The next phase is to ensure that the AISA is implemented correctly.

One measure we are taking is to help the Ministry of Health and the Children's Action Plan Directorate design a form for the Hamilton Children's Team to request information from agencies.

The form will make it clear to agencies whether individuals have provided consent for their information to be disclosed to the panel, or whether they don't need that consent because disclosing will prevent or lessen a serious threat to the life or health of a child.

This achieves the goal of information sharing to help vulnerable children.

It also helps to build in the same structure and judgement that a clinician uses to respond to the facts of a case at 2am.

At the same time, the Children's Action Plan Directorate will work with participating agencies to help people understand how the legal framework works

It's not enough to just put a form in front of someone. We also need them to understand why the form exists and the value it provides.

This is an example of the step by step approach I mentioned before.

My office has also built resources to help support professionals working in this environment.

One example is the "escalation ladder" for front-line social service workers. It asks a series of questions such as "can we get by without naming names?" and "is there a serious threat here?" If an answer to any of the questions is "no," then disclosing information should be avoided. You can find the escalation ladder on our website – privacy.org.nz. Just search "escalation ladder" in the search box.

Another resource is our online education. These are training modules that you can do online, at your own pace, from anywhere. They're also free.

There are modules dedicated to the Health Information Privacy Code and the Privacy Act in general. Both are very good resources for getting up to speed with what you need to know. Doing so makes it easier to build the systems that address those tricky 2am cases.

Like the escalation ladder, these modules are available on our website.

Conclusion

Vulnerable children, information sharing and healthcare delivery are complex issues that deserve complex, thought-out solutions.

These solutions don't present themselves overnight.

So working in this stepped, iterative way is the most effective way to build the 2am decision-making to a large-scale, institutional framework.

In fact, it's the only way.