



**Report of the
Special Commission of Inquiry into
Child Protection Services in NSW**

Volume 1

The Hon James Wood AO QC

November 2008

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Protection Services in NSW, 2008

ISBN 978-1-921301-86-5

Published November 2008



Special Commission of Inquiry into Child Protection Services in New South Wales

24 November 2008

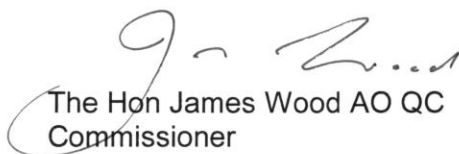
Her Excellency Professor Marie Bashir AC CVO
Governor of the State of New South Wales
Office of the Governor
Macquarie Street
SYDNEY NSW 2000

Your Excellency,

I was appointed by Letters Patent issued under *the Special Commission of Inquiry Act 1983* to conduct an Inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are complete and to report to Your Excellency.

I now present to you the Report of my Inquiry.

Yours sincerely



The Hon James Wood AO QC
Commissioner

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Executive Summary

The child protection system in New South Wales consists of much more than the Department of Community Services (DoCS). NSW Health through its Area Health Services and The Children's Hospital at Westmead fund and deliver many services for children, young people and their families, including prenatal care, home visiting and counselling, with the aim of preventing or minimising harm. Similarly, the Departments of Education and Training, Juvenile Justice and Ageing, Disability and Home Care, Housing NSW and the NSW Police Force offer programs, funding and services, ranging from breakfast programs, diversionary sentencing options for young people, respite for parents of children with disabilities, and housing and youth support activities.

They also have a role in reporting suspicions of abuse or neglect of children and young people, and within their available resources or facilities, responding. The role of the NSW Police Force in investigating criminal offences directed at children, and in responding to family and domestic violence forms a significant part of the child protection system.

Non-government organisations are also key players in the system and provide universal, secondary and targeted and tertiary services to children, young people and their families aimed at minimising the risk of abuse and neglect as well as supporting those children and young people who have been harmed, some of whom will have been removed from their families and placed in out-of-home-care.

The contemporary challenge facing all child protection systems in Australia, and in particular NSW as the largest, is sufficiently resourcing flexible prevention and early intervention services so as to reduce the numbers of children and young people who require the state to step in to keep them safe.

Once children and young people are the subject of reports of being at risk of harm, the challenge is to have adequate skills and tools with which to assess and identify those who need the full attention of the state including removal from their families, and those who can be assisted to remain in their homes with the necessary support being provided. Children and young people who cannot live at home require carers who are financially, emotionally and practically supported by the system, and who have been well matched to them. They also need state assistance to access medical, dental and allied treatment when it is needed.

Importantly, children and young people need to be listened to and participate in decisions which affect them.

A range of complex and often chronic factors characterise many of the families coming into contact with the child protection system such as low income, unemployment, substance abuse, limited social supports, imprisonment,

domestic violence, and mental health issues. Many of these factors are inter-related. The elimination or reduction of each of these factors would significantly lower the number of children and young people reported as being at risk of harm.

DoCS has undergone a period of significant reform since 2002 when it received a substantial injection of funds which took the annual budget in 2007/08 to more than \$1.2 billion. While, in 2008, many of those reforms have been implemented or are underway, insufficient time has passed for the benefits to be fully evident.

In 2008, there are a number of challenges both old and new facing DoCS, some of which are unique to it, but many of which are experienced by most child protection systems within Australia.

Reports

- a. Reports to DoCS of children and young people suspected to be at risk of harm are increasing annually, although the extent of the increase seems to be slowing and those reports which are made are being assessed as less urgent.
- b. A large number of children, young people and families are repeatedly reported, often within short periods, with the result that reports to DoCS are more likely to be about a child or young person already known to it. Thus, in 2006/07 about the top 20 per cent of the children and young people who were frequently reported accounted for more than half the total number of reports.
- c. Most reports to DoCS concern domestic violence, psychological abuse, neglect, carer substance abuse, carer mental health and/or sexual abuse. There is little reliable research to guide effective interventions for children and young people who are neglected, although a report of neglect is more likely to receive greater DoCS attention than one concerning domestic violence.
- d. A detailed examination of what happened to reports to DoCS in 2007/08 reveals that:
 - i. about 13 per cent of the reports were not 'risk of harm' reports as defined in the *Children and Young Persons (Care and Protection) Act 1998* and thus, while the family may have needed assistance, they should have been referred to, and met with a suitable response from, an agency other than DoCS
 - ii. another 21 per cent of reports were assessed by the Helpline as requiring further assessment, but received none from the Community Services Centre to which they were referred
 - iii. 33 per cent received some attention which fell short of a face to face visit

- iv. only 13 per cent of reports resulted in a home visit from a DoCS caseworker, as part of a secondary assessment process
 - v. the remaining reports mainly concerned children and young people who were already being assessed by DoCS.
- e. Too many reports are being made to DoCS which do not warrant the exercise of its considerable statutory powers. As a result, much effort and cost is expended in managing these reports, as a result of which the children and young people the subject of them receive little in the way of subsequent assistance, while others who do require attention from DoCS may have their cases closed because of competing demands on the system (that is, insufficient resources).
- f. Those who are required to report when they reasonably suspect a child or young person to be at risk of harm, known as mandatory reporters, receive insufficient information from DoCS about its response to their reports. As a result, they keep reporting, often to little effect and it is less likely that they will work in partnership with DoCS to assist the child or young person. If informed that DoCS was not in a position to take up the case, they may well provide more assistance themselves.

Infrastructure

- a. DoCS information management technology is not adequately suited for the purpose of supporting workers to assess and intervene in the lives of children and young people, and its complexities and shortcomings continue to be a source of frustration and delay to its staff.

Workforce

- a. While, in the main, DoCS has developed sound, comprehensive and evidence based policies and procedures, they are not consistently implemented, with the result that quality practice in each CSC within its several regions remains challenging.
- b. Recruiting and retaining a skilled, diverse workforce to provide services in all parts of the State is an issue for DoCS, as it is for all other justice and human services agencies in NSW and for non-government organisations working in the welfare sector.

Availability of services

- a. There are not sufficient prevention, early intervention and targeted services provided by state agencies or by the non-government organisations for children and young people at risk and their families.
- b. Currently, the capacity in some non-government organisations and Aboriginal organisations is not sufficiently developed to enable them to properly partner DoCS and other state agencies in working towards the safety, welfare and well-being of the children and young people who need assistance.

- c. There are barriers to non-government organisations and other state agencies working together in the interests of the safety, welfare and well-being of children and young people. Some can be cured by legislation, such as information exchange, but generally a change in attitude and approach including greater acceptance of working in collaboration, is needed.
- d. Aboriginal communities remain over represented in the child protection system and culturally appropriate interventions for Aboriginal children, young people and their families are not widespread in any of the agencies that are expected to work with them.

The legal system

- a. Data collection is generally good at DoCS, but in areas such as the Courts, there is an absence of sufficient data of the kind that is required for an understanding, assessment and monitoring of the operation of the child protection system.
- b. Too many Children's Court decisions are made by non-specialist Magistrates, the Children's Court does not facilitate alternative dispute resolution as was originally intended and its processes are unduly technical.
- c. DoCS does not always present its evidence to the Children's Court in a fair and balanced manner and legal practitioners who appear in the care jurisdiction are not subject to uniform standards or accreditation.

Out-of-home care

- a. There are increasing numbers of children and young people in out-of-home care for longer periods of time and with increasingly complex needs at a cost per child which continues to rise.
- b. There is a decreasing pool of foster carers.
- c. There is a need for a greater number and range of different placement options for children and young people for whom it is not safe to live at home.
- d. Children and young people entering, and in, out-of-home care generally do not receive, as a matter of priority, the medical, dental and allied health assessments and treatments they should receive. Neither do they receive the degree of assistance that is needed when leaving care.

Other matters

- a. The arrangements by which DoCS is scrutinised by other agencies are complex.
- b. There is a duplicative, unduly complex and administratively burdensome funding system.

The principles and goal underpinning the Inquiry's proposed reforms

The key principles which underpin the Inquiry's reforms are as follows. Child protection is the collective responsibility of the whole of government and of the community. Primary responsibility for rearing and supporting children and young people should rest with families and communities, and with government providing support where it is needed, either directly or through the funded non-government sector.

The outcomes sought from the service system should be to ensure children and young people are able to grow up at the very least unharmed by their social, economic and emotional circumstances and are supported to do so by their parents. Where their parents are unable to do this, the state needs to be in a position where it can step in and fill the gap in a humane and responsive way that will preserve the safety of those children and young people.

The participation of children and young people is critical to guiding the delivery of services.

The child protection system should comprise integrated universal, secondary and tertiary services, with universal services comprising the greater proportion. They should be delivered by a mixture of the non-government sector and state agencies, with DoCS being a provider of last resort.

DoCS, and where necessary, the NSW Police should remain responsible for interventions mandated under the *Children and Young Persons (Care and Protection) Act 1998*, and for the investigation and prosecution, in a timely and efficient manner of criminal offences committed against children and young people.

All services should be integrated and, where possible, co-located or operated in 'hubs', with outreach capacity.

Early decision making about permanency planning, including restoration to family, results in better outcomes for children and young people, both in immediate terms and for life after care.

All Aboriginal children and young people in out-of-home care should be connected to their family and their community, while addressing their social, emotional and cultural needs.

Greater in-depth assessment of children and young people coming into care through more comprehensive assessment and interventions in the crucial early stages of placements should be part of agency placement and planning processes.

Carers should be provided with timely information about those in their care, their needs, and the type of support they need to flourish in their care, and given

ongoing support by DoCS or by designated agencies in fulfilling their care responsibilities.

Children and young people where possible should be placed with relatives and/or with siblings, and generally should be placed as close as possible to where their family/kinship and support networks are located.

There should be sufficient health and specialist services including dental, psychological, counselling, speech therapy, mental health and drug and alcohol services available to meet the needs of children and young people in out-of-home care.

Foster, kinship and relative carers should be supported in caring for children and young people, including assistance to work with those with challenging behaviours, to improve the stability of placements. This should include access to regular and planned respite care, behavioural management support, and other evidence based specialist services.

Young people should be assisted when leaving care to transition effectively to stable accommodation and to receive further education and/or training and/or employment, so as to maximise their potential for independent living.

Non-government organisations in partnership with other relevant government agencies such as DoCS, NSW Health, the Department of Education and Training and the Department of Ageing Disability and Home Care should deliver out-of-home care services.

The Key Reforms

Amendment of the *Children and Young Persons (Care and Protection) Act 1998* is proposed so as to require that only children and young people who are suspected, on reasonable grounds, to be at risk of significant harm should be reported to DoCS.

Each of the Area Health Services, The Children's Hospital at Westmead, the Department of Education and Training, NSW Police Force, the Department of Ageing Disability and Home Care and the Department of Juvenile Justice should create a Unit which advises staff on whether a report should be made to DoCS and, if the proposed report does not disclose a risk of significant harm, the Unit should assist the child or young person by, among other matters:

- a. referring them to a newly created Regional Intake and Referral Service. That service is to be located within a non-government organisation and it will determine the nature of the services required and refer the family to the appropriate non-government organisation or other state or Commonwealth agency for services such as case management, home visiting, intensive family support brokerage, quality child care, housing and/or parenting education
- b. referring them to the early intervention program Brighter Futures

- c. working with the child or young person, alone or in combination with another appropriate agency or non-government organisation, to address their need for assistance or specialised services.

Reports made to DoCS, which are assessed as being a report that a child or young person is at risk of significant harm should be investigated by DoCS if the matter is urgent or the risk is high or the child is young. Otherwise, if eligible, the family should be referred to Brighter Futures. If not eligible, the family should be referred to a Regional Intake and Referral Service which should be able to link families with the most appropriate local service to meet their needs.

The Regional Intake and Referral Service should be operated and staffed by a non-government organisation with one or more child protection caseworkers, seconded from DoCS, the number of staff will depend on anticipated demand for that region.

Integrated, multi-disciplinary and co-located child and family services should be established in locations of greatest need to deliver services to children, young people and their families.

Non-government organisations and state agencies should be funded to deliver services that should cover the continuum of universal, secondary and tertiary services and should target key developmental stages and transition points in the lives of children and young people. Such services should include:

- a. home visiting, preferably by professionals, high quality child care, preferably centre based, primary health care, school readiness programs, routine screening for domestic violence, preschool services, school counsellors, breakfast programs and early learning programs
- b. sustained home visiting for at risk families, parent education, supported playgroups, counselling services, the Home School Liaison Program and accommodation and rental assistance
- c. drug and alcohol counselling and rehabilitation services, sexual assault counselling, forensic services for sexual assault victims, Physical Abuse and Neglect of Children services, services for 10-17 year olds who display sexually abusive behaviours and allied health services such as speech pathology and mental health services.

Secondary and tertiary services that include intensive, short term, in-home and crisis interventions and that also provide links to other services following intensive support should also be available and able to respond where needed.

In addition, work should be undertaken to extend current programs including, Brighter Futures, family preservation services provided by non-government organisations, free early childhood education before commencing school for low income families, family and domestic violence programs and the Safe Families Program – Orana Far West.

The capacity of non-government organisations, Aboriginal and non-Aboriginal, to staff and deliver these services to children, young people and families, particularly those who present with a range of needs including those which are complex and chronic, should be developed.

DoCS, Area Health Services, The Children's Hospital at Westmead, NSW Police Force, the Department of Juvenile Justice, the Department of Ageing, Disability and Home Care, the Department of Education and Training and non-government organisations should use a common assessment framework to identify and respond to the needs of children, young people and their families, particularly in the areas of serious and chronic neglect, parental substance abuse, risk taking adolescents, serious mental health issues and high risk domestic violence cases.

Each key agency should identify their most frequent clients, referred to by DoCS as frequently reported families and who, for DoCS are estimated to number between 2,500 and 7,500 families. An integrated case management response to these families, which includes participation by relevant non-government organisations should be provided, together with mechanisms for identifying new families and for enabling existing families to exit with suitable supports in place.

Specialists in substance abuse, mental health, domestic violence and other similar areas should assist DoCS caseworkers in case allocation, planning, assessments and interventions by attending CSCs on a regular basis.

Agencies, including non-government organisations should be free to exchange information for the purpose of the safety, welfare and well-being of a child or young person, and for that to occur, amendment is required in relation to the existing privacy legislation. In addition, enhanced interagency collaboration and acceptance of responsibility for child protection is recommended.

Within three years, case management of families in Brighter Futures should be transferred to Lead Agencies. The responsibility for out-of-home care should similarly be progressively transferred to the non-government sector. The Inquiry supports a revised scheme for voluntary out-of-home care.

A workforce strategy should be established which takes into account the need of non-government organisations to employ additional skilled staff and to accommodate the transition of early intervention and out-of-home care casework to the non-government organisations.

Caseworkers should be employed on a temporary basis, or reassigned from Brighter Futures or out-of-home care work as case management is transferred to the non-government sector, to manage those children and young people who will require DoCS services in relation to statutory intervention.

Other reforms

In relation to reporting, the Inquiry has made recommendations to encourage more and better feedback to mandatory reporters, to provide them with targeted training and access to aggregated data. Its recommendations directed to the NSW Police Force are designed to ensure that victims of domestic violence are better served, and that the system is not overburdened by reports that do not justify DoCS intervention.

The Inquiry has also made recommendations to enhance the information management technology available to DoCS and to ensure consistent, quality casework through supervision and professional development, audits and reviews, clarifying policies and procedures.

Significant amendment of the *Children and Young Persons (Care and Protection) Act 1998* is recommended in relation to the principles which underpin it by giving greater emphasis to the best interests of the child principle, extending the grounds on which a care order may be made, restricting the allocation of parental responsibility by the Children's Court to DoCS, limiting the power of the Children's Court to make contact orders, while confining enhanced powers in the Children's Court in relation to restoration.

In relation to the processes followed by the Children's Court, various recommendations are made designed to simplify the practice and procedure of that Court and to reduce technicality. In addition, the Inquiry urges the greater use of alternative dispute resolution and the development of a code of conduct for all legal representatives practising in the care jurisdiction. The status of the Court should be enhanced by a District Court Judge being appointed as its senior judicial officer.

Building capacity in Aboriginal organisations is a focus of the report, as is the need for the adoption of other methods of reducing Aboriginal representation in the child protection system, and of securing greater participation of Aboriginal agencies in that system.

The review of deaths of children is considered and recommendations are made for a change in the current arrangements, including a reconstitution of the Child Death Review Team to be led by the NSW Ombudsman.

The report concludes with a suggested framework for implementation of the 111 recommendations which have been ranked by degree of priority, and likely cost.

Recommendations

- R.1 In the recommendations which follow, the Inquiry has assigned a priority ranking and a cost ranking to each. In relation to priority, the term 'immediate' means that the implementation of the recommendation should be substantially commenced within six months, 'short term' means that implementation of the recommendation should be substantially commenced within 12 to 18 months and 'long term' means that the implementation of the recommendation should be substantially commenced within two to three years.
- R.2 In respect of some recommendations, specific timeframes have been allocated.
- R.3 Whether the cost of implementing the recommendation is low, medium or high is generally based on information provided by DoCS. As a guide, recommendation 1 is estimated to cost \$17.8 million over three years, and is assigned the category of 'medium'.
- R.4 Many of the recommendations are dependant upon or integrated with other recommendations. The recommendations contained in Chapter 10 are integral to the key reforms contained in this report. The timing of the introduction of the following reforms will be affected by amendments to the Care Act in that, generally they should follow those amendments: recommendations 2.1, 6.1, 6.5, 9.2, 9.3, 9.5, 10.1, 10.2, 10.3, 10.4, 10.7 and 17.2.
- R.5 If the testing of the Structured Decision Making tools proves effective, there will need to be a revision of many of the policies and procedures currently in place, including a number of those about which recommendations have been made.

	<i>Priority</i>	<i>Cost</i>
Chapter 2 Structure and Reform		
Recommendation 2.1	<i>Immediate</i>	<i>Medium</i>
The KiDS Core Redesign Project should be funded and implemented.		
Recommendation 2.2	<i>Immediate</i>	<i>Medium</i>
DoCS Information Management and Technology Strategic Plan should be funded and implemented.		
Recommendation 2.3	<i>Immediate</i>	<i>Low</i>
The trial of the quality review tools should proceed immediately and the approved tools should be then applied in a timely manner. Each CSC should then be audited. Funds should be provided to permit the audits to commence within the 2008/09 year.		
Recommendation 2.4	<i>Immediate</i>	<i>Low</i>
The decision consequent upon the SINC Report to relocate the bulk of the Complaints Unit functions to the Helpline and to revise the complaints handling system, should be implemented.		
Recommendation 2.5	<i>Short term</i>	<i>Low</i>
Carer Support teams should be responsible for liaising with DoCS foster carers and kinship/relative carers in relation to their complaints and to ensure they have the assistance they require.		
Chapter 3 DoCS Workforce Capacity		
Recommendation 3.1	<i>From 1 July 2009</i>	<i>Low</i>
From 1 July 2009 all appointed Managers Casework should be required to possess a relevant tertiary qualification, in addition to experience in child protection work.		
Recommendation 3.2	<i>Short term</i>	<i>Medium</i>
A review should be undertaken to identify tasks that could be appropriately delegated by caseworkers.		
Recommendation 3.3	<i>Short term</i>	<i>Low</i>
A review of financial delegations should be undertaken.		

Priority **Cost**

Chapter 6 Risk of harm reports to DoCS

Recommendation 6.1 *Short term* *Low*

DoCS should revise its case practice procedures to develop clear guidelines for classifying risk of harm reports made and information given to the Helpline. Information which does not meet the statutory test for a report should be classified as a contact and not as a report. Information which meets that test should be classified as a report. The circumstances in which reports are referred for further assessment or forwarded as information only should be clarified and consistently applied.

Recommendation 6.2 *Immediate* *Low*

In relation to *the Children and Young Persons (Care and Protection) Act 1998*:

- a. Sections 23, 24 and 25 should be amended to insert 'significant' before the word 'harm' where it first occurs; and s.27 amended to insert 'significant' before the word 'harm' wherever it occurs.
- b. Section 23 should be amended to insert as paragraph (g) "the child or young person habitually does not attend school."
- c. A provision should be inserted defining that (with the exception of s.23(d)) harm may be constituted by a single act, omission, or circumstance or accumulate through a series of acts, omissions or circumstances.
- d. The penalty provision in s.27 should be deleted.

Recommendation 6.3 *Immediate* *Medium*

Reporters should be advised, preferably electronically in relation to mandatory reporters, of the receipt of their report, the outcome of the initial assessment, and, if referred or forwarded to a CSC, contact details for that CSC should be provided. Caseworkers and their managers should be required to respond promptly and fully to requests for information about the report from mandatory reporters, subject to ensuring the integrity of any ongoing investigation.

Recommendation 6.4 *Short term* *Low*

DoCS should provide the key agencies employing mandatory reporters, namely NSW Police Force, NSW Health, each Area Health Service, The Children's Hospital at Westmead and the Department of Education and Training with quarterly aggregated data about the reports made by the agency and its staff. These data should be made public.

	<i>Priority</i>	<i>Cost</i>
<p>Recommendation 6.5</p> <p>Targeted training strategies for each of the key mandatory reporters, namely the NSW Police Force, NSW Health, each Area Health Service, The Children’s Hospital at Westmead and the Department of Education and Training in relation to the circumstance in which reports need to be made and in relation to the information required, so as to ensure its relevance and quality, should be developed and implemented by each agency in collaboration.</p>	<i>Short term</i>	<i>Low</i>
<p>Recommendation 6.6</p> <p>The trial of e-reporting should be extended to NSW Health, each Area Health Service, The Children’s Hospital at Westmead, the Department of Juvenile Justice and the NSW Police Force.</p>	<i>Short term</i>	<i>Low</i>
<p>Chapter 7 Early intervention</p>		
<p>Recommendation 7.1</p> <p>DoCS should revise its Brighter Futures Guidelines to clarify the account to be taken of child protection history in determining eligibility.</p>	<i>Short term</i>	<i>Low</i>
<p>Chapter 8 Assessment and response</p>		
<p>Recommendation 8.1</p> <p>The JIRT Reform Program, as set out in the Implementation Plan should be completed.</p>	<i>Short term</i>	<i>Medium</i>
<p>Recommendation 8.2</p> <p>JIRT should be regularly audited.</p>	<i>Long term</i>	<i>Low</i>
<p>Recommendation 8.3</p> <p>Pending amendment of the privacy laws as recommended in Chapter 24, a Privacy Direction should be issued in relation to the JIRT process so as to facilitate the free exchange of information between the NSW Police Force, NSW Health, each Area Health Service, The Children’s Hospital at Westmead and DoCS.</p>	<i>Immediate</i>	<i>Low</i>
<p>Recommendation 8.4</p> <p>NSW Health should provide an appropriately trained workforce to provide</p>	<i>Short term</i>	<i>Medium</i>

	<i>Priority</i>	<i>Cost</i>
forensic medical services where needed for children and young persons who have suffered sexual assault and physical injury.		

Recommendation 8.5	<i>Long term</i>	<i>High</i>
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The NSW Government should develop a strategy to build capacity in Aboriginal organisations to enable one or more to take on a role similar to that of the Lakidjeka Aboriginal Child Specialist Advice and Support Service, that is, to act as advisers to DoCS in all facets of child protection work including assessment, case planning, case meetings, home visits, attending court, placing Aboriginal children and young persons in OOHC and making restoration decisions.

Chapter 9 Assessment and response: issues arising

Recommendation 9.1	<i>Short term</i>	<i>Medium</i>
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DoCS should test the use of Structured Decision Making tools at the Helpline and at CSCs in relation to assessments and interventions including restoration.

Recommendation 9.2	<i>Short term</i>	<i>Low</i>
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A common assessment framework should be developed for use by DoCS and other agencies in child protection work which encompasses all risk factors.

Recommendation 9.3	<i>Short term</i>	<i>High</i>
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DoCS should develop a strategy to move to electronic record keeping and abolish the use of paper records.

Recommendation 9.4	<i>Short term</i>	<i>Low</i>
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DoCS should revise its case practice procedures to provide Helpline caseworkers with greater guidance as to determining response times for reports of risk of harm.

Recommendation 9.5	<i>Short term</i>	<i>Low</i>
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For all caseworkers and casework managers there should be a structured program for ongoing professional development which is incorporated into annual Personal Planning and Review agreements.

Recommendation 9.6	<i>Short term</i>	<i>Low</i>
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In addition to individual supervision, there should be a facilitated monthly

Priority **Cost**

group case practice review of selected cases within each CSC and at the Helpline, in which all caseworkers and managers participate and which may include specialists from other agencies, if the cases require it.

Recommendation 9.7*Long term**Low*

DoCS should develop models of professional support for novice caseworkers, such as those offered in other disciplines like medicine, which involve safety and risk factors in decision making.

Recommendation 9.8*Short term**Medium*

The work of the Drug and Alcohol Expertise Unit should be expanded to include mental health and domestic violence.

Chapter 10 Directions for the way forward***The creation of different pathways*****Recommendation 10.1***Short term**High*

Members of the community and mandatory reporters who are not those described below, who suspect that a child or young person is at risk of significant harm (“the statutory threshold”) should report their concerns to the Helpline. Reports should be as comprehensive as the knowledge and professional or expert experience of the reporter permits.

Mandatory reporters from each Area Health Service, The Children’s Hospital at Westmead, the NSW Police Force, the Department of Education and Training, the Department of Juvenile Justice and the Department of Ageing, Disability and Home Care who suspect that a child is at risk of significant harm, which is imminent, should report directly to the Helpline.

Mandatory reporters from each Area Health Service, The Children’s Hospital at Westmead, the NSW Police Force, the Department of Education and Training, the Department of Juvenile Justice and the Department of Ageing, Disability and Home Care who suspect that a child is otherwise at risk of significant harm should report their concerns to a newly created position or Unit within their own agency (“the Unit”). That Unit should be staffed by specialists with knowledge of the work of the agency and knowledge of child protection work (see below).

That Unit should determine whether the report meets the statutory threshold, by use of a common assessment framework, and if so, make the report promptly to the Helpline.

Priority **Cost**

If the report does not meet the statutory threshold, and the Unit considers that the child or young person is in need of assistance, one or more of the following should occur:

- a. The child or young person or family is referred by the Unit or the initial reporter to a newly created Regional Intake and Referral Service. That service should be located within an NGO and should determine the nature of the services required and refer the family to the appropriate NGO or other state or Commonwealth agency for services such as case management, home visiting, intensive family support brokerage, quality child care, housing and/or parenting education.
- b. Families who are assessed by the Unit as meeting the criteria for Brighter Futures should be referred directly to the Lead Agency contracted in the relevant area.
- c. A referral to the Domestic Violence Line should be made by the Unit or the initial reporter if the concern arises primarily from the presence of domestic and family violence and the non-offending parent (usually the mother) requires assistance.
- d. The agency works with the child or young person, alone or in combination with another appropriate agency or NGO.

Recommendation 10.2

Short term *High*

Reports made to DoCS should be assessed at the Helpline with the use of Structured Decision Making tools (after being tested and applied). If a report is assessed as meeting the statutory threshold, the report should be dealt with in one of the following ways:

- a. Families who are assessed by the Helpline as meeting the criteria for Brighter Futures should be referred directly to the Lead Agency contracted in the relevant area.
- b. Where a child or young person is:
 - i. assessed as in need of a response within 24 hours, or
 - ii. assessed as in need of a response within 72 hours and the risk is assessed as high, or
 - iii. under five years and the primary care-giver's functioning or ability to parent is impaired due to current substance abuse, unmanaged mental illness or intellectual disability, and:
 - the child has high support needs, or
 - the primary reported issue is neglect or actual injury, or
 - the child or a sibling has been previously removed from the family by reason of care and protection concerns

then such child or young person should be referred to a CSC that will apply the Structured Decision Making tools in assessing,

	<i>Priority</i>	<i>Cost</i>
<p>intervening and, if ultimately found to be appropriate, removing the child or young person from his or her family.</p> <p>c. Children and young persons who are assessed as in need of a response within 72 hours with a risk assessed as less than high, or as in need of a response within less than 10 days and who do not meet the criteria for Brighter Futures, should be referred to the Regional Intake and Referral Service which should determine the nature of the services required and refer the family to the appropriate NGO or other state or Commonwealth agency for such assistance as may be reasonably available and likely to meet the relevant need.</p>		

The Regional Intake and Referral Service described above should be operated and staffed by an NGO, with one or more child protection caseworkers seconded from DoCS. Where the child protection caseworker forms the view that the child or young person may be at risk of significant harm, the caseworker should perform a history check on KiDS and, if in the caseworker's view, the statutory test is met, the caseworker should refer to the matter to the Helpline. There should be at least one Regional Intake and Referral Service in each DoCS Region.

DoCS structure

Recommendation 10.3

Long term Medium

DoCS should remain as a single department with a centralised Helpline, it should be divided into regions which are aligned with other key agencies and each region should contain such number of CSCs (see Chapter 23) as are appropriate for the level of demand within the region.

Service availability

Recommendation 10.4

Long term High

Services should be integrated, multi-disciplinary and co-located, wherever practicable and child and family services should be established in locations of greatest need, by outreach if necessary.

NGOs and state agencies should be funded to deliver services to the children, young persons and families who fall within the groups listed in recommendations 10.1 a and b and 10.2 a and c above. These services should cover the continuum of universal, secondary and tertiary services and should target transition points for children and young persons. Such services should include:

- a. home visiting, preferably by nurses, high quality child care, preferably centre based, primary health care, school readiness programs, routine screening for domestic violence, preschool services, school counsellors, breakfast programs and early learning

	<i>Priority</i>	<i>Cost</i>
programs		
b. sustained home visiting, parenting education, supported playgroups, counselling services, the Home School Liaison Program and accommodation and rental assistance		
c. drug and alcohol counselling and rehabilitation services, sexual assault counselling, forensic services for sexual assault victims, PANOC services, services for adolescents aged 10-17 years who display sexually abusive behaviours, allied health services such as speech pathology and mental health services		
d. secondary and tertiary services that include intensive, short term, in house and crisis interventions and that provide links to other services following intensive support, where needed		
e. the availability of counselling or other similar services from other agencies should not be dependent upon a risk of significant harm report being made to DoCS, or DoCS having allocated the report/case.		

Recommendation 10.5

	<i>Short term</i>	<i>High</i>
a. Brighter Futures should be extended to provide services to more children aged 0-8 years and integrated into the service system (DoCS estimates that this should assist an additional 1,200 families).		
	<i>Long term</i>	<i>High</i>
b. Brighter Futures should be extended progressively to provide services to children aged 9-14 years with priority of access to services for Aboriginal children and their families (DoCS estimates that this should assist an additional 3,400 families).		
	<i>Short term</i>	<i>High</i>
c. The number and range of family preservation services provided by NGOs should be extended. This should include extending Intensive Family Based Services to Aboriginal and non-Aboriginal families (DoCS estimates that this should assist an additional 3,000 families).		
	<i>Short term</i>	<i>High</i>
d. The Aboriginal Maternal and Infant Health Strategy should be delivered statewide (funds have been allocated for this service).		
	<i>Long term</i>	<i>High</i>
e. Young, first time, isolated mothers with low educational attainment should receive secondary services, particularly sustained home visiting where the focus should be on positive maternal and child outcomes.		

	Priority	Cost
	<i>Short term</i>	<i>High</i>
f. One year of free early childhood education before school should be provided to low income families.		
	<i>Short term</i>	<i>High</i>
g. Co-located child and family centres servicing Aboriginal communities, involving health and education services should be developed.		
	<i>Short term</i>	<i>High</i>
h. In relation to domestic violence, the commitment to the Domestic Violence Court Intervention Model, Integrated Case Management, Non-government sector grants, Staying Home Leaving Violence, the Court Assistance Scheme, Indigenous Programs and police equipment should be implemented.		
	<i>Short term</i>	<i>Medium</i>
i. The commitment to establish the Safe Families Program – Orana Far West should be implemented.		
	<i>Short term</i>	
j. The commitment to fund the Preschool Investment and Reform Plan should be implemented.		
	<i>Short term</i>	
k. The implementation plans for the delivery of the Commonwealth Government's election commitments relating to early childhood education and care, including providing universal access to early learning programs for all Australian four year olds for 15 hours per week and establishing an additional 260 child care centres on primary school grounds and other community land in areas where there are service gaps, should be progressed.		

Recommendation 10.6

Five years High

The capacity of NGOs, Aboriginal and non-Aboriginal, to staff and deliver the services detailed in Recommendations 10.4 and 10.5 a, b, c, e, f and g to children, young persons and families, particularly those who present with a range of needs including those which are complex and chronic, should be developed. The principles underpinning performance based contracting should apply.

Working collaboratively**Recommendation 10.7**

Short term High

DoCS, each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, the Department of Juvenile Justice, the Department of Ageing, Disability and Home Care, the Department of

Priority **Cost**

Education and Training and NGOs should use a common assessment framework to identify and respond to the needs of children, young persons and their families, particularly in the areas of serious and chronic neglect, parental substance abuse, high risk adolescents, serious mental health issues and high risk domestic violence cases.

Each key agency, namely DoCS, each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, Housing NSW, the Department of Juvenile Justice and the Department of Education and Training should identify their high end users, referred to by DoCS as Frequently Reported Families and who, for DoCS are estimated to number between 2,500 and 7,500 families. An integrated case management response to these families, which includes participation by relevant NGOs should be provided including the adoption of mechanisms for identifying new families and for enabling existing families to exit with suitable supports in place.

Specialists in substance abuse, mental health, domestic violence and other similar areas should assist DoCS caseworkers in case allocation, planning, assessments and interventions by attending CSCs on a regular basis.

Agencies, including NGOs should be free to exchange information for the purpose of the safety, welfare and well-being of a child or young person (see Chapter 24).

A multi-agency systems approach to case review should be established (see Chapter 9).

Workforce needs

Recommendation 10.8

Short term *Low*

A workforce strategy should be established which takes into account the needs of NGOs to employ additional staff and to accommodate the progressive transition of early intervention and OOHC (see Chapter 16) casework to the NGOs.

NGOs should receive sufficient funding to develop the infrastructure needed to attract experienced staff, and be assisted in providing uniform training for caseworkers and carers.

Recommendation 10.9

Short term *High*

A Unit of one or more positions, depending on the size of the agency, should be created in each Area Health Service, The Children's Hospital at Westmead, the Department of Education and Training, the NSW Police Force, the Department of Ageing, Disability and Home Care and

Priority **Cost**

the Department of Juvenile Justice to receive reports of risk of significant harm from staff of the agency and to take appropriate action for the protection of children and young persons, including reporting to DoCS. In addition, the Unit should ensure communication with other agencies, primarily the human services agencies and relevant NGOs, and provide advice to the Human Services and Justice CEOs Cluster about any problems or emerging trends concerning interagency collaboration.

The Unit in each agency should:

- a. report to the agency's CEO or a defined and consistent second tier within the agency
- b. use data systems and processes that are common across agencies
- c. meet regularly with the positions created in the same agency and with those in other agencies
- d. keep relevant data which is then shared across agencies
- e. be child protection trained
- f. be positively named.

Recommendation 10.10

Immediate *High*

Caseworkers should be employed on a temporary basis or re-assigned from Brighter Futures or OOHC work as case management is transferred to the NGO sector, to manage those reports meeting the criteria set out in 10.2 b above until Recommendations 6.2, 10.1 and 10.2 are implemented (DoCS estimates that 300 temporary caseworkers are required).

Brighter Futures

Recommendation 10.11

Three to five years *High*

Within three to five years, case management of all families in Brighter Futures should be by Lead Agencies.

Chapter 11 Statutory basis of child protection

Recommendation 11.1

Immediate *Low*

With respect to the *Children and Young Persons (Care and Protection) Act 1998*:

- i. Section 8(a) should be amended to provide as follows:
 - that children and young persons receive such care and protection as is necessary for their safety, welfare and well-being, having regard to the capacity of their parents or other persons responsible for them.

	<i>Priority</i>	<i>Cost</i>
ii.	Section 9 should be amended to provide: The principles to be applied in the administration of this Act are as follows: In all actions and decisions concerning a particular child or young person that are made under this Act the safety, welfare and well-being of the child or young person must be the paramount consideration. Paragraphs (b) to (g) should then be renumbered commencing with (a).	
iii.	Section 18 should be amended to insert the words “or a non-government agency in receipt of government funding for the requested services” after “or agency”.	
iv.	Section 21 should be amended to permit an NGO in receipt of government funding for the requested services to apply on behalf of a child or young person for assistance.	
v.	Section 28 should be proclaimed.	
vi.	Section 29(1)(f) should be amended to reflect the changed reporting structure as set out in Chapter 10.	
vii.	Section 29(1)(f) should be amended to permit the disclosure of the reporter’s details to a law enforcement agency pursuant to the investigation of a serious crime committed upon a child or young person, where that might impact on the child’s safety, welfare or well-being.	
viii.	Section 71 should be amended so that the grounds are not limited to those enumerated, while still retaining each sub-section.	
ix.	The Act should be amended to make clear that, other than emergency care and protection orders made under s.46(2) of the Care Act, the Children’s Court can not allocate parental responsibility to a designated agency or a principal thereof.	
x.	The Act should be amended to limit the power of the Children’s Court to make contact orders to those matters where the Court has accepted the assessment of the Director-General that there is a realistic possibility of restoration.	
xi.	Section 90(3) should be amended to permit the child or young person to make an application pursuant to that section.	
xii.	Part 3 of Chapter 7 should be repealed.	
xiii.	Section 58 (1) (a) should be amended to delete “or unwilling.”	
xiv.	Pursuant to s.82, the Children’s Court should have the power to order that a written report be made to it and, if after receiving that report, it is not satisfied that proper arrangements have been made, it should have the power to re-list the matter with notice to the parties to the original proceedings in order to give any of them an opportunity to make an application pursuant to s.90 or for any other ancillary or incidental order. However, if no party wishes to apply	

	<i>Priority</i>	<i>Cost</i>
<p>for an order varying any of the orders made, the matter should be taken no further. In the absence of a moving party, the Children's Court should not be empowered to make orders of its own motion.</p> <p>In addition, the Children's Court should develop rules concerning timing, notice, confidentiality and procedures to ensure that reports are made to it in a timely fashion, that all parties are provided with a copy of the report and that the process by which a date is set for hearing is also clear.</p> <p>xv. The Children's Court should have the power to order that expert evidence be provided to it, in the form of reports provided by the Children's Court Clinic or otherwise.</p> <p>xvi. Relevant amendments should be made to ensure that <i>Re Rhett</i> [2008] CLN 1 is followed.</p> <p>xvii. The Act should be amended to provide that a decision to restore a child or young person to the care of the parents from whom he or she had previously been removed by an order of the Children's Court, in circumstances where the Children's Court had accepted the assessment of the Director-General that there was not a realistic possibility of restoration, must be made by the Children's Court upon application by the person with parental responsibility.</p>		

Recommendation 11.2*Short term**Low*

There should be a feasibility study into the transfer of the Children's Court Clinic to Justice Health that should also investigate its expansion to provide the services of the kind currently offered by Justice Health in the criminal jurisdiction, as well as an extension of the matters dealt with in the current assessments so as to provide greater assistance in case management decisions.

Recommendation 11.3*Short term**Low*

Data in relation to all aspects of proceedings pursuant to the *Children and Young Persons (Care and Protection) Act 1998* should be kept by DoCS and the Children's Court and made public.

Recommendation 11.4*Immediate**Low*

DoCS should review its Casework Practice Policy, Taking Action in the Children's Court, to ensure it is consistent with the *Children and Young Persons (Care and Protection) Act 1998*, in particular, the principles set out in ss.9, 10 and 36.

Recommendation 11.5*Short term**Low*

DoCS should develop Guidelines for staff in order to ensure adherence

	Priority	Cost
to the Aboriginal and Torres Strait Islander Child and Young Person Placement Principles in s.13 of the <i>Children and Young Persons (Care and Protection) Act 1998</i> .		

Recommendation 11.6	<i>Short term</i>	<i>Low</i>
Evidence based guidelines for Magistrates should be prepared in relation to orders about contact made under s.86 of the <i>Children and Young Persons (Care and Protection) Act 1998</i> .		

Chapter 12 Other models of decision making

Recommendation 12.1	<i>Immediate</i>	<i>Medium</i>
Adequate funding should be provided so that alternative dispute resolution is used prior to and in care proceedings in order to give meaning to s.37 of the <i>Children and Young Persons (Care and Protection) Act 1998</i> , in relation to:		

- a. placement plans
- b. contact arrangements
- c. treatment interventions
- d. long term care issues
- e. determination of the timing/readiness for returning a child to the home
- f. determination of when to discontinue protective supervision
- g. the nature and extent of a parent's involvement
- h. parent/child conflict
- i. lack of, or poor, communication between a worker and parents due to hostility
- j. negotiation of length of care and conditions of return
- k. foster carer/agency/parent issues.

Recommendation 12.2	<i>Not applicable</i>	<i>Medium</i>
The Nowra Care Circle Pilot should be monitored and evaluated. If successful, consideration should be given to its extension to other parts of the State with significant Aboriginal communities.		

Chapter 13 Court Processes in statutory child protection

Recommendation 13.1	<i>Immediate</i>	<i>Low</i>
The <i>Children's Court Act 1987</i> should be amended to insert a provision similar to s.27 of the <i>Local Court Act 2007</i> and the <i>Children's Court Rules</i>		

	<i>Priority</i>	<i>Cost</i>
<p>2000 should be reviewed to ensure that the Rules are consistent with the <i>Children's Court Act 1987</i> and the Care Act, and any practice directions or notes that are issued after amendment of the Act should similarly accord with the legislation.</p>		
<p>Recommendation 13.2</p> <p>There should be no requirement, by way of legislation or practice, that DoCS is to file all material relied upon in care proceedings at the beginning of the proceedings.</p>	<i>Immediate</i>	<i>Low</i>
<p>Recommendation 13.3</p> <p>Care applications by DoCS under ss.45 and 61 should be made by way of an application filed in the Court supported by a written report which succinctly and fairly summarises the information available to DoCS and contains sufficient information to support a determination that a child is in need of care and protection and any interim orders sought, without any requirement for the filing of any affidavit, unless ordered by the Court in circumstances where establishment is contested. The DoCS file or relevant portion of it should be made available to the parties.</p>	<i>Immediate</i>	<i>Low</i>
<p>Recommendation 13.4</p> <p>Section 45 of the <i>Children and Young Persons (Care and Protection) Act 1998</i> should be amended to require DoCS to apply to the Children's Court no later than 72 hours after the child or young person has been removed or care assumed.</p>	<i>Immediate</i>	<i>Low</i>
<p>Recommendation 13.5</p> <p>The Children's Court should revise its practices in relation to changing hearing dates and moving proceedings between courts, as well as its listing practices for callovers and mentions.</p>	<i>Immediate</i>	<i>Low</i>
<p>Recommendation 13.6</p> <p>DoCS caseworkers should be given more specific training and guidance in relation to the nature of care proceedings and in relation to the evidence to be placed before the Court, to ensure its relevance, accuracy and fair balance.</p>	<i>Immediate</i>	<i>Low</i>
<p>Recommendation 13.7</p> <p>Guidelines should be developed for DoCS caseworkers based on the Code of Conduct applicable to the Office of the Director of Public Prosecutions.</p>	<i>Short term</i>	<i>Low</i>

	<i>Priority</i>	<i>Cost</i>
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Recommendation 13.8*Short term**Low*

A code of conduct should be developed applicable to all legal representatives in care proceedings. Specialist accreditation should be regularly available. Any necessary training or assessment mechanisms should be available on an ongoing or regular basis. A similar regime should also be established for Guardians ad Litem.

Recommendation 13.9*Immediate**Low*

A District Court Judge should be appointed as the senior judicial officer in the Children's Court.

Recommendation 13.10*Short term**Medium*

There should be sufficient specialist Children's Magistrates appointed to permit rural and regional circuits to be held to ensure that the proportion of matters in the care and protection jurisdiction presided over by non-specialist Magistrates is reduced to fewer than 10 per cent.

Recommendation 13.11*Short term**Low*

A trial of a 'docket system' in the Parramatta Children's Court for matters in the care and protection jurisdiction should be undertaken.

Recommendation 13.12*Immediate**Medium*

Registrars of the Children's Court should be legally qualified and alternative dispute resolution trained and sufficient in number to perform alternative dispute resolution and to undertake procedural and consent functions.

Chapter 15 Child protection and the criminal justice system

Recommendation 15.1*Long term**Medium*

An after hours bail placement service should be established by the Department of Juvenile Justice similar to the Victorian Central After Hours and Bail Placement Service, that is available to young people aged between 10 and 18 years, who are at risk of being remanded in custody, or who require bail accommodation; or similar to the Queensland Conditional Bail and Youth Program Accommodation Support Service.

*Priority**Cost***Chapter 16 Out-of-home care****Recommendation 16.1***Short term**Medium*

DoCS OOHC/NGO OOHC caseworkers should become involved with children and young persons in OOHC at an earlier stage than final orders and have a responsibility to identify and support the placement of the children or young people, where it has been determined that there is not a realistic possibility of restoration.

Recommendation 16.2*Three to five years**High*

Over the next three to five years, there should be a gradual transition in the provision of OOHC for children and young persons as follows:

- a. Most children and young persons in OOHC should be supported by one of the two following models:
 - i DoCS retains parental responsibility and a non-government organisation is responsible for case management, placement and casework services. The agency has responsibility for assessment, case planning, implementation, review, transition and case closure as well as the placement of a child or young person with an authorised carer, and for any decision to remove a child or young person from a carer. DoCS retains the key decision making role in restoration decisions, developing and approving the initial care plan and has a role in implementation. DoCS and the agency have joint responsibility for decisions to apply to change Court orders and for providing after care assistance.
 - ii DoCS delegates parental responsibility and transfers case management, placement and casework services to a non-government organisation (while retaining residual powers) subject to consultation with the Children's Guardian (see Recommendation 16.15).
 - iii Children and young persons with significantly complex needs or who are assessed as at high risk of immediate or serious harm or whose case management requires high level collaboration with other government agencies will remain case managed by DoCS.
- b. At an early stage, DoCS should progressively commence the transfer of long term kinship/relative carers to NGOs so as to allow the NGOs to carry out any necessary training and to provide ongoing support for these carers.
- c. At an early stage, DoCS should progressively reduce its role in the recruitment of foster carers and transfer current long term foster carers to NGOs.

	<i>Priority</i>	<i>Cost</i>
<p>Recommendation 16.3</p> <p>Within 30 days of entering OOHC, all children and young persons should receive a comprehensive multi-disciplinary health and developmental assessment. For children under the age of five years at the time of entering OOHC, that assessment should be repeated at six monthly intervals. For older children and young persons, assessments should be undertaken annually. A mechanism for monitoring, evaluating and reviewing access and achievement of outcomes should be developed by NSW Health and DoCS.</p>	<i>Short term</i>	<i>Medium</i>
<p>Recommendation 16.4</p> <p>NSW Health should appoint an OOHC coordinator in each Area Health Service and at The Children's Hospital at Westmead.</p>	<i>Immediate</i>	<i>Low</i>
<p>Recommendation 16.5.</p> <p>The Department of Education and Training should appoint an OOHC coordinator in each Region.</p>	<i>Immediate</i>	<i>Low</i>
<p>Recommendation 16.6</p> <p>The NSW Government has a responsibility to ensure that all children and young persons removed from their parents and placed in its care receive adequate health treatment. Thus, there should be sufficient health services including speech therapy, mental health and dental services available to treat, as a matter of priority, children and young persons in OOHC.</p>	<i>Long term</i>	<i>High</i>
<p>Recommendation 16.7</p> <p>The introduction of centralised electronic health records should be a priority for NSW Health. Given that this is likely to take some time, an interim strategy should be developed to examine a comprehensive medical record or a transferable record for children and young persons in OOHC, which should be accessible to those who require it in order to promote or ensure the safety, welfare and well-being of the child or young person.</p>	<i>Short term (interim strategy)</i>	<i>High</i>
<p>Recommendation 16.8</p> <p>Within 30 days of entering OOHC, all preschool and school aged children and young persons should have an individual education plan prepared for them which is reviewed annually by the Department of Education and Training and by the responsible caseworker. A mechanism for monitoring, evaluating and reviewing access and achievement of</p>	<i>Short term</i>	<i>Medium</i>

	<i>Priority</i>	<i>Cost</i>
outcomes should be developed by the Department of Education and Training and DoCS.		
Recommendation 16.9	<i>Long term</i>	<i>Medium</i>
Carer allowances should be reviewed periodically by an independent body and should more closely reflect the actual costs to the carer of providing care, according to the varying categories of need.		
Recommendation 16.10	<i>Immediate</i>	<i>Low</i>
The Memoranda of Understanding between DoCS and respectively, the Department of Ageing, Disability and Home Care, NSW Health and the Department of Education and Training should be revised to reflect the increasing responsibilities of NGOs for the provision of OOHC.		
Recommendation 16.11	<i>Long term</i>	<i>Medium</i>
A common case management framework for children and young people in OOHC across all OOHC providers, should be developed, following a feasibility study on potential models including the Looking After Children system.		
Recommendation 16.12	<i>Long term</i>	<i>Medium</i>
Due to the large numbers of Aboriginal children and young persons in OOHC, priority should be given to strengthening the capacity for Aboriginal families to undertake foster and kinship caring roles.		
Recommendation 16.13	<i>Short term</i>	<i>Medium</i>
There should be sufficient numbers of care options for children and young persons with challenging behaviours that include specialised models of therapeutic foster care.		
Recommendation 16.14	<i>Long term</i>	<i>High</i>
DoCS and/or relevant NGOs should receive sufficient funding to service the actual and projected OOHC population to enable an average ratio of one caseworker to 12 children and young persons.		
Recommendation 16.15	<i>Short term</i>	<i>Low</i>
DoCS should consult with the Children's Guardian before delegating parental responsibility to any person, except in circumstances where DoCS has shared parental responsibility and is delegating to the person with whom it shares parental responsibility. In the event that a		

	<i>Priority</i>	<i>Cost</i>
mechanism for that to occur has not been introduced to the satisfaction of DoCS and the Children's Guardian within 12 months of the publication of this report, the <i>Children and Young Persons (Care and Protection) Act 1998</i> should be amended to require that consultation.		

Recommendation 16.16	<i>Immediate</i>	<i>Medium</i>
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With respect to the *Children and Young Persons (Care and Protection) Act 1998*:

- i. the proposal set out in the draft Cabinet Minute to introduce a revised scheme for voluntary care should be implemented and the Children's Guardian should receive the additional resources necessary to perform the functions of that office that would apply to those within that scheme
- ii. section 183 should be repealed
- iii. section 181(1)(d) should be repealed
- iv. section 181(1)(a) should be repealed
- v. section 186 should be repealed
- vi. section 105(3)(b)(iii) should be amended to delete reference to the Children's Guardian and to replace it with the Director-General of DoCS
- vii. section 90(3)(b) should be repealed
- viii. section 159 should be proclaimed

Chapter 17 Domestic and family violence in child protection

Recommendation 17.1	<i>Immediate</i>	<i>Low</i>
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The NSW Police Force should amend its policies in respect of reporting domestic violence incidents to DoCS to align with the requirements of s.23(d) of the *Children and Young Persons (Care and Protection) Act 1998* and should provide the necessary training to its officers to enable them to comply with the amended legislation.

Recommendation 17.2	<i>Short term</i>	<i>Low</i>
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DoCS and NSW Police should agree on the process and content of information to be exchanged when reporting children or young persons at risk to ensure that information received by DoCS enables an appropriate and timely risk of harm assessment to be made.

Recommendation 17.3	<i>Short term</i>	<i>Medium</i>
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DoCS caseworkers should receive domestic violence specific training, jointly with other relevant agencies and NGO workers.

Priority **Cost**

Chapter 18 Aboriginal over representation in child protection

Recommendation 18.1

Immediate *Low*

The NSW Ombudsman should be given authority to audit the implementation of the Aboriginal Child Sexual Assault Taskforce recommendations as described in Recommendation 21 of the Taskforce's report.

Recommendation 18.2

The NSW Government should consider the following:

Short term *Medium*

- a. Assisting Aboriginal communities to consider and develop procedures for the reduction of the sale, delivery and use of alcohol to Aboriginal communities.

Short term *Medium*

- b. Working with the Commonwealth to income manage Commonwealth and State payments to all families, not only Aboriginal families, in circumstances where serious and persistent child protection concerns are held and there is reliable information available that income is not being spent in the interests of the safety, welfare and well-being of the relevant child or young person.

Short term *Medium*

- c. Introducing measures to ensure greater attendance at school, preferably by means other than incarceration, including the provision of transport and of meals.

Immediate *Medium*

- d. In smaller and more remote communities, introducing the greater use of night patrols to ensure that children are not wandering the streets at night in circumstances where they might be at risk of assault, or alternatively of involvement in criminal activities.

Short term *Medium*

- e. Providing accommodation to Aboriginal children and young people at risk of harm of a boarding nature type where the children are cared for and educated.

Recommendation 18.3

Short term *Medium*

The NSW Government should take steps to ensure that the recommendations of the Aboriginal Child Sexual Assault Taskforce

Priority **Cost**

report, and the actions in the Interagency Plan, which relate to provision of direct services to Aboriginal children, young persons, families and perpetrators, are carried into effect within the lifetime of the plan.

Recommendation 18.4 *Short term* *Low*

The NSW Government should work actively with the Commonwealth in securing the delivery, in NSW, of the services identified in the New Directions Policy and in the 2008/09 Commonwealth Budget that were earmarked for the benefit of Aboriginal people.

Chapter 20 Young people, leaving care and homelessness

Recommendation 20.1 *Short term* *Medium*

DoCS should train and appoint to each DoCS Region, specialist caseworkers to assist in the case management of young people.

Recommendation 20.2 *Short term* *Low*

DoCS should fund a training package to assist foster carers and kinship and relative carers in preparing young people for leaving care.

Recommendation 20.3 *Short term* *Low*

DoCS should fund the provision of detailed information to care leavers as to the assistance which is available to them through State and Commonwealth sources after they leave care, and as to the means by which they can access that assistance.

Chapter 21 Children and young persons and parents with a disability

Recommendation 21.1 *Short term* *Medium*

A data management system should be developed in DoCS and the Department of Ageing, Disability and Home Care to identify joint clients.

Recommendation 21.2 *Immediate* *Low*

The Memorandum of Understanding between DoCS and the Department of Ageing, Disability and Home Care should be revised to provide the operational definitions set out in the 2008 Memorandum of Understanding evaluation and to specify the manner in which joint assessment and planning will occur.

	Priority	Cost
<p>Recommendation 21.3</p> <p>Joint training should be carried out for DoCS and Department of Ageing, Disability and Home Care staff, in relation to the care and protection of children and young persons with a disability, and in relation to the individual and mutual responsibilities of the two agencies.</p>	<i>Short term</i>	<i>Low</i>
<p>Recommendation 21.4</p> <p>The recruitment and training of foster carers who care for children and young persons with a disability in voluntary and statutory OOHC should occur jointly by DoCS and the Department of Ageing, Disability and Home Care.</p>	<i>Short term</i>	<i>Low</i>
<p>Recommendation 21.5</p> <p>The Department of Ageing, Disability and Home Care and DoCS should develop additional models of accommodation and care for children and young persons with a disability who are subject to the parental responsibility of the Minister for Community Services, or for those whose disabilities are such that they are unable to continue to reside in their homes.</p>	<i>Short term</i>	<i>Medium</i>
<p>Recommendation 21.6</p> <p>Consideration should be given to the establishment of a suitable mediation process for those cases where the Department of Ageing, Disability and Home Care considers that services are needed for a child or young person with a disability and 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.</p>	<i>Long term</i>	<i>Low</i>

Chapter 22 Disaster recovery

<p>Recommendation 22.1</p> <p>DoCS responsibilities under the <i>Community Welfare Act 1987</i> should be transferred to the Department of Premier and Cabinet or to such other government department as is entrusted with the principal responsibilities for planning for and responding to disasters or emergencies, with DoCS staff being available to be called upon to provide, under the coordination and direction of the Department of Premier and Cabinet or of such other department, assistance appropriate to the event.</p>	<i>Short term</i>	<i>Medium</i>
<p>Recommendation 22.2</p> <p>In the event that DoCS retains responsibility under the <i>Community</i></p>	<i>Short term</i>	<i>Medium</i>

	<i>Priority</i>	<i>Cost</i>
<i>Welfare Act 1987</i> , it should be resourced sufficiently to adequately perform that role, without frontline child protection caseworkers being deployed.		

Recommendation 22.3	<i>Short term</i>	<i>Low</i>
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The NSW Government should assign responsibility for distributing drought relief to an agency other than DoCS, and such relief as is provided should not be a cost to the DoCS budget.

Chapter 23 Oversight

Recommendation 23.1	<i>Immediate</i>	<i>Low</i>
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The relevant legislation including Part 7A of the *Commission for Children and Young People Act 1998* should be amended to make the NSW Ombudsman the convenor of the Child Death Review Team and the Commissioner for Children and Young People, a member of that Team rather than its convenor. The secretariat and research functions associated with the Team should also be transferred from the Commission for Children and Young People to the NSW Ombudsman.

Recommendation 23.2	<i>Immediate</i>	<i>Low</i>
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DoCS should review the death of any child or young person about whom a report was made within three years of that death, or where such a report was made about a sibling of such a person, within six months of becoming aware of the death.

Recommendation 23.3	<i>Immediate</i>	<i>Low</i>
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The *Community Services (Complaints, Reviews and Monitoring) Act 1993* should be amended by:

- i. repealing s.35(1)(b) and (c)
- ii. replacing the requirement for an annual report, in s.43 with a requirement that a report be made every two years.

Recommendation 23.4	<i>Short term</i>	<i>Low</i>
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Information obtained by persons appointed by the Minister as official visitors should be available to the regulator/accreditor of OOHC with appropriate procedural fairness safeguards and s.8 of *Community Services (Complaints, Reviews and Monitoring) Act 1993* and clause 4 of *Community Services (Complaints, Reviews and Monitoring) Regulation 2004* should be amended to achieve this outcome.

	<i>Priority</i>	<i>Cost</i>
<p>Recommendation 23.5</p> <p>The class or kind agreement between the NSW Ombudsman and DoCS should be revised to require DoCS to notify only serious allegations of reportable conduct and to impose timeframes within which DoCS will investigate those allegations.</p>	<i>Short term</i>	<i>Low</i>
<p>Recommendation 23.6</p> <p>DoCS should centralise its Allegations Against Employees Unit and receive sufficient funding to enable this restructure, and to resource it to enable it to respond to allegations in a timely fashion.</p>	<i>Immediate</i>	<i>Low</i>
<p>Recommendation 23.7</p> <p>DoCS should revise the findings available following an investigation into an allegation against an employee so as to and permit one of the following findings to be made but no other: sustained, not sustained, not reportable conduct. Adequate reasons should be recorded, and kept on file, which should note not only why an allegation was sustained, but also the reasons why an allegation was not reportable or not sustained.</p>	<i>Immediate</i>	<i>Low</i>
<p>Recommendation 23.8</p> <p>The <i>Commission for Children and Young People Act 1998</i> should be amended to require background checks as follows:</p> <ol style="list-style-type: none"> a. in respect of DoCS and other key human service agencies all new appointments to staff positions that work directly or have regular contact with children and young persons (that is, permanent, temporary, casual and contract staff held against positions including temporary agency staff) b. any contractors engaged by those agencies to undertake work which involves direct unsupervised contact to children and young persons, and, in the case of DoCS, access to the KiDS system or file records on DoCS clients c. students working with DoCS officers d. children's services licensees e. authorised supervisors of children's services f. principal officers of designated agencies providing OOHC or adoption agencies g. adult household members, aged 16 years and above of foster carers, family day carers and licensed home based carers h. volunteers in high risk groups, namely those having extended unsupervised contact with children and young persons. 	<i>Short term</i>	<i>Medium</i>

Priority **Cost**

Chapter 24 Interagency cooperation

Recommendation 24.1 *Immediate* *Low*

The legislation governing each human services and justice agency should be amended by the insertion of a provision obliging that agency to take reasonable steps to coordinate with other agencies any necessary decision making or delivery of services to children, young persons and families, in order to appropriately and effectively meet the protection and care needs of children and young persons.

Recommendation 24.2 *Immediate* *Low*

Each human services and justice agency CEO should have, as part of his or her performance agreement, a provision obliging performance in ensuring interagency collaboration in child protection matters and providing for measurement of that performance.

Recommendation 24.3 *Immediate* *Low*

The Director-General, each Deputy Director-General and each Regional Director of DoCS should have, as part of his or her performance agreement, a provision obliging performance in ensuring interagency collaboration in child protection matters and providing for measurement of that performance.

Recommendation 24.4 *Long term* *Medium*

The boundaries of key human services and justice agencies should be aligned.

Recommendation 24.5 *Short term* *Low*

Cross agency training should be delivered in relation to interagency collaboration and cooperation in delivering services to children and young persons.

Recommendation 24.6 *Immediate* *Low*

The *Children and Young Persons (Care and Protection) Act 1998* should be amended to permit the exchange of information between human services and justice agencies, and between such agencies and the non-government sector, where that exchange is for the purpose of making a decision, assessment, plan or investigation relating to the safety, welfare and well-being of a child or young person in accordance with the principles set out in Chapter 24. The amendments should provide, that to the extent inconsistent, the provisions of the *Privacy and Personal*

Priority **Cost**

Information Protection Act 1998 and Health Records and Information Privacy Act 2002 should not apply. Where agencies have Codes of Practice in accordance with privacy legislation their terms should be consistent with this legislative provision and consistent with each other in relation to the discharge of the functions of those agencies in the area of child protection.

Recommendation 24.7

Short term *Low*

An improved structure should be established for regular regional meetings between the key human services agencies and NGOs to facilitate collaborative cross agency work, and to be accountable to the Human Services and Justice CEOs Cluster.

Chapter 25 DoCS funded non-government service system**Recommendation 25.1**

Long term *Medium*

All NSW Government funding to NGOs delivering universal, secondary and tertiary services to children, young persons and their families to prevent or otherwise address child protection concerns should be reviewed, so as to establish a coordinated system for the allocation of their funded resources that will eliminate unnecessary overlap and provide for the delivery of service where most needed.

Acronyms

<i>Acronyms</i>	<i>Phrase/meaning</i>
1987 Act	<i>Children (Care and Protection) Act 1987</i>
AAE	Allegations Against Employees
AAS	Area Assistance Scheme
Aboriginal Affairs	Department of Aboriginal Affairs
Aboriginal Placement Principles	Aboriginal Child Placement Principles
ABS	Australian Bureau of Statistics
AbSec	Aboriginal Child, Family and Community Care State Secretariat
ACSAT	Aboriginal Child Sexual Assault Taskforce
ACWA	Association of Children's Welfare Agencies
ACYFS	Aboriginal, Child, Youth and Family Strategy
ADR	alternative dispute resolution
ADT	Administrative Decisions Tribunal
AHS	Area Health Service
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AMIHS	Aboriginal Maternal and Infant Health Strategy
AODP	Alcohol and Other Drugs Program
Attorney General's	Attorney General's Department
AVO	Apprehended Violence Order
BOCSAR	Bureau of Crime Statistics and Research
CALD	culturally and linguistically diverse
Care Act	<i>Children and Young Persons (Care and Protection) Act 1998</i>
CCYP	Commission for Children and Young People
CCYP Act	<i>Commission for Children and Young People Act 1998</i>
CCYP Act	<i>Commission for Children and Young People Act 1998</i>
CDC	Caseworker Development Course
CDCRU	Child Deaths and Critical Reports Unit (DoCS)
CDRT	Child Death Review Team
CEC	Chief Executives Committee
CEO	Chief Executive Officer
CIW	Corporate Information Warehouse
Clinic	Children's Court Clinic
COAG	Council of Australian Governments
Community Welfare Act	<i>Community Welfare Act 1987</i>
Corrective Services	Department of Corrective Services
CRC	Children's Research Center
CS CRAMA	<i>Community Services (Complaints, Reviews and Monitoring) Act 1993</i>
CSC	Community Services Centre
CSGP	Community Services Grants Program
CYP	Children and young persons
DADHC	Department of Ageing, Disability and Home Care
Discussion Paper	DoCS Discussion Paper, <i>Statutory child protection in NSW: issues and options for reform</i> , October 2006
Displan	NSW State Disaster Plan

<i>Acronyms</i>	<i>Phrase/meaning</i>
District Court	District Court of NSW
DoCS	Department of Community Services
DPP	Office of the Director of Public Prosecutions
Education	Department of Education and Training
EOI	expression of interest
ESD	Enhanced Service Delivery
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
Family Court	Family Court of Australia
Family Law Act	<i>Family Law Act 1975</i>
FGC	family group conferencing
FTE	full time equivalent
Health	NSW Health
HNEAHS	Hunter New England Area Health Service
Housing	Housing NSW
HREOC	Human Rights and Equal Opportunity Commission
HRIP Act	<i>Health Records and Information Privacy Act 2002</i>
IFBS	Intensive Family Based Services
Interagency Guidelines	<i>Interagency Guidelines for Child Protection Intervention 2006</i>
Interagency Plan	Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006-2011
JIRT	Joint Investigation Response Team
JRU	JIRT Referral Unit
Juvenile Justice	Department of Juvenile Justice
KiDS	Key Information and Directory System
LAC	Legal Aid Commission NSW
LAC proposal	Draft Proposal for a Care and Protection Mediation Pilot (Legal Aid NSW)
LAT	Less Adversarial Trial
Law Society	Law Society of NSW
Magellan	Magellan Case Management Model
MOU	Memorandum of Understanding
NCOSS	Council of Social Services of NSW
New Street	New Street Adolescent Service
NGO	non-government organisation
NTER	Northern Territory Emergency Response
OHS	Occupational Health and Safety
Ombudsman	NSW Ombudsman
Ombudsman Act	<i>Ombudsman Act 1974</i>
OOHC	out-of-home care
PANOC	Physical Abuse and Neglect of Children
Police	NSW Police Force
PPIP Act	<i>Privacy and Personal Information Protection Act 1998</i>
PPR	Personal Planning and Review
Premier and Cabinet	Department of Premier and Cabinet
PSA	Public Service Association
RACP	Royal Australian College of Physicians
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCMG	Regional Coordination Management Group

<i>Acronyms</i>	<i>Phrase/meaning</i>
Regulations	<i>Children and Young Persons (Care and Protection) Regulation 2000</i>
Rules	<i>Children's Court Rule 2000</i>
SAAP	Supported Accommodation Assistance Program
SACS Award	Social and Community Services Award
SAS1	Secondary Assessment Stage 1
SAS2	Secondary Assessment State 2
SCAN	Suspected Child Abuse and Neglect
SCI	Special Commission of Inquiry
SDM	Structured Decision Making
SDRC	State Disaster Recovery Centre
SERM Act	<i>State Emergency and Rescue Management Act 1989</i>
SNAICC	Secretariat of National Aboriginal and Islander Child Care
Treasury	NSW Treasury
Triple P	Positive Parenting Program
Usher Review	Review of Substitute Care Services in NSW 1992
Young Offenders Act	<i>Young Offenders Act 1997</i>

Part 1 DoCS structure and workforce

1. Introduction

- 1.1 A boy, aged two years and seven months died on 11 October 2007. His mother was charged in relation to his death on 20 October 2007. A girl, aged seven years, died on 3 November 2007. Her parents were charged in relation to her death on 17 November 2007. Both children and/or their siblings had been the subject of reports of suspected risk of harm to the Department of Community Services (DoCS).
- 1.2 It was largely in response to the deaths of these two children that, on 14 November 2007, a commission was issued for an Inquiry to determine what changes within the child protection system were required to cope with future levels of demand once the current reforms to that system which had been initiated in 2002 were completed.
- 1.3 The deaths of these two children have been the subject of comprehensive reviews by the NSW Ombudsman and DoCS. As criminal proceedings have commenced but not yet finalised, the Inquiry will not comment on the two cases.
- 1.4 However, the Inquiry has had the benefit of reviewing the material gathered from all agencies in relation to their deaths and the findings and lessons from these reviews have informed the considerations and recommendations of the Inquiry.
- 1.5 For the purpose of the Inquiry, the child protection system is defined to include each department or agency in NSW with responsibilities towards children, young persons and their families. They include DoCS, NSW Health and each Area Health Service and The Children's Hospital at Westmead, the Department of Education and Training, the Department of Ageing, Disability and Home Care, the NSW Police Force, the Department of Juvenile Justice, the Department of Aboriginal Affairs and Housing NSW.
- 1.6 In addition, those non-government organisations (NGOs) which receive funding from the Government to provide services to children, young persons and their families are also part of the child protection system. Those NGOs extend from agencies in receipt of tens of millions of dollars in funding to small organisations run by volunteer committees.
- 1.7 Courts and Tribunals are also part of the child protection system, including the Children's Court, the family law courts, the Supreme Court, the District Court, the Administrative Decisions Tribunal and the Coroner's Court.
- 1.8 Commonwealth agencies which provide funding or services also have responsibilities for children, young persons and their families including the Department of Families, Housing, Community Services and Indigenous Affairs, the Department of Education, Employment and Workplace Relations, and the Department of Health and Ageing. Local Councils also provide services to children, young persons and their families.

- 1.9 In addition, there are private sector bodies which provide services such as private schools and day care facilities and those involved in the provision of medical and dental services. Finally, the child protection system encompasses the independent, advisory or watchdog agencies which include the NSW Ombudsman, the Children's Guardian, and the Commission for Children and Young People.
- 1.10 The services to assist children, young persons and their families and to prevent them from entering or escalating within the child protection system range from universally provided services such as prenatal care and quality child care, to more targeted or secondary services such as home visiting and supported playgroups. Tertiary services for those children and young persons who have suffered abuse, include counselling and more intensive services.
- 1.11 The processes and procedures followed by the Inquiry are set out in detail in the various appendices to this report. However, it is important to note that during the course of the Inquiry, the Inquiry staff travelled extensively in NSW from Boggabilla in the north, to Broken Hill in the west and Wagga Wagga in the south and many small and large towns in between. In addition, the Inquiry held Public Forums at many of those locations, as well as speaking with the staff of the local DoCS community services centres and other local agencies involved in the child protection system.
- 1.12 In Sydney, the Inquiry held nine Public Forums to canvass the views of those within, and outside the system, including its clients, concerning the discrete topics covered at each Public Forum.
- 1.13 The Inquiry benefited from the views of many experts in the area, located in Sydney, other parts of Australia and internationally.
- 1.14 While summons were issued to permit lawful disclosure, generally the Inquiry found that each agency readily cooperated with it and provided all relevant material in a timely fashion. In particular, DoCS provided material sought, volunteered much material and undertook significant analysis of data for the Inquiry.
- 1.15 As can be seen from the terms of reference, the Inquiry was required to form a view about future levels of demand. It did so with the assistance of data analyses from DoCS. That can be summarised as follows. While demand as measured by reports of children at risk of harm continue to increase, the rate of increase has slowed. Further, a significant number of children the subject of risk of harm reports are already known to the system.
- 1.16 Unfortunately, however, the number of children and young persons in out-of-home care (OOHC) continues to grow at a significant rate. While reforms to the system generally, and in particular the provision of more and earlier intervention and prevention services should, in the future, reduce the number of children and young persons removed from their home, those children and young persons in

OOHC are staying there longer. The budgetary implications of this are both serious and urgent.

- 1.17 A range of complex and often chronic factors characterise many of the families coming into contact with the child protection system such as low income or unemployment, substance abuse, limited social supports, domestic violence, mental health issues, social or geographic isolation and burdens of sole parenting. Many of these factors are inter-related and inter-generational, and further exacerbate problems faced by families. They continue to present a significant challenge for some Aboriginal¹ communities, whose needs were the subject of particular attention by the Inquiry.
- 1.18 It is almost trite to observe that the attention paid to each of these has a direct impact on the number of children, young persons and families coming into contact with the system.
- 1.19 This report is divided into parts. Part 1, of which this chapter is part, comprises a consideration of the reforms referred to in the terms of reference, DoCS structure and the capacity of its workforce.
- 1.20 Part 2 considers the early intervention and child protection arms of DoCS. For ease of reference, key child protection research and data have been collected in two chapters and that data and research informs the report as a whole. Part 2 addresses the regime by which reports of risk of harm are made to DoCS and considers the contributions and obligations of mandatory reporters. It also details the early intervention work undertaken by DoCS, other state agencies and NGOs, with particular attention to DoCS Brighter Futures program. The assessment and response work of the Department and others is then detailed. Chapter 10 entitled 'Directions for the way forward' collects the principles underpinning the child protection system. It notes the desirable goals and makes general recommendations for the way forward. Each chapter within this and other Parts contains a description of the aspects of the system under consideration followed by the issues which arise from that consideration and recommendations specific to these issues.
- 1.21 Part 3 deals with the legal basis of the child protection system including the powers, functions and processes of the Children's Court, and to a lesser extent the family law courts and the relevant appellate and administrative review processes. The interface between child protection and the criminal justice system is also considered in this part.
- 1.22 Part 4 concerns OOHC and similarly to Chapter 10, collects the principles and goals that should govern OOHC and its goals.

¹ Throughout this report any reference to 'Aboriginal' should be taken to mean 'Aboriginal and Torres Strait Islander' as defined in s.5 of the *Children and Young Persons (Care and Protection) Act 1998*.

- 1.23 Part 5 collects a range of specific areas of particular concern including domestic and family violence, Aboriginal communities, adolescence, children and young people with disabilities and disaster recovery.
- 1.24 Part 6 looks at the roles played and the functions of the other government and non-government agencies which come within the definition of the child protection system as set out above, including the oversight arrangements. It considers the processes by which the non-government sector is funded by DoCS and others to perform or provide services for children, young persons and their families. Specific attention is given to the need for more effective interagency collaboration. Some comment is also made on performance measures.
- 1.25 Part 7 of the report contains commentary about implementation of its recommendations.
- 1.26 The recommendations are collected at the beginning of the report.
- 1.27 Over the 12 months of the Inquiry, more data has become available than that which existed in the early months. In particular, DoCS and other agencies have released their annual reports in recent weeks. Where possible, this report attempts to capture the most recent data available, however, depending upon the topic, the most recent data can vary between 2006/07, April 2007 to March 2008 or the financial year 2007/08. The most recent data available to the Inquiry is used and accordingly, in some areas that data maybe older than in other areas.
- 1.28 The Inquiry was undertaken on the basis that its focus was to be on achieving system reform, rather than on allocating fault or finding a solution for individual cases where families were dissatisfied with the outcome for their children and for themselves.
- 1.29 Any different approach would have delayed the delivery of the report by a very considerable period, and would not, in any event, have been consistent with the terms of reference. Notwithstanding, submissions were received from the public and given careful consideration as to whether they identified deficiencies in the system which the report should address. In some instances the stories told have become case studies in the report.
- 1.30 The Inquiry has been careful to maintain the confidentiality of the families and children whose cases have come to notice, and to observe statutory restrictions on the disclosure of their names and identities. For these reasons, many submissions have not been publicly released. They have, however, provided a useful resource for the Inquiry, and it is grateful for the assistance provided by the very many individuals and agencies that responded to its invitation for submissions.

2 DoCS structure and reform

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Introduction

- 2.1 The terms of reference require the Inquiry to determine what changes within the child protection system are required to cope with future levels of demand once the current reforms to that system are completed.
- 2.2 The Inquiry has interpreted those terms of reference to refer to the Reform Package which was proposed by the then Director-General and subsequently accepted by Cabinet and funded in December 2002. While the Inquiry agrees with the general thrust of the Reform Package, for a variety of reasons some of those reforms are not complete and should not be continued in the manner thought appropriate in 2002. Thus, the Inquiry does not view the terms of reference as constraining it to the acceptance of all the reforms set out in the Reform Package.
- 2.3 Before considering the 2002 Reform Package and its current status, it is necessary to understand some of the key events which preceded it.

Pre 2002

- 2.4 During the 1990s there was significant change in the Government's response to the care and protection of children. First, the Community Services Commission was established to, *inter alia*, review, monitor and deal with complaints in relation to the Government's care and protection of children. Secondly, a review was conducted of the *Children (Care and Protection) Act 1987*. Thirdly, a child death review team was created and ultimately placed in the newly created Commission for Children and Young People. Fourthly, many of the recommendations made in the review of the 1987 legislation were reflected in the *Children and Young Persons (Care and Protection) Act 1998*, (the Care Act) including an extension of mandatory reporting. Finally, the Helpline was operational from 2000.
- 2.5 Then, in 2002 a number of reports critical of DoCS were published.
- 2.6 In April 2002, the NSW Ombudsman (the Ombudsman) made a special report to Parliament which criticised many areas of DoCS' operations including its response to increased reports of child abuse, authorisation and training of foster carers, record keeping, its client information system and the lack of knowledge of staff about policies and procedures.²
- 2.7 A joint DoCS/Public Service Association working party, commonly known as the Kibble Committee, reported in December 2002 and recommended a significant increase in OOHC caseworkers, to between 150 and 200, and in child

² NSW Ombudsman, *DoCS: Critical Issues*, April 2002.

protection caseworkers, to between 700 and 1,000. It also identified various areas to increase efficiency.³

- 2.8 In the same month, the final report on child protection services by the Legislative Council's Standing Committee on Social Issues was published.⁴ It recommended a new Department of Child Development to coordinate and fund the programs that promote the development and well-being of children and young persons. It stated that DoCS should not have a direct service delivery role in early intervention and that secondary prevention should be built largely within the non-government sector.
- 2.9 Its areas of recommendation were broad and included data collection, a better interface between the Department and the court system, creating a core function of research and evaluation, increasing funding in prevention and early intervention and a range of matters in the OOHC system including a recommendation that all children in OOHC should have an identified and designated caseworker.
- 2.10 Matters such as supervision, procedures, external oversight, information systems, mandatory reporting, secondary risk of harm assessment frameworks and reducing time spent by caseworkers on paperwork and general administrative duties were also addressed.
- 2.11 It is against this backdrop of consistent criticism that the then Director-General sought the funds and support of the Government to reform significantly the manner in which DoCS carried out child protection work.

2002 Reform Package

- 2.12 In its 2002 request for funds, DoCS provided a snapshot of the environment in which it then operated.
- 2.13 There had been a 432 per cent increase in child protection reports in the five years 1996/97 to 2001/02. Of the nearly 160,000 reports in 2001/02, about 92,000 were assessed as requiring investigation. Of those cases DoCS could only allocate 55 per cent of those reports requiring a less than 24 hour response to a caseworker for investigation, 26 per cent of those requiring a less than 72 hour response and 12 per cent of those requiring a less than 10 day response.
- 2.14 A child protection demand curve was prepared which noted that demand was continuing to rise at 59.3 per cent per annum and that the OOHC increase was steady at 10 per cent per annum, but with increasing costs per child. On these

³ Joint DoCS/Public Service Association Working Party Report, December 2002.

⁴ NSW Legislative Council Standing Committee on Social Issues, *Care and Support: Final Report on Child Protection Services*, December 2002.

trends, estimated figures for 2006 were 384,000 child protection reports and 12,591 children in OOHC.

- 2.15 Costs per child per annum in OOHC had risen from \$15,422 in 1999/2000 to \$20,246 in 2001/02. It was stated that the estimated increase in cost of OOHC by 2006/07 would be between \$134 million and \$194 million just to maintain the status quo.
- 2.16 It was also reported that there was a DoCS caseworker/client ratio of 1:30 in OOHC as against an international benchmark of 1:12, and a lack of support for, and significant shortage of, foster carers.
- 2.17 DoCS predicted that over time, the proposed changes would result in a downwards trend in child protection reports and unit costs, a stabilising of OOHC costs and a significant reduction in placement breakdowns which would control further cost increases.
- 2.18 In December 2002 the Reform Package was announced comprising a \$1.2 billion package of recurrent funding over the remainder of that year and the next five years taking the DoCS recurrent budget from \$641 million per year to over \$1.2 billion per year by 2007/08, together with a capital injection of over \$80 million in the same period.
- 2.19 The following table sets out the reforms proposed in 2002, the progress made as at March 2008 and a brief comment by the Inquiry. Each matter will be the subject of detailed discussion in the report.

Table 2.1 Progress on implementation of 2002 Reform Package, March 2008.

<i>REFORM PROPOSED IN 2002</i>	<i>PROGRESS BY MARCH 2008</i>	<i>INQUIRY'S COMMENT</i>
Establish a new client information system	KiDS approved prior to reform package, operational from October 2003	KiDS needs significant re-design
Create a new records management system	Mostly not commenced	DoCS needs to move to an electronic records system
To deal with the high cumulative cost of workers compensation claims	Achieved	The Helpline needs particular attention
Replacement of the human resources system	Completed	
Creation of a performance management system	Completed	More by way of professional supervision is needed
Create a corporate information warehouse and minimum data set exchange	Completed	Ongoing work required
An economics capacity	Established	Performs essential and quality work
An Aboriginal services unit	Established	Additional Aboriginal recruitment needed

<i>REFORM PROPOSED IN 2002</i>	<i>PROGRESS BY MARCH 2008</i>	<i>INQUIRY'S COMMENT</i>
An increase in expertise based positions in child protection, early intervention and OOHC	Established	Expertise needed in specific areas, for example mental health, family and domestic violence and young people
Adequately staff the Complaint Handling and External Reviews Unit	Increase in staffing	Location and staffing of the Complaints Unit is currently inadequate for volume of work
A central coordination of what happens in regions	Achieved	More needs to be done to ensure quality and to communicate policy and practice changes
Training	Achieved significant changes in training strategy	Need to integrate research into practice
Changes in corporate support	Achieved	More functions could be transferred to Businesslink
Equivalent to 375 child protection caseworkers were sought at the rate of 75 caseworkers a year between 2003/04 and 2007/08 and 40 casework managers	Achieved, vacancies remain	More needs to be done to divert low risk of harm reports
Additional 30 psychologists to work in Community Services Centres to direct caseworkers support and 3 deputy principal psychologists	Not achieved because of opposition by the union	They should be employed
30 legal officers based in CSCs	Achieved	
To strengthen Joint Investigation Response Teams	Additional positions created	Recent review recommendations need to be implemented
Fund intensive support to Aboriginal families	Achieved	Similar model should be in place for non-Aboriginal children and young persons
Additional 350 caseworkers for early intervention work	350 caseworker positions created, vacancies remain	Universal and secondary or targeted services should be expanded
Increase caseworkers in OOHC by 150, later extended to 300	Largely achieved	Too few caseworkers to support children and young persons in OOHC
Increase the number of foster carers and foster care support systems	Progress made	More needed
Reduce reliance on expensive 'for profit' providers when children first come into care	Significant progress made	The number of 'high needs kids' has increased
Expand the range of service options in the community for children and young persons with challenging behaviours, including professional carers and intensive community based placements	Progress made	Needs to be implemented
Commence funding to increase capacity in the sector particularly in Aboriginal services and identified areas of high demand	Progress made	More needs to be done
Augment Children's Services	Not funded	
A new model of disaster recovery management	Not funded	A new model needed

- 2.20 As can be seen from the above table, most of the reforms identified in 2002 have been implemented or are well underway. However, more and different reforms now need to be undertaken in these and other areas, each of which will be explored in this report.
- 2.21 The Inquiry has conducted its examination of the child protection system based on, *inter alia*, the comprehensive data obtained from DoCS, which are set out in Chapter 5. In addition, the Inquiry has identified the obstacles to reform which were encountered over the past five years and considered the likelihood of them persisting in the current environment.

Obstacles encountered and persisting

- 2.22 Events and situations which prevented or hindered the realisation of all the change sought by the Reform Package, and which are likely to impede any further change include:
- a. a continuing increase in reports of risk of harm
 - b. an inadequate client information system and a reluctance by caseworkers to properly use it
 - c. the expectation of other agencies that DoCS alone can and should protect children and young persons
 - d. the Public Service Association's (PSA) slowness to embrace change, particularly in relation to quality audits of Community Services Centres (CSCs)
 - e. the productivity savings required by the Government of all departments.
- 2.23 This report will deal with the first three matters, and indicate the Inquiry's views concerning the key area in which there remains union disagreement. The final matter is ultimately a question for the Government.

Conclusion

- 2.24 The child protection system the subject of the 2002 Reform Package was essentially limited to the work of DoCS. It was a comprehensive and smart package, focusing primarily on early intervention to deal with the volume of reports then made and the OOH system. It made enormous gains in the face of an increasingly complex client base and spiralling reports. Its full impact will not be realised for some years, in part because the bulk of the funds have only been expended in the last two financial years, and also because of the time needed to embed significant reform.
- 2.25 The Reform Package did not extend to the other agencies with responsibilities in protecting children, or to a detailed examination of the child protection arm of DoCS, about which little comprehensive data was then available. However, shortly before the commencement of the Inquiry in November 2007, DoCS initiated the Child Protection Major Project, a significant piece of work reviewing

child protection practice, based on data available from statistical analyses undertaken within DoCS.

Child Protection Major Project

- 2.26 Key benefits from the Child Protection Major Project thus far have included increased data and analysis about child protection reports, including those families who are frequently reported, and the relationship between reports and socio-economic factors. That analysis has also permitted the conclusion that increasing numbers of child protection reports from police are not related to changes in the numbers of police.
- 2.27 In addition, as part of the project, DoCS reviewed promising child protection programs in other jurisdictions. Its key finding was that all comparable jurisdictions are investing in the development of services earlier in the intervention spectrum, particularly for new mothers and parents generally. The review identified the use of a common assessment framework and alternative ways for dispute resolution, particularly for Aboriginal families, as promising initiatives.
- 2.28 In relation to mandatory reporting, DoCS has introduced e-reporting with some schools and is considering various communication and other strategies to improve the quality of reporting.
- 2.29 Finally, DoCS has enhanced screening and assessment processes for drug and alcohol casework assessment and intervention.
- 2.30 All the work identified by DoCS in late 2007 as desirable, but which has yet to be completed, is supported by the Inquiry and is addressed throughout this Report. It includes:
- a. reviewing the work done in CSCs in case planning and management. Unfortunately, this work has been hampered by the response of the PSA with the effect that the audits planned have not yet taken place
 - b. redesigning DoCS' client information system, and generally improving information and communication technology systems
 - c. strengthening the non-government system including better alignment of service funding with the needs of the child protection system
 - d. identifying service gaps
 - e. introducing a program for legislative reform following from a discussion paper released in October 2006. The Inquiry has considered all proposals put forward prior to and since that discussion paper and this report makes various recommendations both in relation to that program and in relation to additional structural and legislative reform.

DoCS organisational structure and budget

- 2.31 DoCS is the largest child protection agency in Australia. DoCS operates within the legal framework set by the Care Act, the *Community Welfare Act 1987* and the *Adoption Act 2000*.
- 2.32 The Department's key responsibilities are:
- a. providing assessment and casework services for children and young persons at risk of harm
 - b. providing funding, accommodation and support services for children and young persons who can no longer live at home
 - c. funding and regulating children's services such as preschools and day care centres
 - d. funding and monitoring a range of service providers to deliver family support, early intervention, community development and OOHC services to children, families and communities
 - e. coordinating recovery services to help people affected by disasters
 - f. offering community support services to help homeless people and families move to independent living.⁵
- 2.33 Under the NSW State Plan DoCS has lead agency responsibility for two State Plan priorities:
- a. F6: increased proportion of children with skills for life and learning at school entry
 - b. F7: reduced rates of child abuse and neglect.
- 2.34 The DoCS budget for 2008/09 is \$1.348 billion, which is allocated across community services, prevention and early intervention, statutory child protection and OOHC.
- a. Within the community services area, \$194.9 million has been identified for services that aim to support and strengthen families and communities. Services funded within this area include community development and capacity building, crisis support services and disaster recovery services.
 - b. Within the prevention and early intervention area, \$263.2 million has been allocated to children's services, and prevention and early intervention services including the Brighter Futures program.
 - c. \$395.2 million has been identified for statutory child protection.
 - d. \$495.2 million has been allocated for services that aim to support children and young persons who are not able to live at home safely.⁶

⁵ DoCS, *Annual Report 2006/07*, p.2.

⁶ DoCS, *NSW State Budget 2008/09*.

- 2.35 In 2007/08, funding to external service providers accounted for 57 per cent of the total DoCS budget. This included 45 per cent (\$573.1 million) for services from external agencies, and 12 per cent (\$145.8 million) for payments to individuals. Carer payments made up most of this 12 per cent.
- 2.36 The remaining 43 per cent of the 2007/08 DoCS budget was allocated for internal use. Of this, 29 per cent (\$366.7 million) was employee related and a further 14 per cent (\$174.6 million) was allocated for operating costs.
- 2.37 DoCS provides services through its Head Office in Ashfield, Sydney, seven regional offices and 80 CSCs which deliver frontline services. The DoCS Helpline is a 24 hour statewide telephone service to which reports of suspected child abuse or neglect are made. DoCS also operates a statewide Domestic Violence Line which is a toll free 24 hour telephone counselling and referral service.
- 2.38 DoCS employs more than 4,500 full time and part time staff. The workforce includes caseworkers, psychologists, legal officers, community program officers, researchers, statisticians, economists, children's services advisers, communications professionals, policy analysts, managers and administration staff. Caseworkers comprise almost half of the DoCS workforce. Caseworkers can work in a number of different roles, including:
- a. child protection: assessing reports and providing assistance to families to reduce harm or the risk of harm to the child or young person and, if necessary, taking Children's Court action
 - b. street teams: reducing crime, risk taking and antisocial behaviour by children and young persons in areas such as Redfern, Cabramatta and Kings Cross
 - c. Joint Investigation Response Teams (JIRTs): working with Police and Health in undertaking the joint investigation of child protection matters where serious physical or sexual assault of children is involved
 - d. OOHC: supporting children and carers where children are unable to live safely with their birth parents
 - e. early intervention: assessing strengths and needs of families and working with lower risk families
 - f. Helpline: taking initial reports from people with concerns about the safety and well-being of a child or young person, and assessing what further actions may be taken
 - g. Aboriginal Caseworker: consulting and advising on Aboriginal children who are at risk, and on the placements of Aboriginal children and young persons who are in OOHC

- h. Multicultural Caseworker: providing services to children from culturally and linguistically diverse families and communities.⁷

2.39 As at June 2007, DoCS was administered through five divisions.

- a. Operations Division oversees the delivery of frontline services across NSW, supports the introduction of new policies and develops procedures and implements strategies to improve professional practice. It also delivers statewide specialist services such as the Helpline, adoption services, psychology services, JIRTs and disaster recovery with partner organisations.
- b. Communities Division works across the government and non-government sectors to develop coordinated, strategic approaches to issues facing young persons, children and families and to implement community programs locally. These include youth initiatives, services for women experiencing domestic violence and parenting programs. The division is also responsible for reform and regulation of the Children's services sector.
- c. Service System Development Division provides the research, business planning, analysis, policy development and program evaluation to underpin DoCS reform agenda and implement funding reform to achieve the best outcomes for children and families. It develops policy initiatives in early intervention, child protection and out-of-home care.
- d. Strategy, Communication and Governance Division coordinates issues management and accountability in DoCS, including media and communication, freedom of information, governance, investigation and reviews, strategic policy, complaints management, and corporate and ministerial information.
- e. Corporate Services provides administrative, financial and legal services, information and communication technology, funding administration and building management services. There is also a corporate and workforce strategies function which includes Aboriginal and multicultural services, human resources, learning and development, and workforce planning.⁸

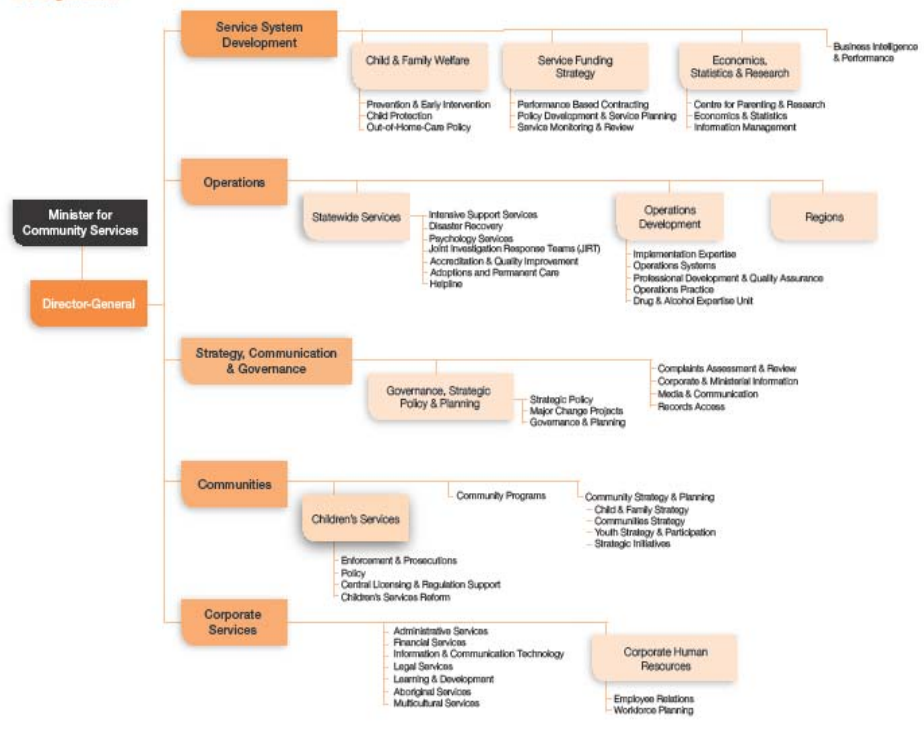
2.40 The organisational structure of DoCS is as follows.⁹

⁷ DoCS, *Annual Report 2007/08*, p.7.

⁸ *ibid.*, p.8.

⁹ Correspondence: DoCS, 17 October 2008.

Our Organisation



- 2.41 Within each of the seven DoCS regions there are two distinct but complementary functions:
- Casework and case management services to children, young persons and their families in the child protection, OOHc and early intervention programs. These are generally delivered by CSCs.
 - Funding and monitoring of non-government and other agencies to provide services to children and families. This is undertaken by Partnerships and Planning Teams located in each region.
- 2.42 While most casework services are undertaken by the 80 CSCs located across the State, there are also a number of specialist services operating in the regions. Specialist services include:
- JIRT
 - OOHC Specialist Teams (including carer recruitment and support)
 - Intensive Family Based Services (Aboriginal specific)
 - Adolescent support teams
 - Domestic violence teams.
- 2.43 There are 18 Partnerships and Planning Network areas. Directors Partnerships and Planning are responsible for managing and monitoring the DoCS funded services within the region. Teams comprise Children's Services Advisers and Community Program Officers.

- 2.44 Children's Services Advisers work within a regulatory framework to licence and monitor a range of early childhood services and are responsible for overseeing funding to community based children's services. Children's Services Advisers and Team Leaders will soon report centrally to the Children Services Directorate in Head Office.
- 2.45 Community Program Officers are responsible for making recommendations on the planning, development and purchasing of external services within the region and the ongoing monitoring and review of services. Community Program Officers are also responsible for the management of service delivery contracts and for the processing of complaints, appeals and prosecutions relating to these services.

Information systems

Key Information and Directory System

- 2.46 DoCS' current client database, the Key Information and Directory System (KiDS), was designed and approved in July 2002, before the DoCS Reform Package was developed. The system went live on 24 October 2003, replacing the 15 year old DoCS Client Information System.¹⁰
- 2.47 KiDS organises client information and records actions undertaken by DoCS staff in the areas of: early intervention; child protection; OOHC; adoptions; service providers (including authorised carers); and financials.
- 2.48 In order to understand the size and complexity of the data kept, as at 1 February 2008, KiDS held information on 1,484,043 persons. There were also:
- a. 1,125,118 case plans
 - b. 5,202,801 records
 - c. 2,742,277 attachments (such as affidavits, scanned identity documents for the subject child or letters)
 - d. 846,595 addresses.
- 2.49 KiDS was designed to support the Care Act. It is based around reports, records and plans rather than DoCS clients.
- 2.50 DoCS Connect is a secure online system launched in December 2007 that allows certain external parties to have limited access to KiDS. Currently, this access is available to Brighter Futures Lead Agencies¹¹ and public schools

¹⁰ DoCS, *Child protection quarterly data, April 2004 to June 2005*, p.1.

¹¹ DoCS, *Inside Out bimonthly newsletter*, January/February 2008.

participating in a trial of electronic reporting.¹² The DoCS Connect portal is accessed from the home page of the DoCS website.

- 2.51 Through DoCS Connect, registered users in Brighter Futures Lead Agencies are able to make referrals to DoCS, accept referrals from DoCS, record details relating to the people their organisations are case managing and make requests for services.
- 2.52 While KiDS is a considerable improvement on the previous client information system, DoCS has acknowledged that there have been a number of challenges to overcome since it went live in 2003:
- a. KiDS was designed prior to the policy and practice changes that occurred as part of DoCS' reform process. While modifications have been made to KiDS over the last five years, a more thorough redesign is now required.
 - b. Data quality is poor, in large part due to the lack of mandatory fields.
 - c. Caseworkers find the system complex, not intuitive and difficult to navigate. There is limited guidance built into the current design of KiDS.
 - d. There is a culture of resistance to KiDS within DoCS as recording and documenting are not always seen as a critical component of good casework practice.
 - e. Case plan processes are problematic and require redesign to replace the current process which involves creating a new plan for each new report. The system often contains multiple open plans on the same person which can result in information about children and families being missed.
 - f. There is duplication in the system regarding person records. On average 500 duplicate person records are merged each month. This duplication makes it difficult to accurately search for individuals on the system and further exacerbates the multiple open plan problem.
 - g. The process for capturing and finding legal proceedings and orders is cumbersome.¹³
- 2.53 DoCS is currently building a support site within KiDS called 'iHelp' which will allow DoCS staff to access policies, procedures and advice on the use of KiDS without having to navigate in and out of different screens. To date, iHelp has been incorporated into the early intervention areas of KiDS.
- 2.54 The Inquiry was advised by DoCS that the core design of KiDS, coupled with inadequate training on the system has led to the perception by caseworkers that rather than being a tool to support casework practice, KiDS is a burden. The Inquiry understands that the resistance to KiDS is very strong in DoCS. One

¹² *ibid.*, May/June 2008.

¹³ DoCS, *KiDS Core Design Update Project Business Case*, August 2007, p.6; Information provided to Government by DoCS, March 2008.

DoCS worker whose job is to support staff in using KiDS stated “the biggest part of our role is trying to change attitudes.”¹⁴

2.55 To address the ongoing issue of poor data quality in the longer term, DoCS has commenced work on the Corporate Information Major Project. The project aims to achieve “a long term and sustainable improvement to the quality of KiDS information and reduce the current reliance on, and the overheads associated with data remediation activities.”¹⁵ DoCS has acknowledged that it would be simplistic to assume that improving KiDS would automatically result in improved data quality.¹⁶

2.56 DoCS has developed the KiDS Core Redesign Project which is designed to deliver:

- a. *an improved method of capturing contact information into KiDS from the Helpline and alerting caseworkers of new activity*
- b. *functionality that will prevent the ongoing proliferation of multiple open plans*
- c. *improved operational reports*
- d. *an efficient search facility that will facilitate a quick and accurate location of records for a known individual*
- e. *an improved user interface for KiDS, making increased use of intuitive and of context-sensitive help and workflow guides or tools*
- f. *a facility to allow KiDS users to correct information that has been identified as incorrect or missing, from within the standard KiDS interface*
- g. *increased automation of certain functions to satisfy current business rules, and to simplify the use of KiDS*
- h. *increased validation rules within KiDS to enforce the capture of mandatory information at the appropriate point in the case development to reduce the need for data remediation*
- i. *process maps for identified business functions.*¹⁷

2.57 DoCS advised the Inquiry that since 2006, it had gathered a significant body of knowledge on the interplay between KIDS, policy and business practice and the user. This identified the need for clear policy on roles and responsibilities in relation to data entry, effective training and user support and an acceptance of

¹⁴ Transcript: Inquiry meeting with DoCS staff, 15 July 2008, p.22.

¹⁵ DoCS, *CIP Steering Committee-project update*, 17 June 2008, p.1.

¹⁶ *ibid.*

¹⁷ DoCS, *KiDS Core Design Update Project Business Case*, August 2007, p.29.

the importance of KiDS. The proposed redesign of KiDS needs to be seen in the context of a broader reform of DoCS business processes and not solely as an information technology project. In this regard a redesigned KiDS could see defined business processes supporting the use of workflows within the system, facilitating its navigation and allowing caseworkers to concentrate on key information requirements.

- 2.58 The estimated cost of the KiDS redesign is \$17.8 million over three years. DoCS' current information, communications and technology budget does not have funds to support the KiDS Core Redesign Project. Therefore additional funding is required before any major redesign of KiDS can proceed.
- 2.59 The Inquiry was advised that at the very least, DoCS has the in-house capability to fix defects at the lower end of the scale.

Corporate Information Warehouse

- 2.60 The Corporate Information Warehouse (CIW) is an integrated and aggregated source of information and data about DoCS core operations and performance that went live in December 2005. It provides online access to corporate and business reporting measures.
- 2.61 The CIW produces statistical information relating to child protection and OOHC for DoCS annual reports, reports to the Australian Institute of Health and Welfare (AIHW) and to its external partner agencies. The quarterly statistical reports published on the DoCS website are also sourced from the CIW.
- 2.62 The CIW has the capacity to provide accurate data on functional performance at departmental, regional and business unit level for managers and senior staff in the department. Such data on performance management is essential in order to measure improvements in practice and inform the allocation/reallocation of resources. In 2007/08 a number of corporate indicators (CIW Indicator Dashboards) have been released allowing management decisions to be informed by relevant data.¹⁸
- 2.63 The proposed redesign of KiDS will have implications for the CIW. DoCS has advised that this would involve a review of all CIW reports, review and modification to counting rules and redesign and/or modification to existing CIW reports.

Data analysis

- 2.64 Established in January 2004, DoCS' economic and statistical analysis function sits within the Service System Development Division and underpins DoCS' research and evaluation capacity. Using the CIW, DoCS has the capacity to undertake very detailed and complex statistical analyses on data recorded in

¹⁸ DoCS, *Annual Report 2007/08*, p.67.

KiDS. Such analyses can improve the Department's understanding of the child protection system and of the factors that contribute to future levels of demand.

- 2.65 DoCS analyses its data and produces reports which show usage trends in child protection, OOHC services, early intervention, and human resources. These are reported quarterly.
- 2.66 Data are also used to inform economic modelling and cost benefit analyses associated with new policies and in assessing the efficiency and effectiveness of services.
- 2.67 The information in the quarterly reports is extensive in so far as it records processes and includes the number of contacts, the number of reports by outcome of initial assessment, and reports by age, gender, Indigenous status, reporter group and primary reported issue. KiDS contains limited data about the types of services provided to children and young persons and families and their effectiveness, and no data about outcomes for children and families. The need for such data is addressed in Chapter 26.
- 2.68 DoCS has established a Benefit Estimation Database during 2007/08 which is designed to increase awareness of benefits associated with child welfare initiatives and allows economists, researchers and practitioners to identify the wide range of benefits associated with child protection and welfare initiatives and improved use of economic techniques to assess the monetary value of these benefits.¹⁹
- 2.69 The database contains summary analyses of international and national child protection and welfare literature containing benefit estimations.
- 2.70 DoCS has also developed economic models to underpin its major funding reforms in early intervention and OOHC. These models show what resources are required and where to fill gaps in services. A unit costing information service has also been developed. Costing models are used in costing existing and new services for the purposes of service planning and comparison.

DoCS Information Management and Technology Strategic Plan

- 2.71 DoCS advised the Inquiry that its Information Management and Technology Strategic Plan incorporates the KiDS redesign, refreshing Helpline technology, and various other management systems including the CIW and improving data quality. DoCS has costed it as \$34 million. The Inquiry agrees that it is essential for this work to proceed.

¹⁹ *ibid.*

Research function

DoCS Centre for Parenting and Research

- 2.72 The Centre for Parenting and Research which commenced in 2003, undertakes research to establish an evidence base to inform decisions about DoCS core businesses. It undertakes literature reviews, program evaluation and primary research. There are a range of internal research projects being undertaken by the centre, as well as external projects that are either being funded or supported by DoCS. Research activity reflects DoCS' four core business areas: prevention and early intervention, child protection, OOHC and community development and capacity building.²⁰ The research program is extensive and has included:
- a. human services and parents with a disability: working cooperatively in the best interest of the child
 - b. early intervention strategies for children and young persons aged 8-14 years: literature review
 - c. effective early intervention strategies for children, young persons and families within Indigenous communities
 - d. parental alcohol misuse and the impact on children: a review of the literature
 - e. neglect risk factors: severity and chronicity
 - f. effective strategies and interventions for adolescents in the child protection context: literature review
 - g. domestic violence: strategies and interventions to support families
 - h. effective strategies and interventions to support children and young persons living with parents who have a mental health problem: a review of the literature
 - i. longitudinal study of wards leaving care: four to five years on.
- 2.73 The centre will soon commence a long term, large scale longitudinal study of children in OOHC.
- 2.74 An annual evaluation agenda has also been developed which sets out the projects and programs that DoCS will evaluate in the coming year to inform program improvements and results for clients.

Research to Practice

- 2.75 The Research to Practice Program aims to encourage the active use of research within the Department. Research to Practice Notes present the key

²⁰ DoCS, *Research Report, 2006/07*.

issues and findings of research reports developed by the Centre for Parenting and Research and other relevant individuals and organisations. Their purpose is to increase knowledge as well as informing staff of practice implications where relevant. Examples of Research to Practice Notes include:

- a. Models of service delivery and interventions for children and young persons with high needs
 - b. Permanency planning and placement stability
 - c. Mental health of children in OOHC in NSW
 - d. Attachment: key issues
 - e. Making decisions about contact.
- 2.76 Staff are alerted to the availability of Research to Practice Notes via email and the notes are available electronically and in hard copy.
- 2.77 As part of the Research to Practice Program, the Centre for Parenting and Research coordinates a seminar series for staff with both local and international guest speakers. Examples of seminars held in 2007/08 include Engaging Fathers, Aboriginal Child Health and Welfare and Developmental Implications of Early Trauma. Seminar kits are distributed to CSCs for all staff to access.²¹

Research Network

- 2.78 A Research Network, made up of regional and Head Office staff, provides advice to the Centre for Parenting and Research in relation to shaping the research agenda and Research to Practice program. Network members also act as research advocates, promoting the availability and active use of research in the field.

Research Advisory Council

- 2.79 The Research Advisory Council was established in 2003 and comprises 10 academics in the areas of child welfare, paediatrics and child psychology relevant to DoCS. The council meets twice yearly to review DoCS' research agenda, review major research projects and advise on research grants. Members act as reviewers for research papers that are to be published in journals or as occasional papers. The council oversees a substantial volume of funded research carried out by academic institutions, post doctoral scholars and PhD students in areas specified by DoCS.²²

²¹ DoCS, *Annual Report 2007/08*, pp.68-69.

²² Information provided to Government by DoCS, March 2008.

DoCS Collaborative Research Program

- 2.80 In addition to developing the capacity for in-house research through the Centre for Parenting and Research, DoCS has collaborated with external research institutions to support research that is relevant to DoCS' needs and help build a culture of research within DoCS and the sector more widely.

2006/09 research agenda

- 2.81 DoCS has developed a three year research agenda to answer the question: "what interventions and practice approaches lead to the desired results for clients of DoCS and in what contexts or circumstances?"²³
- 2.82 For the July 2007 round of the Collaboration Research Program, DoCS' priority for research centred on issues focusing on child protection, that is:
- a. How can DoCS better respond differentially to the range/spectrum of child protection reports received - which must be supported by an adequate service system, including NGOs and others?
 - b. What intervention strategies work to build resilience in those families whose children do not fit early intervention program parameters but who do not require a full statutory response?
 - c. Half of all reports DoCS receives relate to only 20 per cent of children, many of whom are Aboriginal. What intervention strategies would work with this group to reduce the high level of re-reporting of the same children and their siblings from the same families?²⁴
- 2.83 DoCS also undertakes other occasional research. This includes the *Spotlight on Safety* report which is a study of community knowledge, attitudes and behaviours in relation to child protection and well-being.²⁵
- 2.84 The Inquiry is of the view that the DoCS research strategy is sound, and that the production of Research to Practice Notes is an important way of providing evidence based procedures.

Complaints system

- 2.85 In 2004, DoCS established a Complaints Unit located in Head Office to improve the way in which the Department responds to client inquiries and complaints.
- 2.86 It has responsibilities for responding to complaints, tracking and analysing systemic trends, and monitoring complaint handling at the local level, as well as

²³ DoCS, *Research Report 2006/07*, p.i.

²⁴ DoCS, *Collaborative Research Program*, June 2007, p.4.

²⁵ DoCS, *Spotlight on safety: community attitudes to child protection, foster care and parenting*, September 2006.

a responsibility for providing training, specialist advice and assistance to the regions and Head Office. As a result of its tracking and monitoring responsibilities, it has the capacity to identify emerging issues and advise on policy and practice development.

- 2.87 The Unit has a staff establishment of six positions, all of which are occupied. Previous proposals for an increase in staff numbers, and for the filling of specialist positions (for example, those of Foster Care Liaison Officers) have not been implemented.
- 2.88 Complaints can be received by regional offices, CSCs or operational units, by the Complaints Unit via the DoCS Complaints Line or via correspondence. The usual course is for DoCS staff to attempt local resolution, but if this is unsuccessful then typically a formal complaint will be made to the Complaints Unit.
- 2.89 Operational units, regional offices and CSCs are expected to keep a record of complaints that cannot be resolved in the course of day to day business, as well as written complaints, as part of a Local Complaints File. The Inquiry understands that there is no single data system that is capable of capturing and recording all of the complaints that are made, or their outcomes.
- 2.90 Guidance in dealing with complaints is provided in a draft 2007 document Policies and Procedures for Complaints Handling – Complaints Unit CAAR Branch. An additional set of procedures is available as a Casework Practice²⁶ document, Trial – Responding to Complaints, which was updated in September 2006, and prepared for the purpose of providing guidance for responding to complaints which are made directly to staff in operational units.
- 2.91 Other practice documents have been issued dealing with specific areas of complaint, for example, those concerned with privacy issues. The existence of multiple overlapping documents concerned with complaint management does not assist in an easy navigation of the system. Amalgamation and production of a single comprehensive practice guide would be advantageous.
- 2.92 Between 2004/05 and 2007/08, the number of complaints about DoCS increased by 44.0 per cent.

²⁶ Casework Practice is published on the DoCS intranet and contains policies, procedures and resources for casework staff. It was launched in May 2008 and replaced the Business Help site.

Table 2.2 **Number of complaints received by DoCS, 2004/05 to 2007/08**

<i>Year</i>	<i>Total</i>
2004/05	1,494
2005/06	1,835
2006/07	2,324
2007/08	2,151

- 2.93 DoCS Complaints Unit receives and processes other forms of public contact with the Department, including inquiries as to entitlements, suggestions, compliments, and comments, which are not included in the above figures. Historically complaints represent at least two thirds of work done by the Unit.

External reviews of DoCS complaints system

- 2.94 This system has been the subject of three major reviews:
- a. The Clarinda Review in 2006 concluded that gains could be achieved by co-locating the bulk of the Complaint Unit's functions within the Helpline, a change that would see three grade 7/8 positions move to the Helpline and two managers remain at the Head Office to manage investigations, walk-ins and governance functions.
 - b. The Gerrand Review in 2007 analysed current practices and conducted a process mapping exercise to streamline complaints handling using the Helpline infrastructure, which resulted in the preparation of a new complaints process mapping document. It questioned the entrenched culture within the Complaints Unit that saw its role as one that should involve a critical review of the actions and policies of the Department, with the corollary of regarding itself as the key to departmental success.
 - c. The SINC Solutions Review, between November 2006 and October 2007, reviewed a random sample of complaints and came up with similar conclusions and recommendations to those of the earlier reviews, involving the adoption of a triage approach that would be facilitated by co-location at the Helpline.
- 2.95 The SINC Report identified shortcomings in the handling of complaints by the Complaints Unit in relation to the timelines, prioritisation, local resolution referral, record keeping and effective handling of serious issues. It made recommendations to review manuals, train staff, implement the changes recommended in earlier reviews and improve record keeping.
- 2.96 As a consequence of these Reviews the former Director-General of DoCS, on 20 January 2008, approved the relocation of the bulk of the Complaints Unit functions to the Helpline, together with a revision of the complaints handling system. This has been opposed by the PSA and as a consequence the Director-General's decision has not yet been implemented.

Issues arising

KiDS redesign

- 2.97 In submissions from DoCS, former and current DoCS employees, and in meetings with the PSA and with DoCS staff across the State, the Inquiry was advised of a range of problems stemming from the use of KiDS. The four major areas of concern can be summarised as follows:
- a. KiDS is not user friendly and is difficult to navigate
 - b. it is difficult to carry out comprehensive child protection history checks on KiDS
 - c. KiDS is not a tool that supports reflective casework practice
 - d. caseworkers are required to spend too much time completing tasks on KiDS which restricts the amount of time they can spend on field work.
- 2.98 As well as being identified as a problem by DoCS staff and the PSA, the Ombudsman also expressed concerns about the difficulties DoCS staff encounter when conducting history checks. Reviews undertaken by the Ombudsman have consistently identified cases where there have been incomplete or inaccurate history checks undertaken, which in turn impacts directly on the quality of judgements made by caseworkers. The Ombudsman reported that:
- Under the current KiDS system, for a user to apprise themselves of a family's child protection history, they may need to spend hours navigating their way through numerous data fields.²⁷*
- 2.99 A DoCS staff member made a similar point:
- As far as looking up the history, it's just very time consuming. It's very hard. It's easy to miss the history. You need to go to each screen on each report and have a look at it: each record, each child. It's just very time consuming to do that.²⁸*
- 2.100 If the KiDS Core Redesign Project, discussed earlier, achieves all of its aims, it will go a long way to addressing the major concerns about KiDS raised with the Inquiry. Its value would lie in facilitating quicker and better informed decision making and in potentially improving job satisfaction. Further, it is preferable to the more drastic and disruptive option of scrapping the system and starting all over again. This would involve a massive effort in preserving existing data that may be relevant for future care and protection work.

²⁷ Submission: NSW Ombudsman, Assessment and Early Intervention, p.12.

²⁸ Transcript: Inquiry meeting with CSC staff in Western Region, p.6.

- 2.101 The Inquiry accordingly supports the proposed changes to KiDS that aim to effect a more user friendly system in which critical information concerning children and families is recorded. A significant change management process will be required to ensure that the new system is embedded as part of casework practice. As such the design will need to integrate processes that caseworkers and their managers follow when managing a case. It will need to be intuitive and be supported by ongoing training and development.
- 2.102 The Inquiry, as noted in Chapter 9 in this report, recommends a move to one electronic recording system, rather than the current paper file and KiDS records.
- 2.103 The Inquiry supports a related recommendation made in a recent review of DoCS' existing business processes by the Department of Premier and Cabinet (Premier and Cabinet), that the mapping and documenting of statutory child protection business processes occur. This should enable any duplication and waste to be identified and rectified and should occur as part of the KiDS redesign and prior to its completion.

New technologies

- 2.104 It was also suggested to the Inquiry that DoCS and other agencies could make better use of emerging information and communication technologies. For example, DoCS workers could use voice activated systems to record notes soon after a home visit which would then become part of the KiDS record.
- 2.105 Emerging technologies could also assist with case management functions and facilitating linkages between agencies, for example, interagency case conferences, case consultation and planning, transmission of images and data, feedback on assessments, and video link meetings.
- 2.106 These technologies would be of particular assistance in remote and rural locations as a means of reducing travel times, exchanging information, bringing professionals together to discuss cases and supporting supervision and training.
- 2.107 Health has made some advances in this area²⁹ and it may be possible at the interagency level for DoCS to 'piggy back' on the availability of these resources.

Data quality and availability

- 2.108 Quality and timely data underpins evidence based research, policy and practice. The Inquiry has relied extensively on data supplied by DoCS to undertake its analysis and inform its opinion. Without access to the data reports, research papers and literature reviews the time it would have taken the Inquiry to conduct its work would have been significantly lengthened.

²⁹ For example, broadband projects to enable clinical outreach projects, videoconferencing for mental health, electronic medical record and picture archiving, see also www.health.nsw.gov.au.

- 2.109 The Inquiry also notes that it is intended that access to the CIW data be expanded to include a broader group within DoCS. The Inquiry suggests that it would be appropriate to accelerate this expansion as such data can only better inform the work done in the field.
- 2.110 Researchers and academics consistently state that Australia urgently needs to develop a research base for policy and practice in relation to prevention, early intervention, child protection, OOHC and child and family welfare in order to inform practice.³⁰ They say that there are a number of important topics that have not been addressed, as well as insufficient and inadequate research and evaluation.³¹
- 2.111 The establishment of economics, statistics and research function within DoCS is a significant step in this regard. Most of the research and evaluation information is available in a timely way on both the DoCS intranet and on the DoCS website. This represents a significant contribution to the development and dissemination of information and knowledge in this area. It is also important for accountability purposes.
- 2.112 The Inquiry supports the continued building of the research and analysis capability in DoCS in order to assist in making informed decisions and evidence based improvements to policy, programs and service delivery.
- 2.113 The Inquiry acknowledges the links DoCS has built with the academic community and further encourages DoCS to build research and evaluation collaborations with its interagency counterparts in order to build momentum and foster exchange.
- 2.114 Tomison has suggested that a key question for the child protection field is: "how can an evidence based approach be cultivated to better inform practice?"³² Tomison states that in order for agencies to make the most of research opportunities and to develop evidence based practice, agencies must develop a research culture where research is valued and encouraged across the organisation, staff are trained in the process of evidence based practice and the most is made of information that is currently collected.³³
- 2.115 The Inquiry suggests that supporting and expanding the research and evaluation function in DoCS could be developed as a performance indicator to track the extent to which DoCS is developing an evidence based research culture.

³⁰ J Cashmore, D Higgins, L Bromfield, and D Scott, "Recent Australian Child Protection and Out-of-Home Care Research, What's been Done and What Needs to be Done?" *Children Australia*, Vol 31, No.2, 2006, pp.4-11.

³¹ *ibid.*: "Evaluating Child Abuse Prevention Programs," Resource Sheet, No.5, December 2004, *National Child Protection Clearinghouse, Australian Institute of Family Studies*, p.4.

³² A M Tomison, "Evidence-based practice in child protection: What do we know and how do we better inform practice," Keynote presentation, Association of Children's Welfare Agencies Biennial Conference, undated, p.2.

³³ *ibid.*, pp.7-8.

2.116 The Inquiry is also supportive of a national research agenda which would:

...provide a systemic framework to ensure that there is a quality evidence base to inform policy and practice. It would provide guidance to researchers and research funders regarding relative priorities. Routine monitoring and revision of such an agenda would enable accurate assessments of progress and provide professionals within the sector an avenue to ensure that policy and practice needs for evidence are being heard and addressed.³⁴

2.117 The Australian Institute of Family Studies (AIFS) Issues Paper *Developing a road map for research: Identifying the priorities for a national child protection research agenda* noted:

- a. For child abuse prevention and child protection there is a need for a draft national research agenda to be developed in consultation with government and non-government sectors and informed by the systematic review of the existing evidence base and identified research priorities both nationally and internationally.
- b. For OOHC there is a need to routinely (for example, biennially) update systematic literature reviews of the evidence base, monitor and publish the progress of the research groups established following the OOHC research agenda planning forum, and establish mechanisms for new members to become involved.
- c. In order to track the progress of a national research agenda and inform updates to the agenda, audits need to become 'live' accessible databases. There is also a need to ensure there is a national repository of Australian child abuse prevention, child protection and OOHC research. Research agendas need to be consolidated to ensure that there are not gaps at critical transition points. Further, there is a need to review and incorporate research agendas developed by state and territory child protection departments which also commission and conduct research. Finally, any national research agenda itself needs to be accessible, and to be monitored and routinely updated.³⁵

2.118 The Inquiry agrees.

The location and role of the Complaints Unit

2.119 The Inquiry was informed that the Complaints Unit is understaffed and in a state of flux. This is attributable to the unresolved issue concerning the move of the bulk of the unit's functions to the Helpline and to the fact that, while a

³⁴ L Bromfield and F Arney, "Developing a road map for research: Identifying the priorities for a national child protection research agenda, Child Abuse Prevention Issues," *National Child Protection Clearinghouse, Australian Institute of Family Studies, No. 28*, February 2008, p.13.

³⁵ *ibid.*

complaints operating framework was prepared and signed off, it has not been implemented in the field.

- 2.120 The PSA in its submission to the Inquiry has confirmed its opposition to the transfer of any part of the unit's functions to the Helpline. It has also drawn attention to the fact that the unit has continued to be understaffed, with the result that there are delays in speaking to complainants, and an inability to conduct staff training in the field.
- 2.121 The following arguments were advanced by the PSA against locating functions of the Complaints Unit at the Helpline:
- a. there is a lack of experience and knowledge among Helpline staff
 - b. as a front end operational unit, Helpline staff, including CSC staff who provide back up support to the Helpline at times of high demand, may themselves become the subject of complaints, with a consequent risk of a conflict of interest arising
 - c. foster carers and clients may view centralisation as a devaluation of the Department's commitment to complaint handling
 - d. the Helpline is situated at an unadvertised location and is unsuitable for face to face meetings with complainants
 - e. the potential increase in the staff responding to complaints would threaten the consistency of response, and generate a lack of confidence in the system on the part of foster carers
 - f. it would involve a shift in the nature of the call centre approach, involving intake without evaluation, to a more complex response, requiring training, that might also influence overall performance targets
 - g. there would be additional costs in extending the software licence to accommodate new operators as well as in the set up costs involved in a transfer to the Helpline location
 - h. frequent callers would lose their direct contact with Complaints Unit staff, who would otherwise have been familiar with the issues raised
 - i. the confidentiality requirements would restrict access by Helpline staff to the complaints database, denying them the capacity to screen out matters already dealt with
 - j. the need to respond to complaints might divert Helpline staff from higher priority work, or alternatively result in a lower level of priority being given to complainants
 - k. the level of detail that could be recorded on the database could, on the one hand, lead to a widening of access to confidential issues, or, on the other hand, result in complaints that could have been closed on receipt being transferred to the Complaints Unit and closed there with an increase in complainant frustration.

- 2.122 The Inquiry is of the view that these issues can be satisfactorily addressed by a change that would transfer portions of the unit's functions to the Helpline and preserve a complaints management function at Head Office.
- 2.123 Locating complaints officer positions (DoCS suggests three such positions) within the Helpline, with responsibility for triage and allocation of responsibility for management, followed by referral to a Central Complaints Unit or to an operational unit (depending on complexity or seriousness) would fit well within a call centre function which has experience in caller management. This would have the advantage also of diverting the one third of the matters currently received which do not constitute a complaint, to the Community Service Operator at the Helpline. The deployment of specialist complaints officers at the Helpline to respond to complaints would seem to answer the majority of the objections to the proposal.
- 2.124 Such a reform would preserve the capacity of those located at the Central Complaints Unit to deal with complex and serious complaints and with 'walk-ins' who can be violent or vexatious. It would also provide the Unit with the capacity to provide support and training for complaint management at operational unit level, to identify significant practice issues, to assist in the development of policy in relation to complaint handling, and to report to and liaise with senior management as required, for example, where a complaint may require referral to a higher authority for resolution.
- 2.125 It is recognised that there would need to be suitable safeguards adopted to ensure the confidentiality of the complaints databases, and some extension or modification of the software system, to allow its use at the Helpline, as well as at the Central Complaints Unit. While some extra cost would be entailed there would not seem to be any insurmountable difficulty in this respect.
- 2.126 The Inquiry was informed that, because of the limited size of the current Complaints Unit and lack of training or expertise in complaints handling at the regional or CSC level, many complaints were either not addressed or addressed inadequately. This should be capable of being addressed if the Central Complaints Unit at Head Office is tasked with providing training to caseworkers and with acting as a point of reference for advice or support where that is needed by an operational unit.
- 2.127 Of particular concern has been the volume of complaints in relation to foster carer issues, much of which relates to allowances and expenses. The importance of this was recognised by DoCS in 2005, when consideration was given to the creation of specialised Foster Care Complaint Liaison Officer positions, an initiative that has not, however, been carried into effect.
- 2.128 In Chapter 16 the Inquiry notes the establishment of Carer Support teams, which could incorporate the function that was to be allocated to the Foster Care Complaint Liaison Officers. The prompt and equitable resolution of concerns on the part of carers, in relation to issues surrounding the payment of allowances and contingencies, or contact difficulties, is fundamental to the preservation of

the goodwill between DoCS and its carers, and recognition of their value to DoCS.

- 2.129 Also of concern has been the delay in resolving complaints. The SINC Report noted that for 50 per cent of the complaints received by the Complaints Unit, the time taken for resolution was unreasonable. Submissions received by carers and observations made by carers at the Inquiry's Public Forums confirmed the need for concern in this respect.
- 2.130 The model proposed by DoCS would provide for:
- a. 90 per cent of all complaints to be triaged on receipt, prioritised according to complexity or seriousness, and allocated for a response
 - b. the retention of specialist case officers in the Central Complaints Unit who would be available to focus on the complaints that raise significant policy or procedural issues
 - c. referral of the remainder of the complaints for local resolution
 - d. the achievement of a more timely disposal of complaints, so long as it was accompanied by the provision of suitable training for staff at the local level, the development of clear policy guidelines, and the establishment of time standards for the resolution of these matters that are referred out for management by CSCs or other Operational Units.
- 2.131 One benefit to DoCS arising from the establishment of an improved complaints management structure would be a reduction in the number of complaints that escalate to the point where they attract the attention of the Minister or the Ombudsman, and require DoCS staff to process and respond to inquiries in relation to those matters.
- 2.132 Perhaps more significantly, a structure that can provide a more timely response should have the additional benefit of improving relationships between DoCS and its carers and clients. The Inquiry agrees with the proposed model.

Location and role of the Allegations Against Employees Unit

- 2.133 Currently allegations against employees are investigated, for the most part, at CSC or operational unit level, subject to reporting back to the Allegations Against Employees Unit, although more serious allegations remain with that unit. In Chapter 23 we give consideration to whether there should be a restructure to centralise the investigation function in relation to allegations of this kind.

Structure and function of DoCS Head Office

- 2.134 The Inquiry reviewed the existing structure and functions as detailed in DoCS Head Office organisational structure and makes the following observations.

Policy and planning

- 2.135 Presently, the Strategic Policy Unit and the Major Projects and Planning Unit sit within the Strategy, Communication and Governance Division. Functions within these units include the oversight and management of Commonwealth/State relations, coordination of DoCS input to, and monitoring the impact of, a range of state whole of government and human services policy projects as well as management of internal major projects that require a high level of project management.
- 2.136 The Service System Development Division has responsibility for child and welfare policy, service funding, economics, statistics, research and performance of the service system. The division also has responsibility for working with other state and Commonwealth government agencies in the development of policies.
- 2.137 The strategic policy and planning functions currently located in the Strategy, Communication and Governance Division, appear to more closely align with the functions within the Service System Development Division.

Funding and service planning

- 2.138 The Communities Division role is to work across both government and non-government sectors to develop coordinated, strategic approaches to issues facing young persons, children and families and to implement local community programs to deal with these issues. These programs include youth initiatives, services for women experiencing family and domestic violence, parenting and family support services and Families NSW.
- 2.139 The Inquiry believes this is a critical function within DoCS, given the significant amount of funding DoCS provides to other agencies and the need to ensure that services are integrated. There is, however, in the Inquiry's view, room to improve planning, design and funding of the service system currently shared between the Communities Division and Service System Development Division. The Inquiry heard from many agencies that there was a need to develop a more integrated service planning framework and move away from discrete program funding streams to an outcomes based model. These matters are addressed in Chapters 7 and 25.
- 2.140 The Service System Development Division is presently implementing significant funding reforms, which are supported by the Inquiry. Similar processes should equally apply for services funded by Communities Division. It would seem that this should occur in one area within DoCS.
- 2.141 There could be improved efficiencies by examining the role of the DoCS Partnerships and Planning teams at the regional level and those of the regional positions within Communities Divisions and considering whether these roles could be better aligned to ensure a more effective integrated planning mechanism at the regional level.

Corporate support services

- 2.142 At the commencement of the DoCS Reform Package it was proposed that all transaction level functions for corporate services be placed with the shared service supplier, NSW Businesslink and that DoCS would only retain strategic functions and those expertise functions directly involved with core business.
- 2.143 While this has largely been achieved, there were some aspects of these functions that were retained in DoCS as it assessed that Businesslink did not have the capacity to deliver them at the scale or speed required for DoCS reforms. The retained capacity is currently a mix of expertise and transactional skills. Given that the reform has neared completion and Businesslink is considered by DoCS as a sound provider of corporate services,³⁶ the Inquiry is of the view that transition to Businesslink would now be timely.
- 2.144 As there are still significant issues associated with DoCS information technology systems there is some opportunity to examine that which is best provided by Businesslink and that which is necessary to be retained within DoCS. There appears to be a significant cost to DoCS in employing contractors to undertake some of these functions which may be more cost effective through Businesslink.
- 2.145 There appear to be two divisions (Service System Development and Corporate Services) whose focus is on data collection, management, maintenance and quality. Within Service System Development there are also a range of positions located within regions reporting centrally whose main role is to undertake data remediation and assist casework staff. Within Corporate Services, there is a small unit called the KiDS support team which also provides a statewide support service to field staff. It would again appear that these functions could be integrated within one division. Logically that would appear to be Corporate Services, as it also has a training function.

Quality assurance

- 2.146 The Inquiry considers that there would be benefit in developing an integrated framework for all quality assurance functions within DoCS. Presently different aspects of quality assurance are either in development or undertaken in different ways by different divisions (Strategy, Communication and Governance, Operations and Service System Development).
- 2.147 The Inquiry is of the view that key components of an effective quality assurance system include having clear service standards, monitoring mechanisms, evaluations, feedback from service users, complaints mechanisms and routine internal evaluative approaches.
- 2.148 DoCS has and will need to continue to change its policies and practices as the evidence base grows about what works and does not work. While DoCS

³⁶ Information provided to Government by DoCS, March 2008.

presently has a small implementation unit to assist in coordinating and assessing the operational impacts of its reform agenda and any associated staff learning needs, this should be incorporated into a broader quality assurance framework.

- 2.149 The Inquiry is of the view that there appears to be a need for further focus on change management and understanding barriers to effective implementation in the field. This needs to be undertaken in a systematic manner and feedback provided on performance to regions.

Consideration of a restructure

- 2.150 The Inquiry has, in the preceding paragraphs noted some provisional views and comments in relation to the Head Office structure. So far as these involve corporate management issues, it lacks the expertise for the informed conclusions that would be required before any recommendations could be offered. However, the Inquiry is of the view that careful consideration should be given to the need for any restructure of the management of the agency along the lines mentioned that would facilitate the reforms that arise out of this report.

Industrial climate

- 2.151 Both the PSA and DoCS advised the Inquiry that the industrial relations climate has changed over recent times.
- 2.152 There have been no formal disputes or organisational matters listed in the Industrial Relations Commission since the introduction of the Reform Package in 2002, however the PSA has issued industrial bans or directions to its members on ten occasions. The most significant of those, in terms of their effects on the child protection system, relate to the CSC audits program which is, the improvement plan devised following the death of a child in 2006.

Audits of CSCs

- 2.153 As part of DoCS' professional development and quality assurance program, DoCS determined to conduct a limited trial of quality review tools in a CSC over a period of about six weeks, requiring approximately 5–7 hours of staff members' time, with the intention of ultimately conducting audits in every CSC over the next few years.
- 2.154 PSA delegates have issued instructions to members not to participate in the program, and in particular, have blocked a trial of quality review tools. This instruction has effectively halted the audit.
- 2.155 The Inquiry understands that DoCS has informed staff that they are free not to participate, and the trial would not be used to target the practices of individual staff.

- 2.156 The PSA assert that the audit methodology is fundamentally flawed due to CSCs being under staffed and staff being unable to comply with many DoCS directions on a daily basis: “They have no choice but to take short cuts when making important casework decisions.”³⁷
- 2.157 The PSA contends that “DoCS is not staffed or funded adequately to complete basic casework let alone best practice”³⁸ and that many DoCS policies and procedures and Casework Practice topics lack consistency with the DoCS internal systems and with relevant legislation. It is concerned that due to volume and difficulties accessing up to date information, DoCS staff are not always aware of changes to policies, procedures, guidelines and protocols.
- 2.158 The PSA believes that the time DoCS has suggested needed by Caseworkers, Managers Casework and Managers Client Services to complete the work associated with this program is underestimated. It believes that if DoCS takes frontline staff off line to complete the work it may leave children and families unattended and at serious risk.
- 2.159 The PSA is also concerned that “any such CSC review may reveal the vulnerability of staff working in such an unsupported and crisis driven environment” and has noted that PSA members have expressed concern that “information gained through the review will be used for disciplinary purposes.”³⁹
- 2.160 Following a number of meetings, the Inquiry understands that DoCS has agreed to change its proposed audit program. Instead of conducting audits or file reviews, it has agreed to undertake case practice reviews facilitated by Casework Specialists during the usual Thursday morning Practice Solutions sessions.
- 2.161 The Inquiry is most troubled by this concession made by DoCS. As will be seen in subsequent chapters, particularly in Chapters 9 and 16, there continues to be significant criticism of DoCS casework practices and its relationships with carers, non-government organisations and others. An audit of the kind originally intended would have been a critical first step in improving these practices. What has now been agreed to is little more than the usual supervision.
- 2.162 While the Inquiry acknowledges the PSA’s legitimate concern that aspects of the work carried out by its members may be cast in a critical light following the audit for reasons associated with resources and management, it is firmly of the view that the audits are essential to identify and understand the deficiencies in casework practice and management. Once they are defined, further work can be done to unravel the reasons for, such deficiencies and to remove any residual problems.

³⁷ Correspondence: PSA, Letter to Inquiry in response to questions raised at meeting of 19 May 2008.

³⁸ *ibid.*

³⁹ *ibid.*

- 2.163 The Ombudsman holds a similar view. Since 2004, his reports of reviewable deaths have identified the need for DoCS to include in its practice improvement strategies a systemic performance audit of each CSC to identify the degree to which practices were improving over time. In his 2006 report the Ombudsman states that the “proposed quality reviews of CSCs are a significant undertaking in relation to enhancing child protection responses within DoCS.”⁴⁰
- 2.164 It may be that the PSA can be given the opportunity to provide an addendum to any audit which is conducted by which it seeks to indicate reasons for any identified shortcomings and is provided with an assurance that the purpose of the audit process is to improve service and not to investigate staff for disciplinary purposes.
- 2.165 Similarly, and more locally, DoCS developed a plan to improve practices arising from a review following the death of a child in May 2006. The Inquiry understands that the implementation of that plan, which has a component concerning the review of cases dealt with by the two relevant CSCs, has not occurred because of industrial action by the PSA.
- 2.166 The Inquiry is of the view that DoCS should move quickly to complete the audits, and that the resistance of the PSA is out of step with the general acceptance in contemporary commercial and governmental operations of the need for an audit process.

Consultative processes

- 2.167 DoCS has formal consultative mechanisms with the PSA including a bi-monthly State Consultative Committee, Regional Joint Consultative Committees, fortnightly meetings at officer level and ad hoc meetings on request.
- 2.168 The major reforms in DoCS have led to many operational policy and process documents being referred to the PSA for comment. DoCS informs the Inquiry that these comments have been constructive, although the process of consultation has often been extremely detailed and protracted.
- 2.169 In its submission to the Inquiry, DoCS noted that in the second half of 2007, PSA delegates became increasingly concerned about the rate of change and the impact of rising workloads on their members, and as a result, various bans were instituted, including those relating to file remediation where audits had found errors or omissions, or where carer checks had not been completed.
- 2.170 In order to address this situation an industrial relations consultant was engaged to advise on a way forward. A meeting was held on 18 February 2008 where the following was agreed:

⁴⁰ NSW Ombudsman, *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths*, December 2007, p.91.

- a. The PSA Industrial Officer would address the process for instructions to members to be authorised by a PSA official, and not just by delegates.
 - b. DoCS would develop a proposal regarding the types of policies and procedures that do and do not require consultation, and the level and process of consultation required, as the basis for discussion on joint development of a framework for consultation with the PSA.
 - c. DoCS would adopt the practice of preparing and sending to the PSA a list of policies to be developed and indicate the level of consultation they might require (in line with the framework referred to above) so the PSA can anticipate how to coordinate comments from delegates.
 - d. In cases where DoCS believed it had made a reasonable proposal and taken appropriate consultation steps but had failed to reach agreement with the delegates, DoCS would write formally to the PSA to give one or two weeks notice of intention to implement.
- 2.171 In line with these agreements DoCS sent letters to the PSA about a number of key issues on which agreement had not been reached with the delegates and also forwarded a proposed consultation framework for discussion.
- 2.172 This seems a sensible approach. The Inquiry observes that PSA support for the implementation of this Report and its constructive involvement in the process is critical.

Recommendations

Recommendation 2.1

The KiDS Core Redesign Project should be funded and implemented.

Recommendation 2.2

DoCS Information Management and Technology Strategic Plan should be funded and implemented.

Recommendation 2.3

The trial of the quality review tools should proceed immediately and the approved tools should be then applied in a timely manner. Each CSC should then be audited. Funds should be provided to permit the audits to commence within the 2008/09 year.

Recommendation 2.4

The decision consequent upon the SINC Report to relocate the bulk of the Complaints Unit functions to the Helpline and to revise the complaints handling system, should be implemented.

Recommendation 2.5

Carer Support teams should be responsible for liaising with DoCS foster carers and kinship/relative carers in relation to their complaints and to ensure they have the assistance they require.

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DoCS workforce

- 3.1 There are many factors that impact on the capacity of a workforce to conduct its business, such as funding levels, the number and distribution of positions, demand and caseloads, as well as internal organisational factors such as occupational health and safety, leave, business and administrative processes and systems. This chapter focuses on recruitment processes, staff turnover, retention and professional development and supervision.

Staffing

- 3.2 DoCS 2002 Reform Package provided an additional \$186.2 million from 2003/04 to 2007/08 to increase the frontline support capacity in DoCS. Overall there was an increase of 45.6 per cent in the numbers of DoCS staff between 2001/02 (2,683 staff) and 2006/07 (3,907 staff).⁴¹
- 3.3 As part of the Reform Package DoCS established the Enhanced Service Delivery (ESD) project which aimed to improve resources, policies, procedures and systems in each CSC. The implementation of the ESD project in CSCs has involved the creation of extra caseworker positions, the establishment of specialist early intervention casework teams/positions, recruitment and training of new staff, reconfiguration of teams within CSCs, improved support systems and new or refurbished accommodation. As at February 2008, 76 ESD sites were completed.⁴²
- 3.4 As part of the Reform Package, an additional 875 caseworkers were to be recruited over five years from 2003/04 to 2007/08. The 875 new caseworker positions comprise 375 child protection caseworkers, 350 early intervention caseworkers and 150 OOHC caseworkers. By 2005, DoCS determined that the initial allocation of 150 caseworkers for OOHC was insufficient to meet the caseworker-client ratio of 1:16-18 for general foster care case management and 1:5 for high needs children case management. As a result, DoCS funded an additional 150 OOHC caseworker positions from its OOHC budget.
- 3.5 To determine where all new positions were to be allocated, in early 2004, DoCS developed a resource allocation methodology. Specific factors examined under this model are the number of child protection reports referred to each CSC, the age of the children and young persons who are the subject of the reports and the number of children and young persons in OOHC allocated to each CSC. Regional and rural CSCs receive an extra allocation to compensate for longer travelling times involved in undertaking casework duties.
- 3.6 The resource allocation methodology is updated annually as new data become available. DoCS has determined that it is best to adjust the allocation of

⁴¹ Figures are for end of year non casual only and include permanent and temporary employees, executive staff and cadets. Figures are rounded.

⁴² DoCS, *Result and Services Plan 2008/09*.

caseworkers where there are changes of more than 20 per cent in the number of referred reports and children and young persons in OOHC.⁴³

- 3.7 At May 2008, the total number of funded caseworkers positions including the additional 1,025 was 2,146.
- 3.8 The Reform Package also included funding for additional supervisory positions⁴⁴ (to enable a supervisor to caseworker ratio of 1:6). In June 2003, there were 211 funded Manager Casework positions, which, by June 2008, had risen to 437. Additional administrative support (to a ratio of 1:6) was provided so that by 13 January 2008, there were 453 clerical supports positions (115 new positions) in CSCs.
- 3.9 At the commencement of the Reform Package, DoCS needed to recruit an estimated 1,225 caseworkers, of which, 1,025 were new positions.
- 3.10 As at 30 June 2008, DoCS had recruited all but 59 of the 1,025 new caseworkers. By the end of December 2008, DoCS expects to have achieved its recruitment targets and have normal vacancy rates of approximately seven per cent per annum.
- 3.11 The following list illustrates the impact of the 2002 Reform Package on casework staffing numbers between 2001/02 and the end of 2006/07, bearing in mind that staff numbers have increased further since 30 June 2007:
- a. in early intervention the numbers of caseworkers and managers increased from nil to 207
 - b. in child protection the number of caseworkers and managers rose from 825 to 1,308
 - c. in JIRT the number of caseworkers and managers rose from 37 to 58
 - d. in OOHC the number of caseworkers and managers increased from 203 to 395 (general OOHC, intensive support and carer support)
 - e. the number of specialist positions increased from 65 to 156 (Aboriginal, multicultural, casework, domestic violence).
- 3.12 DoCS currently has 77 Casework Specialists who provide clinical support and targeted professional development to CSC casework staff and their managers. In 2007, these positions were revised and upgraded⁴⁵ and recruitment to the new positions was undertaken in late 2007. Casework Specialists are based in CSCs and mentor and coach caseworkers and their managers, undertake case practice reviews and are available to discuss more complex cases.

⁴³ DoCS, *Caseworker Allocation Methodology*, November 2007.

⁴⁴ Managers Casework, Manager Client Services, Director Child and Family.

⁴⁵ Previously a Grade 7, recruitment has recently been completed for these positions and they are now Grade 9, same level as Manager Casework.

Selection and recruitment process

Processing applications

- 3.13 Since 2003, changes to the recruitment process have been progressively implemented to allow DoCS to process larger numbers of applications. Changes have included increased advertising through the print and electronic media, the introduction of an online application process and a graduate recruitment strategy targeting final year university students that included a strengthened student placement program.
- 3.14 Businesslink is the shared corporate services provider to DoCS, Housing NSW (Housing) and the Department of Ageing, Disability and Home Care (DADHC). Businesslink has had responsibility for processing all caseworker applications throughout the DoCS budget reform process.
- 3.15 In March 2006, DoCS established Assessment Centres for the bulk recruitment of caseworkers. Like the conventional selection panel, DoCS staff participate in Assessment Centre recruitment processes. The methodology is standardised and it provides an integrated eligibility list that allows applicants to be considered for positions across the State. DoCS states that the Assessment Centre methodology provides “accuracy in forecasting job performance, consistency of selection standards and a high level of transparency and fairness.”⁴⁶
- 3.16 Businesslink reviews all applications and short lists those applicants that meet the selection criteria.

The Assessment Centre process

- 3.17 The Assessment Centre methodology was designed by a firm of organisational psychologists. As a result of qualitative and quantitative research involving DoCS caseworkers and managers, the core caseworker skills were identified.
- 3.18 Applicants who attend an Assessment Centre undergo a four hour structured assessment process. Specifically, they undertake five activities: a written exercise; a group task; a role play; an interview; and a detailed verbal reasoning test. These activities are observed and considered by a number of assessors who rate each applicant’s performance.
- 3.19 Assessment Centres are located in various metropolitan and regional centres, are operated and managed by Businesslink and are run on a continuous basis according to demand. In addition to the Businesslink officers, eight DoCS assessors and one independent organisational psychologist staff each Assessment Centre. All DoCS assessors are graded at Senior Caseworker,

⁴⁶ Submission: DoCS, Caseworker Recruitment, p.4.

Manager Casework or above and receive specialised assessor training. DoCS has promoted the role of assessor as a professional development opportunity in staff newsletters.

- 3.20 Recommended candidates are advised that, subject to the outcome of pre-employment screening, their names will be placed on the statewide caseworker eligibility list. Successful candidates are offered appointment to vacancies in their preferred locations as they arise and in order of merit. If there are no current vacancies at their preferred locations, candidates are offered alternative positions in other locations where appropriate.
- 3.21 Of the 2,308 applications received during 2006/07, 1,172 applicants were invited to attend an Assessment Centre (1,171 of whom attended). Of these applicants, 678 were recommended for appointment and 520 were appointed. DoCS and Businesslink increased the number of Assessment Centre sessions during 2007/08 to cater for a larger number of applicants.
- 3.22 In 2007/08, DoCS received more than 6,000 applications for caseworker positions, an increase of over 270 per cent from 2006/07.
- 3.23 For the period 1 July 2007 to 31 March 2008, a total of 6,181 caseworker applications were received. As at 24 June 2008, 2,020 of these applicants progressed to the Assessment Centre stage and of 1,736 who attended an Assessment Centre session, 914 had been recommended for appointment.⁴⁷ The total number of permanent appointments for 2007/08 was 644.⁴⁸
- 3.24 Managers Casework are also recruited through the Assessment Centre process. In 2006/07, DoCS received 214 applications for Manager Casework positions. A total of 57 candidates accepted offers of permanent appointment. For the period 1 July 2007 to 31 March 2008, a total of 294 Manager Casework applications were received. Of these, 152 candidates attended an Assessment Centre session of which 68 were recommended for appointment and placed on the eligibility list. A total of 17 candidates accepted offers for permanent appointment. The other successful candidates on the eligibility list will be considered for permanent appointments as they arise, and for filling short and long term acting arrangements.
- 3.25 DoCS does not collect data on either the number of applicants who decline positions or the reasons given for turning down an offer of employment. However, in December 2007, DoCS conducted a review of 32 candidates from metropolitan Sydney who did not take up an offer of employment as a caseworker with DoCS. The following reasons were given for declining the offer of employment:

⁴⁷ Not all applications received by 31 March 2008 would have been finalised by 24 June 2008.

⁴⁸ DoCS, *Annual Report 2007/08*, p.65.

- a. eleven declined the offer because the available position was not in their preferred location
- b. seven had obtained other employment
- c. six declined the offer because they were seeking only part time work
- d. five were unavailable at the time of offer
- e. three could not be contacted.

Timeframes

- 3.26 The selection and recruitment process for caseworkers involves a number of steps, all of which take varying amounts of time to complete. They include conducting referee checks and undertaking pre-employment screening of successful candidates.
- 3.27 In 2006/07, the average time taken from the receipt of an application to a verbal offer being made to a successful candidate was 146 days. In the three month period from January to March 2008, the average time taken from the receipt of an application to a verbal offer being made to a successful candidate had been reduced to 82 days.

Strategies to recruit caseworkers

- 3.28 Since 2006/07, DoCS has implemented an advertising campaign to recruit caseworkers. Advertisements appear in a wide range of local, statewide and interstate print media as well as online media. All advertisements direct applicants to the DoCS website for further information.
- 3.29 In addition to general advertising, DoCS also specifically tailors advertisements to attract caseworkers from different demographic groups, such as Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, older people, or final year university students. In 2007, DoCS also commenced an advertising campaign targeting caseworker positions for difficult to fill locations, most notably in western and north-western NSW.
- 3.30 In 2007/08 DoCS introduced an integrated online application system and recruitment database for casework job applicants, reducing waiting times and providing more information on applicants.⁴⁹

Recruitment of graduates

- 3.31 In October 2004, following agreement with the PSA, a degree level qualification became an essential requirement for all caseworker positions with the exception of Aboriginal caseworker positions. The preferred degrees are those in social work, social science and community welfare, although those with related

⁴⁹ *ibid.*, p.73.

degrees (for example, nursing) and with experience in community work can also be accepted.

- 3.32 DoCS has advised that it has established relationships with over ten universities including all the NSW schools of social work/social welfare and some Queensland and Victorian universities. Relationships with the latter have led to some success in recruiting graduates to border towns.
- 3.33 Strategies to recruit and retain qualified staff in rural and remote areas also include the creation of a joint DoCS/Charles Sturt University senior position at Wagga/Dubbo that contributes to building workforce capacity in isolated and rural areas. This position is used to: support employment strategies; provide student supervisor training; supervise social work student placements (where the staff do not hold social work qualifications); and support practice improvements and solutions, coaching, consultancy and mentoring. University duties for this position may include direct teaching, research and writing curricula.
- 3.34 Many degrees relevant to DoCS professional positions require supervised student placements. DoCS has advised that it has actively promoted itself as a provider of student placements. In 2007, DoCS provided work experience placements for 137 students enrolled in courses directly relevant to the role of caseworker.
- 3.35 DoCS' final year student recruitment strategy targets students in their final semester of study for an undergraduate degree in social work, social science, community welfare or psychology in NSW and interstate universities. For the calendar years 2006 and 2007 there were a total of 220 students recommended for permanent caseworker positions as a result of this recruitment strategy.
- 3.36 DoCS has also negotiated accreditation for some of its internal courses to allow staff to gain advanced standing in a range of tertiary courses.
- 3.37 DoCS has advised that it convenes bi-annual meetings with the NSW Combined Universities Field Education Group to address student placement and caseworker recruitment issues.

Recruitment of Aboriginal caseworkers

- 3.38 As at 30 June 2008, DoCS had the following workers who identified as Aboriginal or Torres Strait Islander: 192 caseworkers (9.0 per cent), which rises to around 20 per cent in Northern and Western Regions; 32 Managers Casework (6.8 per cent); and three Managers Client Services (4.5 per cent). In 2006/07, DoCS had 79 identified Aboriginal positions. However, DoCS has now adopted a strategy of active recruitment of Aboriginal candidates for all caseworker positions rather than for identified positions only.

- 3.39 Some specific initiatives to improve recruitment and retention of Aboriginal staff in 2006/07 included:⁵⁰
- a. mentoring programs for Aboriginal managers and caseworkers
 - b. CDC Plus, through which new and existing Aboriginal casework staff can gain additional support with business writing, information technology, social welfare theory and communications skills.
 - c. a program to enrol about 50 Aboriginal casework staff in the Diploma of Community Services
 - d. the DoCS Aboriginal Cadetship Program, with five cadets enrolled at 30 June 2007, and one graduate of the program gaining permanent employment in DoCS. Three graduates from this program have now been employed by DoCS.
- 3.40 In addition, DoCS:
- a. introduced a twelve month pilot Aboriginal Mentoring for Management program that seeks to develop Aboriginal staff who have the potential to move into management positions
 - b. organises an annual Aboriginal Staff Conference to allow presentation and discussion of current policies and issues as well as networking amongst Aboriginal staff
 - c. plans to increase the number of Aboriginal legal officers from nil in 2002/03 to one legal officer and two legal cadets in 2008
 - d. uses the expertise of the Department's Aboriginal Reference Group which is made up of Aboriginal staff representatives from each regional area, Head Office and the Helpline. The group provides an alternate structure for Aboriginal staff to raise issues of concern and comment on current approaches.
- 3.41 Applicants who identify and are recognised as Aboriginal are exempted from the requirement that they hold a degree level qualification in recognition of the skills and knowledge they would contribute to DoCS engagement with Aboriginal families. In lieu of a degree qualification, Aboriginal applicants are required to have a minimum of two years of relevant community services related work with Aboriginal communities and be successful at the Assessment Centre, where Aboriginal staff are generally involved in the assessment process.

Recruitment of multicultural caseworkers

- 3.42 DoCS also recruits multicultural caseworkers with bilingual and cross-cultural skills to provide casework to children and families from culturally and linguistically diverse backgrounds. Sixty-one of the additional caseworker

⁵⁰ DoCS, *Annual Report, 2006/07*, p.81.

positions funded under the Reform Package are designated as specialised Multicultural Caseworker positions.⁵¹

- 3.43 Multicultural Caseworkers conduct casework with children and families from their target communities and provide information and advice to their colleagues. Under the Community Language Allowance Scheme the Department has 137 staff with registered language skills (covering 30 languages), an increase from 105 staff in the previous year.⁵²

Recruitment strategy for rural and remote NSW

- 3.44 While the number of applications being received for caseworker positions would indicate that there is a strong interest in working for DoCS as a caseworker, there are some locations within NSW where caseworker positions remain difficult to fill. In 2006/07, while 20 successful applicants accepted appointments as caseworkers in DoCS Western Region, a significant number of new and existing caseworker positions remained vacant. DoCS has advised that in response to its limited success in recruiting to the new caseworker positions in Western Region, coupled with the high vacancy rate for already existing caseworker positions, a specific strategy to recruit casework staff for western NSW has been developed and is being considered by Premier and Cabinet.
- 3.45 DoCS is undertaking a number of targeted advertising campaigns to fill vacancies in particular towns in Western Region.
- 3.46 To address serious staff shortages in regional and remote areas of the State in the short term, DoCS has developed an internal short term rural secondment program for experienced metropolitan casework staff, which entitles staff to a travel allowance.⁵³ In 2007/08, 10 rural short term secondments were organised. DoCS promotes this strategy both as a way to fill short term vacancies and as a professional development experience for caseworkers and managers.⁵⁴
- 3.47 DoCS is one of the NSW government agencies participating in the Remote Areas Attraction and Retention Pilot announced by the then Premier in October 2006. Seven caseworker positions in the Bourke CSC grouping are part of this Pilot. As at April 2008, five of these positions were filled and a further position was expected to be filled. Under this Pilot some incentives are offered.⁵⁵
- 3.48 The Inquiry is aware of disquiet because DoCS staff already occupying caseworker positions in similar situations are not eligible for the incentives package given to new caseworkers.

⁵¹ *ibid.*, p.79.

⁵² DoCS, *Annual Report 2007/08*, p.75.

⁵³ DoCS, *Travel Allowance: Guide for Short Term Rural Secondees*, August 2006.

⁵⁴ DoCS, *Annual Report 2007/08*, p.73.

⁵⁵ Remote Areas Attraction and Retention Pilot 2006/09, www.dpc.nsw.gov.au.

- 3.49 As at April 2008, Premier and Cabinet was considering a proposal developed by DoCS that contained incentives more generous than those offered in the Remote Areas Attraction and Retention Pilot, to be offered in nominated locations in western NSW. The proposal is being considered in the context of the broader provision of human services across government agencies.
- 3.50 As evident by the Remote Areas Attraction and Retention Pilot, the recruitment and retention of skilled Aboriginal and non-Aboriginal staff in the rural and remote parts of the State is an ongoing difficulty for all human service agencies. In an effort to develop a longer term response to this problem and to the shortage of suitable staff housing and office accommodation in these areas, Premier and Cabinet has commenced work on the Human Service Delivery in Rural and Remote Areas Project. The Inquiry has been advised that recommendations under this project are to be brought to Cabinet before the end of 2008 addressing four specific issues: new service delivery models; government employee accommodation; uniform public sector incentives; and education, training and government assistance.
- 3.51 As a specific example of initiatives being instituted to recruit and retain workers in rural and remote locations, partner agencies in the Safe Families Program in the Orana Far West will undertake joint recruitment, training, induction and orientation of staff in the initial stages of the Program. In addition, to avoid worker burnout and to aid staff retention, the positions will be linked with a range of new and existing forums to provide support networks including local interagency meetings and forums, linking workers with the broader Aboriginal Family Health Worker network and mainstream community health networks.
- 3.52 DoCS has also recognised that for some locations, particularly in western NSW, an alternative model of service provision may need to be implemented to ensure staff have a supportive working environment. A 'hub and spoke' model of service delivery is being considered, where a caseworker may be permanently placed at a remote location, but is attached to a larger hub office for supervision, training and administrative support. Alternatively, a remote office may only be operated by staff from a hub office on a part time basis, such as three days per week.⁵⁶
- 3.53 This proposal was put to the Aboriginal Reference Group and they were "exceedingly attracted to that as a possible way of dealing with some of the West's problems."⁵⁷

Other factors impacting the recruitment process

- 3.54 DoCS has experienced difficulties in finding suitable accommodation in some locations outside Sydney. This has caused delays in the appointment of additional caseworkers in some areas, particularly in Western Region.⁵⁸

⁵⁶ DoCS, *Recruitment Strategies for Western Region of New South Wales*, April 2008, p.3.

⁵⁷ Transcript: Inquiry meeting with DoCS senior executives, 30 November 2007, p.82.

- 3.55 The recruitment of additional manager positions to support the new caseworker positions has also impacted on DoCS' ability to become fully staffed. As outlined previously, this is largely because many manager positions have been filled by experienced caseworkers, which in turn has increased the number of positions that need to be filled.

Staff retention

- 3.56 The following table provides a breakdown of separation rates for caseworkers and casework managers from 2003/05 to 2006/07.

Table 3.3 **Separation rates for DoCS staff 2003/04 – 2006/07**

<i>Separation Rates</i>	<i>2003/04</i>	<i>2004/05</i>	<i>2005/06</i>	<i>2006/07</i>
Caseworker	6.93	9.05	8.22	7.18
All DoCS	7.72	8.75	6.72	6.35
Manager Casework	3.86	5.45	2.5	2.42
All DoCS	7.72	8.75	6.72	6.35

- 3.57 Data made available to the Inquiry from the Public Sector Workforce Office indicates that for each of the years 2002/03 to 2005/06 the DoCS separation rate of non-casual social welfare professionals (which includes caseworkers and casework managers) was lower than that for the human services sector,⁵⁹ the Public Service⁶⁰ and the total public sector (social welfare professionals).⁶¹ This suggests that, at least in comparison with the public sector, DoCS has no particular difficulty in retaining social welfare professionals.
- 3.58 Caseworkers had a higher turnover compared with all DoCS staff in 2004/05 but caseworker separation rates are close to the organisational average in 2006/07. In 2005/06 and 2006/07 Managers Casework had lower separation rates than the departmental average. In addition, the separation rates for caseworkers and managers have declined since 2004/05.
- 3.59 The highest rates of turnover of caseworkers in 2006/07 were in the Hunter/Central Coast Region (11.6 per cent) and Western Region (10.5 per cent), however these regions had low turnover rates for Managers Casework.
- 3.60 The average tenure of a caseworker in DoCS in 2001/02 was five years. In 2006/07 the average tenure was four years. The average tenure of a Manager Casework in 2001/02 was ten years. This remained unchanged in 2006/07.

⁵⁸ DoCS, *Recruitment Strategies for Western Region of New South Wales*, April 2008, pp.4-5.

⁵⁹ Which includes the Department of Ageing, Disability and Home Care, Department of Community Services, NSW Health (including all Area Health Services), Department of Education and Training, Department of Housing, Department of Aboriginal Affairs.

⁶⁰ This includes employees under Chapter 2 of the *Public Sector Employment and Management Act 2002* who are employed in one of the 47 Departments in the Public Service. Teachers, school support staff and fire fighters are not employed under this Act and therefore are not counted as members of the Public Service for the purpose of comparing separation rates.

⁶¹ Total Public Sector figures include non-casual employees from all public sector agencies including State Owned Corporations.

- 3.61 In 2007/08 DoCS introduced a buddying program aimed at reducing transition time for new staff by actively building on the job skills and confidence.⁶²
- 3.62 DoCS reports that the retention rate for Aboriginal staff is higher than for non-Aboriginal staff.

Caseloads

- 3.63 Caseloads are defined by DoCS as the number of open plans for children and young persons that a full time equivalent (FTE) direct worker (such as a caseworker) has responsibility for at any point in time or over a stated period. Generally, caseworker activities include implementation of the case plan, conducting assessments, coordination of services and supports and monitoring.⁶³

Early intervention

- 3.64 International research and practice evidence suggests that caseload ratios of 1:15 to 1:20 families are appropriate for the Brighter Futures Early Intervention program. When DoCS Early Intervention Caseworkers are delivering the Parents as Teachers Home Visiting program, it is expected that a lower caseload of around 10-15 families will apply.
- 3.65 The average caseload for Early Intervention Caseworkers as at April 2008 was 6.84 plans and 15.95 children and young persons in these plans. At the regional level, caseloads based on plans vary between 5.37 in Hunter/Central Coast Region to 8.29 in Northern Region. The number of children and young persons in plans varied from 12.27 in Hunter/Central Coast Region to 20.11 in Western Region. The Inquiry understands that plans equate to families and, on this basis, the caseloads are, relatively, low.
- 3.66 DoCS informed the Inquiry that it undertook a detailed benchmarking analysis in April 2008 in an effort to increase caseloads in CSCs. At the conclusion of this work as at September 2008, average caseloads were nine cases per caseworker. DoCS also informed the Inquiry there is a time delay in caseload figures until all Early Intervention Caseworker resources have been approved, fully trained, and operational.

Child protection

- 3.67 Caseloads internationally range according to the type of child protection work being undertaken. For example, screening of reports can range from 69-116 per month. Investigations per worker can range from 10-30 per month.

⁶² DoCS, *Annual Report 2007/08*, p.73.

⁶³ DoCS, *Technical Report 2, Caseloads in child and family services*, November 2007, p.3.

- 3.68 Murray reviewed cases of substantiated abuse of children in care in Western Australia and made recommendations for good practice in child protection. Her recommendations of caseload benchmarks of one worker to 15 cases were accepted by the WA Government.⁶⁴
- 3.69 In Tasmania, it has been recommended that the caseloads in the assessment/case management area have been recommended to be limited to 10 children, or 12 if there is a sibling group or less complex cases.
- 3.70 As at April 2008, DoCS' child protection caseload based on plans varied from 9.90 in Hunter/Central Coast Region to 16.98 in Western Region. Overall, however, the average of 12.21 plans for Child Protection Caseworkers is generally within, or lower than, the recommended or actual caseloads of agencies in other jurisdictions. The number of children in plans opened during the month varied from 18.56 in Hunter/Central Coast Region to 30.79 in the Western Region, with a state average of 21.58.
- 3.71 For families that require intensive services, caseloads nationally and internationally are between two and six. The DoCS family preservation/intensive support models are generally within, or lower than the recommended or actual caseloads of similar models.

Out-of-home care

- 3.72 Caseloads in OOHC vary according to the assessed need of children and young persons. Nationally, caseloads recommended vary from 5-20 children and young persons per worker although in practice they can reach 32. Internationally recommended caseloads range from 8-24 although in practice they can reach 49 children and young persons per worker.
- 3.73 There is no universally accepted formula for calculating caseload. On average the literature offers support for a caseload of a round 15 OOHC cases per worker. Research evidence broadly identifies a recommended OOHC caseload range of 12-20 for low need cases/children per caseworker and 5-8 for intensive high need children per caseworker at any given time.
- 3.74 In the USA, research into caseloads for OOHC services has shown that most agencies attempt to adhere to the caseload recommendations of the Council on Accreditation and the Child Welfare League of America. The Council on Accreditation recommends maximum caseloads of 18 children per caseworker dropping to eight children per caseworker for children with higher support needs (therapeutic) at any given time. Comparatively, the Child Welfare League of America recommends a caseload of between 12-15 per caseworker for foster and relative care, depending on needs. Where care is ongoing a caseload of 15-18 children is recommended.

⁶⁴ G Murray, "A Duty of Care to Children and Young People in Western Australia, Report on the Quality Assurance and Review of Substantiated Allegations of Abuse in Care," *National Family Preservation Network*, 2005 cited in DoCS, *Technical Report 2, Caseloads in child and family services*, November 2007, p.6.

- 3.75 As at April 2008, the overall caseload figure of 11.97 plans per OOHC Caseworker within DoCS is within or lower than the recommended or actual figures for 'general' OOHC clients. Caseloads varied from 8.42 plans per worker in Hunter/Central Coast Region to 14.30 plans per worker in the Metro West Region. The number of children and young persons in plans opened during the month per caseworker varied from 11.79 in the Hunter/Central Coast Region to 18.32 in the Western Region. Chapter 16 contains a detailed discussion on caseloads and allocation rates in OOHC.
- 3.76 Caseload data provided by DoCS suggests that for all program areas DoCS is within or lower than average benchmarks in other jurisdictions.

Occupational Health and Safety

- 3.77 On average, DoCS staff take more sick leave than their public service counterparts in the human services sector. The average annual sick leave per employee in the NSW Human Services sector is 5.29, however in DoCS it is 6.75.
- 3.78 DoCS also faces significant challenges in terms of its occupational health and safety (OHS) performance and the amount of time lost to workers compensation claims. Since 2002 DoCS has significantly improved its OHS performance with the number of workers compensation claims reducing from 8.5 claims per 100 FTE employee in 2003/04 to 5.8 claims per 100 FTE in 2007/08. DoCS has also achieved a reduction of 4.5 per cent in claim costs from 2005/06 to 2006/07.
- 3.79 However, examination of DoCS data suggests that there are a number of OHS pressure points in the organisation. The highest number of claims originate from the Helpline, that is 16.3 of claims per 100 FTE compared with 5.3 claims per 100 FTE for the whole of DoCS. The most frequent claim types in 2006/07 for the whole of DoCS were body stressing, followed by vehicle accident, mental stress and falls, trips and slips. Whilst claims are largely spread across DoCS Regions, in 2007/08 49 per cent of body stressing claims came from the Helpline.
- 3.80 The Helpline also has the highest rate of reported incidents.⁶⁵ For 2006/07 the departmental average was 14.4 incidents per 100 FTE whereas at the Helpline there were 43.2 reported incidents per 100 FTE.
- 3.81 The Helpline, therefore, has the highest number of claims per 100 FTE and the highest claim costs per employee and by far the highest number of reported incidents. The number of claims and incidents at the Helpline would have an impact on workforce capacity.

⁶⁵ Incidents are events that had the potential to, or did, cause injury or illness.

- 3.82 Mental stress accounts for 32 per cent of all reported incidents and 26 per cent of claims in DoCS. The highest proportion of time lost to work is attributable to mental stress claims. Mental stress injuries are psychological injuries. The Inquiry does not know the cause of these injuries, that is, whether they have been sustained as a result of the type or nature of work undertaken or whether they are due to 'internal issues' (for example, relationships between staff and supervisors or managers, or amongst staff or workplace culture).
- 3.83 From 2002/03 to 2006/07 DoCS has had 33 'very large' workers compensation claims.⁶⁶ Whilst 'very large' claims account for three per cent of the overall number of claims over the past five financial years, they account for 43 per cent of costs over this period. Mental stress claims are the most common, accounting for 64 per cent of all 'very large' claims. The occurrence of psychological injury in DoCS would have an impact on workforce capacity and would benefit from specific attention as part of DoCS OHS planning, since the nature of the work is inevitably complex and stressful, and is often required to be performed subject to stringent time pressures, particularly where it involves the urgent removal of children from the parents or carers, or is carried out in the JIRT context.

Professional standards

Qualifications

- 3.84 The qualifications for caseworkers are set out above (paras 3.31 and 3.41). Managers Casework are not required to have a degree. They are required to have in depth knowledge of contemporary principles, theory and practice in the field of child, young person and family development and protection as evidenced by:
- a. possession of a degree in social work, relevant social/behavioural science, welfare or related discipline, and/or
 - b. evidence of recent exposure to current academic/theoretical thinking through relevant experience and/or attendance at seminars/conferences, participation in professional groups, enrolment in short courses or diploma course
 - c. capacity to articulate and discuss contemporary theory and practice.
- 3.85 Qualifications required for other relevant casework staff are as follows:
- a. Casework Specialists require a tertiary qualification, as outlined for caseworkers but with at least two years experience in child protection.
 - b. Directors Practice Standards require a postgraduate degree or equivalent experience in child and family services.

⁶⁶ The threshold for 'very large' claims for 2006/07 was \$146,000.

- 3.86 In most other jurisdictions, the equivalent position to a caseworker requires tertiary qualifications, although Victoria accepts diploma level qualifications.⁶⁷

Casework support positions

- 3.87 As part of the Reform Package funding was also provided to improve professional support to assist caseworkers by way of 30 additional psychologists and 30 legal officers. A further 30 JIRT positions were also created, in addition to four JIRT referral team positions.
- 3.88 As at June 2007, the additional legal officers and JIRT caseworkers have been recruited and allocated to regions. The number of legal officers has increased from 19 positions in June 2005 to 48 by October 2008. The number of psychologists, however has decreased from 41 positions in 2001/02 to 36 in 2006/07. DoCS states that not all psychologists have been recruited as a result of "PSA opposition (2003-2007) and centralised award negotiations (2007)."⁶⁸ The PSA opposition, as understood by the Inquiry, was to the management and supervisory structure under which the additional psychologists would work. That has now been resolved. Twenty-three psychologist positions remain to be created and filled in 2008.

Professional supervision

- 3.89 Across professional disciplines, supervision is considered central to high standards of professional practice⁶⁹ and quality outcomes for clients.⁷⁰ High quality, consistent and developmental supervision has been associated with greater worker motivation, productivity and staff retention. It also contributes to the acquisition of essential practice knowledge and skills. Supervisors can help workers to evaluate their performance and to identify and learn from their successes and mistakes.⁷¹
- 3.90 The Inquiry requested information from a range of service providers including area health services (for allied health professionals and nurses), DADHC and DoCS in relation to the policies, procedures, models and structures which they have in place for professional and/or clinical supervision of new and experienced staff.
- 3.91 It was informed that supervision may occur face to face, in group work, peer review, expert panel review, interagency case reviews, case consultation with specialists, within a multi-disciplinary team or discipline specific context, or via

⁶⁷ Victorian Department of Human Services, Child Protection, www.dhs.vic.gov.au, Queensland Department of Child Safety, www.childsafey.qld.gov.au, WA Department for Child Protection, www.community.wa.gov.au.

⁶⁸ Information provided to Government by DoCS, March 2008.

⁶⁹ For example, Australian Association of Social Workers, *National Practice Standards*, p.1; R Bryant, J Cranney, K McConkey, *The Supervision of Psychologists, A Report to the NSW Psychologists Registration Board*, p.1.

⁷⁰ Southern Regional Quality Improvement Centre for Child Protection, *Review of Literature Associated with Social Work Supervision*, p.6.

⁷¹ *ibid.*, pp.5-6.

teleconferencing, online forums or video link up. Supervision may occur weekly, fortnightly or monthly and may vary according to the experience of the supervisee.

- 3.92 Some services have full time senior clinicians who are responsible for supervision, professional support and ongoing learning and development, case consultation, debriefing and working alongside clinicians in complex cases.⁷² In other services the line manager is accountable for all supervision arrangements while in others supervision may be provided by external providers.⁷³
- 3.93 Different agencies and professional associations draw a distinction between professional, administrative or line accountability and clinical supervision.⁷⁴ Professional, administrative or line accountability may be defined as day to day supervision, role clarification, work allocation and service planning, record keeping, time management, and working within the goals and values of the service. Clinical supervision, however, is concerned with the quality of clinical decision making, interventions and skills development.⁷⁵ Quality supervision comprises an opportunity for the development of skills and competencies, reflective practice and case management review.
- 3.94 Best practice models build this flexibility into their frameworks, for instance, to enable a practitioner, or team, to access supervision from outside the agency with the required specialist expertise (for example Aboriginal maternal health). This can be particularly valuable in rural and remote areas, or in the case of sole practitioners. Protocols are then in place in terms of meeting the time, cost and logistic requirements of this arrangement. Confidentiality and other possible ethical dilemmas may also need to be anticipated and clarified between the practitioner and the external consultant.
- 3.95 A number of professional/clinical supervision frameworks share common principles:⁷⁶
- a. supervision is mandatory for clinicians
 - b. the most appropriate supervisor in the first instance is the person who is designated as such in the organisational chart
 - c. an effective supervisory relationship relies on a mutual feeling of respect and trust between both parties. When this cannot be achieved an alternative supervisor should be offered
 - d. the supervisee and supervisor should share a common knowledge base
 - e. when an appropriate supervisor cannot be found from within the agency an external supervisor can be appointed

⁷² For example, Northern Sydney Child Protection Service, Northern Sydney Central Coast Area Health Service.

⁷³ For example, Sexual Assault Services, Greater Western Area Health Service.

⁷⁴ For example, Hunter New England Area Health Service, Sydney South West Area Health Service.

⁷⁵ For example, Sydney South West Area Health Service.

⁷⁶ For example, Sydney South West Area Health Service.

- f. supervisors must be trained and/or be competent in supervision skills
 - g. where an external supervisor is used, clinical standards need to be discussed up front with the external supervisor, and they should provide reports to the manager on what has been achieved in supervision and, in addition, provide feedback into the performance appraisal system
 - h. a contract between the supervisor and the supervisee should be written at the commencement of the supervisory relationship outlining the process for supervision
 - i. supervision logs are used as a method of recording the aims and outcomes of supervision.
- 3.96 The DoCS approach to professional supervision is based on the following principles:
- a. supervision is intrinsically important for quality service delivery and client outcomes
 - b. supervision policy must be located within a performance management framework
 - c. supervisors need training, support and ongoing supervision
 - d. an agency needs an agreed definition of supervision
 - e. it is undesirable to split the administrative and professional functions of supervision in child protection
 - f. learning and professional development will only be effective in a functional learning environment.
- 3.97 Professional supervision within DoCS sits within the broader Personal Planning and Review system process as a specific requirement for field staff.
- 3.98 The need for enhancing professional supervision skills among frontline staff has been raised in internal and external Child Death Reviews and Ombudsman Reports. Professional supervision has also been supported by the PSA as a key priority for frontline staff.

Personal Planning and Review system

- 3.99 DoCS introduced a Personal Planning and Review (PPR) process in 2004 with more than 3,150 staff meeting all aspects of the process in 2006/07.⁷⁷ PPR involves a six monthly and annual review of performance agreements, which is monitored centrally.
- 3.100 In an evaluation of the PPR conducted in 2006 the five key findings were as follows:
- a. there is an acceptance of PPR

⁷⁷ DoCS, *Annual Report 2006/07*, p.80.

- b. the commitment, leadership and people management skills of the manager is crucial to the success of PPR
 - c. there is a perception that PPR is benefiting people's work and continuous improvement
 - d. DoCS is ready to move from a focus on compliance to a focus on the quality of PPR
 - e. there is a need to amend and further communicate aspects of the PPR procedures and forms.⁷⁸
- 3.101 Compliance with PPR processes is part of the performance agreements of Senior Executive Service staff.⁷⁹ The evaluation found that 94 per cent of staff had a PPR Agreement in place. However, the evaluation also found that only 78 per cent of staff participated in the six month formal PPR review and only 78 per cent had the annual review meeting with their supervisor.

DoCS professional supervision

- 3.102 The target group for professional supervision includes Directors Child and Family, Directors Practice Standards, Managers Client Services, Managers Casework, Casework Specialists and Caseworkers. The DoCS policy stipulates that at minimum one hour per month is set aside for professional supervision and should include:
- a. debriefing (discussing recent experiences)
 - b. reflection (considering the impact of interventions)
 - c. development of skills/knowledge (discussion of recent literature, strategies, alternative approaches)
 - d. professional development (progress with any development steps agreed as part of the Learning and Career Development Plan)
 - e. constructive feedback (meaningful feedback on work performance and areas for further development)
 - f. recording of information (tasks and activities to be used as a reflection tool for the next supervision session)
- 3.103 During 2005/06, DoCS implemented its Professional Supervision Strategy which is a key element within the broader DoCS Professional Development Framework. The Strategy consists of a training program and monthly practice groups for directors and managers to support transfer of learning to practice. It also sets requirements around the frequency and standard of supervision to support caseworkers in undertaking their duties.

⁷⁸ DoCS, Intranet, *PPR Evaluation Report*, November 2006, p.4.

⁷⁹ *ibid.*, p.1.

- 3.104 A recent review undertaken by DoCS found that Managers Casework attributed at least some positive change to the training program (88 per cent) and the practice groups (82 per cent). The majority of caseworkers reported their current supervision had a helpful to very helpful impact on nearly all casework practice areas, however 45 per cent stated that the use of contemporary research evidence had a lesser impact.
- 3.105 The assessment by caseworkers of how well their Managers Casework undertook the key function of supervision was not as positive, with only 50.6 per cent agreeing it was done well. 22 per cent of caseworkers were neutral and 27 per cent of responses were negative. Only half of the 480 caseworkers surveyed said they received regular supervision and only 48 per cent said supervision met their needs.
- 3.106 The review highlighted a number of recurring themes of which some have been raised with the Inquiry. These included:
- a. lack of time for supervision due to priorities given to the crisis nature of the work
 - b. supervision being task based
 - c. supervision not being modelled from the 'top down' with a specific focus on the Manager, Client Services/Manager, Casework relationship
 - d. inconsistent attendance by Managers across practice groups with an average of 42 per cent of available staff attending.
- 3.107 Following this survey, DoCS informed the Inquiry that it would:
- a. use experienced managers as mentors to new managers
 - b. develop experienced managers in the role of practice group facilitators
 - c. target support for managers requiring further development in their supervision practice, for example, coaching.
- 3.108 To better measure the effectiveness of professional supervision, DoCS proposes to use the CSC quality reviews discussed in the previous chapter to monitor implementation of supervision practices.

Lines of supervision and supervision ratios

- 3.109 Line management varies across the State. While there are 80 CSCs, there are not 80 Managers Client Services. In some cases, groupings of smaller CSCs are managed by one Manager Client Services (for example, the Orana Far West Grouping in Western Region). In other cases, a small CSC may be a sub-office of a nearby, larger CSC (for example, Bowral CSC, which comes under the Manager Client Services at Campbelltown). In larger CSCs such as Blacktown CSC there are two Managers Client Services and responsibilities are divided along functional lines.

- 3.110 Sufficient ratios of supervisors to caseworkers are needed so that supervisors can adequately determine priorities, guide caseworkers, and ensure the quality of services provided.
- 3.111 DoCS undertook a review of the available literature on caseworker supervision caseloads in child and family services.⁸⁰ DoCS current target supervision ratio of 1:6 is generally in keeping with, or higher than, those identified in the literature.⁸¹ In practice DoCS supervision ratio varies from 1:5 to 1:8 in different teams and different locations.

Caseworker Development Course

- 3.112 The Caseworker Development Course (CDC) is the mandatory entry level training course for caseworkers and is designed to equip new staff to a common level of relevant skills and knowledge to perform the functions of a caseworker. Caseworkers need to complete most of CDC before they are able to take on a caseload.
- 3.113 It consists of a series of learning modules and includes training in the KiDS system functionality relevant to each topic. The learning modes include face to face training and on the job exercises. The preferred timeframe for completion of the CDC in 2006/07 is a maximum of 22 weeks.
- 3.114 The modules in CDC are distributed into eight week blocks in which new caseworkers attend centralised training. The pattern of attendance (one week attending training followed by one to two weeks in the field) is designed to maximise learning. The field experience component allows caseworkers, in theory, to put into practice the new skills learned in training, in a timely and practical manner. Managers and caseworkers are provided with information about what tasks are suitable for the novice caseworker to undertake after each block of training, and how the required skills and knowledge can be developed.
- 3.115 The CDC program now leads to eligibility for a nationally accredited Diploma in Statutory Child Protection through an auspicing arrangement with TAFE NSW.⁸²
- 3.116 In addition, DoCS has introduced a program known as CDC Plus to provide additional skills based support for new Aboriginal caseworkers who do not have formal qualifications in social welfare. CDC Plus is conceptually similar to a bridging program or pre-course work to provide underpinning skills and knowledge. With the addition of some minor extra assessments, caseworkers can receive a Diploma in Statutory Child Protection.

⁸⁰ DoCS, *Technical Report 2, Caseloads in child and family services*, November 2007.

⁸¹ *ibid.*, pp.15-16.

⁸² DoCS, *Annual Report 2007/08*, p.73

Practice Solutions

- 3.117 Every CSC across NSW is closed on a Thursday morning (9am –12.30pm) to enable staff to attend learning and professional development sessions related to child protection, OOHC and early intervention practice within their CSC, called Practice Solutions.
- 3.118 There are different types of Practice Solutions sessions:
- a. briefing sessions - information on new policies or procedures
 - b. practice update sessions - information and analysis of changes to policy or procedures
 - c. practice improvement sessions - reflection on existing practice.

Early Intervention program (Brighter Futures)

- 3.119 Prior to working in the Early Intervention program caseworkers must complete training specific to this program.
- 3.120 One of the key deliverables to families in the Early Intervention program is structured home visiting. To equip staff with skills in this area, DoCS has commenced a partnership with Macquarie University to deliver a five day US accredited Parents as Teachers Program. The Inquiry understands that this program is one of the few where there is an evidence base showing improved outcomes for this population.

Ongoing Training – Post Entry Level

- 3.121 In 2007/08 DoCS staff attended more than 41,600 training days,⁸³ a substantial increase from 30,000 days in 2006/07 and 23,600 in 2005/06.⁸⁴ During 2006/07 more than 400 new staff attended 21 CDC modules. In total there were 16,229 participant training days in this program, an increase on the 13,370 training days delivered the previous year.
- 3.122 DoCS' average cost of training per employee in 2006/07 was \$2,697, which is significantly higher than average overall industry expenditure. The training costs for DoCS as a percentage of base salary costs was 5.1 per cent in 2006/07 compared with 3.0 per cent for average overall industry base salary costs.
- 3.123 In 2002/03, 36.4 per cent of the DoCS workforce were provided with training. In 2006/07 this had risen to 83.3 per cent. Further, the average annual number of training hours per DoCS employee in 2002/03 was 28.6 hours, compared with 52.6 hours in 2006/07. The latter is almost double that of the overall industry average.

⁸³ *ibid.*

⁸⁴ DoCS, *Annual Report 2006/07*, p.81.

Professional Development and Quality Assurance

- 3.124 The DoCS Professional Development and Quality Assurance Program was established to improve the quality and consistency of child protection, early intervention and OOHC practice. Implementation of aspects of the program commenced in 2007. The program has established aspirational practice standards to inform system and staff development and, on a practical level, offers targeted practice management training for managers, practice coaching for new caseworkers, case consultancy and review services to casework teams and quality review and practice improvement programs for CSCs.
- 3.125 The key components of the program are:
- a. Professional Supervision Strategy (detailed earlier in this chapter)
 - b. Research to Practice Program (detailed in the previous chapter)
 - c. Development of Best Practice Standards in assessment and intervention
 - d. Quality Review Program.
- 3.126 The Best Practice Standards in assessment and intervention were drawn from an examination of external and internal reviews of practice, approaches taken in other jurisdictions, national and international research, legislation, policy and procedures and consultation with key stakeholders.
- 3.127 The core of the Quality Review Program is the review of the quality of practice delivered to children, young persons and families through CSCs, and the development of Practice Improvement Plans. It was intended that each CSC would be audited as part of this review over the next four years, although as noted earlier, PSA opposition has prevented these audits taking place.
- 3.128 Other elements of the Professional Development and Quality Assurance program include adaptation of the model to meet the needs of the Helpline, JIRTs and specialist units and the development of a CSC self assessment toolkit.
- 3.129 DoCS established a clinical stream within each region in 2007 and is considering its application to the Helpline. Nine Directors Practice Standards positions - have been established in regions to implement and resource the program. Casework Specialists (who are based in CSCs) report to these senior officer positions.
- 3.130 These positions will coordinate the quality reviews and support CSCs to assess practice quality. They will assist moving towards best practice standards and introduce new professional development resources. They will also play a mentoring role, providing coaching to staff and clinical advice to managers and directors.
- 3.131 In addition, within the program, a range of manager training initiatives have been developed to improve practice management capacity.

- 3.132 DoCS recently undertook a project to understand the current capability levels in the key roles of Caseworker, Manager Casework, Manager Client Services and Director Child and Family positions and to identify key areas that developmental programs should target. This will provide a benchmark for evaluating progress once development activities are undertaken.⁸⁵
- 3.133 Recommendations arising from this project include the development of new programs according to the areas identified above, identification and integration of systematic 'immersive' techniques (for example, secondments, simulations, work based projects, on the job action learning), the creation of a succession management program, a leadership program and executive coaching for Directors Child and Family.⁸⁶

Issues arising

DoCS workforce

- 3.134 The DoCS workforce operates within the broader market context of strong demand, undersupply, high turnover and an ageing community services workforce. Nearly half of the NSW public sector workforce is older than 45 years, compared with just over one third of the NSW working population.⁸⁷ In addition, in 2006, 27 per cent of NSW public sector employees stated that they intended to retire from the public sector in less than five years with an additional 30 per cent stating their intention to retire within the next decade.⁸⁸ The DoCS workforce is younger on average with only just over a third of its workforce over 45 years.
- 3.135 Concerns about DoCS staff were raised on many occasions with the Inquiry. One theme relates to the shortages of caseworkers and to the number of staff vacancies that have emerged particularly in some regional and remote locations, that have led to inexperienced staff being expected to perform work for which they were not adequately prepared, or to cases being closed without allocation. Planned staff reductions across all public sector agencies due to current adverse economic conditions could lead to further shortages in DoCS capacity to deliver essential services.
- 3.136 The Inquiry's visits to regional CSCs disclosed the following. Of the 13 caseworker positions at Griffith in April 2008, six were vacant and four caseworkers were yet to finish training. In Lismore in March 2008, of the 45 caseworkers in place, 15 were undergoing training. In Moree in March 2008, of the 17.5 caseworker positions only eight were then filled. In March 2008,

⁸⁵ DoCS, *Professional Development Project*, 2008, p.2.

⁸⁶ *ibid.*, p.5.

⁸⁷ Department of Premier and Cabinet, *Overview Report for the NSW Public Sector Workforce Profile 2006*, May 2007.

⁸⁸ Public Employment Office NSW, *Retirement Intentions Survey, Report and Findings*, June 2006, p.8.

Wagga Wagga CSC was carrying 6.4 vacancies, but only one was a permanent vacancy. The others were temporary due to staff on maternity leave or because people were acting in other positions.⁸⁹

3.137 From the separation data referred to earlier, it does not appear that DoCS experiences a higher turnover than other similar agencies. Anecdotally, however, it does seem that there are many opportunities to transfer to other positions within DoCS and elsewhere in the government, which, when combined with maternity leave in a predominantly female workforce, may explain many of the vacancies.

3.138 For example, the Inquiry was advised of a CSC in northern NSW where:

there is NOT ONE management position filled by permanent staff. Two Managers Casework are acting up in manager client services positions, five very experienced caseworkers are acting up in Manager Casework positions. This means that five experienced workers are missing at caseworker level with no-one to backfill. In the meantime cases cannot be allocated as the majority of caseworkers ... are going through CDC training. The stress on the very few experienced caseworkers is thus increasing exponentially.⁹⁰

3.139 The movement of staff can and, by reference to submissions, clearly has an adverse effect on CSC relations with some children, their families and their carers and can cause inconsistent practices. The Inquiry accepts the difficulties in recruiting qualified staff, particularly in rural NSW and notes that this issue is not confined to DoCS and is being addressed on a statewide basis.

3.140 A greater pool of temporary staff may assist in dealing with those relatively short term vacancies caused by leave and internal movements, although it is acknowledged that training will always impact on immediate availability. The Inquiry suggests that exit interviews be conducted, if this is not already occurring, with staff who leave CSCs but remain within DoCS. In addition, while the Inquiry notes that there has been a reduction in the time taken to recruit to less than three months, attention should be given to streamlining the process further. It also notes that DoCS has established a vacancy management team in the Workforce Planning Branch, to accelerate the filling of vacancies; and has strategies which can assist in this respect through the Permanent Caseworker Pool and the Short Term Secondment Project.

3.141 A second theme raised with the Inquiry concerns the treatment by DoCS of its workforce. The PSA summarised most of those issues as follows:

⁸⁹ DoCS provided some different data to that provided by the CSCs for the relevant time periods: Griffith 5 vacant and 2 temporarily vacant; Lismore of 50 caseworker positions 5 vacant and 2 temporarily vacant; Moree of 12 caseworker positions, 4 vacant and 1 temporarily vacant; and Wagga Wagga of 26 caseworker positions, 5 vacant and 4 temporarily vacant.

⁹⁰ Submission: Northern Region CSC.

- a. there is a lack of resources
- b. compared with other public service positions, there is a low grading of positions, particularly the entry level grade for a Caseworker and Managers Casework
- c. caseworkers have to do too much paperwork, including administrative tasks like arranging foster carer payments and photocopying subpoenaed files
- d. KiDS is cumbersome and time consuming
- e. there are insufficient Managers Casework and their workloads are too high
- f. the financial delegations system is inefficient and needs to be reviewed. Managers Casework do not have a high enough financial delegation (they can only approve payments of up to \$500)
- g. bullying and scapegoating of staff is not addressed appropriately by DoCS
- h. too many staff have been moved from 'frontline' positions to management positions or 'back room' positions
- i. staff are not consulted in relation to workplace policies. Policies are not consistent or clear, and are often unrealistic in the context of available resources.

3.142 The Inquiry was advised by the PSA that caseworkers have reported spending up to 85 per cent of their time on computers doing administrative tasks that could be performed by clerical staff. Premier and Cabinet recently undertook a survey of 49 DoCS child protection caseworkers across a number of CSCs as part of a project to identify and eliminate any bottlenecks in DoCS assessment and case management practices. The survey found that approximately 20 per cent of caseworker time was spent recording or reviewing information in KiDS,⁹¹ which does not seem unreasonable.

3.143 The Inquiry is concerned at the prevalence of the view that completing tasks in KiDS and casework practice are mutually exclusive activities. This should not be the case. The organised and accurate recording of decisions and plans means that information is documented and communicated in a logical and sequential way and promotes a coordinated and integrated response to the needs of the child or young person. It also ensures that DoCS is accountable to children and families for decisions that have been made that have an impact on their lives.

3.144 Some of the issues raised by the PSA have been acknowledged by DoCS and work is currently occurring to address issues such as KiDS useability, and providing a mechanism to define more clearly when consultation with staff and PSA on policies and procedures should occur.

⁹¹ Department of Premier and Cabinet, *Caseworkers doing casework project*, 31 July 2008.

- 3.145 Many submissions from staff and the PSA were critical of the difficulty in accessing policies and practices on DoCS intranet and of the voluminous and often changing nature of these documents.
- 3.146 The Inquiry was thus interested to learn that, in May 2008, DoCS replaced its Business Help site following issues about its ease of use by staff in locating relevant policies, procedures and research. The intranet now contains a special section for caseworkers called Casework Practice, which contains a wide variety of materials which are more integrated, including policies, procedures, practice guides, tools and research. It also includes a five minute step by step guide to assist in navigation. The new structure was developed following workshops and testing involving more than 70 DoCS staff, mainly caseworkers. In May 2008 DoCS released a draft Caseworker Policy Manual: child protection and out-of-home care which includes all policies, standards, guidelines and links to procedures and resources. This is located on the new Casework Practice site. Briefings on how to use the manual are being provided to staff in Practice Solutions sessions.
- 3.147 It appears that this has made a substantial improvement.
- 3.148 In relation to bullying and harassment the PSA did not provide any specific examples to the Inquiry, nor did the submissions received suggest it to have been a systemic problem for DoCS in recent years. The difficulty with such claims rests on the perceptions of managers and caseworkers which may well differ when competing opinions are expressed or errors are corrected. DoCS does have a policy on bullying and harassment that appears to be adequate and avenues for complaint and independent investigation of bullying claims are available. It has co-signed the Dignity and Respect in the Workplace Charter with the PSA.
- 3.149 DoCS caseworker salaries appear competitive with most other states and it is noted that caseloads appear to conform to standards. The Inquiry agrees that the financial delegations appear low and recommends that DoCS review them. The question of additional resources will be addressed in Chapter 10.

Helpline

- 3.150 Particular issues were also raised by the PSA with regard to the Helpline concerning the following:
- a. high staff vacancies, insufficient staff, too many temporary positions and inflexible working conditions
 - b. the lack of an up to date resources manual or reference document containing information for contacting services (for the purpose of referrals)
 - c. changes to legislation or policy not being communicated to Helpline caseworkers
 - d. the management emphasis on the quantity of calls taken which impacts on the ability of caseworkers to write quality reports and carry out proper

checks. The statistics regarding the calls taken do not take into account the type of call (that is, how complex it was, how distressed the caller was)

- e. service standards have not been revised for many years
- f. Helpline staff are not offered the same level of training as staff in other parts of DoCS. Helpline staff are not given enough career development opportunities
- g. significant numbers of Helpline staff have workers compensation claims.

3.151 The Inquiry understands from DoCS that the Helpline:

- a. is staffed over its establishment
- b. has a relatively high number of temporary staff and a recent offer of permanent employment was made but not taken up by many
- c. staff use the internet to source information about services
- d. has revised service standards as recently as 2007
- e. has the highest number of workers compensation claims, however, its average claim cost is just over half that of the Department's average claim costs.

3.152 The Inquiry also notes that staffing at the Helpline has increased by 60.9 per cent between 2001/02 (184 positions) and 2006/07 (296 positions).⁹² However, as will be seen in a subsequent chapter, the number of reports has also increased.

3.153 The PSA asserted that the current vacancy rate at the Helpline was 40 out of a potential of 140 staff (or approximately 30 per cent). It was suggested that one reason for the level of vacancies at the Helpline was the decision by the Department to recruit permanent staff to Helpline positions.

3.154 According to the staff establishment as at 30 April 2008 there were 317 positions at the Helpline. Twenty-six per cent (82) of these positions were temporary full time positions. The Inquiry also notes that there were recruitment advertisements for various permanent and temporary positions for Helpline Caseworkers in mid August 2008.

3.155 As noted earlier in this chapter vacancy rates are not at the level suggested by the PSA. The Inquiry, however, recognises that further strategies are required to address the high level of workers compensation claims at the Helpline.

3.156 Strategies also need to be developed and implemented to address the professional development of staff at the Helpline to ensure consistent quality practice. Up to date resources are essential for Helpline staff to perform an enhanced triage and referral role as discussed in Chapter 10. Further, as

⁹² Figures are for end of year non casual only and include permanent and temporary employees, executive staff and cadets. Figures are rounded.

indicated in Chapter 9, more by way of written guidelines is necessary to assist Helpline workers.

Recruitment process

- 3.157 The number of applications for caseworker positions has increased substantially over the last two years. However, while just over one fifth of the total number of applications in 2006/07 resulted in a permanent appointment, in the first three quarters of 2007/08 only ten per cent were appointed.
- 3.158 In 2006/07, almost 50 per cent of applications were culled prior to reaching the Assessment Centre stage. Of the applicants who attended the Assessment Centre, 58 per cent were recommended for appointment. In the first three quarters of 2007/08, 67 per cent of applications were culled prior to reaching the Assessment Centre stage. Of the applicants who attended the Assessment Centre, 53 per cent were recommended for appointment.
- 3.159 These figures raise questions about the effectiveness of the culling process.
- 3.160 Also of significance is the situation of the 284 candidates who applied for positions in the period 1 July 2007 to 31 March 2008 and who were invited to but had not attended an Assessment Centre by 24 June 2008. It may be the case that a proportion of these candidates were scheduled to attend an Assessment Centre after 24 June 2008. However, it would appear that a number of applicants who progressed to the Assessment Centre stage subsequently dropped out of the recruitment process, possibly as the result of securing employment elsewhere.
- 3.161 In 2007/08, 644 of the 914 recommended candidates (about 70 per cent) accepted an offer of permanent appointment. In 2006/07 about 75 per cent of recommended candidates accepted permanent employment. This low take up of positions may relate to the shrinking pool of available positions in more popular locations as the recruitment process nears completion or may be related to the time taken to make the offer.
- 3.162 The Inquiry has been advised that there can be lengthy delays in the time DoCS takes to recruit new staff. New DoCS casework staff have reported recruitment times from the point of lodging an application to taking up a position of between four and nine months. One rural CSC reported that an application from a temporary caseworker had been lodged 12 months earlier and the officer had only recently been informed of a date for attending the Assessment Centre.
- 3.163 The PSA has contended that the recruitment process is too slow and raised concerns that the length of time taken by the Commission for Children and Young People (CCYP) to complete the Working with Children Checks delays the recruitment process.
- 3.164 DoCS advised that as part of screening process, CCYP also conducts a broader National Criminal Record Check for DoCS, in parallel with the Working

with Children Check, and it is often the broader check that can delay a result being returned to CCYP.

- 3.165 The Inquiry sought information on actions that need to be completed after a candidate attends the Assessment Centre and prior to the application being finalised. DoCS advised that between January and March 2008 it took, on average, 36 days from the time a candidate attended an Assessment Centre to the time they were notified that they have been placed on an eligibility list.
- 3.166 It may be that the information provided to the Inquiry was of events in the past and that improvements have since been made. However, the Inquiry suggests that DoCS and Businesslink consider reviewing its processes in an effort to reduce delays and increase the quality of applicants selected to attend an Assessment Centre.

Caseworker qualifications

- 3.167 The PSA is of the view that TAFE qualified caseworkers with relevant life experience should be eligible for employment. DoCS has contended that the recruitment statistics do not support the criticism that new degree qualified caseworkers recruited are lacking in life experience. In the period 1 July 2007 to 31 March 2008, the median age of applicants who commenced as permanent caseworkers was 31, and their average age was 34.2.
- 3.168 DoCS advised of consistent feedback from Operations Managers that the average calibre and 'fit' of the new caseworkers is significantly better than was the case prior to the introduction of the degree qualifications requirement and the Assessment Centre methodology. DoCS further advised that the increased number of applications and appointments made in recent years has proven that the degree qualification has not been a significant barrier for the recruitment of generalist caseworkers. It has also pointed out that its requirements have resulted in DoCS and the NGO sector targeting different recruitment pools. This could have the benefit of reducing the potential competition for staff, a matter of some importance if the NGO participation is to increase.
- 3.169 The views of the PSA regarding caseworker qualifications and experience are however shared by Family Services Illawarra, CareSouth and Anglicare Canberra and Goulburn.
- 3.170 The Inquiry is satisfied that the qualifications sought by DoCS are necessary to ensure quality work by CSCs. The Inquiry, however, is concerned that similar qualifications are not mandatory for Managers Casework who have delegated decision making responsibilities in relation to casework. It appears that a number of caseworkers, who lacked degree qualifications at the time of their original appointment, when that was not a requirement, were promoted on an acting or permanent basis during the period of reform when many new caseworkers and managers were appointed. In the future, it is critical that appointments to Manager Caseworker positions have a recognised tertiary

qualification as well as significant field experience. Supervision is particularly important when Managers Caseworker are newly appointed.

- 3.171 The Inquiry recommends that from 1 July 2009 newly recruited Managers Casework be required to hold a relevant tertiary qualification.

Aboriginal staff

- 3.172 Premier and Cabinet noted that:

The Aboriginal workforce is of particular concern to the NSW child protection system. Its capacity to work successfully with Aboriginal children and families is undermined by a shortage of caseworkers.....One pathway to addressing the Aboriginal workforce issues is to build on strengths of the Aboriginal community and its organisations.⁹³

- 3.173 Premier and Cabinet suggested the use of flexible team based approaches, similar to those employed in primary health care in Aboriginal health services, that would allow for the employment of senior members of the Aboriginal community who are already active in looking after children, in a team of child welfare and development professionals:

In such a model professional staff play not only a casework role but also a leadership, standard and protocol setting role as well as providing guidance and mentoring to team members with less formal training. It may be possible to base such services within the more robust Aboriginal health services.⁹⁴

- 3.174 Premier and Cabinet supported a focus on frontline child protection workers in Aboriginal communities and recommended increased recruitment and accelerated training of Aboriginal workers, or non-Aboriginal workers with appropriate cultural awareness training, the development of co-located family centres serving Aboriginal communities and collaboration with the Commonwealth through the COAG Working Group.

- 3.175 The PSA suggested the appointment of an Aboriginal Casework Specialist at Helpline, the on-call availability of an Aboriginal Casework Specialist, the inclusion of at least one Aboriginal caseworker in each team and additional peer support for Aboriginal casework staff.

- 3.176 Aboriginal staff in DoCS reported being called upon to assist with a range of issues concerning Aboriginal families because they were Aboriginal:

I guess contributing to the burn-out rate of Aboriginal staff would be a big factor that, not only are you doing your job, you

⁹³ Submission: Department of Premier and Cabinet, p.42.

⁹⁴ *ibid.*

*are also screening clients at the front counter because you are Aboriginal.*⁹⁵

- 3.177 Some Aboriginal caseworkers reported being harassed and bullied by members of the community and suggested that this can result in a difficulty in recruiting to positions. Staff reported that members of the Aboriginal community approach them after hours and turn up at their houses:

*As recently as this week, we approached a caseworker in Narrabri to have an AVO taken out against a client who made a number of threats. So those things happen on a fairly regular basis when you have been around for a while.*⁹⁶

- 3.178 The Ministerial Advisory Panel on Aboriginal Child Sexual Assault advised the Inquiry that sole workers in communities are not sustainable and that Aboriginal staff can be isolated and very vulnerable in small communities.

- 3.179 Link-Up noted that Aboriginal staff need to be:

*supported to make decisions regarding Aboriginal children, rather than being called on in an ad hoc way that devalues their potential contribution whilst still holding them answerable to the communities in which they live.....Crucial decisions are often still left in the hands of non-Aboriginal workers and managers.*⁹⁷

- 3.180 Aboriginal Child, Family and Community Care State Secretariat (AbSec) reported that while it is still preferable to have Aboriginal caseworkers working with Aboriginal families, there is a belief that sometimes managers use Aboriginal caseworkers as a tool to make their life easier, making them deliver the bad news without having decision making power.

- 3.181 Some submissions identified the shortage of Aboriginal caseworkers, and the lack of respect or of cultural awareness of some DoCS staff when dealing with Aboriginal staff members and clients. The Department of Aboriginal Affairs (Aboriginal Affairs) suggested that better support for Aboriginal workers, increased flexibility in work practices and that traineeships needs to be considered.

- 3.182 The Inquiry supports the current work occurring within DoCS to recruit and support Aboriginal staff and to provide for their career development. Provided they are given the training and mentoring noted above there is good reason to dispense with a degree qualification for this group. The lack of a degree is more than made up for by their knowledge of Aboriginal culture, notions of family and kinship and capacity to access relevant communities. The issue of employing Aboriginal workers in rural and remote NSW is faced by all human

⁹⁵ Transcript: Inquiry meeting with DoCS staff, Northern Region, p.43

⁹⁶ Transcript: Inquiry meeting with DoCS staff, Western Region, p.26.

⁹⁷ Submission: Link-Up, pp.7-8.

services and justice agencies. The Inquiry is of the view that Premier and Cabinet should explore methods of employing Aboriginal workers to provide services for more than one government agency in these areas. This issue is addressed further below.

- 3.183 A strategy used in Western Australia to provide additional workforce support is the type of approach used by Yorganup, an Aboriginal and Islander Child Care Agency in WA that recently developed a nationally accredited Certificate III in Child Care with an additional Aboriginal component. It is delivered over one to two years in community venues and at a pace set by individual students.
- 3.184 The course has enrolled a wide range of young persons and adults from across the community (high school students to grandmothers) allowing them to have financial support while training. The course was designed not only as a workforce development strategy, but also as a child abuse prevention one. Participants that may have been reluctant to attend a parenting education course have gained similar skills through a workforce development course. This in turn has had an impact on their own skills in looking after children, but also on their extended families.

Building workforce capacity

- 3.185 The Inquiry notes that government agencies are competing with the non-government sector for the employment of graduates, and that although there may be a salary and promotion differential in favour of employment by government agencies, very often work within the non-government sector may be perceived as either less demanding or more satisfying.
- 3.186 The need for a sector wide workforce strategy was also recognised by a number of government and non-government submissions to the Inquiry. There were a number of recommendations that a workforce development strategy be developed through the Human Services and Justice CEOs Cluster and the NGO sector to plan for government and non-government workforce requirements over the long term.
- 3.187 It was suggested, and the Inquiry agrees that, NSW should seek to place the development of a workforce strategy for human services workers on the COAG agenda. Such a strategy should address financial and other barriers to tertiary study, remuneration, training and development, Aboriginal staffing levels and the possibility of a government subsidy for post-qualifying university child protection courses. It could build on work already undertaken by the Community and Disability Services Ministers' Conference in this area.
- 3.188 Premier and Cabinet also suggested that:

Workforce reform to support a more balanced approach to child protection requires more effective integration of different professional silos. In parallel with the development of one-stop-shop, coordinated and other integrated models it will be

*necessary in the midterm to engage the professions across child health, care, welfare and education in discussion about areas of skills development and knowledge acquisition each will need to facilitate these initiatives.*⁹⁸

- 3.189 Premier and Cabinet suggested that this responsibility could be allocated to Human Services and Justice CEOs Cluster within the NSW Government.

Expansion of casework support staff

- 3.190 There were numerous suggestions regarding delegating more administrative tasks to free up caseworkers, increasing the number of clerical positions or creating a 'casework assistant' position.
- 3.191 Ballina CSC reported having engaged staff to transport children to various appointments and contact visits. This, the Inquiry was told, worked well and freed up caseworkers. Ballina CSC also reported trialling a Senior Customer Service Officer role to take over all the financial payments through KiDS, and to support foster carers. As payments are being made on time, better working relationships are built and any questions can be answered.
- 3.192 The Inquiry agrees that the following tasks, currently performed by caseworkers could be carried out by a less senior position, or outsourced:
- a. financial payments
 - b. s.248 requests
 - c. transporting children
 - d. supervising and arranging contact in less contentious circumstances
 - e. formal or less complex correspondence
 - f. entering data into KiDS of a casework nature, such as the minutes of meetings prepared by a caseworker.
- 3.193 The preparation and entry of case notes and the like should however remain with caseworkers to ensure their accuracy.
- 3.194 The recommendation made by Premier and Cabinet's review of DoCS' business processes that there be reforms to streamline select caseworker activities such as simplifying the financial payment and approval processes, is also supported.

Professional development

- 3.195 The importance of committing to the continuous professional development and high quality clinical supervision of DoCS staff was raised in a number of submissions to the Inquiry.

⁹⁸ Submission: Department of Premier and Cabinet, p.43.

- 3.196 Some observed that it tends towards being administrative supervision rather than focusing on the quality of case management:

When workload pressures impinge - supervision is the first casualty. The result is technical compliance without any quality input.⁹⁹

- 3.197 Due to the crisis driven environment of DoCS work, supervision was often observed to be unavailable or cancelled.

- 3.198 The capacity of DoCS to deliver high quality casework services was seen to be limited by the high proportion of 'novices' in key services and roles, and the failure of DoCS to adequately support these staff.

- 3.199 Research by Howarth was cited by Centacare Broken Bay to identify risks posed by inexperienced staff who have not had time or support to develop practice experience:

Without appropriate supervision and support it is likely newly qualified staff will focus on gathering information and completing the assessment forms – the security blankets of procedurally driven practice.¹⁰⁰

- 3.200 A number of submissions were critical of the lack of expertise of staff in particular areas, for instance domestic violence, sexual assault, cultural difference, mental health issues, and disability issues.

- 3.201 The Inquiry was told by some current and former DoCS staff that the PPR process is a theoretical and pointless exercise, because in practice, there is very little supervision¹⁰¹ and too many changes to procedures and systems which are introduced without training or exposure to the new system.

- 3.202 Following a child death in one CSC, the DoCS review identified a number of practice issues relating to assessment and intervention. DoCS initiated an audit in this CSC and a neighbouring CSC to examine the appropriateness of decision making and the adequacy of risk assessment to determine if there were any systemic patterns in the poor practice identified in the child death review. The review sampled 20 cases and concluded:

Many of the cases failed to show evidence of regular consultation between a Manager Casework (MCW) and a Caseworker. There was a minority of cases where case reviews were on file and showed evidence of the Caseworker and MCW both being present. There were no cases where this

⁹⁹ Submission: Anscombe, p.9.

¹⁰⁰ J Howarth, "Maintaining a Focus on the Child?" *Child Abuse Review* (11), 2002, p.205 cited in Submission: Centacare Broken Bay, pp.22-23.

¹⁰¹ Author stated he/she has had three supervision sessions in 10 years. Submission: Anonymous DoCS worker.

evidence was present in a regular manner over the life of the case.¹⁰²

- 3.203 One of the cases audited by the Inquiry illustrated the importance of supervision in ensuring proper decision making.

Case Study 1

There were four Judgements and Decisions for A on file all submitted for approval on the same day (17 November 2004) and approved by the manager on the same day (18 November 2004). Two Judgements and Decisions recorded that A had been assessed as safe in her current circumstances and two recorded that she had been assessed as not safe in her current circumstances.

DoCS advised that changes to processes have been made since 2004.

- 3.204 A Manager Client Services told the Inquiry that:

The caseworkers come to us. They then get sent to the caseworker training. That takes seven or eight weeks spread over a few months. They are in and out of the office. They are out of the office one out of three. You can't run a child protection system where you have that level of absenteeism. They need to come to us trained. They need to do their block training, have work experience placements, and once they start at CSC they've had that level of training when they hit the ground...We then to have an on-the-ground mentoring program when they hit the CSC.¹⁰³

- 3.205 This comment illustrates the inherent tension between high workload and the need to develop and support new caseworkers.

- 3.206 A Manager Casework informed the Inquiry that:

[Caseworkers reported that] the level of training is less than what they get at University and as such a waste of time for most of them. However, the RPLs [Recognition of Prior Learning] are so difficult to get that the caseworkers attend just to "get it over with." This is a waste of resources and adds nothing to our caseworkers abilities.

There is no interaction between CDC and the CSC. I recently had a staff member who I had to put on performance management whilst she was at CDC because she was seen a

¹⁰² DoCS, *Review of Casework Practice at two CSCs*, May 2007, p.3.

¹⁰³ Transcript: Meeting with Manager, Client Services from a metropolitan CSC.

number of times to abuse parents, not put information in files and to lie to myself and other Managers Casework. However, when I attempted to gain information from CDC staff they would not talk with me and when they finally did they told me that her "performance was satisfactory." It seemed incomprehensible that this person could "Pass" the assessments at CDC and then act as she did in the CSC.¹⁰⁴

- 3.207 Inevitably, the employment of hundreds of new caseworkers, a lengthy training schedule and the requirement for a tertiary qualification, will result in a disproportionate number of inexperienced staff, who cannot manage a full caseload. DoCS has put in place a number of strategies to manage this occurrence as well as to improve supervision, none of which have yet been operational for sufficient time to deliver observable results. However, the criticisms of the situation between CDC and CSCs warrant the attention of management. The Inquiry understands that the CDC is being overhauled, with a new CDC to be launched during 2009.
- 3.208 A significant issue for DoCS is in embedding a culture that embraces quality supervision and reflective practice. Further work needs to be done to assist Managers Casework and Managers Client Services to better balance the tensions between a high number of child protection reports and quality casework practice. Chapter 9 suggests changes which should be made in the area of professional development and training. The Inquiry supports the recommendations made in the Professional Development Project referred to earlier.
- 3.209 Positively, DoCS should be acknowledged for the following significant achievements:
- a. increased training
 - b. its comprehensive recruitment strategies and models
 - c. its strategies to recruit and retain Aboriginal staff.

Recommendations

Recommendation 3.1

From 1 July 2009 all appointed Managers Casework should be required to possess a relevant tertiary qualification, in addition to experience in child protection work.

¹⁰⁴ Submission: Manager Casework, Western Region.

Recommendation 3.2

A review should be undertaken to identify tasks that could be appropriately delegated by caseworkers.

Recommendation 3.3

A review of financial delegations should be undertaken.

Part 2 Early intervention and child protection

4 Key child protection research

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Introduction

- 4.1 A broad review of literature and research on key trends, evidence and issues in child protection was undertaken to inform the Inquiry. The Inquiry drew on, *inter alia*, the various literature reviews and Research to Practice Notes commissioned or authored by DoCS, material available through the National Child Protection Clearinghouse, AIFS and some research that was made available through submissions to the Inquiry.
- 4.2 Key findings from data made available by DoCS indicates that for the period April 2007 to March 2008 the most common primary reported issue to DoCS was domestic violence followed, in descending order, by neglect, physical abuse, carer drug and alcohol, psychological abuse, carer mental health, sexual abuse and child/young person risk taking behaviour. Most reports concern more than one reported issue.
- 4.3 Detailed analysis of these data will be presented in the following chapter, however, for the purposes of this chapter the Inquiry reviewed research and literature in order to understand what is known about the categories of risk of harm, associated factors and the efficacy of interventions.
- 4.4 The Inquiry found generally that literature reviews and research often conclude that knowledge in the area is significantly limited due to methodological flaws, small sample sizes, over reliance on qualitative studies, poor applicability and the inability to make meaningful comparisons across jurisdictions. More research is required and more evaluations need to be done. As such, research findings are often equivocal. In a policy and practice context it is therefore often difficult to isolate 'what works.'
- 4.5 Research indicates that determining the underlying causes of child abuse and neglect is a complex and multifactorial issue. While a large number of factors associated with child abuse and neglect are discussed in the research there is general agreement that key risk factors are:
- a. child risk factors including younger age, disability, chronic or serious illness and behavioural problems
 - b. parental/family risk factors including mental health, domestic violence, substance abuse, poor parent-child interaction, single parent status and low parental education levels
 - c. social or environmental risk factors including low socio-economic status, stressful life events, lack of access to medical care and adequate child care, parental unemployment, isolation, lack of support, homelessness and dangerous or violent neighbourhoods.¹⁰⁵

¹⁰⁵ J Goldman, MK Salus, D Wolcott and KY Kennedy, "A coordinated response to child abuse and neglect: The foundation for practice," *US Department of Health and Human Services*, 2003 cited in DoCS, *Child protection reports in context*, February 2007.

- 4.6 Researchers currently categorise five different types of child maltreatment: sexual abuse, physical abuse, psychological maltreatment (including emotional abuse and psychological neglect), physical neglect and witnessing family violence.¹⁰⁶ However there is:

*a growing body of evidence that maltreatment sub-types do not occur independently and that a significant proportion of maltreated individuals experience not just repeated episodes of one type of maltreatment, but are likely to be the victim of other forms of abuse or neglect.*¹⁰⁷

- 4.7 It has been estimated that over 90 per cent of abused children experience more than one type of abuse.¹⁰⁸ Bromfield and Higgins suggest that an event oriented approach to child maltreatment can result in practitioners failing to observe, or failing to respond to, a pattern of maltreatment.¹⁰⁹

*The problem with the current conceptualisation of four or five discrete categories is that the overlap between maltreatment is not well understood, and researchers or clinicians may unjustifiably blame the range and severity of negative outcomes on a single form of abuse, especially if other forms of abuse or neglect are not assessed. This is particularly likely when some chronic forms of maltreatment (such as neglect) are harder to define and measure than single episodes of a clearly defined act of physical or sexual abuse.*¹¹⁰

- 4.8 Higgins argues that the distinctions between categories are blurred and that whilst it may be convenient to speak of different types of maltreatment, it may be more meaningful to talk about the degree of negative parental or adult behaviour that is reported (that is, high, medium or low frequency and/or severity of maltreatment) rather than focusing solely on the type of maltreatment.¹¹¹ Higgins further argues that it is the frequency and severity of abusive and neglectful behaviours experienced by children, rather than the particular type of abuse or neglect, that is important in predicting outcomes:

The failure within practice to take into account the effects on children of chronic maltreatment may in part be a consequence of the framing of legislation that has forced courts and statutory child protection services to focus on assessing whether an adult

¹⁰⁶ J Stanley, "'Downtime' for Children in the Internet," *Family Matters, Australian Institute of Family Studies*, No. 65, Winter, 2003, pp.22-27. Stanley argues that given the high and increasing use of the internet by children, we must also recognise the potential of the internet as a new form of child abuse through exposure to inappropriate material, sexual exploitation and use of children in pornography.

¹⁰⁷ D Higgins, "Differentiating between Child Maltreatment experiences," *Family Matters, Australian Institute of Family Studies*, No. 69, Spring/Summer, 2004, p.51.

¹⁰⁸ F Stanley, S Richardson and M Prior, *Children of the Lucky Country?* Macmillan, 2005, p.56.

¹⁰⁹ L Bromfield and D Higgins, "Chronic and isolated maltreatment in a child protection sample," *Family Matters, Australian Institute of Family Studies*, No. 70, Autumn, 2005, p.44.

¹¹⁰ D Higgins, 2004, op. cit., p.51.

¹¹¹ *ibid.*, p.53.

*has acted in an abusive or neglectful manner and the likely impact on the child given their age. The problem with this approach is that it tends to shape our thinking about maltreatment into a rather simplistic 'cause and effect' model....When abusive or negative behaviour occurs in isolation it may not be high risk; if it is repeated over a prolonged period of time the cumulative impact can be detrimental.*¹¹²

- 4.9 The Inquiry has identified a need for DoCS caseworkers to assess more holistically the needs of children, young persons and their families. This matter is addressed in Chapter 9.
- 4.10 The economic costs of child abuse are significant. According to the Productivity Commission's *Report on Government Services 2008*,¹¹³ in 2006/07 approximately \$1.7 billion was spent across Australia on child protection and supported placement services. Further, over the period 2002/03 to 2006/07, real recurrent expenditure on child protection and OOHC services increased in all jurisdictions.¹¹⁴
- 4.11 The personal costs of child abuse are also pronounced. Child maltreatment is associated with a variety of short and long term negative outcomes, including mental illness, drug and alcohol abuse, physical ailments and criminality.¹¹⁵
- 4.12 Before turning to the research on each of the categories of risk of harm as they are reported to DoCS, this chapter will present a summary of key research on risk, protection and resilience, and parenting capacity as two fundamental constructs that inform child protection practice.

Risk, protection and resilience in children and families

- 4.13 An understanding of risk, protection and resilience factors has critical implications for child protection assessment and practice. A risk factor is usually defined as a factor that increases the likelihood of a future negative outcome for a child. A protective factor is a variable that decreases such a probability, and can mediate against the effects of risk factors.¹¹⁶

¹¹² L Bromfield and D Higgins, 2005, op. cit.

¹¹³ Productivity Commission, *Report on Government Services 2008*.

¹¹⁴ P Holzer, "Child Protection in Australia. Children see. Children do. Make your influence positive," September 2008, www.aifs.gov.au.

¹¹⁵ *ibid*.

¹¹⁶ JA Durlak, "Common risk and protective factors in successful prevention programs," *American Journal of Orthopsychiatry*, 68(4), 1998, pp.512-520 cited in DoCS, *Risk, protection and resilience in children and families, Research to Practice Note*, November 2007.

- 4.14 The concept of resilience provides a framework for understanding the varied ways in which some children do well in the face of adversity. Encouraging positive environments within families, schools and communities to counteract risks in children's lives can enhance resilience. Of these three environments the family is the most immediate care giving environment and has the greatest impact on the development of resilience in children although there is some evidence that strengthening protection within communities can provide a buffer for risk experienced by some children within the family environment.
- 4.15 Edwards found that children living in the most disadvantaged neighbourhoods have lower social/emotional and learning outcomes than children living in more affluent neighbourhoods even when family income, parental employment status, mother's education and several other child and family variables were controlled for analyses.¹¹⁷ This is consistent with findings from other studies that suggest neighbourhood socio-economic disadvantage is associated with poorer outcomes for children.¹¹⁸
- 4.16 It is important to recognise the limitations of research in this area. Risk and protective factors are often only correlated with certain outcomes; they are not causally related to these outcomes. It may be that another variable better explains the relationship between the risk/protective factor and the outcome. An example is the correlation between low socio-economic status and physical abuse. Since socio-economic status is also associated with other risks such as parental stress and poor parenting, it may be that these other factors are more directly related to physical abuse than socio-economic status itself.
- 4.17 It is generally recognised that child abuse and neglect are in many cases manifestations of social disadvantage and social exclusion. A cross sectional study undertaken by DoCS in 2007 examined the relationship of child protection reports with the ABS Index of Relative Socio-economic Disadvantage, and associations between child protection reports and other key socio-demographic data series. This study found a strong association between lower levels of disadvantage (high index values) and low report rates.¹¹⁹ However the association between higher levels of disadvantage (low index values) and rates of reporting was less clear, although these appear to be associated with higher rates of reporting, with some exceptions.
- 4.18 The study also found strong positive associations between child protection reporting rates and high proportions of one parent families, low income families, Aboriginal families, adults with low educational attainment and urban location.¹²⁰

¹¹⁷ B Edwards, "Does it take a village? An investigation of neighbourhood effects on Australian children's development," *Family Matters, Australian Institute of Family Studies*, No. 72, Summer 2005, p.41.

¹¹⁸ *ibid.*

¹¹⁹ DoCS, *Child Protection reports in context*, February 2007.

¹²⁰ DoCS, *Socio-demographic factors associated with lower than expected rates of child protection reporting in NSW*, May 2008.

- 4.19 Research shows, however, that it is the presence of a number of risk factors, known as ‘cumulative’ risk, rather than the presence of a single risk factor that affects outcomes. Two models of ‘cumulative’ risk have been proposed.
- a. a ‘threshold’ model, which assumes that after a certain number of risk factors, there is a dramatic increase in negative outcomes
 - b. an ‘additive’ model, which proposes that with an increasing number of risk factors there will be a reasonably steady increase in problematic outcomes.¹²¹
- 4.20 Recent research supports the ‘additive’ rather than the ‘threshold’ model of risk.¹²² This finding suggests that while children who experience more risk factors are at increased risk of problems, there does not appear to be a particular threshold beyond which their outcomes become worse. This finding is important as it suggests that a ‘point of no return’ beyond which services for children are hopeless does not exist.¹²³
- 4.21 Bromfield argues that research largely treats child maltreatment as a single event.¹²⁴ Practice also focuses on single incidents/events. Case histories are used to establish a pattern of behaviour to predict future risk and there is not a focus on cumulative impact. Legislation also typically has an incident or event focus.
- 4.22 Cumulative harm may be caused by an accumulation of a single adverse circumstance or event, or by multiple different circumstances and events. The unremitting daily impact of these experiences on the child can be profound and exponential, and diminish a child’s sense of safety, stability and well-being.
- 4.23 From their review of 100 case files for the period between 1994 and 2002, Bromfield, Gillingham and Higgins identified that a systemic barrier to recognising cumulative harm was that each involvement was treated as a discrete event. That is:
- a. information was not accumulated from one report to the next
 - b. information was lost over time
 - c. it was assumed that problems presented in previous involvements were resolved at case closure
 - d. files were not scrutinised for any pattern of cumulative harm.¹²⁵

¹²¹ K Appleyard, B Egeland, M van Dulmen and L Srouge, “When more is not better: The role of cumulative risk in child behaviour outcomes,” *Journal of Child Psychology and Psychiatry*, 46(3), 2005, pp.235-245 cited in DoCS, *Risk, protection and resilience in children and families, Research to Practice Note*, November 2007, p.2.

¹²² *ibid.*

¹²³ *ibid.*

¹²⁴ L Bromfield, “Cumulative Harm. The effects of chronic child maltreatment,” *National Child Protection Clearinghouse, Australian Institute of Family Studies*, 2008.

¹²⁵ L Bromfield, P Gillingham and D Higgins, “Cumulative harm and chronic child maltreatment,” *Developing Practice*, 19, 2007, pp.34-42 cited in *ibid.*

- 4.24 Bromfield argues that it is unlikely that a child welfare agency will receive a report explicitly due to cumulative harm, however, the majority of children who experience maltreatment experience multiple incidents and multiple types of harm. Bromfield argues that practitioners need to be alert to the possibility of cumulative harm in all reports by noting frequency, type of harm, severity, source of harm and duration. Parental and family indicators of cumulative harm indicate that families who experience cumulative harm have:
- a. multiple inter-linked problems (that is, risk factors) such as domestic violence, alcohol and other drug related problems, mental health problems
 - b. an absence of protective factors
 - c. experience of social isolation/exclusion
 - d. enduring parental problems impacting on their capacity to provide adequate care.¹²⁶
- 4.25 Bromfield argues that in these circumstances, if the parent(s) cannot or will not change, or if it will take too long, the practitioner needs to prioritise the needs of the child. The short and long term effects of cumulative harm matter for the child whether there is intent to harm or not.¹²⁷ Cousins also observes that practitioners:
- can overlook the needs of the child and this can lead to years of postponing the inevitable, sometimes resulting in removal after it is almost too late for a successful outcome for the child.*¹²⁸
- 4.26 The importance of cumulative impact from a combination of factors also appears to apply to protective factors just as it does to risk factors. With an increasing number of protective factors, there is likely to be an increase in positive outcomes.¹²⁹
- 4.27 The knowledge on risk and protective factors have further implications:
- a. Services and interventions should focus on evidence based risk and protective factors which are related to child outcomes. For example, when children have experienced abuse and neglect, the protective factors of personal control and a relationship with a caring adult seem particularly important for child outcomes, so interventions may try to enhance these factors.
 - b. The timing and nature of risk and protective factors within a child's developmental pathway is an important consideration when providing

¹²⁶ L Bromfield, 2008, op. cit.

¹²⁷ C Cousins, "When is it serious enough? The protection of children of parents with a mental health problem, tough decisions and avoiding a 'martyred' child," *Australian e-Journal for the Advancement of Mental Health*, 2004, p.7.

¹²⁸ *ibid.*, p.5.

¹²⁹ M Rutter, "Resilience concepts and findings: Implications for family therapy," *Journal of Family Therapy*, 21(2), 1999, pp.119-144 cited in DoCS, *Risk, protection and resilience in children and families, Research to Practice Note*, November 2007, p.2.

services and interventions. For example, as evidence shows that maltreatment early in life increases children's vulnerability to adjustment problems, providing preventive interventions as early as possible in a child's life may be critical.

- 4.28 However, while the research on risk and protective factors is important to guide policy and practice, risk, protection and resilience may vary depending on the individual child and family and their unique situation. What is a risk or a protective factor for one child may not necessarily be so for another.
- 4.29 While there is increasing research on the factors linked with resilient functioning in children who have experienced abuse and neglect, it should be noted that, according to DoCS, research in this area is still in its infancy and there are significant methodological problems with much of the research conducted to date.

Parenting capacity

- 4.30 The assessment of parenting capacity is a core task in child protection practice, both in the context of assessing parents' capacity to protect children from risk and to enhance their developmental experiences, as well as in deciding whether to remove and/or restore children to their care. Parenting capacity assessments are conducted both to assist in identifying areas of parental strength and needs in order to determine service provision for families, and to inform key decisions on restoration and permanency planning. Formal assessments of parenting capacity can have a significant impact on outcomes for children. However, there is some debate as to whether comprehensive parenting capacity assessments are, in fact, possible.¹³⁰
- 4.31 There are few empirical studies on parenting capacity assessment. This is exacerbated by the lack of any clarity surrounding the definition of parenting. This creates difficulty in defining 'good enough' parenting, and establishing which behaviours, and the 'amount' of these behaviours that practitioners should be considering in their assessments.¹³¹
- 4.32 Parenting is predominantly seen as a task about the socialisation and supervision of children, within the context of their family, neighbourhood, the larger social structure and economic, political and cultural environment. Due to the changing needs of the child over time, parenting skills and behaviours will also change. It is unlikely any single assessment tool can capture this complexity. Definitions of parenting do not address the issue of 'minimal'

¹³⁰ W Cann, "A conceptual model for the provision of parenting support," *Paper presented at DoCS Research to Practice Forum*, 25 November 2004 cited in DoCS, *Assessment of Parenting Capacity Literature Review*, December 2005, p.3.

¹³¹ *ibid.*, p.1.

- parenting competence and this contributes to the difficulty of developing parenting capacity assessments.
- 4.33 However, assessment of parenting capacity should determine whether families need short term support and therapeutic intervention to overcome a specific problem or set of circumstances, or crisis intervention and long term support to enable them to cope with an enduring problem.¹³²
- 4.34 The quality of parenting capacity assessment reports is crucial due, *inter alia*, to the impact of these reports on court decision making processes. Studies of these reports have found the quality to be variable.¹³³ Problems identified include evaluations of parents being completed in a single session, lack of home visits, using few sources of information other than the parent, not referring to previous reports, neglecting to describe the parent's care giving qualities or child's relationship with the parent.
- 4.35 In summary, there is consensus in the literature that parenting capacity is problematic both to define and assess. Parenting is determined by a range of factors and relationships and is not seen as fixed, but as undergoing constant change. Parenting capacity is context driven and is dependent on factors such as the socio-economic surroundings of the family, housing, culture and societal values, as well as family skills and relationships.¹³⁴
- 4.36 This chapter will now focus on research related to issues as they are reported to DoCS.

Domestic violence

- 4.37 For each of the three years 2005/06 to 2007/08, domestic violence has been the most commonly primary reported issue to DoCS, accounting for around one quarter of all reports. Up to three issues can be reported in each report to DoCS.¹³⁵ When considering all three reported issues, domestic violence was a feature in just under one third of all reports for each of the three years 2005/06 to 2007/08.¹³⁶
- 4.38 Research on domestic and family violence and child protection and DoCS data is discussed in more detail in Chapter 17.

¹³² L Bromfield and D Higgins, 2005, op. cit, p.45.

¹³³ C Conley, "A Review of Parenting Capacity Assessment Reports," *OACAS Journal*, 47(3), 2003, pp.16-22; KS Budd, LM Poindexter and ED Felix, "Clinical assessment of parents in child protection cases: an empirical analysis," *Law and Human Behaviour*, 25(1), 2001, pp.93-108 cited in DoCS, *Assessment of Parenting Capacity Literature Review*, December 2005, pp.17-19.

¹³⁴ DoCS, *Assessment of Parenting Capacity Literature Review*, December 2005, pp.51-52.

¹³⁵ Primary, secondary and third reported issue.

¹³⁶ DoCS, *Child Protection 2007/08. A Preliminary Analysis*, August 2008.

Neglect

- 4.39 Neglect is the most common form, and also the fastest growing category, of reported maltreatment in Canada, the USA and the UK.¹³⁷ In Australia overall rates of reporting neglect appear to be lower. However, definitional differences make international and interstate comparisons difficult, that is, the broader the definition of neglect the greater the number of children included. In the literature 'child abuse and neglect' are often fused into one entity and most research actually focuses on abuse with the consequence that trends in neglect need to be qualified.
- 4.40 Several definitions of 'neglect' have been proposed. Most commonly they emphasise that a child's basic developmental needs have not been met by acts of omission on the part of those responsible for that child. In contrast, 'abuse' is associated with acts of commission resulting in harm to the child. Greater specificity of definition is hampered by debates about what constitutes basic developmental needs and the level of care considered adequate to meet these needs.
- 4.41 Traditionally, individual psychopathology was seen as the explanation for neglect by parents. Explanations of neglect have recently expanded to include the broader social context within which the child and family are living such as health, housing and socio-economic status.¹³⁸
- 4.42 Young children (infants and toddlers) and those with a disability are most likely to be neglected, suggesting high levels of dependency are associated with neglect. Unlike other forms of child maltreatment, neglect seems to be unrelated to temperament and gender.
- 4.43 From a literature review undertaken by DoCS,¹³⁹ the 'typical' neglecting family is defined as likely to have a young, single mother who has experienced poor parenting herself, lives in an overcrowded chaotic household with several children and is dependent on public assistance for support. She is likely to have inadequate social support, to abuse substances, to be depressed and, if partnered, to suffer domestic violence. She may fail to adequately care for, be psychologically available to, or supervise her children. The victims are likely to be those who are most vulnerable, that is, children under four years and/or children with a disability. The risk factors for neglect are more likely to be characteristics of the parents than specific child characteristics.¹⁴⁰
- 4.44 According to DoCS data, there is a strong correlation between chronic neglect presentations and parental drug and alcohol use, poverty, domestic violence

¹³⁷ DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.8.

¹³⁸ U Bronfenbrenner and SJ Ceci, "Nature-nurture reconceptualization in developmental perspective: A bioecological model," *Psychological Review*, 101, 1994, pp.568-586 cited in DoCS, *Child Neglect Literature Review*, May 2005, p.9.

¹³⁹ DoCS, *Child Neglect Literature Review*, May 2005, p.19.

¹⁴⁰ *ibid.*

and mental health problems. In these cases, the presenting problem for the parent distracts them from providing the necessary care for their child and frequently dominates the case planning and intervention strategies provided by child protection workers.

- 4.45 While each neglectful incident may seem trivial, the long term consequences of chronic neglect may be more damaging than isolated incidents of physical abuse. Children who have been neglected are prone to internalising problems such as low self esteem, depression, social withdrawal, apathy, passivity and helplessness. They are often delayed in their cognitive and language development, have poor communication skills and difficulty with interpersonal relationships.¹⁴¹ In the longer term, neglected children lack the ability to participate fully in society as adults.
- 4.46 Based on international research examined by DoCS, an estimated half of maltreatment fatalities are attributable to childhood neglect. Cases of neglect that lead to a fatal incident are typically complex and chronic in nature. These deaths can be grouped into two general categories. One category comprises those children who died from chronic physical and medical neglect including malnutrition, or other illnesses, but that would have been treatable had the children been presented for medical care. The second group of deaths arise out of a chronically neglectful lifestyle where, usually as a result of overwhelming problems of their own, parents are unable to make safe decisions regarding the care of their children, who died, for instance, as a result of a car accident, drowning or injury.¹⁴²
- 4.47 Childhood maltreatment fatalities are most often the result of a single life threatening incident; that is, supervisory neglect rather than chronic forms of neglect such as malnutrition.¹⁴³ The association of fatalities with a single critical incident makes the prediction and therefore prevention of fatalities extremely difficult, although younger children are more at risk of fatal neglect.¹⁴⁴
- 4.48 The lack of precise definition of neglect, the range of behaviours it covers and the low probability of neglectful parents seeking help, predisposes these children to be further neglected by service providers. It is likely that neglect has reached chronic levels by the time the family is referred to statutory child protection services. Even then, Tanner and Turney suggest that the apparent trivial nature of each incident contrasts sharply with the competing priority of children whose safety is in immediate danger, with the result that the neglect is even more severe and chronic before the threshold of intervention by statutory child protection agencies is reached.¹⁴⁵

¹⁴¹ *ibid.*, p.21.

¹⁴² *ibid.*, p.25.

¹⁴³ *ibid.*

¹⁴⁴ *ibid.*

¹⁴⁵ K Tanner and D Turney, "What do we know about child neglect? A critical review of the literature and its application to social work practice," *Child and Family Social Work*, 8, 2003, pp.25-35 cited in DoCS, *Child Neglect, Literature Review*, May 2005 p.35.

- 4.49 Despite an increase in the incidence of neglect, effective family interventions have been difficult to demonstrate. Daro argues that interventions with child neglect cases were less likely to succeed, when compared with interventions for other forms of child abuse, because underlying severe neglect is indifference to the child and a lack of empathy.¹⁴⁶ The lack of interest in the children makes neglecting families particularly difficult to recruit and engage in programs.¹⁴⁷
- 4.50 Chronic neglect in children is likely to require long term intervention. Tomison and Poole contend that even if families received an initial follow up after a neglect report, there is a lack of appropriate, intensive long term services that can support a neglecting family.¹⁴⁸ The lack of availability of these services is a common theme in the USA, the UK and Australia.¹⁴⁹
- 4.51 In July 2006, DoCS published a child neglect policy to assist staff to better identify neglect and determine when and how to act in the best interests of children, particularly where neglect is chronic. The policy provides a more holistic view regarding secondary assessment and a greater focus on long term outcomes or underlying features of cases involving both neglect and abuse. However, there is still ongoing work required to identify effective evidence based interventions.
- 4.52 Guidelines to assist practitioners dealing with neglectful families stress the importance of treating the families with respect, targeting their strengths, being culturally sensitive, setting clear achievable goals that require only small incremental change, meeting the families' immediate, practical needs and brokerage to cover basic necessities and purchase services.¹⁵⁰ For maximum effectiveness services should be offered long term, that is, for at least two to three years. The threat of legal action should be used only as a last resort. While there are a number of scales which purport to measure the quality of care giving, they rarely have the predictive validity needed to be useful to practitioners.¹⁵¹
- 4.53 Effective interventions are those that support the parent and provide the child with the cognitive stimulation and the emotional warmth that they lack at home. For this reason high quality child care and education, home visiting programs and co-located multi-component services, which target both parent and child,

¹⁴⁶ D Daro, "Child abuse prevention: new directions and challenges," *Nebraska Symposium on Motivation*, 46, 2000, pp.161-220 cited in DoCS, *Child Neglect Literature Review*, May 2005, p.32.

¹⁴⁷ *ibid.*

¹⁴⁸ AM Tomison and L Poole, "Preventing Child Abuse and Neglect. Findings from an Australian Audit of Prevention Programs," *National Child Protection Clearinghouse, Australian Institute of Family Studies*, 2000 cited in DoCS, *Child Neglect Literature Review*, May 2005, p.36.

¹⁴⁹ C Hallett and E Birchall, "Coordination and child protection: A review of the literature," *Edinburgh: HMSO*, 1992; KE Nelson, EJ Saunders and MJ Landsman, "Chronic child neglect in perspective," *Social Work*, 38(6), 1993, pp.661-672; AM Tomison, "Spotlight on child neglect, Issues in Child Abuse Prevention, Issues Paper 4," *National Child Protection Clearinghouse, Australian Institute of Family Studies*, 1995 cited in DoCS, *Child Neglect Literature Review*, May 2005, p.36.

¹⁵⁰ DoCS, *Neglect: Key intervention strategies, Research to Practice Note*, February 2006.

¹⁵¹ DoCS, *Child Neglect Literature Review*, May 2005, p.iv.

may be effective. However, the greater the severity and chronicity of neglect the more directly the intervention needs to target the child.¹⁵²

- 4.54 In summary, the literature acknowledges that neglect remains the most resistant to current interventions, but given the negative impacts of neglect, service providers need to be able to recognise early indicators of neglect. Providing physical care, nourishing food, stimulating programs and emotional nurturing directly to disadvantaged children has been seen to have a more positive impact on child outcomes than if the intervention is aimed at parents.¹⁵³

Physical abuse

- 4.55 Child physical abuse is harm to children or young persons that is caused by the non-accidental actions of a parent or other person responsible for their care. Acts such as beating, shaking, biting, deliberately burning with an object, attempted strangulation and female genital mutilation are examples of physical abuse.¹⁵⁴ There is still much debate concerning whether physical or corporal punishment of children by parents, care-givers or teachers such as smacking should be defined as child abuse.¹⁵⁵ In some instances, excessive discipline can constitute physical abuse and lead to criminal charges.
- 4.56 The impact of physical abuse on children and young persons may result in long term adverse outcomes in terms of intellectual and cognitive functioning,¹⁵⁶ mental health problems¹⁵⁷ and general ill health.¹⁵⁸ A strong link between adverse child experiences, including physical abuse, and later health problems has been found including heart disease, liver disease, cancer and chronic lung disease.¹⁵⁹ In its most extreme form physical abuse of children and young persons may be permanently disabling or result in death.

¹⁵² *ibid.*

¹⁵³ J Marshall and P Watt, "Child behaviour problems. A literature review of the size and nature of the problem and prevention interventions in childhood," *The Interagency Committee on Children's Futures*, 1999, cited in Submission: DoCS, Service models, p.21.

¹⁵⁴ *NSW Interagency Guidelines for Child Protection Intervention*, 2006, p.8.

¹⁵⁵ N Richardson, "What is Child Abuse?" *National Child Protection Clearinghouse, Australian Institute of Family Studies*, Resource Sheet Number 6, December 2004.

¹⁵⁶ CM Perez and CS Widom, "Childhood Victimization and Long-Term Intellectual and Academic Outcomes in Child Abuse and Neglect," *National Criminal Justice Reference Service, Vol. 18, No. 8*, 1994, pp.617-633 cited in Submission: NSW Health, p.9.

¹⁵⁷ KJ Saywitz, AP Mannarino, L Berliner and JA Cohen, "Treatment for sexually abused children and adolescents," *American Psychologist, Vol 55, No. 9*, 2000, pp.1040-1049; DM Ferguson and PE Mullen, "Childhood sexual abuse: an evidence-based perspective," *Developmental Clinical Psychology and Psychiatry series, Vol 40, Sage Publications Inc.*, Thousand Oaks, California, 1999, cited in Submission: NSW Health, p.9.

¹⁵⁸ VJ Felitti, RF Anda, D Nordenber, DF Williamson, AM Spitz, V Edwards, MP Kiss and JS Marks, "Relationship of Childhood Abuse and Household Dysfunction to many of the Leading Causes of Death in Adults – The Adverse Childhood Experiences (ACE) Study," *American Journal of Preventive Medicine, Vol 14, No. 4*, 1998, pp.245-258 cited in Submission: NSW Health, p.9.

¹⁵⁹ *ibid.*

- 4.57 Risk of harm issues involving infants require specific attention. The findings of a Welsh study into severe physical abuse of babies aged less than one year are as follows:
- a. severe physical abuse is six times more common than that for children aged one to four years and 120 times more common than that for five to 13 year olds
 - b. brain injury and fractures are more common than for older children, and are at their most frequent in the first six months
 - c. the non-accidental death rate is ten times higher than that for children aged one to five years.¹⁶⁰
- 4.58 Both mothers and fathers physically abuse children. A British prevalence study found that while mothers were more likely than fathers to be responsible for physical abuse (49 per cent of incidents compared with 40 per cent),¹⁶¹ part of the difference may be explained by the greater time children spent with their mothers than fathers. Violence was also reported to be perpetrated by stepmothers (three per cent) or stepfathers (five per cent), grandparents (three per cent) and other relatives (one per cent).¹⁶²
- 4.59 There is some evidence that children living with both biological parents are more likely to be physically abused by their fathers than by their mothers. For instance, Creighton and Noyes found that when the child was living with both birth parents, mothers were implicated in 36 per cent of cases and fathers in 61 per cent.¹⁶³
- 4.60 Some research suggests that men living with children are most likely to perpetrate severe physical abuse, especially abuse that results in a child's death.¹⁶⁴
- 4.61 Single parents, adolescent parents, and de facto or step parents (particularly males) have been found to be at higher risk of physically abusing children.¹⁶⁵

¹⁶⁰ P Dale, R Green and R Fellows, "What Really Happened: Child Protection Management of infants with serious injuries and Discrepant Parental Explanations," 2002, cited in *NSW Interagency Guidelines for Child Protection*, 2006, p.9.

¹⁶¹ P Cawson, C Wattam, S Brooker and G Kelly, "Child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect," *London: National Society for the Prevention of Cruelty to Children*, 2000 cited in N Richardson and L Bromfield, "Who Abuses Children?" *National Child Protection Clearinghouse, Australian Institute of Family Studies* Resource Sheet Number 7, February 2005, p.2.

¹⁶² N Richardson and L Bromfield, "Who Abuses Children?" *National Child Protection Clearinghouse, Australian Institute of Family Studies*, Resource Sheet Number 7, February 2005, p.2.

¹⁶³ S Creighton and P Noyes, "Child abuse trends in England and Wales 1983-1987," *London: National Society for the Prevention of Cruelty to Children*, 1989 cited in N Richardson and L Bromfield, 2005, op. cit., p.2.

¹⁶⁴ N Richardson and L Bromfield, 2005, op. cit., pp.2-3.

¹⁶⁵ RJ Gelles, "Child abuse and violence in single-parent families: Parent absence and economic deprivation" *American Journal of Orthopsychiatry*, 59, 1989, pp.492-501, cited in N Richardson and L Bromfield, 2005, op. cit., p.3.

- 4.62 The number of single father families is small¹⁶⁶ and very little is known about whether their risk of providing a context for child maltreatment differs from that of other types of families.¹⁶⁷
- 4.63 Low levels of parental empathy have been associated with parental aggression towards one's child.¹⁶⁸ As child abuse is clearly a form of aggression, researchers have looked to existing models of aggression which highlight empathy as an important factor to understand the processes involved in abuse. Research notes that physically abusive parents have deficits in their perceptions, expectations, interpretations and evaluations of their child's behaviour. Furthermore, parents who have high levels of personal distress, as is often the case with parents deemed 'at risk', commonly have information processing difficulties which makes perspective taking more difficult.¹⁶⁹
- 4.64 However, research has also found different results for high risk mothers and fathers. High risk mothers appear to be at an increased risk of using physical aggression due to high levels of personal distress when observing the suffering of their child. This is thought to be just enough distress to incite an aggressive response but not enough to facilitate perspective taking. On the other hand, high risk fathers tend to be physically aggressive because of their inability to engage in perspective taking.¹⁷⁰
- 4.65 In summary, whilst the data on prevalence of physical abuse are available there are less data on effective interventions for those who physically abuse children. It appears, however, that interventions like home visiting and parenting programs have had some success as well as multi-component interventions that focus on reducing a variety of risk factors in several domains; that is, family, schools, teachers, and peer environments. Meta analyses show that programs using multiple interventions work better than those using a single intervention strategy.¹⁷¹

¹⁶⁶ For example, according to Australian Bureau of Statistics data 2004, single father families account for 2.7 per cent of families in Australia, in *ibid*, p.3.

¹⁶⁷ AM Tomison, "Child maltreatment and family structure," discussion paper, 1, *Australian Institute of Family Studies*, 1996. cited in N Richardson and L Bromfield, 2005, *op. cit.*, p.3.

¹⁶⁸ DM Zeifman, "Predicting adult responses to infant distress: Adult characteristics associated with perceptions, emotional reactions, and timing of intervention," *Infant Mental Health Journal*, 24(6), 2003, pp.597-612, cited in DoCS, *Parental Empathy and Child Maltreatment, Research to Practice Note*, August 2006.

¹⁶⁹ A Perez-Albeniz and J de Paul, "Gender differences in empathy in parents at high-and-low-risk of child physical abuse," 2004, *Child Abuse and Neglect*, 28, pp.289-300 cited in DoCS, *Parental Empathy and Child Maltreatment, Research to Practice Note*, August 2006.

¹⁷⁰ DoCS, *Parental Empathy and Child Maltreatment, Research to Practice Note*, August 2006.

¹⁷¹ J Marshall and P Watt, "Child Behaviour Problems: A Literature Review of its Size and Nature and Prevention Interventions," *Perth, W.A., Interagency Commission on Children's Futures*, 1999, cited in DoCS, *Prevention and Early Intervention, Literature Review*, May 2005, p.3.

Carer drug and alcohol misuse

- 4.66 Substance abuse¹⁷² can seriously affect parenting capacity and place children at significant risk.
- 4.67 Parental substance misuse has been associated with high rates of child maltreatment. A number of large scale cohort and case control studies using community samples have suggested that substance abuse is strongly and directly related to child abuse and neglect.¹⁷³ Studies using administrative records have also found an association between parental substance misuse and high rates of child maltreatment.¹⁷⁴
- 4.68 An Australian National Council on Drugs research paper states that while the literature establishes the negative impact of parental substance misuse, there is no specific comparison between substance classes.¹⁷⁵ For example, it is not possible to determine whether parental amphetamine use poses a greater risk to adverse child outcomes compared with the use of a substance such as heroin.
- 4.69 According to the National Drug and Alcohol Research Centre there is limited research that has examined the impact of different types of illicit substances on parenting and children. Dawe et al comment that the direct effects of the substance being used is likely to influence the quality of parenting provided for the child; opioids for example may be more likely to be associated with child neglect while drugs such as amphetamines and cocaine that are associated with serious disturbances of mental state, including sub-clinical symptoms of psychosis and hostility, may be more likely to be associated with physical abuse.¹⁷⁶ For those using amphetamines, the effects of hyperactivity or 'speediness' may lead to actions being undertaken too quickly without regard for risk, or failure to observe hazards.¹⁷⁷ In addition, children who may become the focus of substance induced paranoia or hallucinations may also be at risk of

¹⁷² Terminology in this research area variously refers to substance abuse, misuse or dependence, drug and/or alcohol abuse, misuse or dependence.

¹⁷³ M Chaffin, K Kelleher and J Hollenberg, "Onset of physical abuse and neglect: psychiatric substance abuse and social risk factors from prospective community data," *Child Abuse and Neglect*, 20(3), 1996, pp.191-203; C Walsh, HL MacMillan and E Jamieson, "The relationship between parental substance abuse and child maltreatment: Findings from the Ontario Health Supplement," *Child Abuse and Neglect*, 27, 2003, pp.1409-1425; K Kelleher, M Chaffin, J Hollenberg and E Fisher, "Alcohol and drug disorders among physically abusive and neglectful parents in a community-based sample," *American Journal of Public Health*, 84(10), 1994 pp.1586-1590; K Street, J Harrington, W Chiang, P Cairns and M Ellis, "How great is the risk of abuse in infants born to drug-using mothers?" *Child: Care, Health and Development*, 30(4), 2004 pp.325-330 cited in Submission: National Drug and Alcohol Research Centre, p.9.

¹⁷⁴ S Magura and AB Lauet, "Parental substance abuse and child maltreatment: Review and implications for intervention," *Children and Youth Services Review*, 18(3), 1996 pp.193-220; BD Smith and MF Testa, "The risk of subsequent maltreatment allegations in families with substance-exposed infants," *Child Abuse and Neglect*, 26, 2002, pp.94-114 cited in Submission: National Drug and Alcohol Research Centre, p.9.

¹⁷⁵ Australian National Council on Drugs, "Drug Use in the Family: Impacts and Implications for Children," *Research Paper 13*, 2007, p.viii.

¹⁷⁶ S Dawe, S Frye, D Best, M Lynch, K Atkinson, C Evans and PH Harnett, "Drug Use in the Family: Impacts and Implications for Children," *Australian National Council on Drugs*, Canberra, 2007 cited in Submission: National Drug and Alcohol Research Centre, p.10.

¹⁷⁷ B Kroll and A Taylor, "Parental substance misuse and child welfare," London, UK, *Jessica Kingsley Publishers*, 2003, cited in Submission: National Drug and Alcohol Research Centre, p.10.

harm. Alcohol misuse, by male partners in particular, has the potential not only to impair partner and family relations but to contribute to physical abuse of partners and children.¹⁷⁸ It has been estimated that alcohol is an important factor in 50 per cent of domestic, physical and sexual violence.¹⁷⁹ Even if abuse and neglect are not present, poor parenting practices are likely to have long term impacts on the children.

- 4.70 The research on the impact of parental alcohol misuse on children's development reveals that children can and do suffer from a range of maladaptive outcomes spanning all areas of development, including cognitive, behavioural, psychological, emotional and social development.¹⁸⁰ It is estimated that 13 per cent of Australian children aged 12 years or less are exposed to an adult who is a regular binge drinker. It has been estimated that 31 per cent of parents involved in substantial cases of child abuse or neglect experience significant problems with alcohol use.¹⁸¹
- 4.71 However, children and families living with parental alcohol misuse differ according to the composition of risk factors that contribute to outcomes, and studies show that not all children experience adverse outcomes. One exception is the epidemiological research that supports an association between the excessive consumption of alcohol by pregnant women and the risk of foetal alcohol syndrome and its effects.¹⁸²
- 4.72 The effects of parental alcohol misuse appear to be cumulative. The longer the child has been exposed to parental alcohol misuse, the greater the impact may be. Disruptive behaviours, such as aggression, hyperactivity and mental health problems, are particularly apparent in boys whose parents misuse alcohol. There is no clear evidence that maternal alcohol misuse has a greater or lesser impact on children than paternal alcohol misuse. However, children of mothers who misuse alcohol are more likely to be exposed to a variety of risks and it is the accumulation of risk factors that poses the greatest threat. Children from families containing three or more immediate or extended family members who misuse alcohol are more likely to have adverse outcomes.¹⁸³
- 4.73 NSW research undertaken in 2006 about illicit drug use in pregnancy examined obstetric and perinatal outcomes.¹⁸⁴ The researchers found that births in each of the drug groups were to women who were in many cases younger, had a

¹⁷⁸ DoCS, *Parental Alcohol Misuse and the Impact on Children, Literature Review*, July 2006, p.10.

¹⁷⁹ Australian Government, "Technical Report No 3: Preventing alcohol-related Harm in Australia: A window of opportunity," *National Preventative Health Taskforce*, 2008, p.14.

¹⁸⁰ DoCS, *Parental Alcohol Misuse and the Impact on Children Literature Review*, July, 2006, p.iii.

¹⁸¹ Australian Government, "Technical Report No 3: Preventing alcohol-related Harm in Australia: A window of opportunity," *National Preventative Health Taskforce*, 2008, p.14.

¹⁸² C O'Leary, "Foetal alcohol syndrome: A literature review," Canberra, Australia: *National Expert Advisory Committee on Alcohol*, 2002 cited in DoCS, *Parental Alcohol Misuse and the Impact on Children Literature Review*, July, 2006, p.iii.

¹⁸³ DoCS, *Parental Alcohol Misuse and the Impact on Children Literature Review*, July, 2006, pp.iii-iv.

¹⁸⁴ L Burns, R Mattick and M Cooke, "The use of record linkage to examine illicit drug use in pregnancy" *Addiction* Vol 101(6) June 2006 pp.873-882 cited in DoCS and NSW Health, *Methadone related child deaths issues paper*, April 2008, p.10.

higher number of previous pregnancies, were Aboriginal, smoked heavily and were not privately insured. Drug exposed babies have an increased risk of experiencing a preterm birth, being small for gestational age, having a prolonged hospital stay, being stillborn and suffering neonatal death.¹⁸⁵ Over the longer term these babies are at higher risk of a number of health and behavioural problems, including hyperactivity disorders, and learning and speech difficulties. The NSW research found that more than 50 per cent of children of opioid dependent women were not living with their biological parents by the time of their fifth birthday.¹⁸⁶

- 4.74 While there is evidence of an association between substance misuse and child abuse and neglect (and poor parenting), it does not describe a causal relationship. Most of the research linking substance misuse and child abuse does not take into account the co-occurring factors in substance misusing families, such as demographic or social factors.¹⁸⁷ Studies that have attempted to isolate the influence of substance misuse on parenting have found that it has less of an influence than other contextual factors.¹⁸⁸ It is suggested that:

*the wide range of factors associated with substance abuse may in fact be the primary causal factors in links between substance abuse and child maltreatment. Some argue that it is now well recognised that it is difficult to separate out the effects of parental substance misuse on parenting from the similar detrimental impact of a number of common psychosocial factors, such as financial, mental health, employment, and social isolation problems.*¹⁸⁹

- 4.75 Substance abuse may however act as the “marker for the presence of, as well as compound the effects of, the other risk factors.”¹⁹⁰

¹⁸⁵ R, Kennare, A Heard and A Chan, “Substance Use during Pregnancy: Risk Factors and Obstetric and Perinatal Outcomes in South Australia,” *Australian and New Zealand Journal of Obstetrics and Gynaecology* 45, 2005, pp.220-225 cited in DoCS and NSW Health, *Methadone related child deaths issues paper*, April 2008, p.10.

¹⁸⁶ DoCS and NSW Health, *Methadone related child deaths issues paper*, April 2008, p.10.

¹⁸⁷ S Dawe, S Frye, D Best, M Lynch, K Atkinson, C Evans and PH Harnett, 2007, op. cit.; J Tunnard, “Parental drug use: A review of impact and intervention studies,” *Research in practice*, www.rip.org.uk, 2002 in Submission: National Drug and Alcohol Research Centre, p.9.

¹⁸⁸ SL Hans, “Parenting and parent-child relationships in families affected by substance abuse,” in H E. Fitzgerald, B. Lester and B. Zuckerman (Eds.), *Children of addiction: Research, health and public policy issues*, New York: Routledge Falmer; L Kettinger, P Nair, and M Schuler, “Exposure to environmental risk factors and parenting attitudes among substance abusing women,” *American Journal of Drug and Alcohol Abuse*, 26(1), 2000, pp.1-10; NE Suchman, and SS Luthar, “Maternal addiction, child maladjustment and socio-demographic risks: Implications for parenting behaviors,” *Addiction*, 95 (9), 2000, pp.1417-1428.; P Nair, ME Schuler, MM Black, L Kettinger, and D Harrington, “Cumulative environmental risk in substance abusing women: Early intervention, parenting stress, child abuse potential and child development” *Child Abuse and Neglect*, 27(9), 2003, pp.997-1017 cited in Submission: National Drug and Alcohol Research Centre, p.9.

¹⁸⁹ SL Hans, “Studies of prenatal exposure to drugs: Focusing on parental care of children” *Neurotoxicology and Teratology*, 24(3), 2002, pp.329-337; B Rittner and C Dozier, “Effects of court-ordered substance abuse treatment in child protective services cases,” *Social Work*, 45, 2000, pp.131-140 cited in Submission: National Drug and Alcohol Research Centre, pp.9-10.

¹⁹⁰ Submission: National Drug and Alcohol Research Centre, pp.9-10.

- 4.76 US research has concluded that children of families with substance abuse problems tend to come to the attention of child welfare agencies at a younger age than other children, are more likely to be placed in care, and once in care are likely to remain in care longer.¹⁹¹ Further:

*amongst mothers who become involved with the child welfare system, those who have substance abuse problems are more likely to lose their parental rights, compared with non substance-abusing mothers.*¹⁹²

Substance abuse has been shown to be “a key risk factor for re-reports or recurrence in families with child welfare involvement.”¹⁹³

- 4.77 Anecdotal reports suggest that:

*significant numbers of parents are entering drug treatment services in response to the involvement of the child protection system in NSW. Entering treatment and ceasing drug use may be a condition of retaining parental responsibility for their children. However, the effectiveness of providing 'treatment' alone may be limited, particularly given the complex range of problems with which the majority of substance misusers present. Treatment programs, particularly in rural and remote areas, may not be equipped to deal with mental health, housing, financial, legal as well as parenting issues. Furthermore, substance users may not be able to access treatment that allows them to retain the care of their children although community-based programs are more likely to enable parents to continue caring for their children, very few residential rehabilitation programs cater for mothers and children.*¹⁹⁴

- 4.78 Some research has found that entering the drug treatment system may not increase the likelihood that substance using parents already involved with the child protection system will retain care of their children. Barth, Gibbons and Guo found that families that enter substance abuse treatment have higher re-

¹⁹¹ J Semidei, LF Radel, and C Nolan, “Substance abuse and child welfare: Clear linkages and promising responses,” *Child Welfare*, 80 (2), 2001, pp.109-28 cited in Submission: National Drug and Alcohol Research Centre, p.11.

¹⁹² MO Marcenko, SP Kemp and NC Larson, “Childhood experiences of abuse, later substance use, and parenting outcomes among low-income mothers,” *American Journal of Orthopsychiatry*, 70, 2000 pp.316-326; CE Grella, Y-I Hser, and Y-C Huang, “Mothers in substance abuse treatment: Differences in characteristics based on involvement with child welfare services,” *Child Abuse and Neglect* 30, 2006, pp.55-73 cited in Submission: National Drug and Alcohol Research Centre, p.11.

¹⁹³ I Wolock, and S Magura, “Parental substance abuse as a predictor of child maltreatment re-reports,” *Child Abuse and Neglect*, 20 (12), 1996, pp.1183-1193; JM Murphy, M Jellinek, D Quinn, G Smith, FG Poitras, and M Goshko, “Substance abuse and serious child mistreatment: Prevalence, risk, and outcome in a court sample,” *Child Abuse and Neglect*, 15(3), 1991, pp.197-211 cited in Submission: National Drug and Alcohol Research Centre, p.11.

¹⁹⁴ W Swift, J Copeland, and W Hall, “Characteristics and treatment needs of women with alcohol and other drug problems: results from an Australian national survey,” *National Drug Strategy Research Report Series: Report no.7*, 1995 cited in Submission: National Drug and Alcohol Research Centre, p.11.

report rates.¹⁹⁵ Dore and Doris found that completing substance abuse treatment was not a strong predictor of preventing the placement of children in foster care.¹⁹⁶ However, a longitudinal study of 1,911 women who had children placed in substitute care found that when women entered treatment more quickly, spent more time in treatment, or completed at least one treatment episode, their children spent fewer days in foster care and were more likely to be reunified with their parents.¹⁹⁷

- 4.79 Marsh et al note that the “pervasive fear about having their children taken away”¹⁹⁸ prevents many substance abusing parents from accessing treatment services. This lack of engagement with treatment services increases the risk for children and it can be very difficult to assess accurately the level of risk to the child.¹⁹⁹
- 4.80 Relevant strategies to assist families and children include parenting education and support, facilitating quality child care and educational opportunities for children, and working with families to improve social and behavioural skills. Home visiting is one of the most well researched interventions, yet there are mixed results regarding its effectiveness for families where alcohol misuse is an issue. While there is still a shortage of evidence regarding the effectiveness of parenting programs as an intervention for families with alcohol and other drug problems, further trials and evaluations suggest promising results. Providing access to quality child care and education is an effective intervention for assisting children. There have also been some positive evaluations from ‘family focused’ programs, which include interventions for both parents and children.²⁰⁰
- 4.81 Where mental illness is also present, treatment programs need to attend to the management of parental mental health issues and their corresponding impact on the parenting role.²⁰¹ This could be done through improved training opportunities for alcohol and other drug workers, improved liaison with mental health services, the provision of guidelines for drug and alcohol workers for the assessment of child protection issues²⁰² and access to linked websites and resources for workers in the drug and alcohol sector.

¹⁹⁵ RP Barth, C Gibbons, and S Guo, “Substance abuse treatment and the recurrence of maltreatment among caregivers with children living at home: A propensity score analysis,” *Journal of Substance Abuse Treatment*, 30, 2006, pp.93-104, cited in Submission: National Drug and Alcohol Research Centre, p.11.

¹⁹⁶ MM Dore, and JM Doris, “Preventing child placement in substance-abusing families, Research-informed practice,” *Child Welfare*, 77(4), 1998, 407-426, cited in Submission: National Drug and Alcohol Research Centre, p.11.

¹⁹⁷ BL Green, A Rockhill, and C Furrer, “Does substance abuse treatment make a difference for child welfare case outcomes? A statewide longitudinal analysis,” *Children and Youth Services Review*, 29, 2007, pp.460-473, cited in Submission: National Drug and Alcohol Research Centre, p.11.

¹⁹⁸ A Marsh, A Dale, and L Willis, “Evidence Based practice Indicators for Alcohol and Other Drug Interventions: Literature Review,” *Drug and Alcohol Office, Health Department, Western Australia*, September, 2007, p.73.

¹⁹⁹ *ibid.*

²⁰⁰ DoCS, *Parental Alcohol Misuse and the Impact on Children Literature Review*, July, 2006, p.v.

²⁰¹ Australian National Council on Drugs “Drug Use in the Family: Impacts and Implications for Children,” *Research Paper 13*, 2007, p.viii.

²⁰² *ibid.* and p.xi.

4.82 According to the National Drug and Alcohol Research Centre:

*one of the strongest messages from the literature is the need for a coordinated service response in addressing substance misuse problems, particularly when children are involved, to address the broader issues associated with substance use.*²⁰³

Thus, child welfare and alcohol and other drug services need to work in partnership to identify and 'treat' harmful substance use and the co-occurring psychological, physical, and social problems in order to reduce the impacts of substance use on both the parent and the child.

4.83 Participants at the 2007 National Family Alcohol and Drug Network Conference called upon Commonwealth, State and Territory Governments to recognise and respond to the connection between parental drug use and alcohol misuse and child protection as a matter of national urgency given that:

*current research shows that at least one in eight of all Australian children are living in a household where there is parental misuse of, or dependence on, alcohol or other drugs; and that parental substance misuse puts children at direct increased risk of Foetal Alcohol Spectrum Disorder, physical and sexual abuse, neglect and exposure to family violence.*²⁰⁴

4.84 The conference resolution urged governments to:

- a. include data on parental status and parental drug and alcohol use in all universally collected data sets
- b. develop effective strategies to prevent alcohol misuse and alert parents to its impact on children
- c. divert a portion of government revenues from the sale of alcohol to fund holistic programs for treating parents with drug and alcohol dependence and meeting the needs of affected children.²⁰⁵

4.85 In summary, the research suggests that parental substance abuse can affect parenting styles and can have a negative impact on children. While there is an association between substance abuse and child abuse and neglect the relationship is not causal and often other risk factors are present. Access to quality child care and education and coordinated service provision that

²⁰³ A Copello, R Velieman, and L Templeton, "Family interventions in the treatment of alcohol and drug problems," *Drug and Alcohol Review*, 24 (4), 2005, pp.369-385; S Greunert, S Ratnam, and M Tsantefski, "The Nobody's Client Project: Identifying and addressing the needs of children with substance dependent parents: Odyssey Institute of Studies," *Odyssey House Victoria*, 2004; J Tunnard, "Parental drug use: A review of impact and intervention studies," *Research in practice*, www.rip.org.uk, 2002; B Kroll and A Taylor, "Parental substance misuse and child welfare," London, UK, Jessica Kingsley Publishers, 2003; CE Grella, Y-I Hser, and Y-C Huang, "Mothers in substance abuse treatment: Differences in characteristics based on involvement with child welfare services," *Child Abuse and Neglect* 30, 2006, pp.55-73 cited in Submission: National Drug and Alcohol Research Centre, p.12.

²⁰⁴ "Parental Substance Use and Child Protection Resolution," *Family Alcohol and Drug Network Conference*, 2007: www.aifs.gov.au.

²⁰⁵ *ibid.*

addresses the broader issues of substance abuse appear to be the most promising interventions.

Psychological abuse

- 4.86 The core issue of emotional or psychological abuse is that it is a sustained pattern of verbal abuse and harassment by an adult that results in damaging a child's self esteem or social competence, resulting in serious emotional deprivation or trauma.²⁰⁶
- 4.87 A US survey found that biological parents were responsible for 81 per cent of cases of psychological maltreatment, non-biological parents were responsible for 13 per cent, and extra familial perpetrators were responsible for five per cent. Of biological parents, mothers were the perpetrators of emotional abuse in 60 per cent of incidents and fathers were the perpetrators in 55 per cent (these figures exceed 100 per cent as in some instances both mothers and fathers perpetrate emotional abuse).²⁰⁷
- 4.88 It is difficult to determine the true extent of psychological maltreatment and to identify who is responsible for perpetrating psychological maltreatment. The difficulties in researching psychological maltreatment stem from ongoing disagreements over defining and measuring this form of maltreatment.²⁰⁸ For example, there is some debate over whether to make a distinction between psychological abuse (for example, verbal abuse) and psychological neglect (for example, ignoring a child).²⁰⁹
- 4.89 Verbal abuse is, perhaps, the core emotionally abusive behaviour. When used as part of a chronic pattern of interaction, things that may be considered as abusive include verbal putdowns, negative prediction, constant negative comparison, scapegoating, shaming, swearing and threats.²¹⁰
- 4.90 Witnessing domestic violence is often considered a form of emotional or psychological abuse. Psychological harm caused by domestic violence may vary depending on the age of the child, the length of exposure to incidents of domestic violence, the nature of the incidents and the nature of any protective factors available to the child and their family. The Inquiry noted that police reports of incidents of domestic violence sometimes reported the incident as

²⁰⁶ AM Tomison and J Tucci, "Emotional Abuse: The hidden form of maltreatment," *Issues in Child Abuse Prevention*, 8, *National Child Protection Clearinghouse, Australian Institute of Family Studies*, 1997 cited in N Richardson and L Bromfield, 2005, op. cit.

²⁰⁷ AJ Sedlak and DD Broadhurst, "Third national incidence study of child abuse and neglect: Final report," *Washington, DC: US Dept of Health and Human Services*, 1996, in N Richardson and L Bromfield, 2005, op. cit.

²⁰⁸ AM Tomison and J Tucci, 1997, op. cit.; DA Black, AM Slep, and RE Heyman, "Risk factors for child psychological abuse," *Aggression and violent behaviour*, 6, 2001, pp.189-201 cited in N Richardson and L Bromfield, 2005, op. cit.

²⁰⁹ N Richardson and L Bromfield, 2005, op. cit.

²¹⁰ *ibid.*

psychological abuse and/or included psychological abuse as either the primary, secondary or third reported issue.

- 4.91 Psychological/emotional abuse is a difficult term and the Inquiry suspects that it is one that is not interpreted consistently within DoCS, or by mandatory reporters.
- 4.92 While research is limited in this area, it could be inferred that suggested interventions would include early intervention strategies to counteract disadvantage and enhance parental competencies and multi-faceted interventions that reduce risk factors and strengthen protective factors.

Carer mental health

- 4.93 The presence of parental mental illness on its own does not automatically lead to poor outcomes for children, but “it is the interaction of the parental mental illness with other variables that will enhance resilience or confer risk upon children.”²¹¹ For instance, Maybery et al cite research that found that mentally ill parents often experience concurrent difficulties with interpersonal relationships, social isolation and financial stresses. Consequently:

*families affected by parental mental illness are not all the same; parents will experience different types of mental illness, levels of illness severity and chronicity, and their children will thus require different levels and types of support.*²¹²

- 4.94 The diagnosis of a mental illness has been shown to impact on parenting behaviour and capacity.²¹³ Oyserman et al found that mothers with a severe and persistent mental illness have significantly less adequate parenting skills than mothers who do not have a mental illness.²¹⁴ However, Riskey-Curtiss et al found that with appropriate diagnosis, support, treatment and medication, most people with a serious mental illness experience improvement in many areas including parenting behaviours.²¹⁵
- 4.95 Several studies have suggested that the diagnostic status of mothers is not a useful predictor of either their functioning or their children’s functioning, and

²¹¹ J Nicholson, K Biebel, B Kinden, A Henry and L Stier, “Critical issues for parents with mental illness and their families,” *Centre for Mental Health Services; Substance Abuse and Mental Health Services Administration*, 2001 cited in D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, “VicHealth Research Report on Children at Risk in Families affected by Parental Mental Illness,” *Victorian Health Promotion Foundation, Melbourne*, 2005, p.5.

²¹² D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, 2005, op. cit., p.5.

²¹³ *ibid.*, p.6.

²¹⁴ D Oyserman, CT Mowbray, P Allen-Meares and K Firminger, “Parenting among mothers with a serious mental illness,” *American Journal of Orthopsychiatry*, 70, 2000, pp.296-315 cited in D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, 2005, op. cit., p.6.

²¹⁵ C Riskey-Curtiss, LK Stromwall, D Trueet Hunt, and J Teska, “Identifying and reducing barriers to reunification for seriously mentally ill parents involved in child welfare cases,” *Families in Society*, 82(1), 2004, pp.107-119 cited in D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, 2005, op. cit., p.6.

have instead emphasised the impact of severity and/or chronicity of a parent's mental illness on child and parenting outcomes.²¹⁶

- 4.96 Although difficult to separate illness, severity and chronicity it appears that higher levels of parental mental illness puts a child at higher levels of risk compared with a child whose parent's mental illness is not severe and/or chronic:

*Such outcomes are probably an interplay of various issues including parenting, socioeconomic circumstances and social supports. Much less clear is the impact of a parent's illness diagnosis on children.*²¹⁷

- 4.97 Research has indicated that children with a severely mentally ill parent,²¹⁸ particularly those in single parent families,²¹⁹ are at increased risk of later mental health and adjustment problems than other children whose parents might have a mild or moderate mental illness and/or who live in a two parent family.

- 4.98 People with a mental illness are also at very high risk of developing problematic drug or alcohol use. Up to 80 per cent of people with a mental illness have substance misuse problems. Similarly, up to 75 per cent of clients with drug and alcohol problems also experience mental health problems, most commonly anxiety or mood disorders, such as depression.²²⁰

- 4.99 Cousins focuses on the effects of long term emotional abuse and neglect due to parental mental health issues.²²¹ She proposes that it is very difficult for adult mental health workers to balance the needs of the adult client and the needs of their children, when sometimes these conflict. Cousins argues for:

*a change in service culture where the ethical and moral nature of these decisions is discussed and debated, rather than what could be seen to be an emerging culture of fear, based on recent critical incidents and unwanted media attention.*²²²

²¹⁶ D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, 2005, op. cit., p.7.

²¹⁷ *ibid.*, p.8.

²¹⁸ K Frankel and R Harmon, "Depressed mothers: They don't always look as bad as they feel," *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 1996, pp.289-298; J Harnish, K Dodge and E Valente, "Mother-child interaction quality as a partial mediator of the roles of maternal depressive symptomatology and socioeconomic status in the development of child behaviour problems," *Child Development*, 66, 1995, pp.739-753; DM Teti, DM Gelfand, D Messinger and R Isabella, "Maternal depression and the quality of early attachment: An examination of infants, preschoolers and their mothers," *Developmental Psychology*, 31, 1995 pp.364-376; S Nolen-Hoeksema, A Wolfson, D Mumme and K Guskin, "Helplessness in children of depressed and nondepressed mothers," *Developmental Psychology*, 31, 1995 pp.377-387, cited in D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, 2005, op. cit., p.16.

²¹⁹ DA Wilson, C Bobier and EM Macdonald, "A perinatal psychiatric service audit in New Zealand: patient characteristics and outcomes," *Archives of Women's Mental Health*, 7, 2004, pp.71-79 cited in D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, "VicHealth Research Report on Children at Risk in Families affected by Parental Mental Illness," 2005, *Victorian Health Promotion Foundation, Melbourne*, p.16.

²²⁰ DoCS, *Dual Diagnosis Support Kit, Caseworker Manual*, 2005, p.2.

²²¹ C Cousins, 2004, op. cit.

²²² *ibid.*, p.1.

- 4.100 Finally, families affected by parental mental illness are more likely to experience crises, such as the hospitalisation of a parent, or an acute mental illness episode and the likelihood of this occurrence is higher again for families in which a parent has a severe mental illness.²²³ It is sometimes under these circumstances that children come to the attention of child protection authorities. Prior planning is therefore important for all members of a family to plan for future episodes of hospitalisation or periods of illness.²²⁴
- 4.101 In summary, a wide range of factors including mental health problems can affect parenting capacity. The impact on parents' cognitions, attributions and capacity to empathise has been associated with increased risk for child maltreatment. Suggested interventions include tailored parenting programs, encouraging support systems for the child and family, and building positive social and emotional connections for the child, for example with child care workers, teachers or peers.²²⁵ Literature also suggests enhanced interagency responses and more effective liaison between mental health, drug and alcohol, and child protection workers.

Sexual abuse

- 4.102 Most sexual abuse is perpetrated by someone who is known to the child, such as a family member, family friend or person with whom the child comes into contact (for example, sports coach, teacher, priest).²²⁶
- 4.103 A review of North American sexual abuse prevalence studies suggested that sexual abuse is committed primarily by males (90 per cent of cases). The review also found that the children knew most perpetrators, with 'strangers' constituting between 10 to 30 per cent of offenders.²²⁷
- 4.104 Non-biological male family members (stepfather or mother's de facto partner) are disproportionately represented as sex offenders. For example, Russell reported that girls living with stepfathers were at a markedly increased risk: 17 per cent had been sexually abused compared with 2.3 per cent of girls living with biological fathers.²²⁸
- 4.105 Although males constitute the majority of perpetrators, a review of the evidence for female sex abusers concluded that females do abuse in a small proportion

²²³ D Maybery, A Reupert, K Patrick, M Goodyear and L Crase, 2005, op. cit., p.18.

²²⁴ R Kirkland and DJ Maybery, "Managing critical incidents in schools, planning your response," *Practising Administrator*, 22(3), 2001, pp.18-23, cited in *ibid* p.18.

²²⁵ *ibid*.

²²⁶ JM Leventhal, "Epidemiology of sexual abuse of children. Old problems, new directions," *Child Abuse and Neglect*, 22, 1998, pp.481-491 cited in N Richardson and L Bromfield, 2005, op. cit., p.1.

²²⁷ D Finkelhor, "Current Information on the scope and nature of child sexual abuse," *The Future of Children*, 4, 1994, pp.31-53 cited in N Richardson and L Bromfield, 2005, op. cit., p.4.

²²⁸ DEH Russell, *The secret trauma: Incest in the lives of girls and women*, New York: Basic Books, 1989 cited in N Richardson and L Bromfield, 2005, op. cit., p.4.

of cases: approximately five per cent of female victims, and 20 per cent of male victims experience sexual abuse perpetrated by a female.²²⁹

- 4.106 It is estimated that one in four girls and one in six boys experience child sexual abuse and live with its impact on their emotional, physical and psychological well-being.²³⁰ However it is also acknowledged that child sexual assault is under reported and that, in particular, intra-familial abuse comprises the most under reported group of all sexual offences.²³¹
- 4.107 Extensive research has demonstrated strong links between experiences of sexual assault and a range of problems in adolescence and adulthood. These problems include:
- a. low self esteem, behaviour, problems and depression²³²
 - b. self harming behaviours²³³
 - c. drug and alcohol abuse²³⁴
 - d. mental health problems²³⁵
 - e. suicidal thinking or behaviour.²³⁶
- 4.108 Child sexual abuse rarely occurs in isolation but usually in the presence of other forms of abuse. Research clearly links childhood sexual abuse with higher rates in adults of depressive and anxiety symptoms, substance abuse disorders, eating disorders and post traumatic stress disorders: "there is no doubt that the physical, emotional and psychological effects accompanying sexual abuse can last a lifetime."²³⁷

²²⁹ D Finkelhor and DEH Russell, "Women as perpetrators," in D. Finkelhor (ed.), *Child sexual abuse: New theory and research*, New York: The Free Press, 1984, pp.171-187 cited in N Richardson and L Bromfield, 2005, op. cit., p.4.

²³⁰ D Finkelhor, "The international epidemiology of child sexual abuse," *Child Abuse and Neglect*, 18, 1994, pp.409-417 cited in V Resofsky, "Stewards of Children: a primary prevention program for child sexual abuse," *Child Abuse Prevention Newsletter*, v.15 no.2, 2007, p.12.

²³¹ J Goodman-Delahunty and J Pratley, "The NSW Pre-Trial Diversion of Offenders (Child Sexual Assault) Program: An Evaluation of Treatment Outcomes," July 2008, p.4.

²³² J Tebbutt, H Swanston, RK Oates, BI O'Toole, "Five Years after Child Sexual Abuse: Persisting Dysfunction and Problems of Prediction," *Journal of American Child and Adolescent Psychiatry*, Vol 36, No. 3, March 1997, pp.330-338 cited in Submission: NSW Health, p.9.

²³³ P Beckinsale, G Martin and S Clark, "Sexual abuse and suicidal issues in Australian young people," *Australian Family Physician*, Vol 28, No. 12, December 1999, pp.1298-1303; AC Salter, "Transforming Trauma: A guide to understanding and treating adult survivors of child sexual abuse," *Sage Publications, Thousand Oaks, California*, 1995 cited in Submission: NSW Health, p.9.

²³⁴ AC Salter, 1995, op. cit., cited in Submission: NSW Health, p.9.

²³⁵ PE Mullen and J Fleming, "Long term effects of child sexual abuse, issues in child abuse prevention," *National Child Protection Clearinghouse Issues Paper, Australian Institute of Family Studies*, No.9, Autumn 1998 cited in Submission: NSW Health, p.9.

²³⁶ RK Oates, A Plunkett, B O'Toole, H Swanston, S Shrimpton, and P Parkinson, "Suicide Risk following Child Sexual Abuse," *American Journal of Ambulatory Paediatrics*, September, Vol 1, No. 5, 2001, pp.262-266; P Beckinsale, G Martin and S Clark, "Sexual abuse and suicidal issues in Australian young people," *Australian Family Physician*, Vol 28, No. 12, December 1999, pp.1298-1303 cited in Submission, NSW Health, p.9.

²³⁷ Kennedy, 2000, cited in L O'Brien and C Henderson, "Reframing responses: improving service provision to women survivors of child sexual abuse who experience mental health problems," *Auseinetter* No.27 Nov 2006, pp.20-21.

- 4.109 Over the last 20 years it has also become apparent that not only is significant harm caused by the sexual abuse of children, but that many of the perpetrators of this abuse are themselves young.²³⁸ Davis and Leitenberg found that juveniles were responsible for between 30 per cent and 50 per cent of all sexual offences involving a child victim.²³⁹ These figures are consistent with other more recent estimates.²⁴⁰ Retrospective data from adult sexual offenders also indicate that many offenders began their offending behaviour in early adolescence or late childhood.²⁴¹ Some studies have found that up to half of all adult sex offenders admit to beginning sexual offending as adolescents.²⁴²
- 4.110 Prevalence studies also consistently appear to suggest high rates of sibling incest and that abuse by a sibling may in fact be more prevalent than other forms of child sexual abuse.²⁴³ However, in spite of what appear to be high prevalence rates: “the empirical knowledge base on sibling incest is very limited. The evidence base for professional practice in this field is therefore weak.”²⁴⁴
- 4.111 In NSW, the rate of child sexual assault of Aboriginal females under the age of 16 years in 2004 was more than double that of non-Aboriginal females in the same age group (respectively, 468.7 and 192.1 per 100,000). However, NSW Health data indicates that of all the children in NSW who accessed services that respond to sexual assault during 2003/04, only 11 per cent were Aboriginal.²⁴⁵
- 4.112 The literature indicates that child sexual assault in Aboriginal communities is a complex problem that is inter-connected with other aspects of Aboriginal disadvantage such as substance abuse, social and economic disadvantage, poor mental and physical health, and exposure to family violence.²⁴⁶
- 4.113 Many jurisdictions have enacted laws directed against perpetrators of child sexual assault, which variously provide for indeterminate sentencing, mandated treatment, community registration and protracted supervision beyond the

²³⁸ DoCS, *Impacts of programs for adolescents who sexually offend: Literature Review*, 2005, p.i.

²³⁹ G Davis and H Leitenberg, “Adolescent sex offenders,” *Psychological Bulletin*, 101, 1987, pp.418-427 cited in DoCS, *Impacts of programs for adolescents who sexually offend: Literature Review*, DoCS, 2005, p.3.

²⁴⁰ ML Bourke and B Donohue, “Assessment and treatment of juvenile sex offenders: An empirical review,” *Journal of Child Sexual Abuse*, 5, 1996 pp.47-65; NJ Boyd, M Hagan and ME Cho, “Characteristics of adolescent sex offenders” A review of the research,” *Aggression and Violent Behaviour*, 5, 1999 pp.137-146; S Righthand and C Welch, “Juveniles who have sexually offended: A review of the professional literature,” *Washington DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention*, 2001; cited in DoCS, *Impacts of programs for adolescents who sexually offend: Literature Review*, 2005, p.3.

²⁴¹ Department of Juvenile Justice, “Profiling Australian Juvenile Sex Offenders: Offenders and Offence Characteristics,” Monograph Series Number 1, 1999.

²⁴² D Lievore, “Recidivism of Sexual Assault Offenders: Rates, Risk Factors and Treatment Efficacy,” *Australian Institute of Criminology*, May 2004, p.55.

²⁴³ S Rayment-McHugh, and I Nisbet, “Sibling incest offenders as a subset of adolescent sexual offenders,” cited in “Conference papers: Child Sexual Abuse: Justice Response or Alternative Resolution Conference,” Adelaide, May 2003. Canberra, *Australian Institute of Criminology*, 2003: www.aic.gov.au.

²⁴⁴ *ibid.*

²⁴⁵ NSW Government, *NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities, 2006-2011*, p.1.

²⁴⁶ *ibid.*

duration of a sentence.²⁴⁷ However, there is a paucity of research that demonstrates that these measures actually reduce rates of sexual offending against children.

- 4.114 Treatment of sex offenders is usually psychological, using a cognitive behavioural framework. This includes cognitive restructuring, training in victim empathy and social skills, and relapse prevention. Increasingly, treatment is targeted towards specific deficits and is individualised, although it may be delivered in group settings. Its effectiveness relies on proper assessment and the use of interventions justified by well constructed research evidence, which is as yet lacking.²⁴⁸
- 4.115 A number of biological treatments are also currently used. Some medications seem to have efficacy in reducing sexual drive, deviant sexual arousal and problem sexual behaviours. Because of their side effects, however, their use tends to be limited to those at higher risk of re-offending.²⁴⁹
- 4.116 However, the evidence base for both types of treatment of sexual offenders is poor. Psychological treatments seldom adhere to specified methodology and are rarely tested for integrity by blinded external raters. For biological treatments, the evidence generally comprises uncontrolled case series with small numbers and limited follow up. Despite the extensive clinical experience with these medications, there is only limited empirical support for their effectiveness.²⁵⁰
- 4.117 There are some reviews, however, that indicate that cognitive behavioural programs are the most effective in managing the risk of re-offending in child sexual offenders.²⁵¹
- 4.118 In its review of 23 adolescent sex offender treatment outcome studies published since 1990, DoCS concluded that:

despite the somewhat confused state of the treatment literature and difficulties in making study comparisons, there appears to be reason to hope that well resourced and carefully constructed treatment programs can have a significant effect in reducing both sexual and non-sexual recidivism. Reductions of 13 per cent in sexual recidivism have been observed between treated and non-treated adolescents in overseas treatment programs. Programs that appear most likely to demonstrate treatment effects are those that address functioning in a broad range of

²⁴⁷ DH Sullivan, PE Mullen and MT Pathé, "Legislation in Victoria on sexual offenders: issues for health professionals," www.mja.com.au/public/issues/183_06_190905/sul10338_fm.html.

²⁴⁸ *ibid.*

²⁴⁹ *ibid.*

²⁵⁰ *ibid.*

²⁵¹ S Wright, "Managing unacceptable risk: the risk assessment and management of child sexual offenders," cited in "Conference papers: Child Sexual Abuse: Justice Response or Alternative Resolution Conference," Adelaide, May 2003. Canberra: *Australian Institute of Criminology*, www.aic.gov.au.

*areas, including the individual, family, school and community systems. While individual service providers in private practice may contribute to a multi-system treatment intervention plan, a reliance on individual-level interventions by themselves appears unlikely to lead to the reductions in recidivism associated with the more holistic treatment approaches. It also appears that involvement of families is an adjunct to successful treatment.*²⁵²

- 4.119 A discussion of particular programs in NSW appears in Chapters 7 and 15.
- 4.120 With respect to prevention programs, Tomison and Poole identified personal safety programs as the most prevalent child sexual abuse prevention programs in Australia.²⁵³ Personal safety and protective behaviours programs are generally school based prevention programs that aim to equip children with self protection strategies through educating them in how their body responds to feeling unsafe, and their right to say no. They are designed to educate children to identify, and therefore protect themselves from, situations in which they are potentially at risk of harm. However, personal safety programs target a single group; they focus on children rather than addressing adult responsibility for children's safety.²⁵⁴
- 4.121 Some commentators have queried whether it is appropriate to expect children to protect themselves, and whether giving this type of message to children could lead them to feel guilt and shame if they were unable to protect themselves from abuse.²⁵⁵
- 4.122 A review of the effectiveness of child abuse prevention programs by the National Child Protection Clearinghouse reported that personal safety programs can be effective in teaching children basic concepts and skills (for example, good touch/bad touch) and are associated with an increase in disclosures. However, "there is no evidence that personal safety programs are actually able to provide children with the knowledge and skills to avoid being abused."²⁵⁶
- 4.123 In terms of other interventions to reduce child sexual assault, Resofsky notes that there have been no large scale community education programs in Australia aimed at the primary prevention of child sexual abuse.²⁵⁷ As a social work practitioner, Resovsky argues for a broad multi-faceted public education program on the complexities of child sexual assault which would concentrate the responsibility for child sexual abuse prevention on adults. Resofsky

²⁵² DoCS, *Impacts of Programs for Adolescents who sexually offend: Literature Review*, 2005, p.i-v.

²⁵³ AM Tomison and L Poole, 2000, op. cit., cited in V Resofsky, "Stewards of Children: a primary prevention program for child sexual abuse," *Child Abuse Prevention Newsletter*, v.15 no.2, 2007, p.12.

²⁵⁴ V Resofsky, 2007, op. cit., p.12.

²⁵⁵ LM Bromfield, "Child protection in Australia: Current challenges and future directions," *Paper presented at the Australasian College of Child and Family Protection Practitioners conference*, Melbourne, 2007 cited in V Resofsky, 2007, op. cit., p.12.

²⁵⁶ LM Bromfield and Holzer, "Child abuse prevention: What works? Paper presented at the Australian Centre for Child Protection," *University of South Australia: Seminar Series*, Adelaide, 2006 cited in V Resofsky, 2007, op. cit., p.12.

²⁵⁷ V, Resofsky, 2007, op. cit., p.19.

describes the Stewards of Children Program: a sexual abuse prevention program that educates adults to recognise, prevent and respond responsibly to child sexual abuse. The program gives adults an overview of the complex nature of child sexual abuse and is appropriate for all adults, whether they work with child focused organisations or are just concerned individuals.²⁵⁸

- 4.124 The program was originally introduced in nine organisations based in the USA, and the training is now available in 34 US states as well as Canada, Iceland, Spain, Peru and the Cayman Islands. An evaluation of the program indicates that it was considered to have a significant influence on participants' knowledge and understanding of child sexual abuse. Specifically, participants reported they were more likely to discuss issues of child sexual abuse with a child or another adult, pay attention to potential signs of sexual abuse, and drop in unexpectedly to ensure the safety of a child in the care of another adult.²⁵⁹
- 4.125 In summary, child sexual abuse is likely to be an under reported form of abuse that has far reaching consequences on the lives of those who are abused. Interventions may be medical, psychological or educative. There is some evidence of successful outcomes for perpetrators as provided through two multi-faceted, holistic programs, that is, the New Street Program and the Cedar Cottage Pre-Trial Diversion of Offenders Program, which are discussed in Chapters 7 and 15.

Child/young person risk taking behaviour

- 4.126 The Inquiry found that there is no clear definition for this term and a lack of guidance for caseworkers as to what constitutes risk taking behaviour and the interventions which may be appropriate. There is also a lack of relevant research with respect to risk taking behaviour and child protection.
- 4.127 There is a considerable body of research, however, that provides evidence linking abuse, childhood adversity, family dysfunction, stressful life events with suicidal thoughts and health risk behaviour among young people.²⁶⁰ Beautrais, Joyce and Mulder, for example, found that young people aged 13-24 years in New Zealand who made medically serious suicide attempts had 'elevated odds' of parental separation, poor parental relationships, parental violence, alcoholism or imprisonment, being 'in care', and sexual and physical abuse.²⁶¹

²⁵⁸ *ibid.*

²⁵⁹ *ibid.*, p.24.

²⁶⁰ A Beautrais, "Risk factors for suicide and attempted suicide among young people," *National youth suicide prevention strategy – Setting the evidence based research agenda for Australia (A literature review)*, Canberra: Commonwealth Department of Health and Aged Care, 2000 cited in J Cashmore and M Paxman, "Longitudinal Study of Wards Leaving Care: four to five years on," *Social Policy Research Centre*, University of New South Wales, January 2007, p.90.

²⁶¹ A Beautrais, PR Joyce and RT Mulder, "Precipitating factors and life events in serious suicide attempts among youths aged 13 through 24 years," *Journal of the American Academy of Child and Adolescent Psychiatry*, 36, 1997, pp.1543-1551 cited in J Cashmore and M Paxman, 2007, *op. cit.*, p.90.

- 4.128 There is also a body of research findings and large scale mental health surveys of young people in which adolescents with depression and other mental health problems report a high rate of suicidal thoughts and other health risk behaviour, including smoking, drinking and drug use.²⁶²
- 4.129 The NSW Child Death Review Team reviewed the deaths of 187 children and young persons (aged 12-17 years) who died from suicide and risk taking in the period January 1996 to December 2000 in NSW.²⁶³
- 4.130 The key findings of this report include that while suicide and risk taking deaths are rare, accounting for nine deaths per 100,000 young persons aged between 12-17 years, this number represents almost one quarter of all deaths of young persons within these ages.
- 4.131 The Child Death Review Team also found that gender is significant. The majority of those who died (71 per cent) were male. Males were more than twice as likely as females to die from suicide or risk taking.
- 4.132 Only half of those who died from suicide or risk taking were enrolled in schools at the time of their death. This is considerably lower than the general school participation rate.²⁶⁴ Forty-two per cent had no record of contact with any human services workers, for example, health workers, school counsellors or DoCS workers.
- 4.133 The majority of the deaths (66 per cent) occurred in young persons who were undergoing significant enduring difficulties which included family dysfunction, mental health problems and severe emotional distress or school related difficulties, or a combination of these factors.
- 4.134 The importance of participation in school as a protective factor which mitigates against extreme risk taking is reinforced by the Child Death Review Team study. The importance of the school as a site for education about help seeking and problem solving is also clear.²⁶⁵
- 4.135 Research on the effect of domestic violence suggests that impacts may be different for adolescents who have been part of an abusive system from their earliest years compared with those who experience it for the first time in adolescence. Violence against mothers in childhood is highly associated with

²⁶² A Beautrais, "Risk factors for suicide and attempted suicide among young people," *National youth suicide prevention strategy – Setting the evidence based research agenda for Australia (A literature review)*, Canberra: Commonwealth Department of Health and Aged Care, 2000 cited in J, Cashmore and M, Paxman, 2007, op. cit., p.93.

²⁶³ Child Death Review Team, *Suicide and Risk taking Deaths of Children and Young People, A study of all deaths of children and young people aged 12 to 17 years in NSW by suicide or risk-taking over a five-year period, January 1996 to December 2000*, 2003.

²⁶⁴ Which was 93 per cent for 15 year olds, 82.4 per cent for 16 year olds and 62.2 per cent for 17 year olds in 2001, Child Death Review Team, "Suicide and Risk taking Deaths of Children and Young People," A study of all deaths of children and young people aged 12 to 17 years in NSW by suicide or risk-taking over a five-year period, January 1996 to December 2000, 2003.

²⁶⁵ Department of Education and Training: "Suicide and Risk-Taking Deaths of Children and Young People Report: What Can We learn?" www.curriculumsupport.education.nsw.gov.au.

ongoing depression in adolescent girls.²⁶⁶ Adolescents from homes where domestic violence is present are more likely to be homeless.²⁶⁷ The stresses associated with violence in the home may make usual adolescent risk taking and escape behaviours worse and they may begin to participate in family violence themselves.²⁶⁸

- 4.136 In a recent study, Abbott-Chapman and Denholm surveyed around 1,000 parents and 1,000 Tasmanian high school and college students across five years about their perception of 'risky' behaviours. The researchers describe a 'risk taking syndrome' of young persons drinking alcohol, looking at internet pornography and truanting from school as an escape from life pressures, such as exams and finding future work. In the surveys, young people were asked to rate 26 risk taking behaviours and placed binge drinking in the lowest of five risk groups, along with watching x-rated videos, smoking cigarettes, sunbaking, missing classes and drinking alcohol. Drug related activities were ranked as the highest risk taking activities.²⁶⁹
- 4.137 According to Abbott-Chapman and Denholm's research, factors likely to reduce risk taking behaviour among young persons include: their ability to talk over personal problems with parents, friends or other family members; religious commitment, or membership of Christian or other religious groups; and membership of community groups (other than sport) which encourage voluntary activities.²⁷⁰
- 4.138 Young people also rated the advice of teachers and parents higher than health and education programs run in schools and the community.²⁷¹
- 4.139 DoCS caseworkers work with children and young persons who display internalising and externalising behaviours reflecting emotional distress such as suicide attempts, sexual offending, school truancy, substance misuse, criminal behaviour, homelessness and placing themselves in 'unsafe situations' (for example with sexual offenders or paedophiles). They may have diagnosed mental health problems, including depression, anxiety, post traumatic stress disorder, conduct disorder and oppositional defiance disorder. As a result their schooling is disrupted, they lack social skills and they may display little empathy. They experience relationship difficulties across the whole spectrum: school, peers and their families. Typically it can be a breakdown of relationships or dysfunctional family relationships that may bring them to the

²⁶⁶ Office of the Status of Women, *Domestic Violence and its Impact on Children's Development*, 1998, p.5.

²⁶⁷ *ibid.*

²⁶⁸ J Howard, "Children hit out at parents physically and emotionally," *Community Quarterly*, 34, 1995, pp.38-43; D Kalmuss, "The intergenerational transmission of marital aggression," *Journal of Marriage and the Family*, 46, 1984, pp.11-19; J McInnes, "Violence within Families: The Challenge of Preventing Adolescent Violence Towards Parents," *The Office for Families and Children*, Adelaide, 1995 cited in Office of the Status of Women, *Domestic Violence and its Impact on Children's Development*, 1998, p.5.

²⁶⁹ *ibid.*

²⁷⁰ *ibid.*

²⁷¹ *ibid.*

attention of authorities. Often these children have a profound sense of loss and little trust in relationships.²⁷²

- 4.140 Caseworkers play a central role in coordinating services and interventions for children and young persons who are at risk and, at times, highly distressed. A DoCS study highlights the sensitive nature of this work and the need for caseworkers to develop effective relationships with adolescents, their families and other agencies.²⁷³ The study also acknowledges that further research directly testing the effectiveness of particular casework strategies or approaches to case management is warranted.²⁷⁴
- 4.141 In summary, the definition of, and response to, child/young person risk taking behaviour is an area for further research.

Summary

- 4.142 Current literature establishes that child abuse and neglect are strongly correlated with other problems such as low birth weight, child behavioural disorders, low literacy, non-completion of school, juvenile drug use and teenage pregnancy.²⁷⁵ These share a common set of risk and protective factors, that is, quality of early parent-child attachment, peer and school connectedness, availability of social support for families, parental poverty. This suggests that whole of government responses which are able to draw in sectors such as housing, health, education and child welfare agencies will be more effective. Durlack's analysis indicates that multi-faceted strategies, which address underlying risks and protective factors, are more effective than those that are single issue focussed.²⁷⁶ Where services are easily accessible to the parents, for instance through co-location, the benefit to families increases.²⁷⁷
- 4.143 Evidence that early intervention can counteract biological and environmental disadvantage and set children on a more positive developmental trajectory continues to build. Early intervention, particularly from birth to three years of age has been identified as an ideal opportunity to enhance parental competencies, reduce risks and aid child development. Early intervention approaches closely linked with universal services are one of the most effective ways to ameliorate the effects of maltreatment.²⁷⁸

²⁷² DoCS, *Effective Casework Practice with Adolescents: Perceptions and Practices of DoCS Staff*, December 2007.

²⁷³ *ibid.*

²⁷⁴ *ibid.*, p.vi.

²⁷⁵ D Scott, "Towards a Public Health Model of Child Protection in Australia," Research Article 1, *Communities, Families and Children Australia*, Volume 1, No. 1, July 2006, p.14.

²⁷⁶ JA Durlack, "Common Risk and Protective Factors in Successful Prevention Programs," *American Journal of Orthopsychiatry*, 68, 1998 pp.512-520 cited in D Scott, 2006, *op. cit.*, p.14.

²⁷⁷ DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.3.

²⁷⁸ Northern Territory Government, "Ampe Akelyernemane Meke Mekarle 'Little Children are Sacred'," *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, Darwin, Australia, 2007, p.259.

- 4.144 There is also mounting evidence that, as far as possible, working with families in a respectful way can minimise the anger and distress of families whose children have been reported to statutory departments and may lead to better and less harmful interventions for children.²⁷⁹
- 4.145 In summary, the literature provides some indicators about 'what works', with which populations groups and under what conditions, and suggests areas for further investigation. Notwithstanding qualifications about the need for further research and evaluation, recurring themes in the literature are for a reorientation to prevention and early intervention services, multi-agency cooperation and inter-connected responses, accessible high quality child care services and flexible service provision.
- 4.146 Recommendations concerning additional services needed to reflect the research findings are considered elsewhere in this report, particularly Chapter 10.

²⁷⁹ G Dumbrill, "Parental experience of child protection intervention: A qualitative study," *Child Abuse and Neglect*, 30, 2006, pp.27-37; R Thorpe, "Family inclusion in child protection practice: building bridges in working with (not against) families," *Communities, Children and Families Australia*, 3, 2007, pp.4-18 cited in Submission: Cashmore, Scott, and Calvert, p.49.

5 Key child protection data

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NSW demographic data

5.1 The source for the following data is the 2006 ABS Population census.

Table 5.1 Total population of each DoCS Region, 2006

<i>Region</i>	<i>Total population</i>	<i>Children aged 0-17 as % of total population</i>	<i>Children aged 0-3 as % of total population</i>
Metro Central	2,032,278	20.2	4.8
Metro West	1,040,917	26.6	5.9
Metro South West	790,318	27.8	6.0
Southern	549,873	24.3	4.8
Hunter/Central Coast	849,626	24.4	5.0
Northern	713,636	24.4	4.5
Western	562,353	26.2	5.4
State total	6,549,174	24.0	5.2

Table 5.2 Indigenous population of each DoCS Region, 2006

<i>Region</i>	<i>Total population</i>	<i>Indigenous population</i>	<i>Indigenous population as % of total population</i>	<i>Indigenous children aged 0-17 as % of Indigenous population</i>	<i>Indigenous children aged 0-3 as % of Indigenous population</i>
Metro Central	2,032,278	11,371	0.6	33.8	7.6
Metro West	1,040,917	16,021	1.5	45.6	10.0
Metro South West	790,318	10,202	1.3	48.2	10.6
Southern	549,873	13,080	2.4	46.2	10.3
Hunter/Central Coast	849,626	20,607	2.4	46.3	10.0
Northern	713,636	34,164	4.8	46.8	10.1
Western	562,353	32,631	5.8	46.5	10.3
State total	6,549,174	138,511	2.1	45.4	10.0

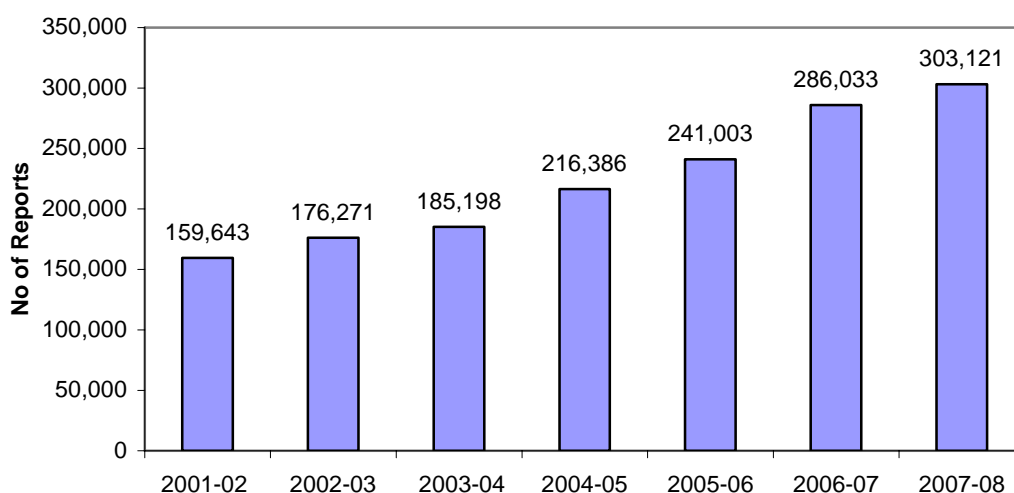
Reporting trends since 2001/02

- 5.2 DoCS has made its most recent data available to the Inquiry. While some 2007/08 data have been finalised, most of the detailed 2007/08 data are preliminary and will differ from finalised 2007/08 data. Where preliminary 2007/08 data are not available, the Inquiry has used data for 2006/07, or for the period April 07/March 08. Whatever the more recent data are used in this and other chapters of this report.

Child protection reports

- 5.3 In 2007/08, DoCS received 303,121 child protection reports.²⁸⁰ This represents an increase of about 90 per cent over the 159,643 child protection reports received in 2001/02. The number of reports received annually from 2001/02 to 2007/08 is set out in the graph below.

Figure 5.1 Total number of child protection reports 2001/02 to 2007/08



- 5.4 Total reports increased by 6.0 per cent from 2006/07 to 2007/08. This increase is far less than the 18.7 per cent recorded for the preceding period from 2005/06 to 2006/07.
- 5.5 NSW is not alone in experiencing increased reporting. A recent report by the AIHW noted that nationally, notifications, substantiations and the number and rates of children under care and protection orders in OOH are all rising.²⁸¹ That report identified an actual increase in the number of children who require a child protection response and an increased awareness of child protection issues in the wider community, as factors which have influenced the rise.

²⁸⁰ DoCS, *Annual Report 2007/08*, p.4.

²⁸¹ Australian Institute of Health and Welfare, *Child Protection Australia 2006/07*, Child welfare series no. 43, 2008, p.10.

- 5.6 However, the Inquiry does not propose to rely on AIHW data in relation to a national comparison of performance. In relation to the states and territories, definitions of notifications differ, reports on unborn children are accepted in some jurisdictions and not others and what is substantiated is not consistent. States also differ in data collection and investigation frequency, and have different definitions of when a child is 'in need of protection' or 'abused' or 'neglected.'
- 5.7 As the AIHW stated in its 2008 report "the data from jurisdictions are...not strictly comparable and should not be used to measure the performance of one jurisdiction relative to another."²⁸²
- 5.8 Thus, the Inquiry will not attempt to do so to inform this report.

Children and young persons involved in reports

- 5.9 As shown in Table 5.3 below, there has been a 54.0 per cent increase in the number of children reported between 2001/02 and 2007/08 (preliminary). In 2001/02, the ratio of reports made to the number of children and young persons reported was 1.88:1 and by 2006/07, it had increased to 2.31:1. The ratio of reports to children remained steady in 2007/08 at 2.32:1.

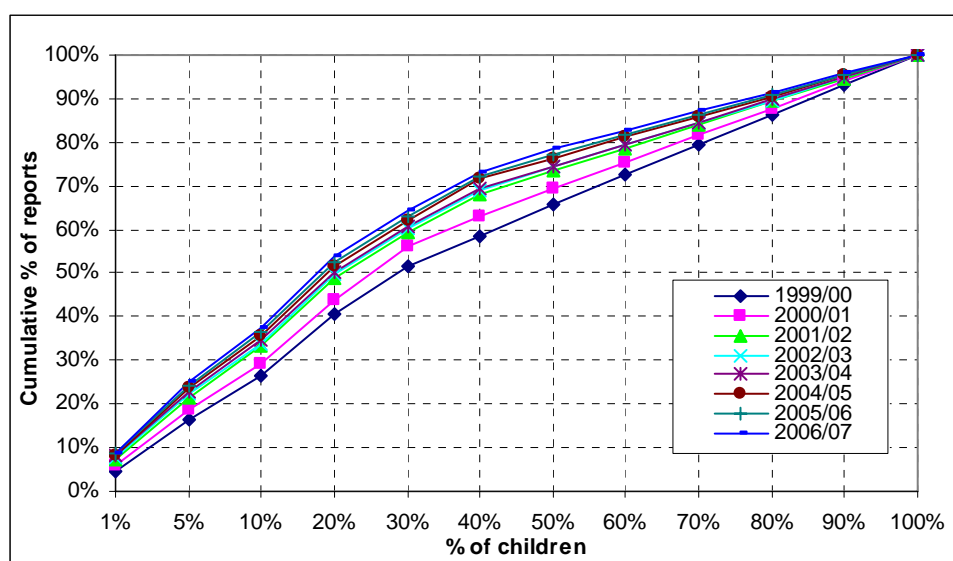
Table 5.3 **Children and young persons involved in reports 2001/02 to 2007/08**

	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08 <i>preliminary</i>
Total	84,965	90,558	94,552	102,349	109,568	123,690	130,869

- 5.10 The occurrence of multiple reports per child has increased over time. Figure 5.2 shows that in 1999/00, the one per cent of children with the highest number of reports accounted for 4.8 per cent of total reports. By 2006/07, the top one per cent accounted for 8.9 per cent of reports. Further, in 2006/07, over half of all reports involved 20 per cent of children and young persons.

²⁸² *ibid.*, p.13.

Figure 5.2 **Percentage of all reports by percentage of children and young persons, 1999/00 to 2006/07**²⁸³



- 5.11 In the period 2001/02 to 2007/08, the rate of children reported per 1,000 population increased from 52.7 to 81.0.²⁸⁴
- 5.12 Similar to reports, there was a 5.8 per cent increase in total number of children and young persons reported from 2006/07 to 2007/08 (preliminary). This is less than half of the 12.9 per cent increase recorded between 2005/06 and 2006/07.
- 5.13 In 2001/02, 54.6 per cent of all children and young persons involved in reports were reported for the first time ever. By 2006/07, children and young persons reported for the first time had fallen to 43.2 per cent of all children and young persons reported. The actual number of first time reports remained fairly steady for 2007/08, but as a proportion of the total number of children reported, the figure dropped further to 41.3 per cent. In other words, by 2007/08 (preliminary), 58.7 per cent of all children and young persons involved in reports already had a child protection history, or were 'known to DoCS.'²⁸⁵
- 5.14 Figure 5.3 illustrates the continuing increase in the share of children reported to DoCS each year who already have a child protection history. The percentage increase of new children reported is just 1.2 per cent from 2006/07 to 2007/08 (preliminary), compared with a growth of 9.3 per cent for known children.²⁸⁶

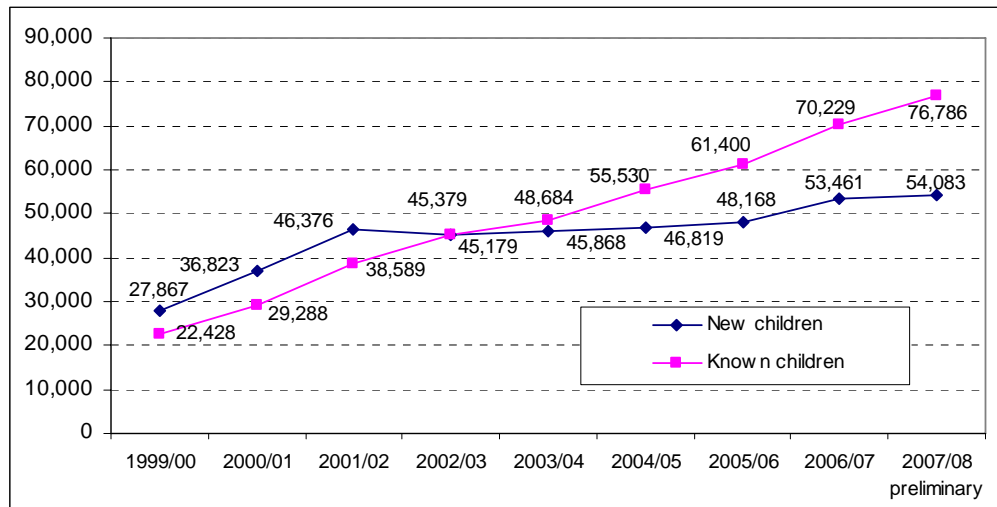
²⁸³ DoCS, *A closer look: Recent trends in child protection reports to DoCS*, December 2007.

²⁸⁴ DoCS, *Annual Report 2007/08*.

²⁸⁵ DoCS, *Child Protection 2007/08. A Preliminary Analysis*, August 2008.

²⁸⁶ *ibid.*

Figure 5.3 **Numbers of new and known children reported to DoCS, 1999/00 to 2007/08**²⁸⁷



Age of children and young persons reported to DoCS

- 5.15 In the period 2001/02 to 2007/08 (preliminary), the reporting trends for each age group have remained relatively steady. There has been a slight increase in the proportion of children aged less than one year that were reported. In 2001/02, these children represented 8.6 per cent of all children and young persons reported and in 2007/08 (preliminary) they represented 10.1 per cent of all children and young persons reported.

Table 5.4 **The number of children and young persons reported to DoCS by age, 2001/02 to 2007/08**

Age group	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08 preliminary
< 1 year	7,342	7,162	7,479	8,308	9,652	11,729	13,158
1-2 years	10,043	10,330	10,472	11,273	12,283	13,791	14,904
3-4 years	10,427	10,823	10,832	11,779	12,500	13,955	14,776
5-11 years	33,752	35,998	36,826	39,504	42,097	46,626	49,009
12-15 years	18,309	20,239	21,283	23,875	25,308	28,225	29,565
16-17 years	3,780	3,894	4,354	4,675	5,143	6,227	6,697
Not stated	1,312	2,022	3,306	2,935	2,585	3,137	2,760
Total	84,965	90,558	94,552	102,349	109,568	123,690	130,869

²⁸⁷ *ibid.*

Table 5.5 **Child protection reports by age, 2006/07 and 2007/08**

<i>Age group</i>	<i>2006/07</i>	<i>2007/08 preliminary</i>
< 1 year	26,853	30,432
1-2 years	33,072	35,778
3-4 years	32,995	34,804
5-11 years	106,710	112,959
12-15 years	70,978	73,207
16-17 years	11,983	12,778
Not stated	3,442	3,019
Total	286,033	302,977

- 5.16 Age distributions for children reported have remained consistent across the three year period 2005/06 to 2007/08 (preliminary). When new and known children are examined by age, not surprisingly, a high percentage of new children are infants.
- 5.17 In 2006/07, DoCS received 5,838 prenatal reports, representing nearly two per cent of all risk of harm reports. Close to half of these were received from NSW Health (49.9 per cent) and just over a fifth from NSW Police Force (20.3 per cent). The most prevalent issues reported were domestic violence (37.6 per cent), drug and alcohol use by carer (33.9 per cent) and carer mental health issues (23.5 per cent). This was a significant increase over the number of reports made since 2004/05, as expected due to the inclusion of prenatal reports as part of the mandatory reporting regime in 2007.

Aboriginal children and young persons involved in reports

- 5.18 In the period 2001/02 to 2007/08 (preliminary), the number of reports involving Aboriginal children and young persons more than tripled from 18,348 to 55,303. This increase is significantly higher than for non-Aboriginal children and young persons. Part of this increase may be due to improved DoCS identification of Aboriginal children and young persons.
- 5.19 In 2001/02, 11.5 per cent of all reports involved Aboriginal children and young persons, compared with 18.3 per cent in 2007/08 (preliminary).

Table 5.6 Number of child protection reports to DoCS by Aboriginality, 2001/02 to 2007/08

<i>Aboriginality</i>	<i>2001/02</i>	<i>2002/03</i>	<i>2003/04</i>	<i>2004/05</i>	<i>2005/06</i>	<i>2006/07</i>	<i>2007/08 preliminary</i>
Aboriginal	18,348	20,017	15,495	31,526	38,297	49,443	55,303
Non Aboriginal	141,295	156,254	169,703	184,860	202,706	236,590	247,674
Total	159,643	176,271	185,198	216,386	241,003	286,033	302,977

Note: Non-Aboriginal includes 'not stated'

5.20 In the period 2001/02 to 2007/08 (preliminary), the number of Aboriginal children and young persons reported to DoCS more than doubled from 7,093 to 18,179. Again this is a greater increase than for non-Aboriginal children and young persons.

5.21 In 2001/02, 8.3 per cent of the children and young persons who were the subject of a report were identified as Aboriginal, compared with 12.8 per cent in 2006/07 and 16.1 per cent in 2007/08 (preliminary).

Table 5.7 Number of children and young persons involved in child protection reports by Aboriginality, 2001/02 to 2007/08

<i>Aboriginality</i>	<i>2001/02</i>	<i>2002/03</i>	<i>2003/04</i>	<i>2004/05</i>	<i>2005/06</i>	<i>2006/07</i>	<i>2007/08 preliminary</i>
Aboriginal	7,093	7,597	5,128	10,910	13,092	15,820	18,179
Non Aboriginal	77,872	82,961	89,424	91,439	96,476	107,870	112,690
Total	84,965	90,558	94,552	102,349	109,568	123,690	130,869

Note: Non-Aboriginal includes 'not stated'

5.22 In 2001/02, 3.7 per cent of children and young persons reported for the first time were Aboriginal and by 2007/08 (preliminary), the figure had risen to 7.7 per cent. Over this period, there was a corresponding decrease in the percentage of non-Aboriginal children and young persons reported for the first time ever.

Table 5.8 Children and young persons reported to DoCS for the first time ever, by Aboriginality, 2001/02 to 2007/08

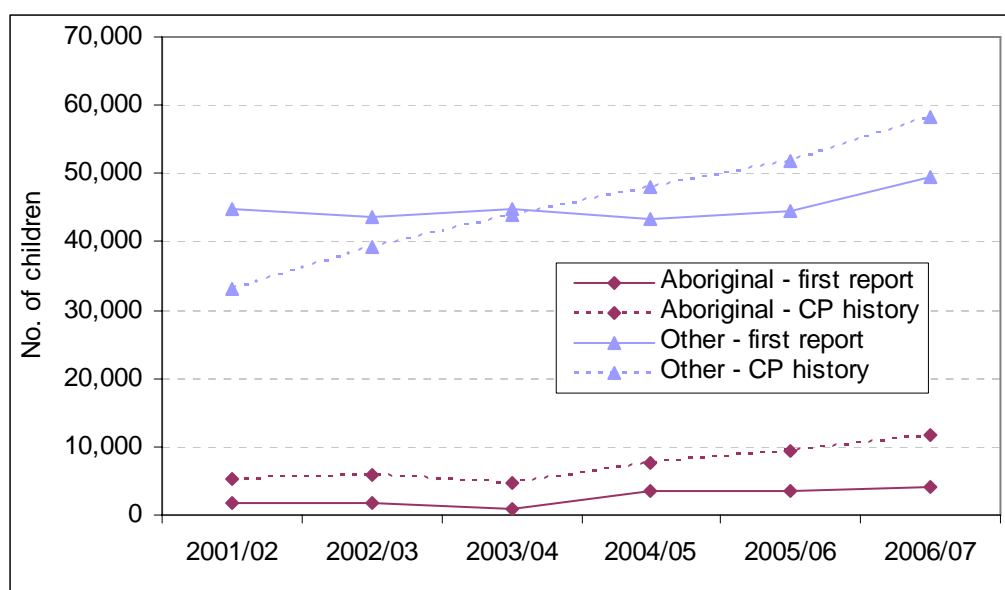
<i>Aboriginality</i>	<i>2001/02</i>	<i>2002/03</i>	<i>2003/04</i>	<i>2004/05</i>	<i>2005/06</i>	<i>2006/07</i>	<i>2007/08 preliminary</i>
Aboriginal	1,697	1,759	990	3,383	3,608	3,964	4,156
Non Aboriginal	44,679	43,620	44,878	43,436	44,560	49,497	49,927
Total	46,376	45,379	45,868	46,819	48,168	53,461	54,083

Note: Non-Aboriginal includes 'not stated'

5.23 In 2001/02, 76.1 per cent (5,396) of the Aboriginal children and young persons who were the subject of a report already had a child protection history. In 2007/08 (preliminary), 77.1 per cent (14,023) of the Aboriginal children and young persons who were the subject of a report already had a child protection history.

5.24 Figure 5.4 shows the number of Aboriginal and other children reported to DoCS by whether the child or young person had been reported previously (history from 1987/88). The pattern for Aboriginal children was quite different from that for other children. In 2006/07, 75 per cent of Aboriginal children reported to DoCS had a child protection history compared with 54 per cent of other children. For each year from 2001/02 to 2006/07 there were more Aboriginal children reported to DoCS who already had a child protection history than there were Aboriginal children who were not previously known. For non-Aboriginal children the number of new children reported to DoCS between 2001/02 to 2005/06 remained stable at around 44,000 per year and increased to 49,497 in 2006/07. Comparatively, the number of non-Aboriginal children with a child protection history increased by 76 per cent from 2001/02 to 2006/07.²⁸⁸

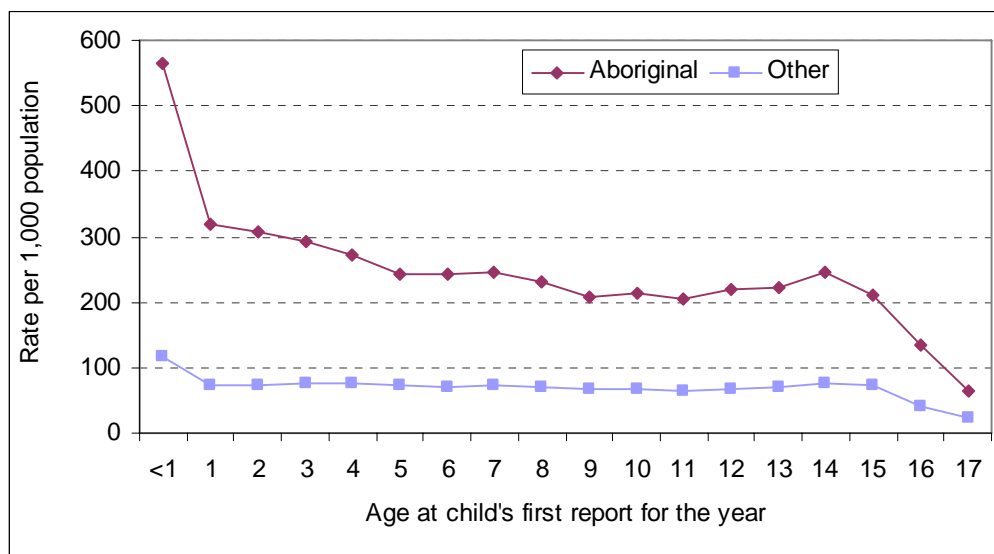
Figure 5.4 **Children and young persons reported to DoCS by Aboriginality and child protection history status, 2001/02 to 2006/07**



²⁸⁸ DoCS, *What DoCS Data tell us about Aboriginal clients*, December 2007.

- 5.25 Aboriginal children are more likely to be the subject of a child protection report than non-Aboriginal children and young persons. In 2007/08 (preliminary), for every 1,000 Aboriginal children and young persons in NSW, 289 were reported to DoCS, compared with the rate of 75 per 1,000 for non-Aboriginal children and young persons.
- 5.26 The rate of Aboriginal children aged less than one year reported is higher than for all Aboriginal children or for non-Aboriginal children aged less than one year. In 2007/08 (preliminary), for every 1,000 Aboriginal children and young persons in NSW aged less than one year, 647 were reported to DoCS, compared with the reporting rate of 130 per 1,000 for non-Aboriginal children aged less than one year.
- 5.27 Figure 5.5 shows that for all ages, the rate of reporting about Aboriginal children in 2006/07 was higher than the rate of reporting about other children. While it varies across age groups, it is most noticeable for children aged less than one year.

Figure 5.5 **Rate of children reported to DoCS per 1,000 population by age group and Aboriginality, 2006/07**²⁸⁹



²⁸⁹ *ibid.*

Reporter type

- 5.28 A comparison of the source of child protection reports by reporter type in 2001/02, 2005/06, 2006/07 and 2007/08 (preliminary) follows.

Table 5.9 Total reports by reporter type 2001/02, 2005/06 to 2007/08

Reporter type	2001/02		2005/06		2006/07		2007/08 preliminary	
	No	%	No	%	No	%	No	%
Police	59,989	34.4	80,406	33.4	93,069	32.5	99,367	32.8
Health	23,309	14.6	38,874	16.1	43,870	15.3	46,598	15.4
School/child care	21,952	13.8	31,557	13.1	35,741	12.5	38,412	12.7
NGO	12,751	8.0	17,165	7.1	21,318	7.5	22,427	7.4
Other mandatory	7,507	4.7	14,077	5.8	18,018	6.3	19,889	6.6
Non mandatory and Other	39,135	24.5	58,924	24.4	74,017	25.9	76,284	25.2
Total	159,643	100	241,003	100	286,033	100	302,977	100

- 5.29 When total reports are examined by reporter type the relative share of reports for each group varies little across the three year period from 2005/06 to 2007/08 (preliminary). During each of the three years, mandatory reporters made around three quarters of reports. Police have consistently accounted for approximately one third of all reports for each of the years, followed by health reporters at 15 per cent to 16 per cent and school/child care reporters at 12 per cent to 13 per cent.²⁹⁰
- 5.30 Consistently, the highest increase has been recorded for the 'other' mandatory reporter group which includes the courts and other government departments. For the period from 2005/06 to 2006/07 reports from this group increased 28.0 per cent and again by 10.4 per cent for the period 2006/07 to 2007/08. These increases are both higher than the average where increases of 18.7 per cent and 6.0 per cent were recorded for these periods respectively.

Reported issue

- 5.31 Tables 5.10 to 5.12 provide details of child protection reports from 2005/06 to 2007/08 (preliminary) by reporter type and reported issue:

²⁹⁰ Police reporters are members of the NSW Police Force. Health reporters include doctors, nurses, dentists, mental health professionals, and all other health workers. School/child care reporters include school and preschool teachers and principals, school counsellors, child care workers and TAFE teachers.

Table 5.10 Child protection reports by reporter type and primary reported issue, 2005/06

	<i>Police</i>	<i>Health</i>	<i>School/ child care</i>	<i>All other mandatory</i>	<i>Non mandatory and Other</i>	<i>Primary reported issue</i>	<i>Total reports</i>
<i>Primary reported issue</i>	<i>As a percentage share of reports for each primary reported issue</i>					<i>No</i>	<i>%</i>
Domestic violence	72.4	9.8	3.2	7.4	7.1	64,916	26.9
Neglect	19.0	11.6	12.9	18.5	38.1	35,116	14.6
Physical abuse	15.9	16.0	26.0	13.6	28.4	34,755	14.4
Carer drug and alcohol	23.0	22.4	6.5	10.2	37.9	22,487	9.3
Psychological abuse	21.5	13.6	21.3	12.5	31.1	20,864	8.7
Carer mental health	14.6	45.7	7.3	12.7	19.9	17,631	7.3
Sexual abuse	18.7	18.6	23.0	14.9	24.9	17,355	7.2
Risk taking behaviour by child or young person	24.1	13.9	17.2	24.1	20.8	13,994	5.8
Other	16.7	12.8	16.9	15.4	38.2	13,885	5.8
Total reports						241,003	100.0

Table 5.11 Child protection reports by reporter type and primary reported issue, 2006/07

	<i>Police</i>	<i>Health</i>	<i>School/ child care</i>	<i>All other mandatory</i>	<i>Non mandatory and Other</i>	<i>Primary reported issue</i>	<i>Total reports</i>
<i>Primary reported issue</i>	<i>As a percentage share of reports for each primary reported issue</i>					<i>No</i>	<i>%</i>
Domestic violence	73.2	8.5	3.4	7.4	7.4	74,283	26.0
Neglect	17.5	11.4	12.1	19.4	39.6	41,947	14.7
Physical abuse	16.2	14.8	25.0	14.7	29.2	40,559	14.2
Carer drug and alcohol	22.4	21.8	6.8	10.3	38.7	28,295	9.9
Psychological abuse	20.8	13.3	18.2	14.3	33.5	25,589	8.9
Carer mental health	13.8	45.2	6.4	13.5	21.2	21,418	7.5
Sexual abuse	18.4	16.9	21.9	17.2	25.7	20,204	7.1
Risk taking behaviour by child or young person	23.3	13.1	18.3	25.0	20.2	15,599	5.5
Other	15.6	11.2	15.1	16.0	42.2	18,139	6.3
Total reports						286,033	100.0

Table 5.12 **Child protection reports by reporter type and primary reported issue, 2007/08 preliminary**

<i>Primary reported issue</i>	<i>Police %</i>	<i>Health %</i>	<i>School/child care %</i>	<i>All other mandatory %</i>	<i>Non mandatory and Other %</i>	<i>Primary reported issue</i>	<i>Total reports</i>
	<i>As a percentage share of reports for each primary reported issue</i>					<i>No</i>	<i>%</i>
Domestic violence	72.7	8.3	3.4	8.2	7.4	76,910	25.4
Neglect	18.2	11.4	13.1	20.5	36.8	46,250	15.3
Physical Abuse	16.4	14.7	24.7	15.5	28.7	43,006	14.2
Carer drug and alcohol	24.4	20.7	7.2	11.4	36.3	31,909	10.5
Psychological abuse	20.9	13.6	18.7	13.4	33.4	25,559	8.4
Carer mental health	15.2	43.2	7.6	15.0	19.0	25,091	8.3
Sexual abuse	18.7	16.8	20.7	18.0	25.8	20,166	6.7
Risk taking behaviour by child or young person	27.5	14.9	19.8	18.1	19.7	14,584	4.8
Other	16.9	10.8	15.9	14.0	42.3	19,461	6.4
Total reports						302,936	100.0

Note: this table does not include reports where the primary reported issue was not recorded.

- 5.32 Up to three issues can be recorded in KiDS for each child protection report made. In 2007/08 (preliminary), all but 44 child protection reports had a primary reported issue. A further 50.1 per cent (151,864) had a secondary reported issue and 19.5 per cent (59,175) of all reports had a third reported issue.
- 5.33 When examining reported issue by the primary issue, or across all three reported issues, only a small variation in terms of percentage share is observed across the three year period from 2005/06 to 2007/08 (preliminary).
- 5.34 Just under one third of reports had a domestic violence issue listed as at least one of the three reported issues during each of the three years. Across this period, around one quarter of reports had issues listed which were categorised as psychological abuse. Given that across the three year period, psychological abuse was the primary reported issue in eight to nine per cent of reports, it is clear that a significant number of reports have psychological abuse as a secondary or third reported issue. Across the period, when taking into consideration primary, secondary and third reported issues, 22 per cent to 23 per cent of reports related to physical abuse and 21 per cent to 23 per cent related to neglect. Carer drug and alcohol issues were listed in 18 per cent to 20 per cent of reports and carer mental health in 12 per cent to 14 per cent. Above average growth was recorded between each of the years for the issues of

neglect, carer drug and alcohol issues, carer 'other' issues, and child drug and alcohol issues.²⁹¹

Table 5.13 **Child protection reports referred to DoCS by reported issue, 2005/06 to 2007/08**²⁹²

	2005/06		2006/07		2007/08 preliminary	
	No	%	No	%	No	%
Reported issue – all 3 issues						
Domestic Violence	77,222	32.0	89,021	31.1	94,139	31.1
Neglect	50,700	21.0	61,397	21.5	68,712	22.7
Physical abuse	54,085	22.4	62,814	22.0	69,409	22.9
Carer Drug and alcohol	43,806	18.2	54,529	19.1	61,416	20.3
Psychological abuse	56,880	23.6	67,959	23.8	74,732	24.7
Carer mental health	29,912	12.4	35,574	12.4	42,493	14.0
Sexual abuse	21,615	9.0	25,064	8.8	25,186	8.3
Carer other	11,564	4.8	16,219	5.7	20,253	6.7
Child drug and alcohol	6,271	2.6	7,642	2.7	8,467	2.8
Child suicide risk	4,839	2.0	5,002	1.7	5,108	1.7
Child runaway	7,825	3.2	8,441	3.0	6,791	2.2
Child inapp. sexual behaviour	4,559	1.9	5,182	1.8	4,966	1.6
Other	92	0.0	209	0.1	230	0.1
Total reports	241,003	100	286,033	100%	302,977	100

Note: As any report can have up to three reported issues recorded the categories presented are not mutually exclusive and the percentages do not total 100 per cent.

Re-reporting

- 5.35 Re-reporting has significantly increased over the last five years and most children now reported have a history of prior reports to DoCS. Of particular interest to the Inquiry is short term re-reporting, which is defined as a report received, with the same issue type, within seven days of another report for the child or young person. For re-reports a report is considered to have the same issue type if any of the three reported issues match those from a previous report. Issues are grouped into physical, sexual, psychological, neglect and carer for matching.
- 5.36 Table 5.14 shows that while the total number of reports increased by 40.0 per cent between 2004/05 and 2007/08 (preliminary), the total number of short term re-reports on the same reported issue increased by 62.0 per cent over the same four year period. The number of short term re-reports by the same reporter type on the same reported issue increased by 76.7 per cent over the four year period. Further, in 2007/08, short term re-reports on the same reported issue accounted for 17.1 per cent of all reports made.²⁹³

²⁹¹ DoCS, *Child Protection 2007/08. A Preliminary Analysis*, August 2008.

²⁹² *ibid.*

²⁹³ DoCS, *Child Protection matters that are re-reported within a 7 day period*, May 2008.

Table 5.14 **Total reports and re-reports within seven days on the same reported issue as a proportion of total reports, 2004/05 to 2007/08**²⁹⁴

Year	Total reports	Re-report same reporter type, same reported issue type		Re-report any reporter type, same reported issue type	
	Number	Number	% of total reports	Number	% of total reports
2004/05	216,386	11,995	5.5	32,055	14.8
2005/06	241,003	15,023	6.2	37,736	15.7
2006/07	286,033	21,245	7.4	50,176	17.5
2007/08 preliminary	302,977	21,197	7.0	51,933	17.1
% change 2004/05 to 2007/08	40.0	76.7	-	62.0	-

Note: 'Re-report same reporter type, same reported issue type' is a subset of 'Re-report any reporter type, same reported issue type'.

- 5.37 While there was a large increase in overall numbers for both re-report indicators from 2004/05 to 2007/08, numbers remained relatively flat from 2006/07 to 2007/08. Despite these fluctuations, the percentage of short term re-reports by the same reporter type has remained consistent at around six per cent to seven per cent of total reports. Short term re-reports by any reporter type also remained relatively consistent across the four year period at around 15 per cent to 18 per cent of total reports.²⁹⁵
- 5.38 During 2006/07, reporters from NGOs (14 per cent), health reporters and relatives (10.3 per cent and 10.2 per cent respectively) accounted for the greatest percentage of short term re-reports. Despite reporting the highest number of total reports, police have a relatively low percentage of short term re-reports at 4.7 per cent, compared with the average for all reporters of 7.4 per cent.²⁹⁶
- 5.39 Of the top 10 primary reported issues that are re-reported within seven days, the issue of 'runaway child/young person' was far more likely to be re-reported within seven days by the same reporter (22.4 per cent) and by any reporter (42.1 per cent) than any other reported issue. Of these short term re-reports by the same reporter type with a primary reported issue of 'runaway child/young person', 64 per cent were made by NGOs.²⁹⁷ The high number of reports about this issue are likely to be due to a number of factors including NGOs reporting each runaway child twice, first when they run away and secondly when they return, and the frequency with which a proportion of children in care run away.
- 5.40 Short term re-reports by the same reporter type were slightly more likely for infants aged less than one year and older children aged 13-15 years.

²⁹⁴ *ibid.* and DoCS, *Child Protection 2007/08. A Preliminary Analysis*, August 2008.

²⁹⁵ DoCS, *Child Protection 2007/08. A Preliminary Analysis*, August 2008.

²⁹⁶ DoCS *Child Protection matters that are re-reported within a 7 day period*.

²⁹⁷ *ibid.*

- 5.41 Of those reports about Aboriginal children, 20 per cent were short term re-reports compared with 17 per cent for other children. A similar pattern is seen for short term re-reports by the same reporter type.

Table 5.15 Re-report on the same issue type within 7 days of a child protection report by selected indicators, 2006/07²⁹⁸

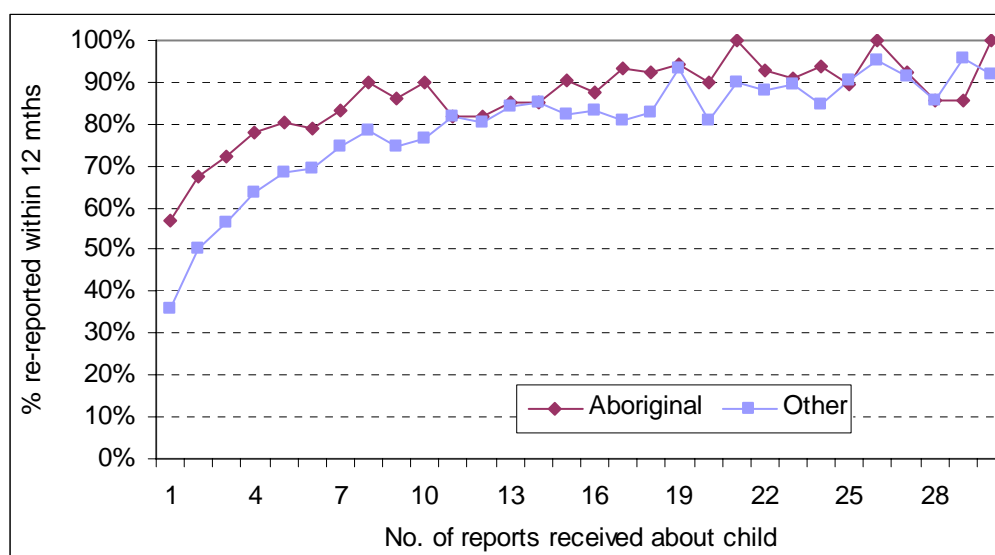
	<i>Total reports</i>		<i>Re-report same reporter type, same reported issue type</i>		<i>Re-report any reporter type, same reported issue type</i>	
	<i>No</i>		<i>No</i>	<i>% of total reports</i>	<i>No</i>	<i>% of total reports</i>
<i>Reporter type (grouped)</i>						
Police	93,069		4,411	4.7		
Health	43,870		4,532	10.3		
School / Child care	35,741		2,065	5.8		
NGO	21,318		3,077	14.4		
Other mandatory	18,018		752	4.2		
Total mandatory	212,016		14,837	7.0		
Relative	45,047		4,607	10.2		
Friend / neighbour	9,276		618	6.7		
Other	19,694		1,183	6.0		
Total non-mandatory / other	74,017		6,408	8.7		
<i>Top 10 Primary reported issues (sorted on re-reports by same reporter type)</i>						
Runaway child / young person	7,412		1,661	22.4	3,118	42.1
Carer: Other Issues: Development disability, carer	325		44	13.5	60	18.5
Carer mental health: Psychiatric disability, carer	4,341		566	13.0	1,194	27.5
Neglect: Failure to thrive, non-organic	225		27	12.0	47	20.9
Suicide risk for child	3,861		454	11.8	937	24.3
Neglect: Inadequate shelter or homeless	14,597		1,588	10.9	3,853	26.4
Suicide risk / attempt of carer	3,016		325	10.8	760	25.2
Carer: Other Issues: Legal guardianship issues	4,521		485	10.7	1,141	25.2
Drug use by child or young person	1,976		207	10.5	418	21.2
Carer mental health: Emotional state of carer	14,061		1416	10.1	3,163	22.5
<i>Age of child at time of first report</i>						
< 1 year	26,853		2,455	9.1	4,952	18.4
1 – 3 years	49,650		3,534	7.1	8,531	17.2
4 – 8 years	78,998		5,057	6.4	13,301	16.8
9 – 12 years	59,873		4,262	7.1	10,153	17.0
13 – 15 years	55,234		5,070	9.2	11,432	20.7
16 – 17 years	11,983		808	6.7	1,709	14.3
Not stated	3,442		59	1.7	98	2.8
<i>Aboriginality</i>						
Aboriginal	49,443		4,464	9.0	9,762	19.7
Non-Aboriginal / not stated	236,590		16,781	7.1	40,414	17.1
Total Reports	286,033		21,245	7.4	50,176	17.5

²⁹⁸ *ibid.*

5.42 The average number of reports per child per year has increased which suggests that there is an increased likelihood of continued contact with DoCS (being reported more times each year) for children and young persons with previous contact with the child protection system, particularly infants, adolescents and Aboriginal children and young persons.²⁹⁹

5.43 Figure 5.6 shows the likelihood of being reported again by the number of reports for Aboriginal and other children and young persons. The more reports that have been received about a child, the more likely it was that the child was reported again within 12 months. However, the overall likelihood for Aboriginal children to be reported again was greater than for other children. Once an Aboriginal child received his or her first report, they were more likely to be reported again within 12 months than not, with the likelihood of a further report being 57 per cent. This may be compared with a 36 per cent likelihood for other children. For Aboriginal children the likelihood of a further report increases to over two thirds (68 per cent) from the second report onwards, and to over 80 per cent from the fifth report onwards. Comparatively, for other children, the likelihood of being reported again within 12 months rises above two thirds (68 per cent) from the fifth report onwards and above 80 per cent for 10 or more reports.³⁰⁰

Figure 5.6 **Percentage of children and young persons aged 0-16 years reported July-September 2004 who were reported again within 12 months, by Aboriginality and number of reports received about the child in 2005/06**³⁰¹



²⁹⁹ DoCS, *A closer look: Recent trends in child protection reports to DoCS December 2007*.

³⁰⁰ DoCS, *What DoCS Data tell us about Aboriginal clients*, December 2007.

³⁰¹ *ibid.*

Frequently reported children and families

- 5.44 Table 5.16 shows that of the frequently reported children and young persons in the period January to June 2007, there was an even gender split. School aged children from 5-15 years accounted for more than two thirds of all the frequently reported children. While in 2006/07, 12.8 per cent of children involved in child protection reports were Aboriginal, they accounted for 23.3 per cent of frequently reported children.

Table 5.16 Children and young persons who were the subject of 8 or more reports between January to June 2007 by age, gender and Aboriginality

<i>Total children and young persons</i>		1,739	% of 1,739
As a percentage of the total number of children and young persons involved in child protection reports , January to June 2007 (total estimated at 61,845)		2.8%	
Gender	Male	872	50.1
	Female	863	49.6
	Not stated	4	0.2
Age Group	Under 1 year	148	8.5
	1-2 years	186	10.7
	3-4 years	184	10.6
	5-11 years	621	35.7
	12-15 years	544	31.3
	16-17 years	56	3.2
Aboriginality	Aboriginal	406	23.3
	Non-Aboriginal	1,314	75.6
	Not stated	19	1.1
Whether in OOHC	Yes	47	2.7
	No	1,692	97.3

- 5.45 Table 5.17 provides some insight into the size of family groups of frequently reported children and young persons. Almost one quarter of all frequently reported children in the sample group were the subject of a plan, and in all likelihood from families, with three or more children.

Table 5.17 Children and young persons who were the subject of 8 or more reports between January to June 2007 by number of plans and children under the plan

<i>Number of children and young persons per plan</i>	<i>Number of plans</i>	<i>Percentage of plans</i>	<i>Total children involved</i>	<i>Percentage of children</i>
1	934	75.4	934	53.7
2	190	15.3	380	21.9
3	70	5.6	210	12.1
4	22	1.8	88	5.1
5	15	1.2	75	4.3
6	5	0.4	30	1.7
7	2	0.2	14	0.8
8	1	0.1	8	0.5
Total	1,239	100	1,739	100

Sibling groups

- 5.46 Over the three year period, from 2004/05 to 2006/07, the number of sibling groups³⁰² increased by 14 per cent. This compares with a 32 per cent increase in reports received by DoCS and a 21 per cent increase in children reported.
- 5.47 DoCS receives many reports from a small proportion of sibling groups. In each year from 2004/05 to 2006/07, around three per cent of sibling groups (ordered by the most frequently reported) accounted for a quarter of all reports while around 12 per cent of sibling groups accounted for half of all reports. For the combined three year period, reports were even more concentrated in the frequently reported sibling groups – the top 2.2 per cent and 8.5 per cent of sibling groups accounted for a quarter and a half of all reports respectively.
- 5.48 The most frequently encountered groups in 2005/06:
- had the largest sibling groups
 - were relatively more likely in the regions of Hunter/Central Coast, Northern and Western and relatively less likely in the other regions (based on the sibling group's last referred report)
 - had an over representation of sibling groups where at least one child was identified as Aboriginal
 - were more likely to have reports involving neglect or carer drug and alcohol, and less likely to be reports involving sexual abuse and domestic violence

³⁰² DoCS' definition of a sibling group is "children in KiDS that are related (using the 'relationship' component with types: sibling of, sibling to be of, unborn sibling, half sibling of and step sibling of) and for those not matched using the 'relationship' component, where their address was the same." DoCS, *Child protection reports, Analysis of sibling groups*, February 2008.

- e. accounted for a large proportion of the assessment work undertaken by DoCS and were more likely to have reports determined to involve actual harm or risk of harm
- f. were more likely to have children who had ever been in OOHC and who entered OOHC after a child protection report in 2005/06
- g. had higher proportions of short term re-reports.³⁰³

Requests for assistance

Table 5.18 **Number of requests for assistance – s.20 and s.21, 2006/07**

<i>Legal Basis (Caseworker's Perspective)</i>	<i>Assessment – IA – Outcome</i>	<i>No of Reports</i>
Section 20 C/YP request assistance	To CSC/JIRT further assessment	336
	Info forwarded to DoCS unit	91
	Info only provided	38
	Advice and guidance only	16
	CW does not believe ROH	13
	Referral	6
	Reporter info already known	3
	Initial assessment end premature	1
	Not entered	0
Total – section 20 C/YP request assistance		504
Section 21 parent request assistance	To CSC/JIRT further assessment	4803
	Info forwarded to DoCS unit	863
	Info only provided	201
	Advice and guidance only	49
	CW does not believe ROH	47
	Referral	31
	Reporter info already known	18
	Initial assessment end premature	6
	Not entered	5
Total – section 21 Parent request assistance		6,023
Total section 20 and 21		6,527

- 5.49 The 6,527 section 20 and 21 requests for assistance made to the Helpline in 2006/07 were in addition to the 286,033 child protection reports. Of these, the great majority came from parents requesting assistance.

³⁰³ *ibid.*

Outcome of assessment at the Helpline

- 5.50 The data in the following sections largely relates to those reports referred to a CSC/JIRT for secondary assessment. The data referred to as 2007/08 in these sections relate to the 12 month period from April 07/March 08.
- 5.51 Over the four years from 2004/05 to 2007/08, between 30 and 35 per cent of reports did not proceed to a CSC/JIRT for further assessment. In the last two years the percentage has been around 30 per cent. However, not all of these reports were closed at the Helpline. A significant number were forwarded as information to a CSC/JIRT. In 2004/05, such reports accounted for 21.9 per cent of all reports and in 2007/08, the figure was 17.7 per cent.

Table 5.19 **Reports assessed as not requiring further investigation at the Helpline, 2004/05 to 2007/08**

Outcome of Helpline Assessment	2004/05		2005/06		2006/07		1 April 2007/31 March 2008	
	No	%	No	%	No	%	No	%
Information/advice or referral provided	14,853	6.9	20,616	8.6	23,299	8.1	27,505	9.3
No further assessment required	13,640	6.3	10,854	4.5	9,827	3.4	11,137	3.8
Not stated	399	0.2	318	0.1	153	0.1	214	0.1
Information forwarded to DoCS unit	47,310	21.9	48,373	20.1	51,546	18.0	52,630	17.7
<i>Total number of reports assessed as <u>not</u> requiring further investigation</i>	<i>76,202</i>	<i>35.2</i>	<i>80,161</i>	<i>33.3</i>	<i>84,825</i>	<i>29.7</i>	<i>91,486</i>	<i>30.8</i>
Total number of reports	216,386	100	241,003	100	286,033	100	296,769	100

Note: percentage is of the total number of reports received for each year

Reports referred to a CSC/JIRT for further assessment

- 5.52 Since 2001/02, the proportion of reports referred to a CSC/JIRT for further assessment has increased slightly. The proportion of reports referred remained fairly steady between 2006/07 and 2007/08 at around 70 per cent.

Table 5.20 **Total reports and reports referred to a CSC/JIRT for further assessment, 2001/02, 2005/06, 2006/07 and 1 April 2007/31 March 2008**³⁰⁴

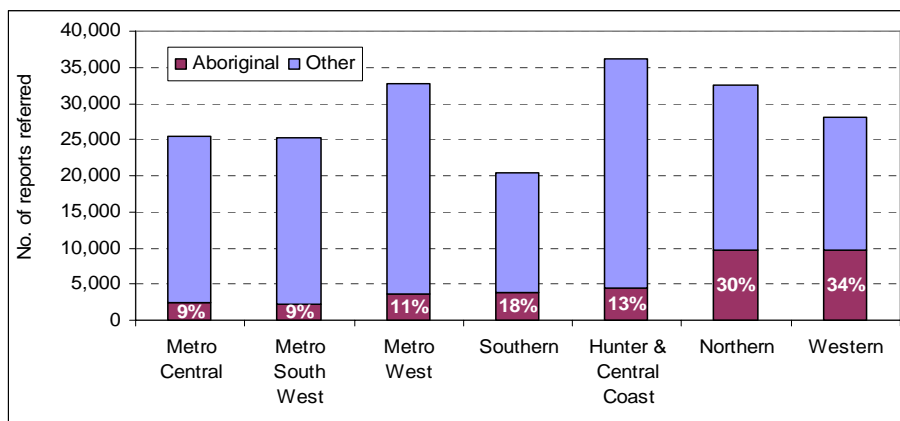
	2001/02		2005/06		2006/07		1 April 2007/31 March 2008	
	No	%	No	%	No	%	No	%
Referred to CSC/JIRT for further assessment	103,074	64.6	160,842	66.7	201,208	70.3	205,283	69.2
Other	56,569	35.5	80,161	33.3	84,825	29.7	91,486	30.8
Total	159,643	100	241,003	100	286,033	100	296,769	100

Region

5.53 The percentage share of referred reports by Region has remained consistent across each year in the period 2005/06 to 2007/08. Hunter and Central Coast Region has had the highest share of reports across each of the three years at 18 per cent to 19 per cent. Metro South West (including high demand localities such as Campbelltown, Liverpool and Fairfield) is the only Region to have consistently experienced higher than average growth rates across the period – with a 29 per cent increase from 2005/06 to 2006/07 and a six per cent increase from 2006/07 to 2007/08, where the State average was 25 per cent and three per cent growth respectively.³⁰⁵

5.54 Figure 5.7 shows that Western, Northern and Southern Regions had the highest proportions of reports referred to a CSC/JIRT for further assessment involving Aboriginal children and young persons (34 per cent, 30 per cent and 18 per cent respectively). This may be compared with a rate around 10 per cent for the other regions.³⁰⁶

Figure 5.7 **Number of reports referred to a CSC/JIRT for further assessment by DoCS region and Aboriginality, 2006/07**³⁰⁷



³⁰⁴ The finalised figures for 2007/08 are 209,015 reports referred to a CSC/JIRT for further assessment, which accounts for 69.0 per cent of total reports. DoCS, *Annual Report 2007/08*, p.4.

³⁰⁵ DoCS, *Child Protection 2007/08. A Preliminary Analysis*, August 2008.

³⁰⁶ DoCS, *What DoCS Data tell us about Aboriginal clients*, December 2007.

³⁰⁷ *ibid.*

Required response time and risk of harm

Table 5.21 Selected indicators for child protection reports referred to CSC/JIRT for secondary assessment, 2005/06 to 2007/08

	2005/06		2006/07		1 April 2007/31 March 2008	
	No	%	No	%	No	%
<i>Required Response Time</i>						
< 24 hours	17,406	10.8	19,193	9.5	18,970	9.2
< 72 hours	63,741	39.6	73,687	36.6	68,169	33.2
< 10 days	70,960	44.1	96,657	48.0	106,648	52.0
Other/missing	8,735	5.4	11,671	5.8	11,496	5.6
<i>Risk of harm</i>						
High	55,548	34.5	73,979	36.8	66,011	32.2
Medium	72,666	45.2	93,067	46.3	103,061	50.2
Low	24,035	14.9	22,636	11.3	24,665	12.0
Other/missing	8,593	5.3	11,526	5.7	11,546	5.6
<i>Region</i>						
Metro Central	19,867	12.4	25,371	12.6	25,696	12.5
Metro West	26,182	16.3	32,741	16.3	33,545	16.3
Metro South West	19,521	12.1	25,233	12.5	26,299	12.8
Southern	15,454	9.6	20,314	10.1	20,219	9.8
Hunter and Central Coast	30,373	18.9	36,171	18.0	36,425	17.7
Northern	26,485	16.5	32,622	16.2	32,828	16.0
Western	22,495	14.0	28,159	14.0	29,531	14.4
Statewide Services/other	465	0.3	597	0.3	740	0.4
Total referred for secondary assessment	160,842	100	201,208	100	205,283	100

- 5.55 For those reports referred to a CSC/JIRT for secondary assessment, a required response time and risk of harm level are recorded. Table 5.21 above shows that in 2007/08, 9.2 per cent of reports had a required response time of less than 24 hours, 33.2 per cent a response time of less than 72 hours and 52.0 per cent a response time of less than 10 days. Those reports with a more urgent response time (less than 24 hours or less than 72 hours) have been decreasing as a percentage of referred reports across the three year period, while those reports with less urgent response times (less than 10 days) have been increasing.³⁰⁸
- 5.56 Likewise, there has been a general decrease in the percentage of referred reports classified as high risk. There has however been a increase in those classified as medium risk. In 2007/08, 32.2 per cent of referred reports were classified as high risk, down from 36.8 per cent in 2006/07. Whereas medium

³⁰⁸ DoCS, *Child Protection 2007/08. A Preliminary Analysis*, August 2008.

risk reports made up 50.2 per cent of referred reports in 2007/08, compared with 46.3 per cent in 2006/07 and 45.2 per cent in 2005/06.³⁰⁹

Required response time and primary reported issue

5.57 In 2006/07, of the domestic violence reports made by mandatory reporters and referred to a CSC/JIRT for further assessment:

- a. 2.3 per cent were assigned a response time of less than 24 hours
- b. 31.7 per cent were assigned a response time of less than 72 hours
- c. 62.4 per cent were assigned a response time of less than 10 days.

Table 5.22 **Domestic violence reports (primary reported issue) referred to the CSC/JIRT for further assessment by required response time and reporter, 2006/07**

<i>Reporter type</i>	<i>< 24 hours</i>	<i>< 72 hours</i>	<i>< 10 days</i>	<i>10+ days/not stated</i>	<i>Total</i>
Police	609	10,549	23,604	1,121	35,883
Health	235	1,907	2,527	262	4,931
School/childcare	68	683	1,158	86	1,995
Other Mandatory	162	1,706	1,946	251	4,065
Total mandatory	1,074	14,845	29,235	1,720	46,874
Non-Mandatory	194	1,745	1,892	276	4,107
Total	1,268	16,590	31,127	1,996	50,981

5.58 In 2006/07, of the neglect reports made by mandatory reporters and referred to a CSC/JIRT for further assessment:

- a. 19.9 per cent were assigned a response time of less than 24 hours
- b. 38.5 per cent were assigned a response time of less than 72 hours
- c. 35.8 per cent were assigned a response time of less than 10 days.

Table 5.23 **Neglect reports (primary reported issue) referred to the CSC/JIRT for further assessment by required response time and reporter, 2006/07**

<i>Reporter type</i>	<i>< 24 hours</i>	<i>< 72 hours</i>	<i>< 10 days</i>	<i>10+ days/not stated</i>	<i>Total</i>
Police	1,469	2,173	2,032	242	5,916
Health	816	1,739	1,044	230	3,829
School/childcare	347	1,342	2,213	202	4,104
Other Mandatory	1,248	2,259	1,681	457	5,645
Total mandatory	3,880	7,513	6,970	1,131	19,494
Non-mandatory	2,648	4,748	4,578	641	12,615
Total	6,528	12,261	11,548	1,772	32,109

³⁰⁹ *ibid.*

- 5.59 In 2006/07, of the physical abuse reports made by mandatory reporters and referred to a CSC/JIRT for further assessment:
- a. 14.3 per cent were assigned a response time of less than 24 hours
 - b. 42.3 per cent were assigned a response time of less than 72 hours
 - c. 38.9 per cent were assigned a response time of less than 10 days.

Table 5.24 Physical abuse reports (primary reported issue) referred to the CSC/JIRT for further assessment by required response time and reporter, 2006/07

<i>Reporter type</i>	<i>< 24 hours</i>	<i>< 72 hours</i>	<i>< 10 days</i>	<i>10+ days/not stated</i>	<i>Total</i>
Police	659	1,999	1,977	262	4,897
Health	841	2,213	1,479	268	4,801
School/childcare	1,180	3,303	3,715	208	8,406
Other Mandatory	524	1,960	1,536	265	4,285
Total mandatory	3,204	9,475	8,707	1,003	22,389
Non-mandatory	1,073	4,121	3,247	433	8,874
Total	4,277	13,596	11,954	1,436	31,263

- 5.60 In 2006/07, of the carer drug and alcohol reports made by mandatory reporters and referred to a CSC/JIRT for further assessment:
- a. 7.4 per cent were assigned a response time of less than 24 hours
 - b. 40.0 per cent were assigned a response time of less than 72 hours
 - c. 46.4 per cent were assigned a response time of less than 10 days.

Table 5.25 Carer drug and alcohol reports (primary reported issue) referred to the CSC/JIRT for further assessment by required response time and reporter, 2006/07

<i>Reporter type</i>	<i>< 24 hours</i>	<i>< 72 hours</i>	<i>< 10 days</i>	<i>10+ days/not stated</i>	<i>Total</i>
Police	433	1,941	2,480	236	5,090
Health	316	2,017	2,096	370	4,799
School/childcare	90	531	858	95	1,574
Other Mandatory	181	990	928	150	2,249
Total mandatory	1,020	5,479	6,362	851	13,712
Non-mandatory	483	3,624	3,555	664	8,326
Total	1,503	9,103	9,917	1,515	22,038

5.61 In 2006/07, of the psychological abuse reports made by mandatory reporters and referred to a CSC/JIRT for further assessment:

- a. 3.3 per cent were assigned a response time of less than 24 hours
- b. 25.9 per cent were assigned a response time of less than 72 hours
- c. 63.9 per cent were assigned a response time of less than 10 days.

Table 5.26 Psychological abuse reports (primary reported issue) referred to the CSC/JIRT for further assessment by required response time and reporter, 2006/07

<i>Reporter type</i>	<i>< 24 hours</i>	<i>< 72 hours</i>	<i>< 10 days</i>	<i>10+ days/not stated</i>	<i>Total</i>
Police	108	593	2,192	166	3,059
Health	86	927	1,293	155	2,461
School/childcare	57	518	2,150	168	2,893
Other Mandatory	96	691	1,105	249	2,141
Total mandatory	347	2,729	6,740	738	10,554
Non-mandatory	136	1,536	3,425	352	5,449
Total	483	4,265	10,165	1,090	16,003

5.62 In 2006/07, of the carer mental health reports made by mandatory reporters and referred to a CSC/JIRT for further assessment:

- a. 11.3 per cent were assigned a response time of less than 24 hours
- b. 45.8 per cent were assigned a response time of less than 72 hours
- c. 36.8 per cent were assigned a response time of less than 10 days.

Table 5.27 Carer mental health reports (primary reported issue) referred to the CSC/JIRT for further assessment by required response time and reporter, 2006/07

<i>Reporter type</i>	<i>< 24 hours</i>	<i>< 72 hours</i>	<i>< 10 days</i>	<i>10+ days/not stated</i>	<i>Total</i>
Police	224	865	899	133	2,121
Health	823	3,623	2,754	443	7,643
School/childcare	88	448	469	76	1,081
Other Mandatory	344	1,076	716	157	2,293
Total mandatory	1,479	6,012	4,838	809	13,138
Non-mandatory	547	1,345	1,091	242	3,225
Total	2,026	7,357	5,929	1,051	16,363

- 5.63 In 2006/07, of the sexual abuse reports made by mandatory reporters and referred to a CSC/JIRT for further assessment:
- 8.8 per cent were assigned a response time of less than 24 hours
 - 36.5 per cent were assigned a response time of less than 72 hours
 - 47.8 per cent were assigned a response time of less than 10 days.

Table 5.28 Sexual abuse reports (primary reported issue) referred to the CSC/JIRT for further assessment by required response time and reporter, 2006/07

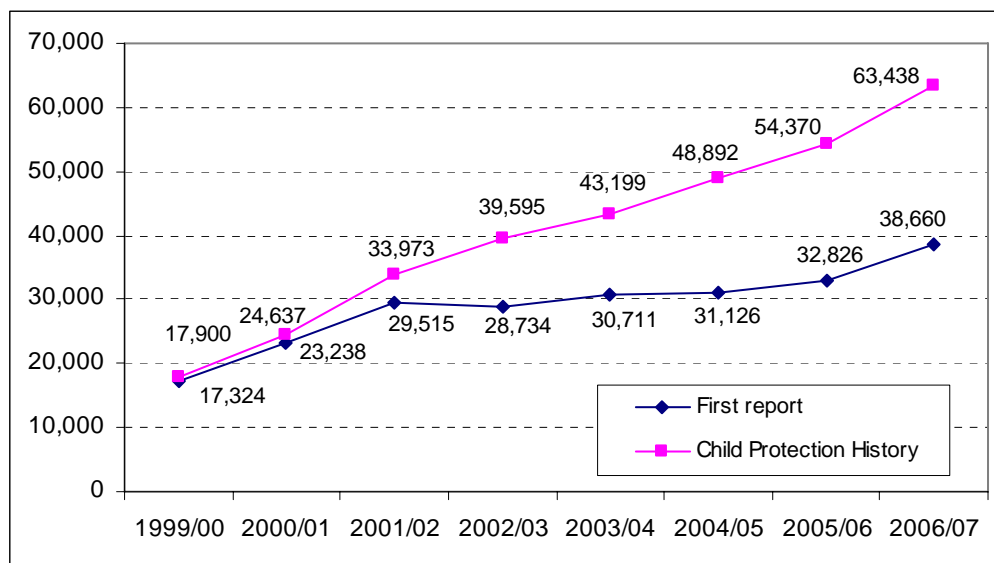
<i>Reporter type</i>	<i><24 hours</i>	<i><72 hours</i>	<i><10 days</i>	<i>10+ days/not stated</i>	<i>Total</i>
Police	445	1,230	1,156	149	2,980
Health	181	929	1,060	230	2,400
School/childcare	177	802	1,953	159	3,091
Other Mandatory	158	1,023	1,041	209	2,431
Total mandatory	961	3,984	5,210	747	10,902
Non-mandatory	209	1,386	1,786	301	3,682
Total	1,170	5,370	6,996	1,048	14,584

- 5.64 Thus, reports by mandatory reporters where the primary reported issue was neglect were more likely to be assigned a response time of less than 24 hours than any other reports. Neglect reports were followed by physical abuse reports, and then by carer mental health, sexual abuse, and carer drug and alcohol reports in this respect. The reports that were least likely to receive a response time of less than 24 hours were reports where the primary reported issue was domestic violence.

Child protection history

- 5.65 The number of children and young persons who were the subject of reports requiring further assessment at a CSC/JIRT and who were known to DoCS has increased at a substantially higher rate than that for the number of new children similarly referred. In 2006/07, 62.1 per cent of those children who were the subject of a report referred to CSC/JIRT for further assessment had a child protection history compared with 50.8 per cent in 1999/00.³¹⁰
- 5.66 In 2006/07, a higher proportion of known children and young persons were the subject of reports that were referred to a CSC/JIRT for further assessment compared with new children and young persons similarly referred. Reports on 90.3 per cent of the 70,229 known children and young persons who were subject of a child protection report in 2006/07 were referred to a CSC/JIRT. In contrast, reports on 72.3 per cent of the 53,461 new children and young persons who were subject of a child protection report in 2006/07 were similarly referred (see Figure 5.8).

Figure 5.8 **Children and young persons who were the subject of a report referred to a CSC/JIRT for further assessment by child protection history status, 1999/00 to 2006/07**³¹¹



Allocation rates

- 5.67 DoCS calculates allocation rates based on the number of reports that have a Secondary Assessment Stage 1 (SAS1) or a Secondary Assessment Stage 2 (SAS2) commenced on KiDS as a percentage of the number of reports referred to a CSC/JIRT for secondary assessment.

³¹⁰ DoCS, *A closer look: Recent trends in child protection reports to DoCS*, December 2007.

³¹¹ *ibid.*

Table 5.29 Allocation rates by required response time and regions, 2006/07

Region	Required Response Time		
	Less than 24 hours	Less than 72 hours	Less than 10 days
Hunter/Central Coast	96.6	60.7	31.6
Metro Central	99.2	65.0	38.8
Metro South West	95.5	60.7	42.6
Metro West	96.4	64.0	40.7
Northern	97.6	73.1	61.1
Southern	97.0	64.8	51.3
Western	98.0	74.9	59.1
Statewide average	97.2	66.3	45.9

Table 5.30 Allocation rates 2006/07 and 2007/08

Required response time	2006/07	1 April 2007/31 March 2008
Less than 24 hours	97.2%	98.0%
Less than 72 hours	66.3%	75.5%
Less than 10 days	45.9%	55.9%
Percentage of all reports referred to CSC/JIRT that were allocated	61.3%	66.9%

- 5.68 Allocation rates in 2006/07 were 97.2 per cent for reports with a less than 24 hours response time, 66.3 per cent for reports with a less than 72 hours response time and 45.9 per cent for reports with less than 10 days response time. Allocation rates during April 07/March 08 have increased to 98.0 per cent, 75.5 per cent and 55.9 per cent respectively.

Section 248 directions

Table 5.31 Child protection reports with Section 248 directions made, 2006/07

	Total number	As a percentage of total number of reports with s.248 directions made	As a percentage of the total number of reports referred to CSC/JIRT
Reports with Section 248 directions made by DoCS	15,414	100	7.7
Reports with Section 248 directions made that were closed before secondary assessment due to competing priorities (total = 77,386)	321	2.1	0.2
Reports with Section 248 directions made that received a SAS1 and then closed due to competing priorities (total = 17,705)	895	5.8	0.4

- 5.69 Of the total number of child protection reports received in 2006/07, 15,414 had s.248 directions made in relation to them. This represents 5.4 per cent of total reports and 7.7 per cent of reports referred to a CSC/JIRT for further assessment.

- 5.70 Of those 77,386 reports that were closed at the CSC before any secondary assessment due to 'current competing priorities', 0.4 per cent had been subject to a s.248 direction.
- 5.71 Of those 17,705 reports that were closed after a SAS1 due to competing priorities, 5.1 per cent were subject of a s.248 direction.
- 5.72 Overall fewer than 10 per cent of s.248 directions were made in circumstances where the case had been referred to a CSC and was subsequently closed due to competing priorities.
- 5.73 KiDS data do not distinguish multiple section 248 directions that may have been made about one child protection report. DoCS advises that the data in the above table have been obtained from coded fields in KiDS, and the quality and completeness of data has not been tested.

Sections 17 and 248 – Requests to NSW Health

- 5.74 The Inquiry has been informed that DoCS does not have the capacity to keep statistics on s.17 requests and responses. NSW Health (Health), however, does, and its data follows.

Table 5.32 **Requests made to NSW Health under ss.17 and 248, 2006/07 and 2007/08**

<i>Health service</i>	<i>Section 248 directions received</i>		<i>Section 17 requests</i>	
	<i>2006/07</i>	<i>2007/08</i>	<i>2006/07</i>	<i>2007/08</i>
Hunter New England AHS	1,016	1,203	33	22
Northern Sydney Central Coast AHS	792	983	3	3
The Children's Hospital at Westmead	272	288		
Greater Southern AHS	381	513	0	0
Greater Western AHS	190	320	0	2
South Eastern Sydney Illawarra AHS	735	765	0	2
Sydney South West AHS	1,226	1,388	25	27
South West AHS	1,650	2,415	32	16
Justice Health		30		
Total	6,262	7,905	93	72

- 5.75 Health received 6,262 s.248 requests in 2006/07, increasing to 7,905 requests in 2007/08, which represents a 26.2 per cent increase.
- 5.76 In 2006/07, 40.6 per cent of all s.248 directions by DoCS were made to Health.
- 5.77 The level of urgency assigned to s.248 requests varied considerably between health services. Hunter New England Area Health Service, Sydney South West Area Health Service, Northern Sydney Central Coast Area Health Service and

The Children's Hospital at Westmead reported that up to one quarter of the s.248 requests were urgent. South West Area Health Service reported up to one third were urgent and Greater Western Area Health Service reported over 40 per cent were urgent. In contrast, South Eastern Sydney Illawarra Area Health Service reported that no s.248 requests were urgent and Greater Southern Area Health Service reported that less than five per cent were urgent.

Case closure

Table 5.33 Reports closed at CSC/JIRT before any secondary assessment

	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	1 April 2007/31 March 2008
Reports closed before any secondary assessment							
Number	30,647	66,717	n/a	65,975	69,347	77,567	63,115
As a Percentage of the total reports referred to CSC/JIRT	29.7	58.0	n/a	47.1	43.1	38.6	30.7
Number of reports referred to CSC/JIRT for further assessment	103,074	115,000	121,368	140,184	160,842	201,208	205,283

Notes: n/a – not available. DoCS advises limited data were available for 2003/04 due to the introduction of the new client information system, KiDS. Data is not comparable between 2001/02, 2002/03 and 2004/05 to 2007/08 because of the change in the data series.

Table 5.34 Reports closed due to current competing priorities, 2006/07 and 2007/08

	2006/07	1 April 2007/31 March 08
Number of reports closed before any secondary assessment due to current completing priorities	77,386	62,568
Number of reports closed after SAS1 due to current completing priorities	17,705	23,137
Total closed at CSC/JIRT due to current competing priorities	95,091	85,705
Total closed at CSC/JIRT due to current competing priorities as a percentage of total reports referred to CSC/JIRT	47.3%	41.7%

- 5.78 The percentage of reports that were referred to a CSC/JIRT but were closed before any secondary assessment occurred has significantly decreased since 2002/03 when 58.0 per cent of all reports referred to a CSC/JIRT were so closed. In the period April 07/March 08, the percentage had fallen to 30.7 per cent of referred reports.
- 5.79 The number of reports closed at the CSC due to current competing priorities also decreased between 2006/07 and April 07/March 08. While the majority of these reports were closed prior to any secondary assessment commencing, a

significant proportion were closed after SAS1. Of all reports closed at the CSC due to competing priorities in April 07/March 08, 27.0 per cent were closed after SAS1. The corresponding figure for 2006/07 is 18.6 per cent.

Secondary Assessment Stage 2

Table 5.35 **Child protection reports subject of SAS2 by region, required response time and percentage of all reports referred, 2006/07**

<i>Region</i>	<i>Required response time</i>					<i>Total SAS2</i>	<i>Total reports referred</i>	<i>% of total reports referred</i>
	<i>< 24 Hours</i>	<i>< 72 hours</i>	<i>< 10 days</i>	<i>10 days or more</i>	<i>Not stated</i>			
Hunter/Central Coast	1,909	2,570	1,522	15	1,943	7,959	36,171	22.0
Metro Central	1,166	1,577	1,110	8	1,491	5,352	25,371	21.1
Metro South West	1,173	1,567	936	16	894	4,586	25,233	18.2
Metro West	1,359	1,700	897	11	975	4,942	32,741	15.1
Northern	1,654	2,511	1,809	23	2,230	8,227	32,622	25.2
Southern	883	1,428	1,027	6	1,098	4,442	20,314	21.9
Western	1,532	2,700	1,736	7	1,655	7,630	28,159	27.1
Statewide services	69	20	14	1	53	157	596	26.3
Total	9,745	14,073	9,051	87	10,339	43,295	201,208	21.5

Note: 'not stated figures include 'not specified'.

- 5.80 Table 5.35 shows a regional variation in the proportion of reports that received a SAS2 in 2006/07.
- 5.81 Table 5.36 indicates that the most likely outcome for children who received multiple SAS2s was to be reported multiple times in the 12 months following the six month assessment period. More than 60 per cent of the 2004 cohort who were the subject of multiple SAS2s were further reported more than twice. Over 35 per cent were subsequently reported five or more times. This was substantially higher than for children with only one SAS2 during the assessment period. Children who did not receive a SAS2 and who did not have a report allocated were most likely not to be reported again within the following 12 months.³¹²
- 5.82 Of the children detailed in Table 5.36 with multiple SAS2s, approximately one quarter entered an OOHC placement in the six month assessment period.

³¹² DoCS, *A closer look: recent trends in child protection reports-supplementary analysis*, February 2007.

Table 5.36 **Highest level of assessment received by children reported July – September 2004 in a 6 month assessment period by the number of subsequent reports in 12 months following the assessment period**³¹³

<i>Highest level of assessment</i>		<i>Number of subsequent reports in 12 months following the 6 month assessment period</i>				<i>Total</i>
		<i>1 report</i>	<i>2-4 reports</i>	<i>5+ reports</i>	<i>Not reported again</i>	
More than one SAS2	No	55	94	132	93	374
	%	14.7	25.1	35.3	24.9	100%
One SAS2	No	710	957	783	1,690	4,140
	%	17.1	23.1	18.9	40.8	100%
Allocated but no SAS2	No	1,628	2,163	1,332	4,483	9,606
	%	16.9	22.5	13.9	46.7	100%
Unallocated	No	2,903	2,581	1,082	12,111	18,677
	%	15.5	13.8	5.8	64.8	100%
Total	No	5,296	5,795	3,329	18,377	32,797
	%	16.1	17.7	10.2	56.0	100%

Assessment path

Assessment path of all child protection reports

5.83 In the following pages, the action DoCS took in respect of reports in 2006/07 and in April 07/March 08 is set out in Figures 5.9 to 5.12 prepared by the Inquiry with data provided by DoCS.

³¹³ *ibid.*

Child Protection Reports to DoCS 2006/07

HELPLINE outcome of initial assessment

286,033 reports

involving 123,690 children and young persons (CYP)

Unless stated otherwise, all percentages are of 286,033

Primary reported issue

Domestic Violence	26.0%	74,283
Police	19.0%	54,376
Health	2.2%	6,342
Education	0.9%	2,518
Other Mandatory	1.9%	5,534
Non-mandatory	1.9%	5,513
Neglect	14.7%	41,947
Police	2.6%	7,327
Health	1.7%	4,765
Education	1.8%	5,091
Other Mandatory	2.9%	8,154
Non-mandatory	5.8%	16,610
Physical Abuse	14.2%	40,559
Police	2.3%	6,590
Health	2.1%	6,022
Education	3.5%	10,141
Other Mandatory	2.1%	5,944
Non-mandatory	4.1%	11,862
Carer D&A	9.9%	28,295
Police	2.2%	6,340
Health	2.2%	6,172
Education	0.7%	1,937
Other Mandatory	1.0%	2,901
Non-mandatory	3.8%	10,945
Psychological Abuse	8.9%	25,589
Police	1.9%	5,318
Health	1.2%	3,394
Education	1.6%	4,661
Other Mandatory	1.3%	3,647
Non-mandatory	3.0%	8,569
Carer Mental Health	7.5%	21,418
Police	1.0%	2,954
Health	3.4%	9,677
Education	0.5%	1,374
Other Mandatory	1.0%	2,882
Non-mandatory	1.6%	4,531
Sexual Abuse	7.1%	20,204
Police	1.3%	3,709
Health	1.2%	3,414
Education	1.5%	4,430
Other Mandatory	1.2%	3,467
Non-mandatory	1.8%	5,184
CYP Risk taking Behaviour	5.5%	15,599*
Police	1.3%	3,632
Health	0.7%	2,046
Education	1.0%	2,859
Other Mandatory	1.4%	3,906
Non-mandatory	1.1%	3,156
Other	6.3%	18,139*

Reporter type

Police	32.5%	93,069
Health	15.3%	43,870
Education	12.5%	35,741
Other Mandatory	13.8%	39,336
Non-mandatory		
& Other	25.9%	74,017
All Mandatory	74.1%	212,016

Required Response Time

< 24 hrs	6.7%
< 72 hrs	25.8%
< 10 days	33.8%
10+ days	0.2%
Not stated	3.9%
Info forwarded to DoCS unit	18.0%
Stayed at Helpline	11.6%

Reports with more than one reported issue

Second issue listed	46.0%	131,582
Third issue listed	17.4%	49,677

Aboriginality

Reports		
Aboriginal	17.3%	49,443
Non-Aboriginal	82.7%	236,590

Number of children and young persons
% of 123,690

Aboriginal	12.8%	15,820
Non-Aboriginal	87.2%	107,870

Children and young persons
% of 123,690

Age of children & young persons		
< 1 year	9.5%	11,729
1-2 years	11.1%	13,791
3-4 years	11.3%	13,955
5-11 years	37.7%	46,626
12-15 years	22.8%	28,225
16-17 years	5.0%	6,227
Not stated	2.5%	3,137

Number of reports for each child or young person

1 to 3 reports	83.9%	103,826
4 to 10 reports	14.0%	17,291
11 to 20 reports	1.8%	2,214
more than 20 reports	0.3%	359

Reports not referred for any further assessment

84,825 reports

29.7% of 286,033 = 84,825 reports

All percentages are of 84,825

Primary Reported Issue

Domestic Violence	27.5%	23,302
Neglect	11.6%	9,838
Psychological Abuse	11.3%	9,586
Physical Abuse	11.0%	9,296
CYP-Risk taking Behaviour	7.7%	6,542
Carer D&A	7.4%	6,257
Sexual Abuse	6.6%	5,620
Carer Mental Health	6.0%	5,055
Other	11.0%	9,329

Reporter type

Police	35.3%	29,932
Health	12.1%	10,266
Education	10.4%	8,859
Other	42.2%	35,768

Assessment status of these reports

All percentages are of 286,033

Information forwarded to DoCS Unit	18.0%	51,546
CYP		29,386
Info/advice or referral provided	8.1%	23,299
CYP		21,099
No further assessment	3.4%	9,827
CYP		9,328
Not stated	0.1%	153

Reports referred for further assessment to the CSC/JIRT

201,208 reports

70.3% of 286,033 = 201,208 reports, involving 102,098 CYP

All percentages are of 201,208

Primary reported issue

Domestic Violence	25.3%	50,981
Neglect	16.0%	32,109
Physical Abuse	15.5%	31,263
Carer D&A	11.0%	22,038
Carer Mental Health	8.1%	16,363
Psychological Abuse	8.0%	16,003
Sexual Abuse	7.2%	14,584
CYP Risk-taking Behaviour		
Other	4.4%	8,808

Reporter type

Police	31.4%	63,137
Health	16.7%	33,604
Education	13.4%	26,882
Other	38.6%	77,585

Required response time

< 24 hrs	9.5%	19,193
< 72 hrs	36.6%	73,687
< 10 days	48.0%	96,657
10+ days	0.3%	559
Not stated	5.5%	11,095*

*Almost all of these reports were related to a current SAS1 or SAS2 record at the CSC/JIRT

Note:

Primary reported issue 'CYP Risk taking Behaviour' category comprises data on:

1. D&A use by CYP
2. Suicide risk for child
3. Runaway CYP

Reported issue 'Other' category comprises data on:

1. Carer other issues
2. Child inappropriate sexual behaviour
3. Other issues
4. No risk or harm issues
5. No primary Issues entered

Action taken at CSC / JIRT

Closed at CSC/JIRT before any Secondary Assessment	SAS1 only completed	SAS2 / Judgements and Decisions completed	Outcome of SAS2/J&D																																																																																																																																																																																																																																																																																						
<p>77,567 reports 27.1% of total reports 38.6% of referred reports involving 55,774 CYP</p> <p>All percentages are of 77,567</p> <p>Primary Reported Issue</p> <table> <tr><td>Domestic Violence</td><td>32.8%</td><td>25,441</td></tr> <tr><td>Physical Abuse</td><td>15.0%</td><td>11,657</td></tr> <tr><td>Neglect</td><td>12.4%</td><td>9,587</td></tr> <tr><td>Carer D&A</td><td>10.3%</td><td>7,979</td></tr> <tr><td>Psychological Abuse</td><td>9.3%</td><td>7,207</td></tr> <tr><td>Carer Mental Health</td><td>6.7%</td><td>5,172</td></tr> <tr><td>Sexual Abuse</td><td>5.5%</td><td>4,235</td></tr> <tr><td>CYP Risk taking Behaviour</td><td>4.4%</td><td>3,447</td></tr> <tr><td>Other</td><td>3.7%</td><td>2,842</td></tr> </table> <p>Reporter type</p> <table> <tr><td>Police</td><td>37.9%</td><td>29,417</td></tr> <tr><td>Education</td><td>15.2%</td><td>11,805</td></tr> <tr><td>Health</td><td>14.4%</td><td>11,187</td></tr> <tr><td>Other</td><td>32.4%</td><td>25,158</td></tr> </table> <p>Required Response Time</p> <table> <tr><td>< 24 hrs</td><td>0.7%</td><td>528</td></tr> <tr><td>< 72 hrs</td><td>31.8%</td><td>24,663</td></tr> <tr><td>< 10 days</td><td>67.2%</td><td>52,119</td></tr> <tr><td>10+ days</td><td>0.3%</td><td>257</td></tr> </table> <p>Reason for case closure</p> <table> <tr><td>No further assessment required or possible</td><td>0.2%</td><td>181</td></tr> <tr><td>Current competing priorities</td><td>99.8</td><td>77,386</td></tr> </table>	Domestic Violence	32.8%	25,441	Physical Abuse	15.0%	11,657	Neglect	12.4%	9,587	Carer D&A	10.3%	7,979	Psychological Abuse	9.3%	7,207	Carer Mental Health	6.7%	5,172	Sexual Abuse	5.5%	4,235	CYP Risk taking Behaviour	4.4%	3,447	Other	3.7%	2,842	Police	37.9%	29,417	Education	15.2%	11,805	Health	14.4%	11,187	Other	32.4%	25,158	< 24 hrs	0.7%	528	< 72 hrs	31.8%	24,663	< 10 days	67.2%	52,119	10+ days	0.3%	257	No further assessment required or possible	0.2%	181	Current competing priorities	99.8	77,386	<p>76,884 reports 26.9% of total reports 38.2% of referred reports involving 49,589 CYP</p> <p>All percentages are of 76,884</p> <p>Primary Reported Issue</p> <table> <tr><td>Domestic Violence</td><td>23.9%</td><td>18,404</td></tr> <tr><td>Neglect</td><td>17.3%</td><td>13,266</td></tr> <tr><td>Physical Abuse</td><td>15.2%</td><td>11,688</td></tr> <tr><td>Carer D&A</td><td>10.2%</td><td>7,880</td></tr> <tr><td>Carer Mental Health</td><td>9.3%</td><td>7,178</td></tr> <tr><td>Sexual Abuse</td><td>7.4%</td><td>5,721</td></tr> <tr><td>Psychological Abuse</td><td>7.4%</td><td>5,691</td></tr> <tr><td>CYP Risk taking Behaviour</td><td>4.2%</td><td>3,229</td></tr> <tr><td>Other</td><td>5.0%</td><td>3,827</td></tr> </table> <p>Reporter type</p> <table> <tr><td>Police</td><td>28.6%</td><td>21,977</td></tr> <tr><td>Health</td><td>18.1%</td><td>13,949</td></tr> <tr><td>Education</td><td>12.3%</td><td>9,454</td></tr> <tr><td>Other</td><td>41.0%</td><td>31,504</td></tr> </table> <p>Required Response Time</p> <table> <tr><td>< 24 hrs</td><td>10.6%</td><td>8,169</td></tr> <tr><td>< 72 hrs</td><td>43.4%</td><td>33,395</td></tr> <tr><td>< 10 days</td><td>44.7%</td><td>34,340</td></tr> <tr><td>10+ days</td><td>0.3%</td><td>207</td></tr> </table> <p>Note: 772 'not entered' and 1 'no response required'</p> <p>Reason for case closure</p> <table> <tr><td>Eligible Early Intervention</td><td>10.5%</td><td>8,108</td></tr> <tr><td>Other Information:</td><td></td><td></td></tr> <tr><td>- Early Intervention</td><td>0.6%</td><td>474</td></tr> <tr><td>- Close</td><td>55.9%</td><td>42,940</td></tr> <tr><td>- Referral-close</td><td>8.2%</td><td>6,325</td></tr> <tr><td>Closed:</td><td></td><td></td></tr> <tr><td>- Case Closure Policy</td><td>23.0%</td><td>17,705</td></tr> <tr><td>- Subjects not located</td><td>0.8%</td><td>643</td></tr> <tr><td>Streamed back to intake</td><td>0.9%</td><td>689</td></tr> </table>	Domestic Violence	23.9%	18,404	Neglect	17.3%	13,266	Physical Abuse	15.2%	11,688	Carer D&A	10.2%	7,880	Carer Mental Health	9.3%	7,178	Sexual Abuse	7.4%	5,721	Psychological Abuse	7.4%	5,691	CYP Risk taking Behaviour	4.2%	3,229	Other	5.0%	3,827	Police	28.6%	21,977	Health	18.1%	13,949	Education	12.3%	9,454	Other	41.0%	31,504	< 24 hrs	10.6%	8,169	< 72 hrs	43.4%	33,395	< 10 days	44.7%	34,340	10+ days	0.3%	207	Eligible Early Intervention	10.5%	8,108	Other Information:			- Early Intervention	0.6%	474	- Close	55.9%	42,940	- Referral-close	8.2%	6,325	Closed:			- Case Closure Policy	23.0%	17,705	- Subjects not located	0.8%	643	Streamed back to intake	0.9%	689	<p>43,295 reports 15.1% of total reports 21.5% of referred reports involving 15,346 CYP</p> <p>All percentages are of 43,295</p> <p>Primary Reported Issue</p> <table> <tr><td>Neglect</td><td>19.6%</td><td>8,498</td></tr> <tr><td>Physical Abuse</td><td>16.9%</td><td>7,299</td></tr> <tr><td>Domestic Violence</td><td>14.9%</td><td>6,451</td></tr> <tr><td>Carer D&A</td><td>13.3%</td><td>5,766</td></tr> <tr><td>Sexual Abuse</td><td>10.2%</td><td>4,407</td></tr> <tr><td>Carer Mental Health</td><td>8.6%</td><td>3,708</td></tr> <tr><td>Psychological Abuse</td><td>6.7%</td><td>2,894</td></tr> <tr><td>CYP Risk taking Behaviour</td><td>5.3%</td><td>2,280</td></tr> <tr><td>Other</td><td>4.6%</td><td>1,992</td></tr> </table> <p>Reporter type</p> <table> <tr><td>Police</td><td>25.1%</td><td>10,850</td></tr> <tr><td>Health</td><td>18.1%</td><td>7,842</td></tr> <tr><td>Education</td><td>11.9%</td><td>5,162</td></tr> <tr><td>Other</td><td>44.9%</td><td>19,441</td></tr> </table> <p>Required Response Time</p> <table> <tr><td>< 24 hrs</td><td>22.5%</td><td>9,745</td></tr> <tr><td>< 72 hrs</td><td>32.5%</td><td>14,073</td></tr> <tr><td>< 10 days</td><td>20.9%</td><td>9,051</td></tr> <tr><td>10+ days</td><td>0.2%</td><td>87</td></tr> </table> <p>Note: 10,323 'not entered' and 16 'no response required'</p> <p>Ongoing secondary assessment / Investigation</p> <p>3,462 reports involving 2,794 CYP</p>	Neglect	19.6%	8,498	Physical Abuse	16.9%	7,299	Domestic Violence	14.9%	6,451	Carer D&A	13.3%	5,766	Sexual Abuse	10.2%	4,407	Carer Mental Health	8.6%	3,708	Psychological Abuse	6.7%	2,894	CYP Risk taking Behaviour	5.3%	2,280	Other	4.6%	1,992	Police	25.1%	10,850	Health	18.1%	7,842	Education	11.9%	5,162	Other	44.9%	19,441	< 24 hrs	22.5%	9,745	< 72 hrs	32.5%	14,073	< 10 days	20.9%	9,051	10+ days	0.2%	87	<p>Harm or risk of harm 93.5% 40,472 No risk of harm 5.9% 2,556 Missing assessed issue 0.6% 267</p> <p>Substantiated Reports 40,472 reports involving 14,010 CYP All percentages are of 40,472</p> <p>Actual Harm 70% 28,335</p> <table> <tr><td>Psychological</td><td>27.7%</td><td>11,209</td></tr> <tr><td>Neglect</td><td>23.4%</td><td>9,451</td></tr> <tr><td>Physical</td><td>11.7%</td><td>4,722</td></tr> <tr><td>Sexual</td><td>7.3%</td><td>2,953</td></tr> </table> <p>Risk of Harm 30% 12,137</p> <table> <tr><td>Risk of Psychological Harm</td><td>11.8%</td><td>4,794</td></tr> <tr><td>Risk of Neglect</td><td>8.3%</td><td>3,376</td></tr> <tr><td>Risk of Physical Harm</td><td>6.9%</td><td>2,775</td></tr> <tr><td>Risk of Sexual Harm</td><td>2.9%</td><td>1,192</td></tr> </table> <p>Summary:</p> <table> <tr><td>Psychological/Risk of Psychological Harm</td><td>39.5%</td></tr> <tr><td>Neglect/Risk of Neglect</td><td>31.7%</td></tr> <tr><td>Physical/Risk of Physical Harm</td><td>18.5%</td></tr> <tr><td>Sexual /Risk of Sexual Harm</td><td>10.2%</td></tr> </table> <p>Primary Reported Issue</p> <table> <tr><td>Neglect</td><td>19.8%</td><td>8,004</td></tr> <tr><td>Physical Abuse</td><td>16.4%</td><td>6,618</td></tr> <tr><td>Domestic Violence</td><td>15.5%</td><td>6,274</td></tr> <tr><td>Carer D&A</td><td>13.5%</td><td>5,483</td></tr> <tr><td>Sexual Abuse</td><td>9.6%</td><td>3,874</td></tr> <tr><td>Carer Mental Health</td><td>8.7%</td><td>3,533</td></tr> <tr><td>Psychological Abuse</td><td>6.7%</td><td>2,699</td></tr> <tr><td>CYP Risk taking Behaviour</td><td>5.3%</td><td>2,136</td></tr> <tr><td>Other</td><td>4.6%</td><td>1,850</td></tr> </table> <p>Required Response Time</p> <table> <tr><td>< 24 hrs</td><td>22.3%</td><td>9,018</td></tr> <tr><td>< 72 hrs</td><td>32.5%</td><td>13,136</td></tr> <tr><td>< 10 days</td><td>20.9%</td><td>8,445</td></tr> <tr><td>10+ days</td><td>0.2%</td><td>81</td></tr> </table> <p>Note: 9,776 'not entered' and 16 'no response required'</p> <p>Age when harm or risk of harm determined % of 14,010 CYP All percentages are of 14,010</p> <table> <tr><td>< 1 year</td><td>14.0%</td><td>1,960</td></tr> <tr><td>1-2 years</td><td>13.0%</td><td>1,819</td></tr> <tr><td>3-4 years</td><td>12.2%</td><td>1,710</td></tr> <tr><td>5-11 years</td><td>37.1%</td><td>5,195</td></tr> <tr><td>12-15 years</td><td>21.4%</td><td>3,004</td></tr> <tr><td>16-17 years</td><td>2.2%</td><td>313</td></tr> <tr><td>Not stated</td><td>0.1%</td><td>9</td></tr> </table>	Psychological	27.7%	11,209	Neglect	23.4%	9,451	Physical	11.7%	4,722	Sexual	7.3%	2,953	Risk of Psychological Harm	11.8%	4,794	Risk of Neglect	8.3%	3,376	Risk of Physical Harm	6.9%	2,775	Risk of Sexual Harm	2.9%	1,192	Psychological/Risk of Psychological Harm	39.5%	Neglect/Risk of Neglect	31.7%	Physical/Risk of Physical Harm	18.5%	Sexual /Risk of Sexual Harm	10.2%	Neglect	19.8%	8,004	Physical Abuse	16.4%	6,618	Domestic Violence	15.5%	6,274	Carer D&A	13.5%	5,483	Sexual Abuse	9.6%	3,874	Carer Mental Health	8.7%	3,533	Psychological Abuse	6.7%	2,699	CYP Risk taking Behaviour	5.3%	2,136	Other	4.6%	1,850	< 24 hrs	22.3%	9,018	< 72 hrs	32.5%	13,136	< 10 days	20.9%	8,445	10+ days	0.2%	81	< 1 year	14.0%	1,960	1-2 years	13.0%	1,819	3-4 years	12.2%	1,710	5-11 years	37.1%	5,195	12-15 years	21.4%	3,004	16-17 years	2.2%	313	Not stated	0.1%	9
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< 24 hrs	0.7%	528																																																																																																																																																																																																																																																																																							
< 72 hrs	31.8%	24,663																																																																																																																																																																																																																																																																																							
< 10 days	67.2%	52,119																																																																																																																																																																																																																																																																																							
10+ days	0.3%	257																																																																																																																																																																																																																																																																																							
No further assessment required or possible	0.2%	181																																																																																																																																																																																																																																																																																							
Current competing priorities	99.8	77,386																																																																																																																																																																																																																																																																																							
Domestic Violence	23.9%	18,404																																																																																																																																																																																																																																																																																							
Neglect	17.3%	13,266																																																																																																																																																																																																																																																																																							
Physical Abuse	15.2%	11,688																																																																																																																																																																																																																																																																																							
Carer D&A	10.2%	7,880																																																																																																																																																																																																																																																																																							
Carer Mental Health	9.3%	7,178																																																																																																																																																																																																																																																																																							
Sexual Abuse	7.4%	5,721																																																																																																																																																																																																																																																																																							
Psychological Abuse	7.4%	5,691																																																																																																																																																																																																																																																																																							
CYP Risk taking Behaviour	4.2%	3,229																																																																																																																																																																																																																																																																																							
Other	5.0%	3,827																																																																																																																																																																																																																																																																																							
Police	28.6%	21,977																																																																																																																																																																																																																																																																																							
Health	18.1%	13,949																																																																																																																																																																																																																																																																																							
Education	12.3%	9,454																																																																																																																																																																																																																																																																																							
Other	41.0%	31,504																																																																																																																																																																																																																																																																																							
< 24 hrs	10.6%	8,169																																																																																																																																																																																																																																																																																							
< 72 hrs	43.4%	33,395																																																																																																																																																																																																																																																																																							
< 10 days	44.7%	34,340																																																																																																																																																																																																																																																																																							
10+ days	0.3%	207																																																																																																																																																																																																																																																																																							
Eligible Early Intervention	10.5%	8,108																																																																																																																																																																																																																																																																																							
Other Information:																																																																																																																																																																																																																																																																																									
- Early Intervention	0.6%	474																																																																																																																																																																																																																																																																																							
- Close	55.9%	42,940																																																																																																																																																																																																																																																																																							
- Referral-close	8.2%	6,325																																																																																																																																																																																																																																																																																							
Closed:																																																																																																																																																																																																																																																																																									
- Case Closure Policy	23.0%	17,705																																																																																																																																																																																																																																																																																							
- Subjects not located	0.8%	643																																																																																																																																																																																																																																																																																							
Streamed back to intake	0.9%	689																																																																																																																																																																																																																																																																																							
Neglect	19.6%	8,498																																																																																																																																																																																																																																																																																							
Physical Abuse	16.9%	7,299																																																																																																																																																																																																																																																																																							
Domestic Violence	14.9%	6,451																																																																																																																																																																																																																																																																																							
Carer D&A	13.3%	5,766																																																																																																																																																																																																																																																																																							
Sexual Abuse	10.2%	4,407																																																																																																																																																																																																																																																																																							
Carer Mental Health	8.6%	3,708																																																																																																																																																																																																																																																																																							
Psychological Abuse	6.7%	2,894																																																																																																																																																																																																																																																																																							
CYP Risk taking Behaviour	5.3%	2,280																																																																																																																																																																																																																																																																																							
Other	4.6%	1,992																																																																																																																																																																																																																																																																																							
Police	25.1%	10,850																																																																																																																																																																																																																																																																																							
Health	18.1%	7,842																																																																																																																																																																																																																																																																																							
Education	11.9%	5,162																																																																																																																																																																																																																																																																																							
Other	44.9%	19,441																																																																																																																																																																																																																																																																																							
< 24 hrs	22.5%	9,745																																																																																																																																																																																																																																																																																							
< 72 hrs	32.5%	14,073																																																																																																																																																																																																																																																																																							
< 10 days	20.9%	9,051																																																																																																																																																																																																																																																																																							
10+ days	0.2%	87																																																																																																																																																																																																																																																																																							
Psychological	27.7%	11,209																																																																																																																																																																																																																																																																																							
Neglect	23.4%	9,451																																																																																																																																																																																																																																																																																							
Physical	11.7%	4,722																																																																																																																																																																																																																																																																																							
Sexual	7.3%	2,953																																																																																																																																																																																																																																																																																							
Risk of Psychological Harm	11.8%	4,794																																																																																																																																																																																																																																																																																							
Risk of Neglect	8.3%	3,376																																																																																																																																																																																																																																																																																							
Risk of Physical Harm	6.9%	2,775																																																																																																																																																																																																																																																																																							
Risk of Sexual Harm	2.9%	1,192																																																																																																																																																																																																																																																																																							
Psychological/Risk of Psychological Harm	39.5%																																																																																																																																																																																																																																																																																								
Neglect/Risk of Neglect	31.7%																																																																																																																																																																																																																																																																																								
Physical/Risk of Physical Harm	18.5%																																																																																																																																																																																																																																																																																								
Sexual /Risk of Sexual Harm	10.2%																																																																																																																																																																																																																																																																																								
Neglect	19.8%	8,004																																																																																																																																																																																																																																																																																							
Physical Abuse	16.4%	6,618																																																																																																																																																																																																																																																																																							
Domestic Violence	15.5%	6,274																																																																																																																																																																																																																																																																																							
Carer D&A	13.5%	5,483																																																																																																																																																																																																																																																																																							
Sexual Abuse	9.6%	3,874																																																																																																																																																																																																																																																																																							
Carer Mental Health	8.7%	3,533																																																																																																																																																																																																																																																																																							
Psychological Abuse	6.7%	2,699																																																																																																																																																																																																																																																																																							
CYP Risk taking Behaviour	5.3%	2,136																																																																																																																																																																																																																																																																																							
Other	4.6%	1,850																																																																																																																																																																																																																																																																																							
< 24 hrs	22.3%	9,018																																																																																																																																																																																																																																																																																							
< 72 hrs	32.5%	13,136																																																																																																																																																																																																																																																																																							
< 10 days	20.9%	8,445																																																																																																																																																																																																																																																																																							
10+ days	0.2%	81																																																																																																																																																																																																																																																																																							
< 1 year	14.0%	1,960																																																																																																																																																																																																																																																																																							
1-2 years	13.0%	1,819																																																																																																																																																																																																																																																																																							
3-4 years	12.2%	1,710																																																																																																																																																																																																																																																																																							
5-11 years	37.1%	5,195																																																																																																																																																																																																																																																																																							
12-15 years	21.4%	3,004																																																																																																																																																																																																																																																																																							
16-17 years	2.2%	313																																																																																																																																																																																																																																																																																							
Not stated	0.1%	9																																																																																																																																																																																																																																																																																							

Child Protection Reports to DoCS 1 Apr 2007 – 31 Mar 2008

HELPLINE outcome of initial assessment

<p>296,769 reports involving 128,673 children and young persons (CYP) Unless stated otherwise, all percentages are of 296,769</p>		<p>Reports not referred for any further assessment</p> <p>91,486 reports 30.8% of 296,769 = 91,486 reports</p> <p>All percentages are of 91,486</p>		<p>Reports referred for further assessment to the CSC/JIRT</p> <p>205,283 reports 69.2% of 296,769 = 205,283 involving 104,535 CYP</p> <p>All percentages are of 205,283</p>			
<p>Primary reported issue</p> <p>Domestic Violence 25.9% 76,792</p> <p>Police 18.9% 55,976 Health 2.1% 6,326 Education 0.8% 2,472 Other Mandatory 2.1% 6,274 Non-mandatory & Other 1.9% 5,744</p> <p>Neglect 15.0% 44,407</p> <p>Police 2.8% 8,197 Health 1.7% 5,011 Education 1.9% 5,513 Other Mandatory 3.0% 8,988 Non-mandatory & Other 5.6% 16,698</p> <p>Physical Abuse 14.1% 41,953</p> <p>Police 2.3% 6,891 Health 2.1% 6,168 Education 3.5% 10,283 Other Mandatory 2.1% 6,336 Non-mandatory & Other 4.1% 12,275</p> <p>Carer D&A 10.4% 30,981</p> <p>Police 2.4% 7,247 Health 2.2% 6,530 Education 0.7% 2,213 Other Mandatory 1.1% 3,388 Non-mandatory & Other 3.9% 11,603</p> <p>Psychological Abuse 8.6% 25,626</p> <p>Police 1.8% 5,383 Health 1.2% 3,442 Education 1.6% 4,815 Other Mandatory 1.2% 3,444 Non-mandatory & Other 2.9% 8,542</p> <p>Carer Mental Health 8.0% 23,759</p> <p>Police 1.2% 3,492 Health 3.5% 10,409 Education 0.6% 1,746 Other Mandatory 1.2% 3,428 Non-mandatory & Other 1.6% 4,684</p> <p>Sexual Abuse 6.7% 19,890</p> <p>Police 1.3% 3,776 Health 1.1% 3,309 Education 1.4% 4,158 Other Mandatory 1.2% 3,573 Non-mandatory & Other 1.7% 5,074</p> <p>CYP Risk taking Behaviour 4.9% 14,434</p> <p>Police 1.3% 3,859 Health 0.7% 2,131 Education 1.0% 2,892 Other Mandatory 0.9% 2,715 Non-mandatory & Other 1.0% 2,837 Other 6.4% 18,927*</p>		<p>Reporter type</p> <p>Police 33.1% 98,114 Health 15.3% 45,396 Education 12.4% 36,945 Other Mandatory 13.8% 40,835 Non-mandatory & Other 25.4% 75,479 All Mandatory 74.6% 221,290</p> <p>Required Response Time</p> <p>< 24 hrs 6.4% < 72 hrs 23.0% < 10 days 35.9% 10+ days 0.2% Not stated 3.7% Stay at Helpline - no response time assigned 30.8%</p> <p>Reports with more than one reported issue</p> <p>Second issue listed 48.8% 144,716 Third issue listed 18.9% 56,017</p> <p>Aboriginality</p> <p>Reports</p> <p>Aboriginal 18.5% 54,760 Non-Aboriginal 81.5% 242,009</p> <p>Number of children and young persons</p> <p>% of 128,673</p> <p>Aboriginal 14.0% 17,982 Non-Aboriginal 86.0% 110,691</p>		<p>Primary Reported Issue</p> <p>Domestic Violence 28.6% 26,127 Neglect 12.0% 10,995 Physical Abuse 11.0% 10,063 Psychological Abuse 10.8% 9,878 Carer D&A 7.8% 7,113 Carer Mental Health 6.5% 5,932 Sexual Abuse 6.4% 5,879 CYP Risk taking Behaviour 6.2% 5,631 Other 10.8% 9,868</p> <p>Reporter type</p> <p>Police 36.9% 33,788 Health 12.2% 11,164 Education 10.4% 9,525 Other Mandatory 15.1% 13,813 Non-mandatory and Other 25.4% 23,196</p>		<p>Primary reported issue</p> <p>Domestic Violence 24.7% 50,665 Neglect 16.3% 33,412 Physical Abuse 15.5% 31,890 Carer D&A 11.6% 23,868 Carer Mental Health 8.7% 17,827 Psychological Abuse 7.7% 15,748 Sexual Abuse 6.8% 14,011 CYP Risk taking Behaviour 4.3% 8,803 Other 4.4% 9,059</p> <p>Reporter type</p> <p>Police 31.3% 64,326 Health 16.7% 34,232 Education 13.4% 27,420 Other Mandatory 13.2% 27,022 Non-mandatory and Other 25.5% 52,283</p> <p>Required response time</p> <p>< 24 hrs 9.2% 18,970 < 72 hrs 33.2% 68,169 < 10 days 52.0% 106,648 10+ days 0.2% 470</p> <p>Note: 11,026 listed as 'no response required' or 'not stated'</p>	
<p>Assessment status of these reports</p> <p>All percentages are of 296,769</p> <p>Information forwarded to DoCS Unit 17.7% 52,630</p> <p>Info/advice or referral provided 9.3% 27,505</p> <p>No further assessment 3.8% 11,137</p> <p>Not stated 0.1% 214</p>		<p>Note:</p> <p>Primary reported issue 'CYP Risk taking Behaviour' category comprises data on:</p> <ol style="list-style-type: none"> 1. D&A use by CYP 2. Suicide risk for child 3. Runaway CYP <p>Reported issue 'Other' category comprises data on:</p> <ol style="list-style-type: none"> 1. Carer other issues 2. Child inappropriate sexual behaviour 3. Other issues 4. No risk or harm issues 5. No primary Issues entered 					
<p>Children and young persons</p> <p>Age of children & young persons</p> <p>% of 123,690</p> <p><1 year 9.9% 12,745 1-2 years 11.4% 14,661 3-4 years 11.4% 14,623 5-11 years 37.5% 48,264 12-15 years 22.7% 29,208 16-17 years 5.1% 6,546 Not stated 2.0% 2,626</p> <p>Number of reports for each child or young person</p> <p>1 to 3 reports 83.8% 107,787 4 to 10 reports 14.3% 18,337 11 to 20 reports 1.7% 2,208 more than 20 reports 0.3% 341</p>							

Action taken at CSC / JIRT

Closed at CSC/JIRT before any Secondary Assessment	SAS1 only completed	SAS2 / Judgements and Decisions completed	Outcome of SAS2/J&D																																																																																																																																																																																																																																																																																															
<p>63,115 reports 21.3% of total reports 30.7% of referred reports involving 46,599 CYP</p> <p>All percentages are of 63,115</p> <p>Primary Reported Issue</p> <table> <tr><td>Domestic Violence</td><td>30.6%</td><td>19,288</td></tr> <tr><td>Physical Abuse</td><td>15.9%</td><td>10,052</td></tr> <tr><td>Neglect</td><td>12.7%</td><td>8,019</td></tr> <tr><td>Carer D&A</td><td>10.5%</td><td>6,617</td></tr> <tr><td>Psychological Abuse</td><td>9.3%</td><td>5,873</td></tr> <tr><td>Carer Mental Health</td><td>6.8%</td><td>4,265</td></tr> <tr><td>Sexual Abuse</td><td>5.4%</td><td>3,439</td></tr> <tr><td>CYP Risk taking Behaviour</td><td>5.1%</td><td>3,200</td></tr> <tr><td>Other</td><td>3.7%</td><td>2,362</td></tr> </table> <p>Reporter type</p> <table> <tr><td>Police</td><td>37.7%</td><td>23,809</td></tr> <tr><td>Health</td><td>13.9%</td><td>8,798</td></tr> <tr><td>Education</td><td>15.7%</td><td>9,907</td></tr> <tr><td>Other Mandatory</td><td>10.0%</td><td>6,306</td></tr> <tr><td>Non-mandatory and Other</td><td>22.6%</td><td>14,295</td></tr> </table> <p>Reason for case closure</p> <table> <tr><td>No further assessment required or possible</td><td>0.9%</td><td>547</td></tr> <tr><td>Current competing priorities</td><td>99.1%</td><td>62,568</td></tr> </table> <p>Required Response Time</p> <table> <tr><td>< 24 hrs</td><td>0.5%</td><td>335</td></tr> <tr><td>< 72 hrs</td><td>25.7%</td><td>16,252</td></tr> <tr><td>< 10 days</td><td>73.4%</td><td>46,344</td></tr> <tr><td>10+ days</td><td>0.3%</td><td>184</td></tr> </table>	Domestic Violence	30.6%	19,288	Physical Abuse	15.9%	10,052	Neglect	12.7%	8,019	Carer D&A	10.5%	6,617	Psychological Abuse	9.3%	5,873	Carer Mental Health	6.8%	4,265	Sexual Abuse	5.4%	3,439	CYP Risk taking Behaviour	5.1%	3,200	Other	3.7%	2,362	Police	37.7%	23,809	Health	13.9%	8,798	Education	15.7%	9,907	Other Mandatory	10.0%	6,306	Non-mandatory and Other	22.6%	14,295	No further assessment required or possible	0.9%	547	Current competing priorities	99.1%	62,568	< 24 hrs	0.5%	335	< 72 hrs	25.7%	16,252	< 10 days	73.4%	46,344	10+ days	0.3%	184	<p>98,656 reports 33.2% of total reports 48.1% of referred reports involving 61,596 CYP</p> <p>All percentages are of 98,656</p> <p>Primary Reported Issue</p> <table> <tr><td>Domestic Violence</td><td>25.5%</td><td>25,163</td></tr> <tr><td>Neglect</td><td>16.8%</td><td>16,589</td></tr> <tr><td>Physical Abuse</td><td>14.5%</td><td>14,307</td></tr> <tr><td>Carer D&A</td><td>11.4%</td><td>11,251</td></tr> <tr><td>Carer Mental Health</td><td>9.7%</td><td>9,605</td></tr> <tr><td>Psychological Abuse</td><td>7.3%</td><td>7,153</td></tr> <tr><td>Sexual Abuse</td><td>6.2%</td><td>6,124</td></tr> <tr><td>CYP Risk taking Behaviour</td><td>3.7%</td><td>3,686</td></tr> <tr><td>Other</td><td>4.8%</td><td>4,778</td></tr> </table> <p>Reporter type</p> <table> <tr><td>Police</td><td>30.0%</td><td>29,561</td></tr> <tr><td>Health</td><td>17.7%</td><td>17,426</td></tr> <tr><td>Education</td><td>12.1%</td><td>11,983</td></tr> <tr><td>Other Mandatory</td><td>13.7%</td><td>13,476</td></tr> <tr><td>Non-mandatory and Other</td><td>26.6%</td><td>26,210</td></tr> </table> <p>Reason for case closure</p> <table> <tr><td>Eligible Early Intervention</td><td>16.2%</td><td>15,965</td></tr> <tr><td>Other Information</td><td></td><td></td></tr> <tr><td>- Early Intervention</td><td>2.4%</td><td>2,375</td></tr> <tr><td>- Close</td><td>47.1%</td><td>46,420</td></tr> <tr><td>- Referral - Close</td><td>6.5%</td><td>6,412</td></tr> <tr><td>Closed</td><td></td><td></td></tr> <tr><td>- Case Closure Policy</td><td>23.5%</td><td>23,137</td></tr> <tr><td>- Subject Not Located</td><td>0.7%</td><td>691</td></tr> <tr><td>Streamed Back To Intake</td><td>3.7%</td><td>3,656</td></tr> </table> <p>Required Response Time</p> <table> <tr><td>< 24 hrs</td><td>8.4%</td><td>8,255</td></tr> <tr><td>< 72 hrs</td><td>39.0%</td><td>38,484</td></tr> <tr><td>< 10 days</td><td>50.5%</td><td>49,818</td></tr> <tr><td>10+ days</td><td>0.2%</td><td>210</td></tr> </table> <p>Note: 1,889 listed as 'no response required' or 'not stated'</p>	Domestic Violence	25.5%	25,163	Neglect	16.8%	16,589	Physical Abuse	14.5%	14,307	Carer D&A	11.4%	11,251	Carer Mental Health	9.7%	9,605	Psychological Abuse	7.3%	7,153	Sexual Abuse	6.2%	6,124	CYP Risk taking Behaviour	3.7%	3,686	Other	4.8%	4,778	Police	30.0%	29,561	Health	17.7%	17,426	Education	12.1%	11,983	Other Mandatory	13.7%	13,476	Non-mandatory and Other	26.6%	26,210	Eligible Early Intervention	16.2%	15,965	Other Information			- Early Intervention	2.4%	2,375	- Close	47.1%	46,420	- Referral - Close	6.5%	6,412	Closed			- Case Closure Policy	23.5%	23,137	- Subject Not Located	0.7%	691	Streamed Back To Intake	3.7%	3,656	< 24 hrs	8.4%	8,255	< 72 hrs	39.0%	38,484	< 10 days	50.5%	49,818	10+ days	0.2%	210	<p>38,745 reports 13.1% of total reports 18.9% of referred reports involving 14,443 CYP</p> <p>All percentages are of 38,745</p> <p>Primary Reported Issue</p> <table> <tr><td>Neglect</td><td>20.0%</td><td>7,752</td></tr> <tr><td>Physical Abuse</td><td>17.5%</td><td>6,764</td></tr> <tr><td>Domestic Violence</td><td>13.7%</td><td>5,327</td></tr> <tr><td>Carer D&A</td><td>13.7%</td><td>5,309</td></tr> <tr><td>Sexual Abuse</td><td>10.6%</td><td>4,106</td></tr> <tr><td>Carer Mental Health</td><td>9.2%</td><td>3,559</td></tr> <tr><td>Psychological Abuse</td><td>6.3%</td><td>2,446</td></tr> <tr><td>CYP Risk taking Behaviour</td><td>4.6%</td><td>1,782</td></tr> <tr><td>Other</td><td>4.4%</td><td>1,700</td></tr> </table> <p>Reporter type</p> <table> <tr><td>Police</td><td>24.8%</td><td>9,625</td></tr> <tr><td>Health</td><td>18.6%</td><td>7,210</td></tr> <tr><td>Education</td><td>12.7%</td><td>4,937</td></tr> <tr><td>Other Mandatory</td><td>16.7%</td><td>6,486</td></tr> <tr><td>Non-mandatory and Other</td><td>27.1%</td><td>10,487</td></tr> </table> <p>Required Response Time</p> <table> <tr><td>< 24 hrs</td><td>24.1%</td><td>9,347</td></tr> <tr><td>< 72 hrs</td><td>30.0%</td><td>11,613</td></tr> <tr><td>< 10 days</td><td>22.2%</td><td>8,594</td></tr> <tr><td>10+ days</td><td>0.1%</td><td>54</td></tr> </table> <p>Note: 9,137 listed as 'no response required' or 'not stated'</p>	Neglect	20.0%	7,752	Physical Abuse	17.5%	6,764	Domestic Violence	13.7%	5,327	Carer D&A	13.7%	5,309	Sexual Abuse	10.6%	4,106	Carer Mental Health	9.2%	3,559	Psychological Abuse	6.3%	2,446	CYP Risk taking Behaviour	4.6%	1,782	Other	4.4%	1,700	Police	24.8%	9,625	Health	18.6%	7,210	Education	12.7%	4,937	Other Mandatory	16.7%	6,486	Non-mandatory and Other	27.1%	10,487	< 24 hrs	24.1%	9,347	< 72 hrs	30.0%	11,613	< 10 days	22.2%	8,594	10+ days	0.1%	54	<p>Harm or risk of harm 93.2% 36,129 No risk of harm 5.8% 2,238 Missing assessed issue 1.0% 378</p> <p>Substantiated Reports 36,129 reports involving 13,205 CYP All percentages are of 36,129</p> <p>Actual Harm 69.8% 25,220</p> <table> <tr><td>Psychological</td><td>26.1%</td><td>9,422</td></tr> <tr><td>Neglect</td><td>24.0%</td><td>8,674</td></tr> <tr><td>Physical</td><td>12.3%</td><td>4,449</td></tr> <tr><td>Sexual</td><td>7.4%</td><td>2,675</td></tr> </table> <p>Risk of Harm 30.2% 10,909</p> <table> <tr><td>Risk of Psychological</td><td>12.4%</td><td>4,498</td></tr> <tr><td>Risk of Neglect</td><td>7.6%</td><td>2,734</td></tr> <tr><td>Risk of Physical</td><td>6.8%</td><td>2,472</td></tr> <tr><td>Risk of Sexual</td><td>3.3%</td><td>1,205</td></tr> </table> <p>Summary:</p> <table> <tr><td>Psychological/Risk of Psychological</td><td>38.5%</td></tr> <tr><td>Neglect/Risk of Neglect</td><td>31.6%</td></tr> <tr><td>Physical/Risk of Physical</td><td>19.2%</td></tr> <tr><td>Sexual/Risk of Sexual</td><td>10.7%</td></tr> </table> <p>Primary Reported Issue</p> <table> <tr><td>Neglect</td><td>20.2%</td><td>7,282</td></tr> <tr><td>Physical Abuse</td><td>17.2%</td><td>6,219</td></tr> <tr><td>Domestic Violence</td><td>14.2%</td><td>5,113</td></tr> <tr><td>Carer D&A</td><td>13.8%</td><td>4,993</td></tr> <tr><td>Sexual Abuse</td><td>10.0%</td><td>3,629</td></tr> <tr><td>Carer Mental Health</td><td>9.3%</td><td>3,374</td></tr> <tr><td>Psychological Abuse</td><td>6.3%</td><td>2,262</td></tr> <tr><td>CYP Risk taking Behaviour</td><td>4.7%</td><td>1,698</td></tr> <tr><td>Other</td><td>4.3%</td><td>1,559</td></tr> </table> <p>Required Response Time</p> <table> <tr><td>< 24 hrs</td><td>23.9%</td><td>8,620</td></tr> <tr><td>< 72 hrs</td><td>29.9%</td><td>10,811</td></tr> <tr><td>< 10 days</td><td>22.1%</td><td>7,991</td></tr> <tr><td>10+ days</td><td>0.1%</td><td>52</td></tr> </table> <p>Note: 8,655 listed as 'no response required' or 'not stated'</p> <p>Age when harm or risk of harm determined as % of 13,205 cyp All percentages are of 13,205</p> <table> <tr><td><1 year</td><td>13.9%</td><td>1,835</td></tr> <tr><td>1-2 years</td><td>13.7%</td><td>1,804</td></tr> <tr><td>3-4 years</td><td>12.0%</td><td>1,591</td></tr> <tr><td>5-11 years</td><td>36.2%</td><td>4,786</td></tr> <tr><td>12-15 years</td><td>21.7%</td><td>2,860</td></tr> <tr><td>16-17 years</td><td>2.4%</td><td>315</td></tr> <tr><td>Not stated</td><td>0.1%</td><td>14</td></tr> </table>	Psychological	26.1%	9,422	Neglect	24.0%	8,674	Physical	12.3%	4,449	Sexual	7.4%	2,675	Risk of Psychological	12.4%	4,498	Risk of Neglect	7.6%	2,734	Risk of Physical	6.8%	2,472	Risk of Sexual	3.3%	1,205	Psychological/Risk of Psychological	38.5%	Neglect/Risk of Neglect	31.6%	Physical/Risk of Physical	19.2%	Sexual/Risk of Sexual	10.7%	Neglect	20.2%	7,282	Physical Abuse	17.2%	6,219	Domestic Violence	14.2%	5,113	Carer D&A	13.8%	4,993	Sexual Abuse	10.0%	3,629	Carer Mental Health	9.3%	3,374	Psychological Abuse	6.3%	2,262	CYP Risk taking Behaviour	4.7%	1,698	Other	4.3%	1,559	< 24 hrs	23.9%	8,620	< 72 hrs	29.9%	10,811	< 10 days	22.1%	7,991	10+ days	0.1%	52	<1 year	13.9%	1,835	1-2 years	13.7%	1,804	3-4 years	12.0%	1,591	5-11 years	36.2%	4,786	12-15 years	21.7%	2,860	16-17 years	2.4%	315	Not stated	0.1%	14
Domestic Violence	30.6%	19,288																																																																																																																																																																																																																																																																																																
Physical Abuse	15.9%	10,052																																																																																																																																																																																																																																																																																																
Neglect	12.7%	8,019																																																																																																																																																																																																																																																																																																
Carer D&A	10.5%	6,617																																																																																																																																																																																																																																																																																																
Psychological Abuse	9.3%	5,873																																																																																																																																																																																																																																																																																																
Carer Mental Health	6.8%	4,265																																																																																																																																																																																																																																																																																																
Sexual Abuse	5.4%	3,439																																																																																																																																																																																																																																																																																																
CYP Risk taking Behaviour	5.1%	3,200																																																																																																																																																																																																																																																																																																
Other	3.7%	2,362																																																																																																																																																																																																																																																																																																
Police	37.7%	23,809																																																																																																																																																																																																																																																																																																
Health	13.9%	8,798																																																																																																																																																																																																																																																																																																
Education	15.7%	9,907																																																																																																																																																																																																																																																																																																
Other Mandatory	10.0%	6,306																																																																																																																																																																																																																																																																																																
Non-mandatory and Other	22.6%	14,295																																																																																																																																																																																																																																																																																																
No further assessment required or possible	0.9%	547																																																																																																																																																																																																																																																																																																
Current competing priorities	99.1%	62,568																																																																																																																																																																																																																																																																																																
< 24 hrs	0.5%	335																																																																																																																																																																																																																																																																																																
< 72 hrs	25.7%	16,252																																																																																																																																																																																																																																																																																																
< 10 days	73.4%	46,344																																																																																																																																																																																																																																																																																																
10+ days	0.3%	184																																																																																																																																																																																																																																																																																																
Domestic Violence	25.5%	25,163																																																																																																																																																																																																																																																																																																
Neglect	16.8%	16,589																																																																																																																																																																																																																																																																																																
Physical Abuse	14.5%	14,307																																																																																																																																																																																																																																																																																																
Carer D&A	11.4%	11,251																																																																																																																																																																																																																																																																																																
Carer Mental Health	9.7%	9,605																																																																																																																																																																																																																																																																																																
Psychological Abuse	7.3%	7,153																																																																																																																																																																																																																																																																																																
Sexual Abuse	6.2%	6,124																																																																																																																																																																																																																																																																																																
CYP Risk taking Behaviour	3.7%	3,686																																																																																																																																																																																																																																																																																																
Other	4.8%	4,778																																																																																																																																																																																																																																																																																																
Police	30.0%	29,561																																																																																																																																																																																																																																																																																																
Health	17.7%	17,426																																																																																																																																																																																																																																																																																																
Education	12.1%	11,983																																																																																																																																																																																																																																																																																																
Other Mandatory	13.7%	13,476																																																																																																																																																																																																																																																																																																
Non-mandatory and Other	26.6%	26,210																																																																																																																																																																																																																																																																																																
Eligible Early Intervention	16.2%	15,965																																																																																																																																																																																																																																																																																																
Other Information																																																																																																																																																																																																																																																																																																		
- Early Intervention	2.4%	2,375																																																																																																																																																																																																																																																																																																
- Close	47.1%	46,420																																																																																																																																																																																																																																																																																																
- Referral - Close	6.5%	6,412																																																																																																																																																																																																																																																																																																
Closed																																																																																																																																																																																																																																																																																																		
- Case Closure Policy	23.5%	23,137																																																																																																																																																																																																																																																																																																
- Subject Not Located	0.7%	691																																																																																																																																																																																																																																																																																																
Streamed Back To Intake	3.7%	3,656																																																																																																																																																																																																																																																																																																
< 24 hrs	8.4%	8,255																																																																																																																																																																																																																																																																																																
< 72 hrs	39.0%	38,484																																																																																																																																																																																																																																																																																																
< 10 days	50.5%	49,818																																																																																																																																																																																																																																																																																																
10+ days	0.2%	210																																																																																																																																																																																																																																																																																																
Neglect	20.0%	7,752																																																																																																																																																																																																																																																																																																
Physical Abuse	17.5%	6,764																																																																																																																																																																																																																																																																																																
Domestic Violence	13.7%	5,327																																																																																																																																																																																																																																																																																																
Carer D&A	13.7%	5,309																																																																																																																																																																																																																																																																																																
Sexual Abuse	10.6%	4,106																																																																																																																																																																																																																																																																																																
Carer Mental Health	9.2%	3,559																																																																																																																																																																																																																																																																																																
Psychological Abuse	6.3%	2,446																																																																																																																																																																																																																																																																																																
CYP Risk taking Behaviour	4.6%	1,782																																																																																																																																																																																																																																																																																																
Other	4.4%	1,700																																																																																																																																																																																																																																																																																																
Police	24.8%	9,625																																																																																																																																																																																																																																																																																																
Health	18.6%	7,210																																																																																																																																																																																																																																																																																																
Education	12.7%	4,937																																																																																																																																																																																																																																																																																																
Other Mandatory	16.7%	6,486																																																																																																																																																																																																																																																																																																
Non-mandatory and Other	27.1%	10,487																																																																																																																																																																																																																																																																																																
< 24 hrs	24.1%	9,347																																																																																																																																																																																																																																																																																																
< 72 hrs	30.0%	11,613																																																																																																																																																																																																																																																																																																
< 10 days	22.2%	8,594																																																																																																																																																																																																																																																																																																
10+ days	0.1%	54																																																																																																																																																																																																																																																																																																
Psychological	26.1%	9,422																																																																																																																																																																																																																																																																																																
Neglect	24.0%	8,674																																																																																																																																																																																																																																																																																																
Physical	12.3%	4,449																																																																																																																																																																																																																																																																																																
Sexual	7.4%	2,675																																																																																																																																																																																																																																																																																																
Risk of Psychological	12.4%	4,498																																																																																																																																																																																																																																																																																																
Risk of Neglect	7.6%	2,734																																																																																																																																																																																																																																																																																																
Risk of Physical	6.8%	2,472																																																																																																																																																																																																																																																																																																
Risk of Sexual	3.3%	1,205																																																																																																																																																																																																																																																																																																
Psychological/Risk of Psychological	38.5%																																																																																																																																																																																																																																																																																																	
Neglect/Risk of Neglect	31.6%																																																																																																																																																																																																																																																																																																	
Physical/Risk of Physical	19.2%																																																																																																																																																																																																																																																																																																	
Sexual/Risk of Sexual	10.7%																																																																																																																																																																																																																																																																																																	
Neglect	20.2%	7,282																																																																																																																																																																																																																																																																																																
Physical Abuse	17.2%	6,219																																																																																																																																																																																																																																																																																																
Domestic Violence	14.2%	5,113																																																																																																																																																																																																																																																																																																
Carer D&A	13.8%	4,993																																																																																																																																																																																																																																																																																																
Sexual Abuse	10.0%	3,629																																																																																																																																																																																																																																																																																																
Carer Mental Health	9.3%	3,374																																																																																																																																																																																																																																																																																																
Psychological Abuse	6.3%	2,262																																																																																																																																																																																																																																																																																																
CYP Risk taking Behaviour	4.7%	1,698																																																																																																																																																																																																																																																																																																
Other	4.3%	1,559																																																																																																																																																																																																																																																																																																
< 24 hrs	23.9%	8,620																																																																																																																																																																																																																																																																																																
< 72 hrs	29.9%	10,811																																																																																																																																																																																																																																																																																																
< 10 days	22.1%	7,991																																																																																																																																																																																																																																																																																																
10+ days	0.1%	52																																																																																																																																																																																																																																																																																																
<1 year	13.9%	1,835																																																																																																																																																																																																																																																																																																
1-2 years	13.7%	1,804																																																																																																																																																																																																																																																																																																
3-4 years	12.0%	1,591																																																																																																																																																																																																																																																																																																
5-11 years	36.2%	4,786																																																																																																																																																																																																																																																																																																
12-15 years	21.7%	2,860																																																																																																																																																																																																																																																																																																
16-17 years	2.4%	315																																																																																																																																																																																																																																																																																																
Not stated	0.1%	14																																																																																																																																																																																																																																																																																																
		Ongoing secondary assessment / Investigation 4,767 reports																																																																																																																																																																																																																																																																																																

Assessment path of Aboriginal reports

Figure 5.11 Aboriginal Child Protection Reports 2006/07

Child Protection Reports to DoCS 2006/07 focusing on Aboriginal reports														
49,443 reports involving 15,820 Aboriginal children and young persons (CYP)	Helpline: outcome of initial assessment	Action taken at CSC/JIRT												
<p>Reported issues</p> <p>In reference to Primary, Secondary and Third reported issues, at some time during 2006/07:</p> <p>Neglect was a recorded in the reports of 44% of Aboriginal CYP compared with 26% of other CYP</p> <p>Carer issues were recorded in the reports of 67% of Aboriginal CYP compared with 55% of other CYP. Of these: Carer alcohol (27% compared with 13%) Carer drug (24% compared with 13%) Carer drug &/or alcohol (43% compared with 23%)</p> <p>Domestic violence was recorded in the reports of 49% of Aboriginal CYP compared with 45% of other CYP.</p>	<p>Of the 49,443 reports, 35,972 (72.8%) were referred to the CSC/JIRT for further assessment (involving 14,029 Aboriginal CYP)</p>													
	<p>Required response time</p> <p>Of the 35,972 Aboriginal reports: <24 hours 12.7%</p>	<p>Closed at CSC/JIRT before any Secondary Assessment</p> <p>8,848 Aboriginal reports 11.4% of 77,567 reports</p>												
	<p>Reporting trends</p> <p>Reports involving Aboriginal children and young persons as a % of the total number of reports for each year:</p> <table border="1"> <tr><td>2001/02</td><td>11.5%</td></tr> <tr><td>2002/03</td><td>11.4%</td></tr> <tr><td>2003/04</td><td>8.4%</td></tr> <tr><td>2004/05</td><td>14.6%</td></tr> <tr><td>2005/06</td><td>15.9%</td></tr> <tr><td>2006/07</td><td>17.3%</td></tr> </table>	2001/02	11.5%	2002/03	11.4%	2003/04	8.4%	2004/05	14.6%	2005/06	15.9%	2006/07	17.3%	<p>SAS1 only completed</p> <p>15,412 Aboriginal reports 20.0% of 76,884 reports</p>
2001/02	11.5%													
2002/03	11.4%													
2003/04	8.4%													
2004/05	14.6%													
2005/06	15.9%													
2006/07	17.3%													
	<p>Reporting rates (per 1,000 CYP)</p> <table border="1"> <tr><td>All CYP:</td><td>79 per 1,000</td></tr> <tr><td>Aboriginal CYP:</td><td>251 per 1,000</td></tr> <tr><td>Non-Aboriginal children <1 year:</td><td>116 per 1,000</td></tr> <tr><td>Aboriginal children <1 year:</td><td>565 per 1,000</td></tr> </table> <p>12.8 % (15,820) of all CYP who were subject of a report were Aboriginal</p>	All CYP:	79 per 1,000	Aboriginal CYP:	251 per 1,000	Non-Aboriginal children <1 year:	116 per 1,000	Aboriginal children <1 year:	565 per 1,000	<p>Ongoing secondary assessment/Investigation</p> <p>3,462 total reports</p>				
All CYP:	79 per 1,000													
Aboriginal CYP:	251 per 1,000													
Non-Aboriginal children <1 year:	116 per 1,000													
Aboriginal children <1 year:	565 per 1,000													
	<p>Reporter type</p> <p>At some time during 2006/07: 57% of Aboriginal CYP and 49% of other CYP were the subject of a report by Police. 34% of Aboriginal CYP and 25% of other CYP were the subject of a report by either relatives, friends or neighbours.</p>	<p>SAS2 / Judgements and Decisions completed</p> <p>11,068 Aboriginal reports 25.6% of 43,295 reports</p>												
	<p>Frequency of Reports</p> <p>Of the 123,690 CYP involved in reports:</p> <table border="1"> <tr><td>103,826 reported between 1 to 3 times</td><td>11.1% Aboriginal (11,563)</td></tr> <tr><td>17,291 reported between 4 to 10 times</td><td>21.0% Aboriginal (3,637)</td></tr> <tr><td>2,214 reported between 11 to 20 times</td><td>24.0% Aboriginal (531)</td></tr> <tr><td>359 reported more than 20 times</td><td>24.8% Aboriginal (89)</td></tr> <tr><td>53,461 reported for the first time ever</td><td>7.4% Aboriginal (3,964)</td></tr> </table>	103,826 reported between 1 to 3 times	11.1% Aboriginal (11,563)	17,291 reported between 4 to 10 times	21.0% Aboriginal (3,637)	2,214 reported between 11 to 20 times	24.0% Aboriginal (531)	359 reported more than 20 times	24.8% Aboriginal (89)	53,461 reported for the first time ever	7.4% Aboriginal (3,964)	<p>Reports Substantiated</p> <p>10,401 Aboriginal reports 25.7% of 40,472 reports</p>		
103,826 reported between 1 to 3 times	11.1% Aboriginal (11,563)													
17,291 reported between 4 to 10 times	21.0% Aboriginal (3,637)													
2,214 reported between 11 to 20 times	24.0% Aboriginal (531)													
359 reported more than 20 times	24.8% Aboriginal (89)													
53,461 reported for the first time ever	7.4% Aboriginal (3,964)													
	<p>Of the 49,443 reports, 13,471 (27.2%) were assessed as not requiring any further assessment (involving 1,791 Aboriginal CYP)</p>	<p>Actual Harm:</p> <p>Psychological (11,029) 28.3% Aboriginal (3,170)</p> <p>Neglect (9,451) 32.1% Aboriginal (3,036)</p> <p>Physical (4,722) 20.0% Aboriginal (945)</p> <p>Sexual (2,953) 15.3% Aboriginal (451)</p>												
		<p>Risk of Harm:</p> <p>Risk of Psychological Harm (4,794) 15.2% Aboriginal (728)</p> <p>Risk of Neglect (3,376) 36.3% Aboriginal (1,227)</p> <p>Risk of Physical Harm (2,775) 21.3% Aboriginal (591)</p> <p>Risk of Sexual Harm (1,192) 21.2% Aboriginal (253)</p>												

Figure 5.12 Aboriginal Child Protection reports 2007/08

Child Protection Reports to DoCS April 07/March 08 focusing on Aboriginal reports																
54,760 reports involving 17,982 Aboriginal children and young persons (CYP)	Helpline: outcome of initial assessment	Action taken at CSC/JIRT														
<p>Reported issues</p> <p>In reference to Primary, Secondary and Third reported issues, at some time during April 2007 to March 2008:</p> <p>Neglect was recorded in the reports of 45.2% of Aboriginal CYP compared with 26.6% of other CYP</p> <p>Carer issues were recorded in the reports of 67.3% of Aboriginal CYP compared with 56.9% of other CYP. Of these: Carer alcohol (28.6% compared with 14.6%) Carer drug (24% compared with 13.6%) Carer drug &/or alcohol (43.3% compared with 24.5%)</p> <p>Domestic violence was recorded in the reports of 48.8% of Aboriginal CYP compared with 44.8% of other CYP.</p>	<p>Of the 54,760 reports, 39,666 (72.4%) were referred to the CSC/JIRT for further assessment (involving 15,960 Aboriginal CYP)</p>															
	<p>Required response time</p> <p>Of the 39,666 Aboriginal reports: <24 hours 11.7%</p>	<p>Closed at CSC/JIRT before any Secondary Assessment</p> <p>7,443 Aboriginal reports 11.8% of 63,115 reports</p>														
	<p>Reporting trends</p> <p>Reports involving Aboriginal children and young persons as a % of the total number of reports for each year:</p> <table border="1"> <tr><td>2001/02</td><td>11.5%</td></tr> <tr><td>2002/03</td><td>11.4%</td></tr> <tr><td>2003/04</td><td>8.4%</td></tr> <tr><td>2004/05</td><td>14.6%</td></tr> <tr><td>2005/06</td><td>15.9%</td></tr> <tr><td>2006/07</td><td>17.3%</td></tr> <tr><td>Apr07-Mar08</td><td>18.5%</td></tr> </table>	2001/02	11.5%	2002/03	11.4%	2003/04	8.4%	2004/05	14.6%	2005/06	15.9%	2006/07	17.3%	Apr07-Mar08	18.5%	<p>SAS1 only completed</p> <p>20,807 Aboriginal reports 21.1% of 98,656 reports</p>
2001/02	11.5%															
2002/03	11.4%															
2003/04	8.4%															
2004/05	14.6%															
2005/06	15.9%															
2006/07	17.3%															
Apr07-Mar08	18.5%															
	<p>Reporting rates</p> <p>(per 1,000 CYP)</p> <table border="1"> <tr><td>All CYP:</td><td>82 per 1,000</td></tr> <tr><td>Aboriginal CYP:</td><td>286 per 1,000</td></tr> <tr><td>Non-Aboriginal children <1 year:</td><td>124 per 1,000</td></tr> <tr><td>Aboriginal children <1 year:</td><td>657 per 1,000</td></tr> </table> <p>14.0% (17,982) of all CYP who were subject of a report were Aboriginal</p>	All CYP:	82 per 1,000	Aboriginal CYP:	286 per 1,000	Non-Aboriginal children <1 year:	124 per 1,000	Aboriginal children <1 year:	657 per 1,000	<p>Ongoing secondary assessment/Investigation</p> <p>4,767 total reports</p>						
All CYP:	82 per 1,000															
Aboriginal CYP:	286 per 1,000															
Non-Aboriginal children <1 year:	124 per 1,000															
Aboriginal children <1 year:	657 per 1,000															
	<p>Reporter type</p> <p>At some time during April 2007 and March 2008: 56.2% of Aboriginal CYP and 49.7% of other CYP were the subject of a report by Police. 32.5% of Aboriginal CYP and 23.9% of other CYP were the subject of a report by either relatives, friends or neighbours.</p>	<p>SAS2 / Judgements and Decisions completed</p> <p>10,296 Aboriginal reports 26.6% of 38,745 reports</p>														
	<p>Frequency of Reports</p> <p>Of the 128,673 CYP involved in reports:</p> <ul style="list-style-type: none"> 107,787 reported between 1 to 3 times 12.3% Aboriginal (13,219) 18,337 reported between 4 to 10 times 22.5% Aboriginal (4,128) 2,208 reported between 11 to 20 times 24.5% Aboriginal (542) 341 reported more than 20 times 27.3% Aboriginal (93) 53,525 reported for the first time ever 7.9% Aboriginal (4,232) 	<p>Reports Substantiated</p> <p>9,564 Aboriginal reports 26.5% of 36,129 reports</p>														
	<p>Reports by Region</p> <p>Metro Central (25,696): 9.6% Aboriginal (2,474)</p> <p>Metro South West (26,299): 9.1% Aboriginal (2,399)</p> <p>Metro West (33,545): 12.0% Aboriginal (4,016)</p> <p>Hunter/Central Coast (36,425): 14.4% Aboriginal (5,227)</p> <p>Northern (32,828): 32.4% Aboriginal (10,638)</p> <p>Southern (20,219): 19.5% Aboriginal (3,949)</p> <p>Western (29,531): 36.3% Aboriginal (10,733)</p>	<p>Actual Harm:</p> <p>Psychological (9,422) 27.2% Aboriginal (2,563)</p> <p>Neglect (8,674) 31.4% Aboriginal (2,726)</p> <p>Physical (4,449) 24.3% Aboriginal (1,082)</p> <p>Sexual (2,675) 15.0% Aboriginal (400)</p>														
	<p>Of the 54,760 reports, 15,094 (27.6%) were assessed as not requiring any further assessment (involving 2,022 Aboriginal CYP)</p>	<p>Risk of Harm:</p> <p>Risk of Psychological Harm (4,498) 21.7% Aboriginal (974)</p> <p>Risk of Neglect (2,734) 33.0% Aboriginal (901)</p> <p>Risk of Physical Harm (2,472) 25.6% Aboriginal (633)</p> <p>Risk of Sexual Harm (1,205) 23.7% Aboriginal (285)</p>														

Outcome of assessment of all child protection reports

- 5.84 Table 5.37 shows that the proportion of reports closed at the CSC/JIRT prior to any secondary assessment has fallen steadily since 2004/05. The sharpest drop is between 2006/07 and April 07/March 08. Therefore, in April 07/March 08, almost 80 per cent of all reports referred to the CSC/JIRT received some level of secondary assessment, compared with 69 per cent in 2004/05 and 73 per cent in 2006/07.
- 5.85 The data indicate that a greater proportion of reports received a SAS1 in April 07/March 08 than in previous years. However, the proportion of reports that were subject to a completed secondary assessment (SAS2) fell from 15.1 per cent in 2006/07 to 13.1 per cent in April 07/March 08. The actual number of reports that were the subject of a completed secondary assessment also fell from 43,295 in 2006/07 to 38,745 in April 07/March 08.³¹⁴ Between 2006/07 and April 07/March 08 the number of reports that were subject to a completed SAS2 fell by 10.5 per cent.
- 5.86 Therefore, in April 07/March 08, both proportionately and in actual numbers, fewer children and young persons received a completed SAS2 than in 2006/07.

Table 5.37 Outcome of assessment, 2004/05 to 2007/08 (summary table)

Outcome of Assessment	2004/05		2005/06		2006/07		1 April 2007/31 March 2008	
	No	%	No	%	No	%	No	%
Reports closed at the Helpline	28,892	13.4	31,788	13.2	33,279	11.6	38,856	13.1
Information forwarded to DoCS unit	47,310	21.9	48,373	20.1	51,546	18.0	52,630	17.7
Subtotal	76,202	35.2	80,161	33.3	84,825	29.7	91,486	30.8
Reports referred to CSC/JIRT for further assessment	140,184	64.8	160,842	66.7	201,208	70.3	205,283	69.2
Closed at CSC/JIRT before secondary assessment	65,795	30.5	69,347	28.8	77,567	27.1	63,115	21.3
Closed after completed SAS1	36,895	17.1	49,055	20.4	76,884	26.9	98,656	33.2
Subject of completed SAS2	18,880	8.7	35,536	14.7	43,295	15.1	38,745	13.1
Ongoing secondary assessment	18,434	8.5	6,904	2.7	3,462	1.2	4,767	1.6
Total reports	216,386	100	241,003	100	286,033	100	296,769	100
Harm/risk of harm substantiated	16,705	7.7	32,390	13.4	40,472	14.2	36,129	12.2

Note: percentage is of the total number of reports received for each year

³¹⁴ DoCS advises that the finalised figure for 1 July 2007 to 30 June 2008 is 39,559.

Outcome of assessment of reports involving Aboriginal children and young persons referred to the CSC/JIRT

Table 5.38 Outcome of assessment of reports concerning Aboriginal children and young persons 2004/05 to 2007/08

Assessment outcome	2004/05		2005/06		2006/07		1 April 2007/31 March 2008	
	No	%	No	%	No	%	No	%
Closed at CSC/JIRT prior to secondary assessment	7,844	36.4	8,293	31.0	8,848	24.6	7,443	18.8
Closed after Secondary Assessment Stage 1	5,901	27.4	8,679	32.5	15,412	42.8	20,807	52.5
Completed Secondary Assessment Stage 2	3,817	17.7	8,180	30.6	11,068	30.8	10,296	26.0
Total number of Aboriginal reports referred to CSC/JIRT	21,525	100	26,713	100	35,972	100	39,666	100

Note: Percentages are of the total number of Aboriginal reports referred to a CSC/JIRT for each year. Table does not include data on the number of reports that were the subject of ongoing secondary assessment.

- 5.87 In 2006/07 and April 07/March 08, the percentages of reports about Aboriginal children and young persons referred to a CSC/JIRT for further assessment that were closed before any secondary assessment were lower than for all reports similarly referred in 2004/05 and 2005/06.
- 5.88 In each year from 2004/05 to April 07/March 08, proportionately more reports about Aboriginal children and young persons were the subject of either a SAS1 only or a completed SAS2 than reports about non-Aboriginal children and young persons.

Substantiation rates

- 5.89 The data show that harm or risk of harm is substantiated in a great majority of reports that are subject to a SAS2. In 2006/07 and April 07/March 08, the substantiation rate has remained steady at around 93 per cent. However, because the number of completed SAS2s fell in April 07/March 08, the number of substantiated reports also fell.

Table 5.39 **Substantiation rates, 2004/05 to 2007/08**

	2004/05	2005/06	2006/07	1 April 2007/31 March 2008
Total number of reports	216,386	241,003	286,033	296,769
Number of reports referred to CSC/JIRT for further assessment	140,184	160,842	201,208	205,283
Number of completed SAS2	18,880	35,536	43,295	38,745
Number of substantiated reports (harm or risk of harm determined)	16,705	32,390	40,472	36,129
Substantiated reports (as % of total number of reports)	7.7	13.4	14.1	12.2
Substantiated reports (as % of reports referred to CSC/JIRT)	11.9	20.1	20.1	17.6
Substantiated reports (as % of reports that received a completed SAS2)	88.5	91.1	93.5	93.2

- 5.90 Table 5.40 indicates a significant increase over time in the percentage of children who were the subject of a substantiated report and then a further substantiation within the following 12 months. However, it is likely that this increase partially reflects the increase in the number of reports that were substantiated in 2006/07 (an increase of 25.0 per cent from 32,390 to 40,472).

Table 5.40 **Percentage of children and young persons who were the subject of a substantiated report in the previous year, and were the subject of a further substantiation within the following 12 months**

2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
11.1	13.2	No data	No data	19.8	24.0

Child protection history prior to entering OOHC

- 5.91 The great majority of children and young persons who entered care in 2006/07 already had a child protection history (94.1 per cent); that is, prior to the report that resulted in entry to OOHC, they had been the subject of other child protection reports. Further, children and young persons re-entering OOHC were similarly likely to have had at least one other child protection report in the period between their last OOHC episode and the report that resulted in re-entry into OOHC.
- 5.92 Similar proportions of Aboriginal and non-Aboriginal children and young persons had been reported prior to entering care.³¹⁵

³¹⁵ DoCS, *Analysis of children and young people who entered OOHC in 2006/07*, June 2008.

Table 5.41 **Children and young persons entering OOHC in 2006/07 by selected indicators**³¹⁶

	Aboriginal		Non-Aboriginal		Total	
	No	%	No	%	No	%
Total	1,377	100	3,271	100	4,648	100
<i>New entry/re-entry</i>						
New entry children and young persons	905	65.7	2,377	72.7	3,282	70.6
Re-entry children and young persons	472	34.3	894	27.3	1,366	29.4
<i>Child protection reports (prior to report resulting in entry to OOHC)</i>						
Not reported before entering care	61	4.4	214	6.5	275	5.9
Reported before entering care	1,316	95.6	3,057	93.5	4,373	94.1

Note: 'non-Aboriginal' includes 'not stated'

For re-entry children 'not reported before entering care' refers to no reports between last OOHC episode and the report resulting in re-entry to care

- 5.93 Of the 1,035 children and young persons entering relative/kinship care in 2006/07, 15.3 per cent were the subject of a report, however, there was no secondary assessment recorded. For 1.2 per cent of these children and young persons, there was no child protection report recorded prior to entering care.
- 5.94 In 2006/07, new entry children who were aged 1-5 years were on average the subject of 11.6 reports in total (with 1.4 reports having a required response time of within 24 hours and 4.0 reports requiring a response time of within 72 hours).
- 5.95 In 2006/07, a higher proportion of children aged less than one year who entered OOHC had at least one report referred to a CSC/JIRT than children of other ages. They were also more likely to have had at least one report with a SAS2 completed. This pattern is the same for new entry and re-entry children.³¹⁷
- 5.96 Overall the average number of reports per child (ever) before entering OOHC were higher for re-entry children than for new entry children for all age groups and all levels of assessment.³¹⁸

³¹⁶ *ibid.*

³¹⁷ *ibid.*

³¹⁸ *ibid.*

Table 5.42 **Average number of reports per child or young person prior to entering OOHC**³¹⁹

Age	Average number of all reports	Average no of reports within 1 year before entering care or after last OOHC episode if re-entry
<i>New entry children and young persons</i>		
<1 year	6.0	5.9
1-5 years	11.6	6.2
6-12 years	12.7	5.2
13-17 years	12.0	5.6
<i>Re-entry children and young persons</i>		
<1 year	8.0	2.6
1-5 years	15.1	4.0
6-12 years	19.9	4.8
13-17 years	26.4	4.0

5.97 Over two thirds of children aged 1-5 years who entered care for the first time in 2006/07 received their first report when they were aged less than one year.³²⁰

5.98 More than one third of children and young persons entering OOHC for the first time in 2006/07 were more likely to have had previous reports with the same or less urgent required response times compared with their last report before entering care, indicating some degree of escalation or sustained level of urgency. The pattern for re-entry children was similar.

Table 5.43 **Children entering OOHC in 2006/07 who had at least one report after 30 June 2002, by the level of their previous reports (excluding their last report) and by the level of their last report before entering care**³²¹

Level of last report before entering care	<i>Previous reports (excluding last report) before entering OOHC</i>				Total children
	No previous report	Previous reports assigned same or lower levels	Previous reports assigned higher levels	Previous reports assigned various levels	
<i>New Entry Children and young persons</i>					
Total number	269	1,117	757	870	3,013 (100.0%)
<i>Percentage of children and young persons</i>					
<24 hours	9.4	90.6	-	-	765 (25.4)
<72 hours	9.2	43.4	1.8	45.7	786 (26.1)
<10 days	13.0	14.1	11.5	61.5	524 (17.4)
10 days +	0.0	0.0	0.0	100.0	10 (0.3)

³¹⁹ *ibid.*

³²⁰ *ibid.*

³²¹ DoCS, *A preliminary analysis of possible patterns in the required response times of child protection reports about children before they enter OOHC*, July 2008.

<i>Previous reports (excluding last report) before entering OOHC</i>					
Not stated	1.4	0.3	36.1	62.2	288 (9.6)
Not referred to CSC	8.3	1.3	90.5	-	640 (21.2)
Average %	8.9	37.1	25.1	28.9	
<i>Re-entry children and young persons</i>					
Total number	152	358	246	283	1,039 (100.0%)
<i>Percentage of children and young persons</i>					
<24 hours	5.2	94.8	-	-	191 (18.4)
<72 hours	16.5	40.8	3.6	39.2	309 (29.7)
<10 days	16.4	15.8	13.3	54.5	165 (15.9)
10 days +	25.0	0.0	0.0	75.0	4 (0.4)
Not stated	4.0	2.0	25.7	68.3	101 (9.7)
Not referred to CSC	21.9	8.6	69.5	-	269 (25.9)
Average %	14.6	34.5	23.7	27.2	

- 5.99 Table 5.44 provides details of the number of children and young persons who entered care in 2006/07 by age group. It also provides details of the outcome of the most recent SAS2 that was undertaken in the two years prior to entry into care.
- 5.100 Across all age groups, neglect or risk of neglect was found in 26.7 per cent of the cases involving the 4,658 children and young persons who entered care in 2006/07. Psychological harm or risk of harm was found in 25.0 per cent of cases, followed by physical harm or risk of harm (12.8 per cent) and sexual harm or risk of harm (4.5 per cent).
- 5.101 Neglect or risk of neglect was found in the cases of 37.1 per cent of children entering care aged less than one year. Psychological harm or risk of harm followed neglect or risk of neglect in 34.2 per cent of cases.
- 5.102 In the case of children aged 1-2 years, psychological harm or risk of harm was found in 36.3 per cent of cases and neglect or risk of neglect in 33 per cent of cases.
- 5.103 With age, the proportion of cases where neglect and psychological harm were found gradually decreased, and the proportion of cases where physical and sexual abuse were found increased. In the case of children aged 12-15 years, physical harm or risk of harm was found in 17.9 per cent of cases, slightly higher than psychological harm or risk of harm which was found in 14.3 per cent of cases, but lower than neglect or risk of neglect, which was found in 21.2 per cent of cases.

Table 5.44 Number of children and young persons (C/YP) who entered care between 1 July 2006 and 30 June 2007, by age group, and by the type of harm or risk of harm determined as a result of the secondary assessment

<i>Outcome of secondary assessment</i>	<i>Age at first entry</i>							<i>Total</i>
	<i><1 year</i>	<i>1-2 years</i>	<i>3-4 years</i>	<i>5-11 years</i>	<i>12-15 years</i>	<i>16-17 years</i>	<i>Unknown</i>	
<i>Actual harm</i>								
Physical	41	33	42	152	91	6	0	365
Sexual	0	6	12	50	61	11	0	140
Emotional/Psychological	152	164	135	251	86	10	0	798
Neglect	139	117	136	282	170	21	0	865
<i>Risk of harm</i>								
Risk of physical	44	25	21	55	85	1	0	231
Risk of sexual	5	2	11	30	20	1	0	69
Risk of psychological	64	54	44	144	55	6	0	367
Risk of neglect	95	81	53	108	39	2	0	378
<i>No risk of harm</i>	6	10	11	29	29	6	0	91
<i>Missing assessed issue</i>	1	3	6	14	5	1	0	30
Total	547	495	471	1,115	641	65	0	3,334
No Matched SAS2 records	84	105	138	540	344	110	3	1,324
Total C/YP entering care	631	600	609	1,655	985	175	3	4,658

Note: 1,324 (28.4 per cent) children and young persons (C/YP) entering OOHC during 2006/07 did not have a secondary assessment recorded within two years prior to entry to OOHC.

Possible reasons include:

In 2006/07, 19.6 per cent of C/YP entered OOHC voluntarily or with no legal order.

Some C/YP may have a secondary assessment that was determined after the data extraction cut-off date for annual reporting (31 August). Hence the secondary assessment records for some C/YP may not be included in the current annual reporting extract files.

Data quality issues related to the recording of assessed issues.

- 5.104 Table 5.45 provides details of the OOHC status of children and young persons in the 12 months following a substantiated report in 2005/06.
- 5.105 Of these 11,659 children and young persons, just over 20 per cent subsequently entered OOHC in the following 12 months.
- 5.106 Of the 2,377 children and young persons who entered OOHC, 26.0 per cent were the subject of a SAS2 where the finding was emotional/psychological abuse. There was a finding of neglect in the case of 23.5 per cent of the children and young persons.
- 5.107 Emotional/psychological abuse or risk of psychological abuse was the finding of the SAS2 for 41.4 per cent of the children and young persons entering OOHC in the following 12 months.
- 5.108 Neglect or risk of neglect was the finding of the SAS2 in 33.7 per cent of the children and young persons entering OOHC.
- 5.109 Physical abuse or risk of physical abuse was the finding of the SAS2 for 19.2 per cent of the children and young persons entering OOHC.

- 5.110 Sexual abuse or risk of sexual abuse was the finding of the SAS2 for 5.7 per cent of the children and young persons entering OOHC.
- 5.111 Children and young persons who were the subject of a SAS2 where the finding was risk of neglect were most likely to enter OOHC (28.4 per cent compared with 20.4 per cent of all children and young persons entering OOHC).
- 5.112 The next most likely finding of harm or risk of harm to result in a child or young persons entering OOHC was risk of psychological abuse (24.7) followed by risk of physical abuse (24.5 per cent), neglect (24.0 per cent), emotional/psychological abuse (20.6 per cent) and physical abuse (18.7 per cent).
- 5.113 The findings that were least likely to result in entry to OOHC were sexual abuse (7.0 per cent) and risk of sexual abuse (10.2 per cent). This may be because the person found to be causing harm had been removed from the household and therefore the risk issues were no longer current.

Table 5.45 Children and young persons reported in 2005/06 and determined to be at risk of harm or actual harm at secondary assessment by their OOHC status in the 12 months following their last report during 2005/06 and type of harm or risk

Outcome of secondary assessment	OOHC status after 12 months					
	Entered OOHC		Did not enter OOHC		Total	
	No	%	No	%	No	%
Physical	310	18.7	1,347	81.3	1,657	100.0
Sexual	89	.0	1,186	93.0	1,275	100.0
Emotional	617	20.6	2,384	79.4	3,001	100.0
Neglect	559	24.0	1,770	76.0	2,329	100.0
Risk of physical	147	24.5	454	75.5	601	100.0
Risk of sexual	47	10.2	414	89.8	461	100.0
Risk of psychological	367	24.7	1,120	75.3	1,487	100.0
Risk of neglect	241	28.4	607	71.6	848	100.0
Total	2,377	20.4	9,282	79.6	11,659	100.0

Notes: This table does not include children and young persons who were in OOHC at the time of their report.

The outcome of secondary assessment category is based on the child or young person's last secondary assessment if multiple secondary assessment were conducted.

Care proceedings

Table 5.46 **Number of care proceedings and particular applications
2005/06 and 2006/07**

	2005/06	2006/07
Total care proceedings commenced	4,439	5,196
Emergency care and protection applications	786	867
Care application under s.61	1,476	1,815
Applications for assessment under ss.53 or 54	308	387
Applications for variation or rescission	793	686

- 5.114 The Inquiry sought data on care proceedings from the Children's Court and was provided with the data in Table 5.46. It was told that the following statistics are not kept:
- a. the number of children and young persons subject to applications for emergency care and protection orders, or s.61 applications for a care order
 - b. the outcome of applications for emergency care and protection orders (s.46)
 - c. the number of orders made under s.48 authorising removal
 - d. the Aboriginal status of children and young persons subject to care applications and care orders
 - e. the number of interim care orders made (s.69)
 - f. the grounds on which findings have been made that a child is in need of care and protection
 - g. the number of orders for support services (s.74), orders to attend a therapeutic treatment program (s.75), or orders for supervision (s.76)
 - h. the number of orders allocating parental responsibility (s.79)
 - i. the number of contact orders (s.86).

Time taken to complete care proceedings

- 5.115 The Chief Magistrate of the Local Court has imposed time standards on the disposal of care proceedings as follows:
- a. 90 per cent of care matters should be finalised within nine months of commencement
 - b. 100 per cent of care matters should be finalised within 12 months of commencement.³²²
- 5.116 Data obtained from the Local Courts Statistics Unit indicate that for the period November 2006 to October 2007, 88.9 per cent of all care proceedings were

³²² Children's Court NSW, *Time Standards for Care Applications*.

finalised within nine months, and 95.5 per cent of all care proceedings were finalised within 12 months. In the same period, 93.8 per cent of contested care proceedings were finalised within nine months, and 98.4 were finalised within 12 months.

- 5.117 Data obtained from the Local Courts Statistics Unit indicate that for the period November 2006 to October 2007, the Chief Magistrate's time standards were complied with at: Bathurst, Bidura, Broken Hill, Cooma, Coonabarabran, Cootamundra, Cowra, Eden, Glen Innes, Kempsey, Lithgow, Macksville, Maclean, Moruya, Mudgee, Mullumbimby, Narooma, Nyngan, Orange, Parkes, Scone, Temora, Tumut, Warialda, Wee Waa, Wentworth, Wyong and Young.
- 5.118 Data from the same source and in relation to the same period indicate that more than 25 per cent of care proceedings at the following locations were not finalised within 12 months: Albury, Bega, Condobolin, Griffith, Katoomba, and Walgett. Clearly, the number of new care proceedings at each location may affect the time taken. For example, at Condobolin there were eight new matters while at Bidura there were 351 new care matters in 2007.
- 5.119 The Children's Court provided data on the average times taken for the finalisation of care proceedings in 2005/06 and 2006/07 around the State.

Table 5.47 Time taken for finalisation of care proceedings (in weeks)

	<i>2005/06</i>	<i>2006/07</i>
All care proceedings (all locations)	18.2	16.3
Parramatta	n/a	12.7
Bidura	n/a	13.3
Campbelltown	40.7	6
Woy Woy	18	25.1
Broadmeadow	2.9	19.9
Port Kembla	27.3	6.6

Note: Parramatta Children's Court opened in November 2006. Care proceedings were not heard at Bidura Children's Court until November 2006.

- 5.120 During the Inquiry, DoCS and the Children's Court agreed that the mean duration of care matters was seven months. The period during which the mean duration was assessed is not clear to the Inquiry. It would appear that it represents a significant improvement on the figures reported as the average time for finalisation in the table above.
- 5.121 DoCS sought to locate comparable figures in other jurisdictions and advised that Magellan cases in the Family Court had a mean duration of almost 12 months in the Melbourne Registry, and about 16 months in the Sydney Registry.
- 5.122 In England, only a minority of care matters take less than 40 weeks.

Children's Magistrates' caseload

- 5.123 No statistics are held in relation to the caseload of each of the 13 Children's Magistrates, nor on the proportion of each caseload that comprises care matters (rather than criminal matters).
- 5.124 DoCS told the Inquiry that in 2007 the specialist Children's Court Magistrates dealt with 68 per cent of care matters, the remainder being dealt with by Magistrates whose principal workload was in the Local Court.

Future Demand

Child protection

- 5.125 As shown in Figure 5.1, while numbers of child protection reports have continued to increase each year from 2001/02, the size of the increase follows no clear pattern. The volatility of the variation from year to year makes it difficult to predict future trends with any certainty.

Table 5.48 **Percentage changes by year for total reports, 2001/02 to 2007/08**

	<i>% change</i>
2001/02 to 2002/03	10.4
2002/03 to 2003/04	5.1
2003/04 to 2004/05	16.8
2004/05 to 2005/06	11.4
2005/06 to 2006/07	18.7
2006/07 to 2007/08	6.0

- 5.126 Table 5.49 considers the percentage change over the most recent period from 2005/06 to 2007/08 in six-monthly segments. This shows a pattern of slowing increase – with a 21 per cent increase from the July to December 2005 period compared with the July to December 2006 period, through to a three per cent increase when the January to June 2007 period is compared with the more recent period of January to June 2008.

Table 5.49 **Percentage changes by six-month period for total reports, 2005/06 to 2007/08**

	<i>% change from 2005/06 to 2006/07</i>	<i>% change from 2006/07 to 2007/08 preliminary</i>
July – December	21	9
January – June	16	3
Total	19	6

- 5.127 If the pattern of slowing increase shown in Table 5.49 continues, there would be relatively little increase in the numbers of reports in 2008/09.

- 5.128 Data provided by DoCS reveal the following:
- a. The number of reports and of children reported both increased by around 6 per cent from 2006/07 to 2007/08. Both these increases were far lower than those experienced in the 2005/06 to 2006/07 period.
 - b. The percentage of reports that were forwarded to a CSC/JIRT for secondary assessment remained constant.
 - c. The percentage share of total reports about known children continues to increase.
 - d. The percentage of reports with more urgent required response times and classified as high risk have decreased.
 - e. Slight changes have been observed across reported issue groups.
 - f. As a percentage of the total, factors such as reporter type, re-reports within seven days and the Region to which reports were referred all remained relatively constant.
- 5.129 Given a steady state – meaning no substantial changes to in the way that DoCS does business and no unpredictable increases in the number of reports or any significant deterioration in economic circumstances that would lead to an increase in socio-economic disadvantage or in homelessness – there are suggestions that 2008/09 will stabilise, with possibly an increase on 2007/08 of no more than three per cent to six per cent. Given past trends, it is likely that around 40 per cent of those children reported to DoCS in 2008/09 will have no child protection history. The Inquiry however notes that current unfavourable economic conditions may lead to increasing unemployment and stresses that could have a significant impact on the recent trend.

Out-of- home care

- 5.130 There has been a 90 per cent increase in child protection reports between 2001/02 and 2007/08 and a significant increase in OOHC demand during the same period.
- 5.131 The OOHC population has steadily increased over recent years, there having been a significant increase from 30 June 2006 to 30 June 2008 of 38 per cent. The increase in the OOHC population cannot be simply attributed to increased child protection reports. The overall OOHC profile has changed and children and young persons are generally spending longer in care. For example, between 2001 and 2005, while care periods of up to two years significantly decreased there was a dramatic rise in care periods of more than four years.
- 5.132 DoCS have developed a funding model to estimate the number of children and young persons predicted to be in OOHC to 2011/12. Assumptions underlying this modelling include that entry rates and length of stay patterns will remain constant over time unless there is a demonstrated sustained shift in historical data. It is estimated that the number of children and young persons in OOHC

will increase by 15.3 per cent between 2007/08 and 2008/09 rising to 32.9 per cent between 2007/08 and 2010/10.

Table 5.50 Actual and projected OOHC numbers, by OOHC status

	<i>Actual</i> As at 30 June 2005	<i>Actual</i> As at 30 June 2006	<i>Actual</i> As at 30 June 2007	<i>Actual</i> As at 30 June 2008	<i>As at</i> 30 June 2009	<i>As at</i> 30 June 2010	<i>As at</i> 30 June 2011	<i>As at</i> 30 June 2012
Total Aboriginal	2,686	3,033	3,865	4,575	4,710	4,968	5,250	5,498
Total non-Aboriginal	7,271	7,562	8,822	10,073	10,895	12,025	13,045	13,997
Not entered	84	28	25	19				
Total	10,041	10,623	12,712	14,667	15,605	16,993	18,295	19,495

Table 5.51 Actual and projected OOHC numbers, placement and expenditure

	<i>Actual</i> 2005/06	<i>Actual</i> 2006/07	<i>Actual</i> 2007/ 08	2008/09	2009/10	2010/11	2011/12
Relative/Kin	5,340	6,497	7,397	7,987	8,605	9,111	9,565
Other	5,283	6,215	6,719	7,618	8,388	9,184	9,930
Total	10,623	12,712	14,116	15,605	16,993	18,295	19,495
Expenditure \$m (excludes all caseworkers)	\$225.3	\$270.2	\$253.7	\$387	\$407	\$459	\$476
Current OOHC caseworkers	334	362	512	512	512	512	512
Caseworker \$m	\$52.4	\$56.8	\$80.3	\$80.3	\$80.3	\$80.3	\$80.3

Table 5.52 Projected OOHC population, expenditure and additional caseworkers (cumulative) required to attain DoCS caseloads of 15

	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Relative/Kin	7,496	7,987	8,605	9,111	9,565	9,963	10,387
Other	7,171	7,618	8,388	9,184	9,930	10,370	10,811
Total	14,667	15,605	16,993	18,295	19,495	20,332	21,197
Current DoCS OOHC Caseworkers	512	512	512	512	512	512	512
DoCS Caseworker \$m	84	84	84	84	84	84	84
1:15 Caseload: Caseworkers	-	300	400	490	550	600	650
Extra Caseworker \$m	-	50	66	81	91	99	107
Estimated increase in allowances for additional children in OOHC \$m	-	25	39	53	68	74	85

6 Risk of harm reports to DoCS

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Reporting trends

- 6.1 From the data set out in the preceding chapter the following emerges.
- 6.2 Between 2006/07 and 2007/08, there was the lowest annual percentage increase in reports and number of children and young persons involved in reports since 2003/04; and there was no increase in the ratio of reports to children and young persons from the past year: it remained at the 2006/07 level of 2.3:1.
- 6.3 There was an increased concentration of reports made about a small group of children and young persons in 2006/07, with the top 20 per cent of frequently reported children and young persons accounting for more than half the total number of reports.
- 6.4 As a proportion of total children and young persons, the number of children and young persons who were the subject of a report for the first time has every year fallen since 2001/02.
- 6.5 There has been little variation in reported issues since 2005/06. In 2007/08 (preliminary), the seven most common primary reported issues in order were domestic violence, followed by neglect, physical abuse, carer drug and alcohol, psychological abuse, carer mental health and sexual abuse.
- 6.6 In 2007/08 (preliminary), when considering primary, secondary and third reported issues, the same seven issues were the most commonly reported but the order was different. Domestic violence was followed by psychological abuse, physical abuse, neglect, carer drug and alcohol, care mental health and sexual abuse.
- 6.7 Between 2004/05 and 2007/08 (preliminary), short term re-reporting (defined as a report received within seven days of a previous report that has the same reported issue), accounted for a significant proportion of the total reports made (between 15 and 18 per cent). Of these, the number of short term re-reports by the same reporter type on the same reported issue accounted for between six and seven per cent of total reports.
- 6.8 The number of short term re-reports by the same reporter type and issue has increased at almost twice the rate of increase in the number of all reports. In 2006/07, the most common reported issue for short term re-reports was a runaway child or young person. The highest proportion of short term re-reports within specific reporting groups in 2006/07 were from NGOs followed by health reporters and relatives.
- 6.9 Reports with a more urgent response time (less than 24 hours and less than 72 hours) have been decreasing as a percentage of reports referred to a CSC/JIRT for further assessment over the three years 2005/06 to April 07/March 08.

- 6.10 The number of referred reports with a high risk of harm level increased between 2005/06 and 2006/07 and decreased between that year and April 07/March 08. Medium risk of harm reports increased over the three year period. Low risk of harm reports decreased between 2005/06 and 2006/07, and then increased between 2006/07 and April 07/March 08.
- 6.11 Of those reports made by mandatory reporters, neglect reports were most likely to be assigned a less than 24 hours response time and domestic violence reports were least likely to be so assigned.
- 6.12 In relation to the outcomes of assessment since 2004/05, there has been:
- a. little change in the percentage of reports closed at Helpline
 - b. a slight decrease in the percentage of reports referred to a CSC/JIRT for information
 - c. an increase in the percentage of reports referred to a CSC/JIRT for further assessment to 2006/07, remaining stable for the period April 07/March 08
 - d. a significant decrease in the percentage of those reports closed at the CSC before any secondary assessment
 - e. a significant increase in the number and percentage of reports receiving a completed SAS1 before being closed
 - f. an increase in the number and percentage of reports receiving a completed SAS2 between 2004/05 and 2006/07
 - g. a decrease between 06/07 and April 07/March 08 in the number and percentage of reports subject to a completed SAS2
 - h. an increase in the number and percentage of reports where harm or risk of harm was substantiated between 2004/05 and 2006/07
 - i. a decrease in both the number and percentage of reports where harm or risk of harm was substantiated between 2006/07 and April 07/March 08.
- 6.13 The percentage of children and young persons who were the subject of a substantiated report in the previous year and were the subject of a further substantiation within the following 12 months, has doubled since 2001/02 and increased by about 20 per cent between 2005/06 and 2006/07.

Frequently reported families

- 6.14 DoCS has recently examined a number of families within each of the seven DoCS regions to identify factors driving repeat reporting.³²³ DoCS has identified the following issues relevant to reporting trends:
- a. The capacity of the CSC to allocate the case had a direct impact on reports, with a number of examples of mandatory reporters appearing to

³²³ DoCS defines 'repeat reporting' as multiple reports in relation to the same risk issue and reports which do not meet the legislative threshold for risk of harm.

continue to make reports because of a lack of response from the CSC to their concerns.

- b. There appeared to be a pattern of refuges and residential units using reports to update the Department rather than to report risk of harm. In some cases a practice of daily reporting was apparent. For example:

*Often the reporters made a report to the Helpline as they wanted to update the allocated worker with information.... There were at times reports by Health which did not need to become a [risk of harm] report. It may have only required a phone call to the allocated Caseworker to provide the updated information as opposed to reporting directly to the Helpline.*³²⁴

- c. Contact by children, young persons and families with multiple services led to multiple reporters each reporting the same concern or incident.
- d. There were a number of examples where repeat reporting continued unabated despite good case management and interagency contact taking place.³²⁵

Reporter trends

- 6.15 Since 2001/02 around three quarters of all child protection reports have been made by mandatory reporters. There has been little variation in the share of reports by all reporters since 2001/02. Of these, over 60 per cent were made by police, health and school/child care reporters, with police making about one third, health 15 per cent and school/child care reporters slightly less at 13 per cent.
- 6.16 Between 2001/02 and 2007/08, there was a slight increase in the proportion of reports from other mandatory reporters, including reporters from NGOs.
- 6.17 In 2007/08, domestic violence was the primary reported issue in almost 60 per cent of all police reports. Police domestic violence reports accounted for almost three quarters of all reports where domestic violence was the primary reported issue. After domestic violence, the three most frequently reported issues by police were neglect, carer drug and alcohol use and physical abuse. Each accounted for approximately seven to nine per cent of all police reports.
- 6.18 In 2007/08, carer mental health reports accounted for almost one quarter of all health reports. Health reporters accounted for over 40 per cent of all reports where carer mental health was the primary reported issue. After carer mental health, the three most frequently reported issues by health reporters were carer

³²⁴ DoCS, *Frequently Reported Families Project- Report for the Child Protection Major Project Board*, July 2008, p.6.

³²⁵ *ibid.*

drug and alcohol abuse, domestic violence and physical abuse. Each accounted for approximately 13 to 14 per cent of all health reports.

- 6.19 Physical abuse reports accounted for almost 30 per cent of all reports from the school/child care sector in 2007/08. These reports accounted for one quarter of all reports where physical abuse was the primary reported issue. After physical abuse, the three most frequently reported issues by school/child care reporters were neglect, psychological abuse and sexual abuse. Each accounted for between approximately 10 and 16 per cent of all school/child care reports.
- 6.20 Reports with the required response time of less than 24 hours in 2006/07 accounted for 7.0 per cent of all police reports referred for further assessment, which was below the 2006/07 average of 9.5 per cent of referred reports assigned a less than 24 hour response. School/child care reports with a less than 24 hour response time were also below the average at 7.8 per cent. On the other hand, 10.6 per cent of health reports received a less than 24 hour response rating which was higher than the average for all reports.
- 6.21 During 2006/07, the proportion of reports that were assigned a less than 24 hour response time where the primary reported issue was domestic violence was much lower than for most other reported issues. Only 2.3 per cent of referred domestic violence reports by mandatory reporters were assigned a less than 24 hour response time, which is much lower than the average of 9.5 per cent.
- 6.22 The average figures relating to required response times assigned to police reports during 2006/07 are skewed because of the large number of domestic violence reports made by police. If the data on domestic violence reports were put aside, the average proportion of less than 24 hour response ratings assigned to police reports would increase to 13.9 per cent, which is above the 9.5 per cent average. For non-domestic violence reports by health and school/child care reporters, health reports to be assigned a required response time of less than 24 hours would increase to 11.6 per cent and school/child care reports would increase to 8.2 per cent.
- 6.23 This would indicate that, apart from police domestic violence reports, a greater proportion of police reports were assigned a higher priority response rating than reports made by the other two key mandatory reporter groups.
- 6.24 During 2006/07, almost one quarter of all police reports, one quarter of all school/child care reports and one quarter of all health reports were closed at a CSC/JIRT prior to any secondary assessment.
- 6.25 The results for 1 April 2007 to 31 March 2008 differ from 2006/07 because significantly fewer referred reports were closed at the CSC/JIRT before any secondary assessment. In this period, almost one quarter of all police reports, over one quarter of all school/child care reports and almost one fifth of all health reports were closed at the CSC/JIRT prior to any secondary assessment.

- 6.26 In 2006/07, over one quarter of reports from the three key mandatory reporter groups were closed after a SAS1. From 1 April 2007 to 31 March 2008, almost one third of reports from the three key mandatory reporter groups were closed at this point.
- 6.27 Of the 286,033 reports received during 2006/07, 15.1 per cent had a SAS2. Of the three key mandatory reporter groups, 11.7 per cent of all police reports, 14.4 per cent of all school/child care reports and 17.9 per cent of all health reports were the subject of a completed SAS2.
- 6.28 The figures for 1 April 2007 to 31 March 2008 are different from 2006/07 because fewer reports progressed to a SAS2. Of the 296,769 reports received in this period, 13.1 per cent were the subject of a completed SAS2. Of the three key mandatory reporter groups, 9.8 per cent of all police reports, 13.4 per cent of all school/child care reports and 15.9 per cent of all health reports had a SAS2.

Substantiations

- 6.29 In 2006/07, 93.5 per cent of all reports which resulted in a SAS2, were the subject of a finding that harm or risk of harm was substantiated, compared with 93.2 per cent in 1 April 07/31 March 08. From 1 April 2007 to 31 March 2008, as a percentage of those reports which had been referred for further assessment, about 17.6 per cent were substantiated, while substantiated reports were about 12.2 per cent of all reports received.
- 6.30 From 1 April 2007 to 31 March 2008, over one fifth of all substantiated reports had neglect as the primary reported issue, that being the largest single category followed by physical abuse then by domestic violence.
- 6.31 Actual harm was found in around 70 per cent of substantiated reports and risk of harm in the remaining 30 per cent in both 06/07 and 1 April 07/31 March 08. Psychological harm then neglect were most prevalent in each category.

Reports which receive no further assessment

- 6.32 Over 13 per cent of reports received between 1 April 2007 and 31 March 2008 went no further than the Helpline. DoCS captures these as either information, advice, referral provided or no further assessment required. DoCS advised the Inquiry that in these cases no risk of harm had been identified. It appears to the Inquiry that these reports, some 38,856, should not be recorded as child protection reports but instead as contacts, as they do not meet the threshold test under the Care Act. DoCS routinely records other calls to the Helpline which do not amount to risk of harm, in this manner.

- 6.33 Nearly 18 per cent of all reports made between 1 April 2007 and 31 March 2008 were forwarded to a CSC or JIRT for information only. A distinction is made by DoCS between these reports and the 70 or so per cent which were referred to the CSC or JIRT for further assessment. The Inquiry has attempted to unravel the reasons for this distinction.
- 6.34 It seems that reports are forwarded to a CSC or JIRT for information only when there is an open case plan. The report may in fact be a new report (and thus should be classified as a report of risk of harm), a request for assistance (which should not be so classified) or additional information related to the current casework (which may or may not be a report). Helpline caseworkers are not required to carry out a full initial assessment on reports forwarded for information only, presumably on the basis that there is an allocated caseworker, who is aware of the child and his or her circumstances.
- 6.35 This issue has been identified by others. For example, in his report on reviewable deaths occurring in 2006, the Ombudsman found that:
- Reports sent as information only contained, at least in part, additional information that raised new concerns not previously identified to DoCS. This meant that new information was not subject to analysis by the CSC. At times however, CSCs did review, and subsequently act on, information only reports containing new concerns.*³²⁶
- 6.36 In addition, a recent analysis undertaken by DoCS, based on the work done in four CSCs, found that 21 per cent of all initial assessments referred for secondary assessment were regarded as conveying additional information about known events or issues. Thus, it would have been appropriate for them to be transferred as 'information only'.
- 6.37 The consequences of this inconsistent recording and referral of reports are that potentially inaccurate data are collected about numbers of reports, reports are not being fully assessed by the intake caseworkers at the CSC and resources are being wasted at the Helpline and at the CSC.
- 6.38 To place these figures into perspective, of the nearly 30,000 police reports which were not referred for further assessment in 2006/07, just under one half (13,506) were forwarded to a CSC for information only, some of which may or may not have been reports of risk of harm. More than half (16,426) did not meet the statutory test and went nowhere. It is likely that most of these were reports involving domestic violence incidents.
- 6.39 In relation to health reports, 6.3 per cent similarly failed the statutory test and for school/child care reports the figure was 10.1 per cent.

³²⁶ NSW Ombudsman, *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths*, December 2007, p.45.

- 6.40 It is clearly a waste of police, health, school/child care and DoCS resources to make and process thousands of reports which DoCS believes do not amount to a risk of harm as defined in the Care Act. The need for further education of mandatory reporters is addressed later in this chapter.
- 6.41 In addition, DoCS calculates the number of substantiations as a percentage of those reports referred for further assessment. The lower the number of reports referred for assessment, the higher the potential percentage of substantiations. If some of the nearly 18 per cent, or over 52,000 reports referred for information only were included in the referral for assessment figure, and were not substantiated, then the substantiation rate may be lower.

Mandatory reporting

Current provisions

- 6.42 Certain members of the community are legally required to make a report to the Director-General of DoCS about children who are at risk of harm or living away from home without parental permission. 'Child' means a person who is under the age of 16 years. The mandatory reporting regime accordingly does not apply to 'young persons' who are defined as those aged 16 to 18 years, although reports may be made to the Director-General in relation to them by reference to the same considerations as apply to children.³²⁷
- 6.43 Mandatory reporting applies to all persons who deliver:
- a. health care
 - b. welfare
 - c. education
 - d. children's services
 - e. residential services, or
 - f. law enforcement
- to children as part of their professional work or paid employment, or manage those who do so.³²⁸
- 6.44 It also applies to people who:
- a. are paid to provide or manage a child minding service out of school hours, for children aged at least 6 years, but less than 13 years, or
 - b. in the course of their professional work deliver disability services to children.³²⁹

³²⁷ *Children and Young Persons (Care and Protection) Act 1998 s.24.*

³²⁸ *Children and Young Persons (Care and Protection) Act 1998 s.27.*

- 6.45 Mandatory reporting of children who are living away from home without parental permission applies to a person who provides residential accommodation.³³⁰ With the consent of a young person, his or her homelessness may be reported to DoCS.³³¹
- 6.46 A mandatory reporter must make a report to DoCS if he or she has “reasonable grounds to suspect” that a child is or a class of children are, at risk of harm.³³² Under s.23 of the Care Act, a child is defined as being at risk of harm if:

current concerns exist for the safety, welfare or well-being of the child or young person because of the presence 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 care-givers have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care,*
- (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 care-giver 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.³³³*

³²⁹ *Children and Young Persons (Care and Protection) Regulation 2000* cl.10.

³³⁰ *Children and Young Persons (Care and Protection) Act 1998* s.122.

³³¹ *Children and Young Persons (Care and Protection) Act 1998* s.121.

³³² *Children and Young Persons (Care and Protection) Act 1998* s.27(2).

³³³ *Children and Young Persons (Care and Protection) Act 1998* s.23.

- 6.47 Mandatory reporting is the responsibility of the individual (rather than, for example, the employer) although the Care Act does not stipulate how the obligation is to be discharged. Failure to report can result in prosecution and a fine of up to \$22,000, although there have been no prosecutions under the Care Act resulting from a failure to report.
- 6.48 A person who reports in good faith is not in breach of professional ethics or regarded as departing from acceptable standards of conduct, is not liable for defamation, is not exposed to specified civil proceedings, has his or her identity protected, cannot be compelled to produce the report or give evidence about it and the report itself is not generally admissible in legal proceedings apart from care proceedings.³³⁴ It has generally been assumed that it would give rise to a lawful excuse for the purpose of the defence provisions under privacy legislation.
- 6.49 Significantly and, the Inquiry suspects, often overlooked, is the provision in the Care Act which, “for the avoidance of doubt”, declares that a reporter is not prevented from responding to the needs of the child because of having made the report.³³⁵
- 6.50 Section 29(3A) of the Care Act extends the protections referred to above to any person who provided information on the basis of which the report was made and to any person concerned in making or causing a report to be made, in each case subject to them acting in good faith.

Selected history

- 6.51 The final report of the review of the *Children (Care and Protection) Act 1987*, released in 1997, noted that there was overwhelming community support for mandatory reporting. It made a number of recommendations about the mandatory reporting regime then in existence, which are largely reflected in the current Care Act. In December 2000 further amendments were made to the Care Act which clarified and extended the requirements for mandatory reporting. At the same time, the Helpline commenced operations, and became the single central intake point to receive reports.
- 6.52 Section 265 of the Care Act required the Care Act to be reviewed and a report on the review to be presented to Parliament by 5 December 2006. A report dated November 2006 was duly presented, indicating that amendments had been made to, among other things, provide for prenatal reporting, the admissibility of evidence of previous removal of children from a family and to introduce Parent Responsibility Contracts. The report indicated that a Discussion Paper had been prepared. *Statutory child protection in NSW: issues and options for reform* (the Discussion Paper) was published in October 2006. It identified and discussed some contentious matters including mandatory

³³⁴ *Children and Young Persons (Care and Protection) Act 1998* s.29.

³³⁵ *Children and Young Persons (Care and Protection) Act 1998* s.29A.

reporting, the exchange of information, the objects, best interests and other principles of the Care Act and the role of the Children's Court. Each of those matters will be dealt with later in this report.

- 6.53 In relation to mandatory reporting, DoCS' position as expressed in the Discussion Paper was that the central issue was whether there was:

*sufficient clarity about what must be reported and why, and whether reports are of sufficient quality to facilitate the most effective assessment and allocation of the report.*³³⁶

To that end, DoCS stated:

- a. mandatory reporting is not the cause of increased reporting as the trend is evident in jurisdictions where there is not mandatory reporting
 - b. the expansion of mandatory reporting criteria has not led to a decrease in the proportion of reports that are investigated
 - c. mandatory reporting is a means of collecting information over time, particularly in cases of neglect.
- 6.54 Four improvements suggested in the Discussion Paper were:
- a. requiring reporters to provide clearer evidence of risk
 - b. inserting illicit drug use as a circumstance relevant to the risk of harm in s.23 of the Care Act
 - c. amending s.23 to be more explicit on neglect as a risk of harm circumstance
 - d. specifying that evidence of past or emerging behaviour that may cause future harm to a child is a basis for reporting a risk.
- 6.55 There was general support in the submissions made in response to the Discussion Paper for the latter three matters, while requiring reporters to provide clearer evidence of risk was roundly rejected.
- 6.56 The announcement and subsequent commencement of this Inquiry has had the effect of the matters raised in the Discussion Paper being stayed.

Abolish or retain?

- 6.57 There was limited, and primarily academic support expressed to the Inquiry for abolition of the mandatory reporting provisions. The principal reason advanced was that the child protection system was being flooded with reports, the response to which used up scarce resources and diverted attention from those families whose children were in need of the State's intervention.

³³⁶ DoCS, *Statutory Child Protection in NSW, Issues and Options for Reform*, October 2006, p.21.

- 6.58 The Inquiry is aware of a deal of academic commentary in relation to the increasing numbers of reports and, expressly or implicitly about mandatory reporting. According to Testro and Peltola the focus of child protection services on reporting has led to:
- a. a perception in the community that this is the best way to protect children
 - b. the dominance of risk assessment and risk management paradigms
 - c. an overemphasis on standardised processes and procedures and documentation
 - d. the 'primacy' of the responsibility of the child protection agency at the expense of the involvement of other agencies. Given the complexity of child protection issues and the need for multifaceted responses this diminishes the safety of children.³³⁷
- 6.59 Scott argues that child protection policies and laws have become increasingly applied to situations where children are seen 'at risk.' This has led to "dramatic net widening" and the subsequent "epidemic of child protection notifications."³³⁸ However, Scott further argues that there is no evidence of an actual increase in the prevalence of child abuse and neglect in Australia.³³⁹
- 6.60 Scott also outlines the dangers of an 'overloaded system':
- a. Children are missed due to a focus on escalating notifications.
 - b. Children who are at risk but below the threshold for statutory intervention are missed.
 - c. Inappropriate reporting of and subsequent investigation of low risk families, leading to increased parental stress, and thus to increased risk of harm for children.
 - d. Children in state care are adversely affected when resources are redirected to deal with more investigations.
 - e. The large gap between the threshold for making a notification and that for statutory intervention leads to strained relationships between statutory child protection services and services making notifications. Scott states this leads to 'corrosive' relationships between organisations as dynamics such as 'gatekeeping' and 'poison ball' in relation to resource hungry cases become survival strategies.
 - f. There are negative impacts on staff leading to stress and turnover.³⁴⁰

³³⁷ P Testro and C Peltola, *Rethinking Child Protection: A New Paradigm? A Discussion Paper*, Prepared for PeakCare Queensland Inc, January 2007, pp.18-21.

³³⁸ D Scott, 2006, op. cit., p.10.

³³⁹ *ibid.*, p.11.

³⁴⁰ D Scott, *Sowing the Seeds of Innovation in Child Protection*, Paper presented to the 10th Australasian Child Abuse and Neglect Conference, Wellington, New Zealand, February 2006, p.9.

- 6.61 Those working in the system were generally in favour of the retention of mandatory reporting while supporting various amendments to the manner in which it operated.
- 6.62 The Inquiry is persuaded that the requirement to report should remain. It agrees with DoCS that the trend towards increased reporting is evident in jurisdictions where there is not mandatory reporting. In addition, the data cited in the previous chapter indicate that the substantiation rates almost doubled from 2004/05 to 2006/07, with a slight reduction from that year to April 07/March 08. Further, the number and percentage of reports referred for further assessment have increased since 2001/02, although they have remained steady over the last two financial years. The numbers of reports that are subject to a completed SAS2 has more than doubled since 2004/05 and have also increased as a percentage of the total reports received.
- 6.63 While these data are probably related, at least in part, to the implementation of the DoCS Reform Package, evidence of a flood of reports with a reduction in outcomes, at least by reference to investigations and substantiations, is not evident.
- 6.64 What is particularly interesting, is that the extent of the increase in reporting appears to have slowed in 2007/08. Thus, the percentage change in number of reports, and the number of children and young persons reported has reduced between 2006/07 to 2007/08. However, at the same time, multiple reporting has increased and the level of seriousness of reports has decreased, with the former adding unnecessary stress to the system.
- 6.65 The Inquiry believes that mandatory reporting has the useful effect of overcoming privacy and ethical concerns by compelling the timely sharing of information where risk exists and of raising awareness among professionals working with children and young persons. There are other mechanisms by which professionals such as health workers and teachers are obliged to report, with the failure to do so sometimes carrying with it disciplinary consequences. To abolish mandatory reporting may leave such people obliged to report, but without the protections in the current Care Act, and could also weaken the opportunity for interagency collaboration which the Inquiry considers essential for an effective child protection system.
- 6.66 The preferable approach to deal with the large numbers of reports, and one which is reflected in this report, is for the system of reporting and assessment to be modified to ensure that children at risk of significant harm receive the attention of DoCS and its NGO partners while families in need of assistance are directed to services, be they universal or more targeted in orientation. Further, that those outside DoCS working in child protection, be encouraged to improve the quality of their reports, more frequently exercise their professional judgement and work collaboratively and cooperatively with DoCS to better use their resources in the best interests of children. Education of mandatory

reporters and enhancing the availability of differential responses should reduce multiple reporting rates.

The test for reporting

- 6.67 As set out above, the obligation on mandatory reporters arises when they have 'reasonable grounds to suspect' that a child is at risk of harm, with the latter phrase being exhaustively defined in s.23 and requiring 'current' concerns to exist for the safety welfare or well-being of that child.
- 6.68 The requirement of 'reasonable grounds to suspect' means that:
- a. the suspicion must have some evidence to support it, although it does not require the same level of certainty as a belief, which requires that the evidence has been tested to some degree
 - b. it is the suspicion of the reporter and as such, may not be shared by others, including DoCS if faced with the same set of circumstances
 - c. it does not require the reporter to investigate or determine the source of the harm before reporting
 - d. what constitutes 'reasonable grounds' will vary in accordance with the professional capacity and experience of the person involved.
- 6.69 The *Interagency Guidelines for Child Protection Intervention 2006* advises that 'reasonable grounds' could be derived from either:
- a. first hand observations about the child or family
 - b. what a practitioner has been told by a child, his or her parent or another person
 - c. what a practitioner can reasonably infer based on professional training and/or experience.
- 6.70 Agencies are also advised that if it is possible, likely or probable that something will occur, the mandatory reporter should consider reporting. General indicators of abuse, psychological harm, domestic violence and neglect are provided.
- 6.71 Not all of the key mandatory reporting agencies have provided staff with detailed guidance as to their reporting obligations. DADHC is a notable agency which has not done so.
- 6.72 There are differences across states and territories as to who should report and when, and whether past or present abuse or future concerns are reportable. The Inquiry takes the view that where reform is desirable, it is preferable to increase similarities in legislation with other states and territories rather than to extend the differences.
- 6.73 The tests for the reporting of child protection concerns to the relevant authorities in each state or territory are as follows:

- a. Victoria: significant concern for the well-being of a child or an unborn child.³⁴¹
 - b. Queensland: the suspicion that a child, or an unborn child, has been, is being, or is likely to be, harmed.³⁴²
 - c. South Australia: the suspicion on reasonable grounds that a child has been, or is being, abused or neglected.³⁴³
 - d. Western Australia: there is no mandatory reporting, however a person can, in good faith, provide information to the relevant authority that raises concern about the well-being of a child.³⁴⁴
 - e. Tasmania: for mandatory reporters, the knowledge, or belief or suspicion on reasonable grounds, that a child has been, or is being, abused or neglected (by anyone), or that there is a reasonable likelihood of a child being killed or abused or neglected by a person with whom the child resides. For non-mandatory reporters, the knowledge, or belief or suspicion on reasonable grounds, that a child is suffering, has suffered, or is likely to suffer, abuse or neglect.³⁴⁵
 - f. Australian Capital Territory: for mandatory reporters, the belief on reasonable grounds that a child or young person has experienced, or is experiencing, sexual abuse or non-accidental physical injury. For non-mandatory reporters, the belief or suspicion that a child or young person is, being, or is at risk of being abused or neglected.³⁴⁶
 - g. Northern Territory: the belief on reasonable grounds that a child has been (or is likely to be) a victim of a sexual offence, or has otherwise suffered (or is likely to suffer) harm or exploitation.³⁴⁷
- 6.74 Clearly, NSW has one of the lowest thresholds for reporting. Equally clear from the data cited in the previous chapter, in 2007/08, only about 13 per cent of all reports to DoCS were responded to with a sighting of the family and child and a detailed assessment.
- 6.75 From an examination of the data and discussions with many of those working in and around the child protection system, the Inquiry has concluded that, conservatively, 30 per cent of reports to DoCS do not warrant the statutory intervention of the State. The 13 per cent closed at the Helpline and the 17.8 per cent, comprising those closed after a SAS1 for reasons of 'other information,' which means the report was referred elsewhere or closed, are likely not to have warranted the State's intervention. The families the subject of these reports may need the assistance of either a government agency or an

³⁴¹ *Children, Youth and Families Act 2005 (Vic)* s.28 and 29

³⁴² *Child Protection Act 1999 (Qld)* s.22.

³⁴³ *Children's Protection Act 1993 (SA)* s.11(1).

³⁴⁴ *Children and Community Services Act 2004 (WA)* s.240.

³⁴⁵ *Children, Young Persons and their Families Act 1997 (Tas)* ss.13 and 14(2).

³⁴⁶ *Children and Young People Act 2008 (ACT)* ss.354 and 356.

³⁴⁷ *Care and Protection of Children Act 2007 (NT)* s.26.

NGO to better support and nurture their children. However, to obtain that assistance, a report to a body with the powers to assume the care of children should not be required, particularly as this can provide a barrier to those families seeking or accepting assistance.

6.76 This view is supported by DoCS. In 2007 it undertook an analysis to determine the appropriateness of child protection reports referred to CSCs for secondary assessment, and whether some of those reports did not reflect real child protection concerns. DoCS found that intake workers at the four CSCs selected believed that about 80 per cent of initial assessments that were referred for secondary assessment were risk of harm reports, and 20 per cent were not.

6.77 In its submission to the Inquiry, DoCS concluded that 25–35 per cent of children and young persons reported fall within this group. DoCS described them as:

Children and young people who enter and exit the system quickly. These cases are: (i) generally not referred to a CSC because they are assessed as below the current risk of harm threshold, or (ii) if referred to a CSC, are assessed at local level intake to be of a much lower priority than others, and as requiring minimal attention within the child protection system (that is, no further secondary assessment). This group in total comprises around 25-35 per cent of children and young people who are currently reported to DoCS in any year. A significant number of these children and young people are reported by NSW Police, with a large proportion having only Police reports. Under a raised mandatory reporting threshold, the majority of these cases will be 'out of scope' for the child protection system. While some other government (for example Health or Housing) or non-government family support services might be required, there would be no need for DoCS intervention if the risk of harm threshold is not met.³⁴⁸

6.78 As Ms Freeland, then DoCS Executive Director for the Helpline said at the Public Forum held by the Inquiry into mandatory reporting:

We should not underestimate how significant and serious it is to invite the statutory child protection system into people's lives and that statutory child protection intervention ought be something that is reserved for those matters that really warrant it. Intervention by the State in private family life is a very serious thing.³⁴⁹

³⁴⁸ Submission: DoCS, Child Protection Assessment Models and Processes, pp.14-15.

³⁴⁹ Transcript: Public Forum, Mandatory Reporting, 15 February 2008, p.39.

- 6.79 The Inquiry has concluded that the threshold for reporting should be raised so that families and children do not have the stigma of being ‘known to DoCS’ in circumstances where the risk of harm does not warrant its attention.
- 6.80 This could be achieved in a number of ways. The Inquiry is not persuaded that the introduction of a test incorporating “reasonable evidence,” or requiring consideration by the reporter of “likelihood of harm,” will best achieve the goal. The former calls for a level of investigation capable of providing tangible evidence while the latter introduces a need for foresight or prediction of what is likely to occur. Similarly, it does not consider that a test based on “belief” would be appropriate as it would convey a degree of confidence in a state of affairs that could raise the threshold too high. The Inquiry is more concerned with the nature of the harm which should attract an obligation to report.
- 6.81 The Care Act incorporates the concept of seriousness in s.23(d) and (e) in relation to the effect of domestic violence and other behaviours by parents. It also appears in provisions concerning removal of children. Section 36(1)(c) provides that removal of a child or young person may occur only “where it is necessary to protect the child or young person from risk of serious harm” and s.43(1)(a) permits removal without a warrant if a child or young person “is at immediate risk of serious harm.”³⁵⁰
- 6.82 The Victorian legislation employs the term ‘significant’ to express the level of harm which will indicate that the child is in need of protection.³⁵¹ Similarly, the Queensland legislation defines harm as “any detrimental effect of a significant nature on the child’s physical, psychological or emotional well-being.”³⁵² In Western Australia, harm is defined as any detrimental effect of a significant nature on the child’s well-being³⁵³ and Northern Territory similarly uses the phrase “significant detrimental effect.”³⁵⁴ The English system also uses the concept of significant harm, although it does not have mandatory reporting.
- 6.83 The Inquiry is concerned not to raise the threshold so as to equate it with a risk commensurate with the need to remove a child from his or her family. It is not persuaded, therefore, that an increased threshold should incorporate the concept of seriousness. It should be said that the Inquiry is of the view that the term ‘serious’ connotes a higher degree of risk, where used for example in ss.44 and 46 of the Care Act, than the term ‘significant.’
- 6.84 Changing the reporting regime, for both mandatory and voluntary reporters, to one which applies in relation to children who are suspected by the reporter, on reasonable grounds, to be ‘at risk of significant harm’, rather than ‘at risk of harm,’ should have the effect of reducing the number of reports to those children who are likely to need the powers of the State under s.34 of the Care

³⁵⁰ See also: *Child and Young Persons (Care and Protection) Act 1998* ss.44, 46, 71(1)(e).

³⁵¹ *Children, Youth and Families Act 2005 (Vic)* s.162.

³⁵² *Child Protection Act 1999 (Qld)* s.9.

³⁵³ *Children and Community Services Act 2004 (WA)* s.28.

³⁵⁴ *Care and Protection of Children Act 2007 (NT)* s.15.

Act, exercised for their protection. This is not to say that those for whom a risk of lesser harm is suspected should be without assistance. This issue will be more fully addressed in Chapter 10.

- 6.85 The Inquiry is conscious that evaluations of some laws have shown that the vagueness and ambiguity of concepts like ‘reasonable cause’ and ‘significant harm’ cause problems for reporters in knowing when a report should or should not be made.³⁵⁵
- 6.86 It is certainly the case that reporting duties should be expressed in language that is as clear as possible, and that reporters need good training to gain knowledge of the indicators of abuse and neglect, to know when a report is and is not required, and to know how to make a report that provides useful assistance to child protection authorities.
- 6.87 Whether mandatory reporters have the qualifications, skills or judgement necessary to form a suspicion of risk of significant harm has been raised with the Inquiry. The data indicate that 60 per cent of reports are made by police, health and school/child care reporters. In the main, most of those who have sufficient contact with children to consider reporting, are required to exercise professional judgement daily about the safety, welfare and well-being of a child or young person. Teachers assess such matters in the learning environment, health workers do so in the context of making complex decisions about diagnosis and treatment and police officers are expected to do so in relation to making applications for Apprehended Violence Orders (AVO) and other matters.
- 6.88 With the exception of police and domestic violence incidents, which are addressed later in Chapter 16, none of those with whom the Inquiry spoke suggested any difficulty in having sufficient expertise to form the necessary suspicion. The Inquiry is confident that with sufficient quality training and guidelines mandatory reporters can be equipped to properly satisfy any amended statutory test.

Grounds for reporting risk of harm

- 6.89 The Inquiry received a number of submissions, including submissions from DoCS, Department of Education and Training (Education), and NSW Police Force (Police) supporting the amendment of s.23 to more expressly incorporate neglect, drug and alcohol use by carers, mental health issues of carers and habitual non-attendance at school, as relevant risk of harm circumstances.
- 6.90 In 2007/08 (preliminary), neglect was the second most common primary reported issue after domestic violence, accounting for around 15 per cent of all

³⁵⁵ See for example, B Levi, G Brown and C Erb, “Reasonable suspicion: A pilot study of paediatric residents,” *Child Abuse and Neglect*, 30(4), 2006, pp.345-356; R Deisz, H Doueck, N George and M Levine, “Reasonable Cause: A Qualitative Study of Mandated Reporting,” *Child Abuse and Neglect*, 20(4), 1996, pp.275-287; P Swain, “The Significance of ‘Significant’ – When is Intervention Justified Under Child Abuse Reporting Laws?” 14(1), *Australian Journal of Family Law*, 2000, pp.26-35.

reports. When also taking secondary and third reported issues into account, neglect was a reported issue in almost one quarter of all child protection reports. While non-mandatory reporters made almost one quarter of all reports in 2006/07, they accounted for almost 40 per cent of neglect reports. 'Family' represented the largest group of reporters where neglect was the primary reported issue, accounting for 8,525 reports.

- 6.91 During 2006/07, 20.3 per cent of all referred reports with neglect as the primary reported issue were assigned a required response time of less than 24 hours. This was significantly higher than the average across all referred reports, which was 9.5 per cent. It indicates that in 2006/07 a greater proportion of neglect reports were assigned a high response priority than any other primary reported issue.
- 6.92 There has been no rise in the reporting of neglect as a primary issue in recent years. Rather, the number of neglect reports as a proportion of total reports has remained steady between 2004/05 and 2007/08 at about 15 per cent.
- 6.93 In both 2006/07 and April 07/March 08, neglect reports accounted for around 20 per cent of all reports subject to a completed SAS2, whereas in each year they accounted for around 15 per cent of total reports. Reports where the primary reported issue was neglect also accounted for around 20 per cent of all substantiated reports in both 2006/07 and April 07/March 08.
- 6.94 Of particular note, as evidenced in April 07/March 08 data, is that while neglect is the primary reported issue in 20.2 percent of substantiated reports, there was a finding of neglect or risk of neglect in 31.6 per cent of substantiated reports. This may be a reflection of the significant number of reports where neglect was a secondary or third reported issue.
- 6.95 Further, in 2006/07 more than a quarter of children entering OOHC did so after a finding of neglect or risk of neglect, which was more than any other single issue.
- 6.96 In April 07/March 08, drug and alcohol concerns of carers was the fourth most reported issue, being reported in 10.4 per cent of reports. It accounts for 13.8 per cent of all substantiated reports. Carer mental health was the primary reported issue in 8.0 per cent of reports and accounted for 9.3 per cent of substantiated reports.
- 6.97 In the view of the Inquiry, and of some others who made submissions including the Ombudsman and Health, a combination of paragraphs (a), (b), (c) and (e) of s.23 is sufficiently wide to permit or require neglect, mental health issues and drug or alcohol use by carers to be reported. Neglect is clearly a significant issue for both mandatory reporters and DoCS and has been for some time, and it seems unlikely that amendment to include it as a specific at risk circumstance would lead to any change in reporting patterns or outcomes.

- 6.98 The Ombudsman submitted that s.23 provides a clear framework for appropriately identifying the range of circumstances that may warrant a statutory response. The Inquiry agrees.
- 6.99 Health submitted that there may be difficulties in defining mental illness and substance abuse if they were included as specific at risk circumstances. Further, it pointed out that effective parenting is not necessarily compromised by those conditions, for example, if a parent is following an appropriate treatment program. It submitted that a recent Drug and Alcohol Child Protection Training Strategy has been initiated which is designed to ensure that drug and alcohol workers can identify and respond to children at risk. Similarly, mental health workers are provided with guidance and examples about the relationship between adult mental health and risk of harm.
- 6.100 The Inquiry agrees that many forms of mental illness are capable of being managed by medication and may have no adverse impact on parenting. It is the view of the Inquiry that where the mental health of a carer provides a risk to a child, that risk is adequately catered for in s.23. To extend it would be to potentially capture families who should not be subject to child protection oversight or intervention.
- 6.101 The Inquiry accepts that, as submitted by DoCS, there is a “significant body of evidence to support the assertion that parental drug misuse (and particularly use of illicit drugs) is inherently risky for children.”³⁵⁶ However, if there was a suspicion of serious and persistent parental illicit drug use and as a consequence the child or young person was at risk of not having his or her basic physical or psychological needs met, it is clear that paragraph (a) of s.23 would apply.
- 6.102 DoCS also observed that the reference to ‘current concerns’ in s.23 is open to the interpretation that the perceived risk of harm must be immediate and present. However, it seems to the Inquiry that this blurs the distinction between the concerns which in fact exist at any given moment and their possible consequences either now or in the future in terms of the safety, welfare or well-being of this child. As most of the paragraphs expressly advert to ‘risk’, any amendment to remove ‘current’ would seem to be unnecessary and may result in reporting matters which will not warrant intervention.
- 6.103 On balance, the Inquiry is of the view that s.23 is sufficiently broad and has not been a barrier to issues of drug and alcohol, mental illness and neglect being reported.
- 6.104 However, the Inquiry is of the view that there is some force in including habitual non-attendance at school as a risk circumstance in s.23. It is acknowledged that habitual non-attendance is more likely to meet the increased threshold when accompanied by one or more other risk factors.

³⁵⁶ Submission: DoCS, Mandatory Reporting, p.23.

- 6.105 In addition, the Inquiry is attracted to the provision in the Victorian legislation which states that harm may be constituted by a single act, omission, or circumstance or accumulate through a series of acts, omissions or circumstances. An amendment to this effect would capture the concept of ongoing and persistent concerns about a child which may arise from non-attendance at school, neglect or attributes of a child's carer. Further, the research referred to in Chapter 4 supports an emphasis on the impact of cumulative harm to children and young persons.

Who should report?

- 6.106 No submissions have been made, or other material gathered which suggests the need for any change to those categories of people currently mandated to report risk of harm. It is noted that of the states and territories in Australia, NSW has one of the broadest groupings of those who must report.
- 6.107 The Care Act imposes a personal obligation to report.
- 6.108 DoCS, Education, the Catholic Education Commission NSW and the NSW Association of Independent Schools have a Memorandum of Understanding (MOU) in place to facilitate centralised reporting from schools. Under this MOU, each school has a designated central officer (usually the principal) who reports to the DoCS Helpline on behalf of school staff. However, the obligation remains on the individual to report to the principal who retains no discretion; he or she must make the report to DoCS.
- 6.109 DoCS commenced an electronic reporting pilot in February 2008. Forty-one public schools are participating in the pilot of the system known as 'e-reporting.' As at 30 June 2008, 153 reports had been made using the system. A further 440 public schools will join the pilot in the second half of 2008.³⁵⁷ Rather than phoning the Helpline or faxing in a risk of harm report, the principals of participating schools key information directly into KiDS via the DoCS Connect portal. Reports are forwarded to the Helpline, which then undertakes an initial assessment to determine whether to refer the report to a CSC or JIRT for further assessment. Non-urgent matters are reported in this e-reporting pilot.
- 6.110 DoCS has recently evaluated e-reporting. The evaluation was generally positive, and found that overall the system was straight forward for users and resulted in some savings in the Helpline's average report processing time compared with phone and fax reports. However, the quality of information contained in the e-reports was not as good as reports received by fax. It appears that DoCS now proposes to expand the trial to a more diverse group of mandatory reporters including Health staff, general practitioners and Department of Juvenile Justice (Juvenile Justice) staff. The Inquiry supports this approach and suggests that it also be extended to Police with whom a

³⁵⁷ DoCS, *Vox*, May 2008, p.6.

system should be developed with compatibilities with the Police client database, COPS.

- 6.111 From the data referred to above, it appears that NGOs, health reporters and relatives are more likely to be responsible for making multiple reports than other reporter groups. This is supported by information gathered during the Inquiry. It seems that not infrequently, for example, a child or parent attending an Emergency Department of a hospital may be reported by the Emergency Department medical officer and nurse, by the nurse and attending medical officer on the ward, by the social worker attached to the ward, and by any specialist who comes into contact with the child or parent.
- 6.112 Also, the Inquiry was aware of examples where a child may be reported by a hospital social worker, parent's mental health worker, parent's drug and alcohol counsellor and community nurse for the same incident without apparent awareness that the other reports had been made. Given the volume of calls to the Helpline, these reports are likely to be assessed by different DoCS workers, who are required to, in each case, access the history of the family, if any, and undertake an initial assessment.
- 6.113 Clearly, this is not an efficient use of time by DoCS or health workers. There appears to be a deal of merit in the arrangement with the schools. Those within the education sector with whom we spoke, gave favourable evidence about its operation. The benefit of a central point of reporting in all key mandatory reporting agencies would permit the organisation to play a more active role in the subsequent support provided to the child and family, and would also be likely to provide a more comprehensive initial report through the pooling of information available to individual staff members.
- 6.114 The Inquiry believes there is merit in establishing positions or a Unit in each of the key agencies to triage risk of harm reports as well as to take a case management role in relation to those reports which do not reach the increased threshold of a significant risk of harm. These positions can also provide value in enhancing interagency collaboration, a matter addressed in Chapter 24.
- 6.115 The approach reflects the view of the Inquiry that child protection is the responsibility of all in the community including every government agency. It is responsive to the reality that DoCS carries out a detailed investigation including a home visit for only about 13 per cent of reports received. It enables better interagency cooperation to the ultimate benefit of the child and family. Most importantly, it should provide a service to those families who do not belong in the statutory child protection system and need assistance to stay out of that system.
- 6.116 An essential part of this structure would be the creation of a common assessment framework. The Inquiry notes that work is being done in the area of domestic violence towards developing a cross agency risk assessment approach. This work, led by Health and involving Police, DoCS and the Attorney General's Department (Attorney General's), has arisen from a number

of reports by the Ombudsman. This matter will be discussed at greater length in the following chapter.

6.117 In its submission, Health supported an institutional based reporting system, while noting that the Sydney Children's Hospital and The Children's Hospital at Westmead effectively make team reports. The Director-General of Health noted that any system would need also to work at a rural hospital in the middle of the night.³⁵⁸

6.118 In its submission, Education supported a system by which reporters may refer:

*appropriately defined 'low level' matters to alternate services – such as family support, early intervention or specialist disability services – this may also assist in ensuring the capture of data about risk while enabling a direct service response for matters which are unlikely to warrant statutory intervention.*³⁵⁹

6.119 Education noted that the 78 School Education Directors in NSW monitor and support schools in relation to risk of harm reports. Further, it noted that with the introduction of the enrolment and registration number, "there may also be potential in the future to maintain information centrally about risk of harm reports made by schools."³⁶⁰

6.120 Police submitted that the current arrangements should remain, largely because individual reporting aligns with the obligation to report and investigate crime and with timeliness.

6.121 The Inquiry's view of the changes which need to be made to the system, as a whole, to improve reporting practices and outcomes for children and young persons, appear in Chapter 10. Generally, however, it supports a greater centralisation of reporting, preserving the right of individual members of the relevant agencies to make a direct report where, by reason of the imminent nature of the risk, a considered decision is made to follow that course.

Feedback

6.122 The *Interagency Guidelines for Child Protection Intervention 2006* (Interagency Guidelines) advise mandatory reporters that, with the exception of Police, they will be advised in writing either that the report has been closed at the Helpline or transferred to a specified CSC or JIRT. The Interagency Guidelines note that a CSC will provide feedback to mandated reporters who request it and who have an ongoing role with the child, young person or family and the feedback will enable that work to continue. They note that a case meeting might be indicated and encourages mandatory reporters to initiate contact and request feedback.

³⁵⁸ Transcript: Public Forum, Mandatory Reporting, p.13.

³⁵⁹ Submission: Department of Education and Training, p.4.

³⁶⁰ Submission: Department of Education and Training, p.12.

The Inquiry agrees with these guidelines, however, they seem not to be followed in practice.

- 6.123 Sections 248 and 254 of the Care Act permit feedback to be provided to mandated reporters where the disclosure is for the purpose of furthering the safety, welfare and well-being of the child or young person.
- 6.124 In its advice to CSCs, DoCS states that a response to a request for feedback is dependent on the capacity of the CSC to respond and, if it has sufficient capacity, only occurs where the feedback is requested by a mandated reporter who has an ongoing relationship with the child or family and feedback will enable that work to continue.
- 6.125 There was much dissatisfaction expressed to the Inquiry from mandatory reporters that they received no, inadequate or delayed feedback. A frequent response by them to that unhappy situation was to report the same incident repeatedly in an attempt to receive action from DoCS. Alternatively, some reporters lost confidence in DoCS and sought intervention for children through other means. This contrast with the conclusions of the evaluation of the NSW Interagency Guidelines which found that:

*information exchange is occurring smoothly – mandatory reporters seeking feedback are receiving it, and case meetings are being held to ensure that children and young people can access services.*³⁶¹

- 6.126 Those working in the education field provided the following advice to the Inquiry:

*Mr Coutts-Trotter (Director-General, Education): Beyond that there is the frustration that principals particularly don't get adequate feedback about where in the processes within DoCS a report is up to and I think, as you described, that can lead to a range of behaviours. At one extreme, school staff doing things that are deleterious and actually create problems in the managing of a child's and families' interests or, alternatively, as we have heard from many people, that there is a re-reporting of the same incident. We would be very strongly in favour of earlier and more constant feedback.*³⁶²

*Mr Wilson (Director, Compliance, Association of Independent Schools of NSW): Generally the level of feedback is not what our schools would desire. They would like to have more information so that they can help with supporting that child.*³⁶³

³⁶¹ DoCS, *Evaluation of the NSW Interagency Guidelines for Child Protection Intervention 2006, Final Report, Volume 1*, 24 September 2008, p.46.

³⁶² Transcript: Public Forum, Mandatory Reporting, 15 February 2008, p.58.

³⁶³ *ibid.*, p.60.

Mr Chudleigh (Deputy Chairperson, Public Schools Principals Forum): Many principals continue to report until they do get some response.³⁶⁴

6.127 Health representatives said the following:

Dr Gliksman (Chairperson, Australian Medical Association (NSW) Limited): We believe that providing that feedback really would be very helpful in terms of practitioners knowing what to do next and being able to refine their practice and ability to detect where and when a report should be made and where it shouldn't.³⁶⁵

Dr Tzioumi (Director, Child Protection, Sydney Children's Hospital): If we feel that the child remains in significant risk, but whatever information has been given on the first report to the Department does not translate into an intervention, then we will make further reports, essentially on the same issue, and sometimes multiple reporters, multiple members of the health team who have come into contact with the family who don't have a response, will make reports.³⁶⁶

6.128 The DADHC representative said:

Ms Mills (Deputy Director-General, Development, Grants and Ageing, DADHC): What is the information we can use to build our knowledge base around the appropriateness of reporting? A lot of the discussion today has been about anecdotes, of necessity because that's all the information we have: do we over-report or do we under-report. We really don't have a handle on some of those issues and the more we get feedback, the more we can build up an evidence base.³⁶⁷

6.129 The Police representative said:

Det Supt Begg (Detective Superintendent (Child Protection and Sex Crime Squad) NSW Police Force): Generally, there is no feedback to Police and obviously if that could be done in some form of electronic format, that would be most beneficial. My one concern is that if feedback is given by DoCS, if there is an ongoing or there's going to be a criminal investigation, that that may jeopardise that.

³⁶⁴ *ibid.*, p.18.

³⁶⁵ *ibid.*, p.62.

³⁶⁶ *ibid.*, p.15.

³⁶⁷ *ibid.*, p.63.

Any information given would have to be done in a format that wouldn't jeopardise any future activity being undertaken, particularly by the JIRTs.³⁶⁸

- 6.130 As is clear from above, feedback is useful at two levels. First, to inform the reporter of the action taken by DoCS and to provide an opportunity for discussion as to the work which can be done by the reporter to assist the family and secondly, to equip the agency to better educate its mandatory reporters by advising of aggregated data as to the number, nature, assessments and outcomes of reports made by those within the agency.
- 6.131 However, there are also complexities to do with privacy, the integrity of any criminal investigations, the use of electronic means and the cost.
- 6.132 DoCS estimate that providing feedback to a range of mandatory reporters in the health and school/child care sectors to be \$5.76 million per annum. It is not clear to the Inquiry precisely what those costs entail, given that a letter of acknowledgement, albeit brief and often delayed, is now sent to these reporters. Electronic feedback may reduce these costs.
- 6.133 It may also be the case that if feedback results in reduced re-reporting, savings may be made.
- 6.134 The Inquiry accepts that there is force in DoCS submission that:

It has been the experience of DoCS that some people who make a report then consider that their obligation to the child will have transferred to DoCS and therefore ceased in terms of their own response. While it carries no weight at law, section 29A was recently specifically included within the legislation to provide guidance that may correct this misunderstanding about the need for everyone to take appropriate steps to care for and protect children. Any mandatory reporting scheme should therefore recognise the respective roles of both the reporter and DoCS. The provision of information is just part of the role of the reporter in responding to the needs of the child. Making a report does not absolve the reporter or the reporter's employer from taking such other steps as are reasonable in the circumstances. It is reasonable for DoCS to expect that this will be the case and to base its response on the assurance that normal responses of others are happening.³⁶⁹

- 6.135 Communication between DoCS and reporters and constructive relationships between agencies are essential and the provision of feedback is one method by which that may be accomplished. It can assist in overcoming the very problem

³⁶⁸ *ibid.*, p.64.

³⁶⁹ Submission: DoCS, Mandatory Reporting, p.13.

which DoCS identified. If the reporter is informed that DoCS does not intend to intervene then the reporter is better placed to determine, and if necessary to carry out further investigations, and to decide what action it should take. Conversely, if armed with information that DoCS intends to intervene, the reporter can hold back from taking action that might interfere with a CSC or JIRT response.

- 6.136 Feedback needs to be lawful, timely, meaningful and useful. Electronic means of forwarding the advice is clearly preferable. DoCS and Education are currently trialling e-reporting which uses a standardised form to record and lodge risk of harm reports and to generate an instant receipt. This is managed through a secure online system accessed through the DoCS website. Use of this technology should be explored to provide feedback.
- 6.137 As noted above, this provides a valuable opportunity for an interagency response to be made to the family where necessary. At the very least it should ensure that the reporter does not make a further report out of frustration at the silence which followed the initial report.
- 6.138 Clarifying, and where necessary changing the privacy laws, to permit exchange of such information is necessary. This will be discussed in Chapter 24. In addition, DoCS should provide aggregated data to each of the key mandatory reporters to better educate them about the matters reported and their outcomes, if not for the families, at least as to DoCS processes. That data should be made public.

Breach of the Act

- 6.139 For mandatory reporters, a failure to report is an offence. In the *Children (Care and Protection) Act 1987*, a breach of the mandatory reporting requirements was punishable by a fine of 10 penalty points or imprisonment. In the current Care Act, the penalty was raised to 200 penalty units, currently equivalent to a fine of \$22,000, and imprisonment was removed.
- 6.140 It was anecdotally asserted to the Inquiry that the criminalisation of the failure to report may have resulted in a risk averse approach to reporting and thus an increase in reports. This was most prevalent with education workers. The health mandatory reporters with whom the Inquiry spoke strongly rejected that view. They report because of what they refer to as a 'duty of care.' However, Health noted that some workers may be motivated to report cases against their professional judgement when they do not believe that a child is facing a real risk of harm.
- 6.141 There has been no prosecution brought under the current Care Act and, the Inquiry understands that only in Education and Police has there been any internal disciplinary action taken against an employee for any deficiency in reporting.

- 6.142 The Inquiry is of the view that the key agencies which employ mandatory reporters should have adequate systems in place to ensure compliance with the terms of the legislation. Those systems should include disciplinary consequences for failure to report. The power to prosecute has not been exercised, may result in over cautious reporting and should be unnecessary in the presence of adequate internal systems. The Inquiry accordingly favours the repeal of the penal consequences attaching to a failure to report particularly in circumstances where the prosecution power has never been used, and those potentially subject to its application are subject to professional obligations. This reflects the consensus of most of the key agencies that dealt with this issue in their submission to the Inquiry.

The need for education of mandatory reporters

- 6.143 The Inquiry has been informed by DoCS of significant work which was undertaken since 1999 to inform relevant professionals of their obligations to report to DoCS. The main current source of information is the Interagency Guidelines referred to earlier, the DoCS website and procedures published by each of the key agencies.
- 6.144 However, it is clear from the data presented in this chapter that at least 13 per cent of all reports, over 38,000 reports, most of which are from mandatory reporters are not considered by DoCS to meet the test of 'risk of harm.' In addition, there is significant multiple reporting which does little to protect children and much to require unnecessary work by DoCS and others. The Public Schools Principals' Forum advised the Inquiry that it:

does have data based or gathered from the six surveys that they have conducted during the last six years. ...It was obvious from that, when you looked at the type and location and size of school, that there are clearly ... numbers of principals who are, for whatever reason, reporting excessively. Schools, for example, some in western and south western Sydney, in a six month period are reporting several thousand reports from a school with a pupil population around 400 students. You compare that with a school just down the road in a very similar context with nowhere near the same number of reports being made.³⁷⁰

- 6.145 While it is hoped that the implementation of the recommendations in this report would alleviate the burden of dealing with some of these reports, more by way of education of all reporters is needed, not only to avoid unnecessary reporting but also to achieve a greater consistency in reporting.
- 6.146 DoCS has undertaken a comparison with other jurisdictions in relation to communication strategies with mandatory reporters. That work has revealed

³⁷⁰ Transcript: Public Forum, Mandatory Reporting, 15 February 2008, p.29.

that there is value in evaluating the reporting behaviour of particular groups and targeting strategies to meet the gaps in skills and knowledge of those groups, as well as in the quality of the reports provided. Quality is important for the identification of assessment of children who are at risk, and for efficiency in reducing the need for extensive follow up with the reporter or further research.

Recommendations

Recommendation 6.1

DoCS should revise its case practice procedures to develop clear guidelines for classifying risk of harm reports made and information given to the Helpline. Information which does not meet the statutory test for a report should be classified as a contact and not as a report. Information which meets that test should be classified as a report. The circumstances in which reports are referred for further assessment or forwarded as information only should be clarified and consistently applied.

Recommendation 6.2

In relation to the *Children and Young Persons (Care and Protection) Act 1998*:

- a. Sections 23, 24 and 25 should be amended to insert 'significant' before the word 'harm' where it first occurs; and s.27 amended to insert 'significant' before the word 'harm' wherever it occurs.
- b. Section 23 should be amended to insert as paragraph (g) "the child or young person habitually does not attend school."
- c. A provision should be inserted defining that (with the exception of s.23 (d)) harm may be constituted by a single act, omission, or circumstance or accumulate through a series of acts, omissions or circumstances.
- d. The penalty provision in s.27 should be deleted.

Recommendation 6.3

Reporters should be advised, preferably electronically in relation to mandatory reporters, of the receipt of their report, the outcome of the initial assessment, and, if referred or forwarded to a CSC, contact details for that CSC should be provided. Caseworkers and their managers should be required to respond promptly and fully to requests for information about the report from mandatory reporters, subject to ensuring the integrity of any ongoing investigation.

Recommendation 6.4

DoCS should provide the key agencies employing mandatory reporters, namely NSW Police Force, NSW Health, each Area Health Service, The Children's Hospital at Westmead and the Department of Education and Training with quarterly aggregated data about the reports made by the agency and its staff. These data should be made public.

Recommendation 6.5

Targeted training strategies for each of the key mandatory reporters, namely the NSW Police Force, NSW Health, each Area Health Service, The Children's Hospital at Westmead and the Department of Education and Training in relation to the circumstance in which reports need to be made and in relation to the information required, so as to ensure its relevance and quality, should be developed and implemented by each agency in collaboration.

Recommendation 6.6

The trial of e-reporting should be extended to NSW Health, each Area Health Service, The Children's Hospital at Westmead, the Department of Juvenile Justice and the NSW Police Force.

7 Early intervention

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Introduction

Early intervention is a collection of service systems whose roots extend deeply into a variety of professional domains, including health, education, and social services ... It is a field whose knowledge base has been shaped by a diversity of theoretical frameworks and scientific traditions, from the instruction-oriented approach of education ... to the psychodynamic approach of mental health services ... and from the conceptual models of developmental therapies ... to the randomised control trials of clinical medicine ... At its best, early intervention embodies a rich and dynamic example of multidisciplinary collaboration. Less constructively, it can reflect narrow parochial interests that invest more energy in the protection of professional turf than in serving the best interests of children and families.³⁷¹

- 7.1 Prevention and early intervention programs operate across the continuum of support. They aim to prevent or lower the incidence or prevalence of specific problems or issues in a population or a sub-population.³⁷² Early intervention is a key concept in the NSW Government's State Plan priorities F4 and F6.
- 7.2 Primary or universal services are offered to whole communities or population groups in order to build public resources and attend to the social factors that contribute to child abuse and neglect. The aim of these services in the child protection context is to prevent the development of risk factors/vulnerabilities that lead to family dysfunction and to build resilience in children and families.
- 7.3 Examples of primary or universal services include the supports and services available through maternal and child health clinics, the provision of high quality child care services and universal home visiting programs.
- 7.4 While primary or universal services are offered to whole communities or population groups, they are not necessarily offered evenly across the State. They may only be available in particular geographic areas.
- 7.5 Secondary services target families who may exhibit risk factors for child abuse and neglect and need additional support or help to alleviate identified problems so as to prevent them from either entering, or escalating in the child protection system. The services may target particular communities because of the existence of high levels of disadvantage or they may target particular families who have identified vulnerabilities or needs. Generally, secondary services are categorised as early intervention services because they seek to address risk

³⁷¹ J Shonkoff and D Phillips (eds), *From Neurons to Neighbourhoods: The Science of Early Childhood Development*, 2000, p.339 cited in Submission: Department of Premier and Cabinet, p.36.

³⁷² DoCS, *Prevention and Early Intervention Literature Review*, May 2005.

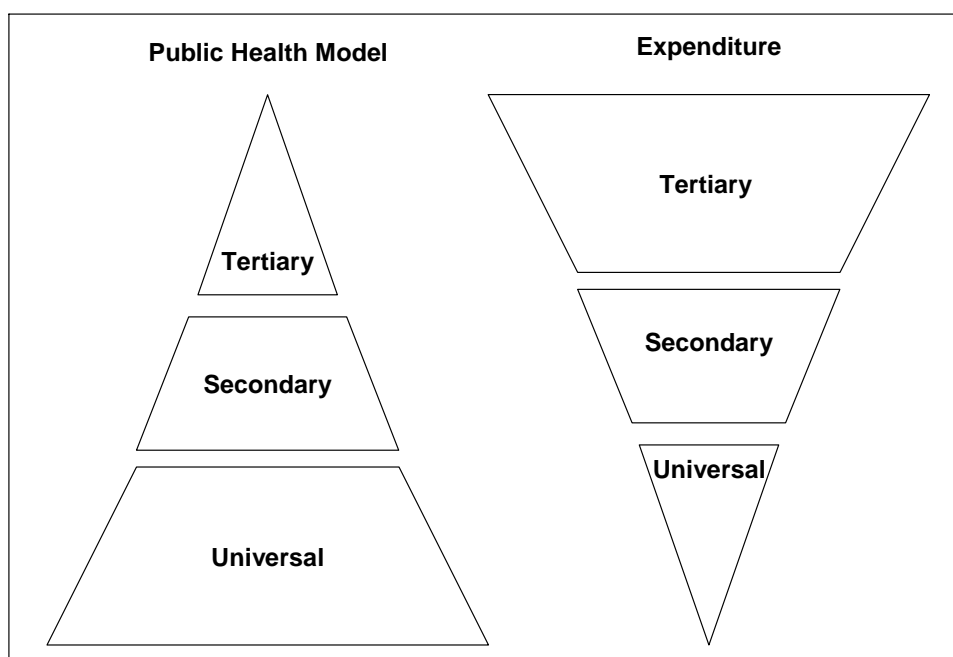
factors and build resilience in children and families so that they can stay together.

- 7.6 Examples of targeted secondary services with an early intervention focus include sustained home visiting, parent education, supported playgroups and counselling services.
- 7.7 Tertiary services target children and families where child abuse or neglect has already occurred. In the first instance, tertiary services involve protective action to ensure that the children in the family are safe. Generally, they are provided directly by the government agency with statutory responsibility for child protection. This may involve court action. Tertiary services also seek to reduce the long term implications of child abuse and neglect and to prevent it recurring. They are also known as 'acute' services.
- 7.8 In the child protection context, tertiary services include:
- a. protective intervention and support, such as sexual assault counselling, intensive family support services and therapeutic services
 - b. OOHC and support, such as foster care, kinship care or residential care
 - c. crisis support, such as crisis accommodation for women and children escaping domestic violence, and youth homelessness services.
- 7.9 There is significant overlap between the three service types because some service models can be offered as a primary or universal service but also as a more targeted secondary service (such as supported playgroups). Similarly, some service models can be offered as a secondary service, but can also be offered to clients who require tertiary services (such as drug and alcohol counselling). As a result, it is more useful to envisage a continuum of care and support services rather than three distinct and separate service types.
- 7.10 According to the public health model, there should be sufficient universal interventions available for all families. These services can then be used to leverage targeted services. That is, when necessary, families can be identified at the universal stage and referred for more intensive services in a non-stigmatising way.
- 7.11 The public health model only works if there are sufficient targeted services available to meet the needs of identified families. From this perspective, tertiary child protection services are a last resort, and the least desirable option for families or the state. In submissions received by the Inquiry it was clear that there are presently significant gaps in targeted services for children and families in NSW.
- 7.12 The AIFS has observed that:

From a public health perspective, the capacity of health and welfare services are conceptualised as a pyramid. However, spending in these areas more closely resembles an inverted

pyramid or an hourglass (see Figure 7.1). Such observations are emblematic of a critical problem within the continuum of child welfare services: child protection is currently the most visible entry point for raising concerns about families in need and facilitating their access to services.³⁷³

Figure 7.1 **Services for vulnerable children: the public health model compared with government services**



- 7.13 There is significant potential to reconfigure children’s universal health and education services so that they reduce the risk factors associated with child maltreatment by working more effectively with vulnerable families and communities. Scott argues that this can be achieved through broadening the role of primary service providers and using a multi-stranded approach to overcome a number of organisational and professional obstacles.³⁷⁴
- 7.14 Scott suggests that a significant benefit of a public health approach to child protection lies in the fact that it lends itself to tackling the underlying causal and contributory factors related to child abuse and neglect from a whole of government perspective which includes health, education and child welfare service and draws in sectors such as housing and employment services.³⁷⁵
- 7.15 The limitations of the public health model are that some programs are both secondary and tertiary, or primary and secondary. For example, a parenting

³⁷³ Submission: Australian Institute of Family Studies, p.13.

³⁷⁴ D Scott “Towards a public health model of child protection in Australia,” *Communities, Families and Children Australia*, 1(1), July 2006, p.13.

³⁷⁵ *ibid.*, p.14.

program may contain parents who have been referred because their children are considered to be at risk of abuse and neglect, as well as parents who have been referred from child protection services because their children have already experienced actual abuse and neglect and they are required to complete the program to help ameliorate the risk of further maltreatment.³⁷⁶

- 7.16 A 2008 report prepared by the National Child Protection Clearinghouse for the Community and Disability Services Ministers' Advisory Council observes that historically, tertiary interventions have been the dominant feature in child protection systems. However, it notes:

*primary and secondary interventions have gained increasing attention as government bodies, non-government organisations, and community alliances have recognised the importance of proactive strategies, which intervene before maltreatment occurs. Further, government agencies have recognised the benefits of providing composite interventions (e.g. secondary and tertiary responses) to maximise a family's opportunity for sustained success.*³⁷⁷

- 7.17 Table 7.1 outlines the continuum of services needed to support the range of needs that children, young persons and families may have at a point in time.

Table 7.1 Service types by aim and target client group

	Service Types		
	Universal Services	Secondary Services	Tertiary Services
Aim of the service	Prevention Early intervention	Prevention Early Intervention	Protective Intervention and Support Prevention Early Intervention
Target client group	All children and families based on the premise that supporting the whole community can prevent problems occurring	Children and families with identified vulnerabilities either at risk of entering or at the low to medium risk end of the child protection system	Children and families where abuse has already occurred. Often with intensive and complex support needs.

Research

- 7.18 Current thinking about early intervention:

increasingly accepts the premise that early childhood experience crucially determines health and well-being and the attainment of competencies at later ages, and that investment

³⁷⁶ L Bromfield and P Holzer, "A national approach for child protection-Project report" *National Child Protection Clearinghouse, Australian Institute of Family Studies*, 2008, pp.54-55.

³⁷⁷ *ibid.*, p.54.

*in the early years will be reflected in improved education, employment, and even national productivity.*³⁷⁸

7.19 Further, there is evidence that:

*early intervention can counteract biological and environmental disadvantage and set children on a more positive developmental trajectory continues to build.*³⁷⁹

7.20 Apart from the human capital return, savings from early intervention in the critical early years have been estimated from \$4 to \$17 for every \$1 invested.³⁸⁰

7.21 Interventions before the age of three years are:

*deemed particularly important in relation to the prevention and treatment of child abuse and neglect as this is a high risk period as well as a crucial time for the development of the infant-parent relationship.*³⁸¹

7.22 Generally, programs that intervene earlier have stronger effects.³⁸²

7.23 Universal services are some of the most effective ways to ameliorate the effects of maltreatment.³⁸³ For instance, maternal and child health services such as home visiting have been noted for their success in identifying families at risk of maltreatment prior to the concerns reaching a level requiring protective intervention.³⁸⁴

³⁷⁸ D Keating and C Hertzman (eds), "Developmental health and the wealth of nations: social, biological and educational dynamics," 1999 cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.5.

³⁷⁹ J Brookes-Gunn, L Berlin and A Fuligni, "Early childhood intervention programs: what about the family?" cited in J Shonkoff and S Meisels (eds), *Handbook of early childhood intervention*, (2nd ed), pp.549-599, cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.5.

³⁸⁰ J Heckman, "The Economics, Technology and Neuroscience of Human Capital Formation –Discussion Paper," *Institute for the Study of Labour*, 2007.

³⁸¹ F Press, *What about the kids? Policy directions for improving the experiences of infants and young children in a changing world*, prepared for the NSW Commission for Children and Young People, Queensland Commission for Children and Young People and The National Investment for Early Years, 2006, p.12.

³⁸² J Waldfogel, "Early Childhood Interventions and Outcomes," *Centre for analysis of social exclusion*, 1999 cited in F Press, 2006, op. cit., p.12.

³⁸³ C Widom, "The cycle of violence," *Child Protection Seminar Series No.5, NSW Child Protection Council*, 1992, R Clarke, "A research agenda-what does it mean?" paper presented to *Research Agenda Workshop, Youth and Family Services Division, Department of Human Services Victoria*, Melbourne, March 20, 1997, A Tomison and S Wise, "Community-based approaches in preventing child maltreatment," *National Child Protection Clearinghouse Issues Paper No.11, Australian Institute of Family Studies*, 1999 cited in Northern Territory Government, "Ampe Akelyernemane Meke Mekarle 'Little Children Are Sacred'" *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, 2007, Darwin, Australia, p.259.

³⁸⁴ D Olds, C Henderson, R Chamberlain and R Tatelbaum, "Preventing child abuse and neglect: A randomised trial of nurse intervention" *Pediatrics*, N.78, 1986, D Olds, J Eckenrode, C Henderson, H Kitzman, J Powers, R Cole, K Sidora, "Long term effects of home visitation on maternal life course and child abuse and neglect," *Journal of the American Medical Association*, Vol.278, No.8, 1997; R Chalk and P King (eds), *Violence in families: assessing prevention and treatment programs*, 1997, cited in Northern Territory Government, "Ampe Akelyernemane Meke Mekarle 'Little Children Are Sacred'" *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, 2007, Darwin, Australia, p.260.

- 7.24 Studies show that exposure to chronic violence, a lack of nurturing and or chaotic, 'socially toxic' environments³⁸⁵ may significantly alter a child's neural development and result in a failure to learn, in emotional and relationship difficulties and in a predisposition to violent and/or impulsive behaviours.³⁸⁶ That is, the brain may develop in ways that are maladaptive. A child may develop a chronic fear response or may become unresponsive and withdrawn which may aid in adaptation to a violent home environment but will be maladaptive in other environments like school or when making friends.
- 7.25 Infants of adolescent mothers with depressive symptoms show developmental and growth delays if their mother's symptoms persist over the first six months of the infant's life, thus highlighting the importance of identifying those mothers for early intervention.³⁸⁷
- 7.26 Research demonstrates a link between specific violence related stressors in childhood, including child abuse and neglect or repeated exposure to domestic violence, with risky behaviours and health problems in adulthood.³⁸⁸
- 7.27 The relationship between an infant and his or her parent or carer, known as 'attachment' also has implications for the child's future outcomes. The most important time for a primary attachment to develop is between six and 18 months. Attachment is generally categorised as being either 'secure', 'insecure' or 'disorganised'.³⁸⁹
- 7.28 Secure attachment to parents or carers has been associated with a range of indices of well-being, including high self esteem and low anxiety. Children are better able to cope with traumatic experiences when their earlier experiences are of being safe and protected.
- 7.29 Children raised by a carer who is reluctant to respond to their needs, or reacts in an angry resentful way when they express distress, may experience insecure attachment. Insecure attachments may lead to an inability to trust adults, a lack of interest in learning, difficulty in recognising their own feelings, and a lack of empathy for others.

³⁸⁵ J Garbarino, *Raising Children in a socially toxic environment*, 1995, cited in Northern Territory Government, "Ampe Akelyernemane Meke Mekarle 'Little Children Are Sacred'" *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, 2007, Darwin, Australia, p.259.

³⁸⁶ R Pynoos, A Steinberg and R Wraith, "A developmental model of childhood traumatic stress," in D Cicchetti and D Cohen (eds), *Developmental Psychopathology, Volume 2: Risk Disorder and Adaptation*, 1995, pp.72-75, cited in Northern Territory Government, "Ampe Akelyernemane Meke Mekarle 'Little Children Are Sacred'" *Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*, 2007, Darwin, Australia, p.259.

³⁸⁷ T Field, J Pickens, M Prodromidis, J Malphurs, N Fox, D Bendell, R Yando, S Schanberg and C Kuhn, "Targeting Adolescent Mothers with Depressive Symptoms for Early Intervention," *Adolescence, Volume 35, No. 138*, 2000, pp.381-414.

³⁸⁸ J Middlebrooks, N Audage, "The Effects of Childhood Stress on Health Across the Lifespan," prepared for the US Department of Health and Human Services, Centres for Disease Control and Prevention, National Centre for Injury Prevention and Control, 2008, p.5.

³⁸⁹ DoCS, *Attachment: Key Issues, Research to Practice Note*, August 2006.

- 7.30 Disorganised attachment is commonly observed in children whose carers are abusive, neglectful, addicted to drugs or alcohol, victims of domestic violence and/or have had disrupted attachments in their own childhood.³⁹⁰ Disorganised attachment is generally thought to arise when a child experiences his or her carer as either frightening or frightened. Disorganised attachment behaviour in infancy has been linked to a high risk of serious behaviour problems in later childhood.³⁹¹
- 7.31 While the early years are crucial there also remains an imperative to address the needs of children, adolescents and their parents across multiple life phases and transition points like birth and starting school.³⁹²
- 7.32 Failure to provide effective services to vulnerable children and young persons can increase the demand for child protection and OOHC services, as well as for health and justice services. In an ideal world intervention services would form the greater proportion of the child and family welfare service provided by the State.

Types of early intervention services

Home visiting

- 7.33 Research has found that home visiting programs can be effective in ameliorating risk factors for child maltreatment (for example, by addressing poor family functioning), although there is limited evidence to suggest that home visiting assists specifically in preventing child maltreatment.³⁹³ Home visiting may also be less beneficial where there is domestic violence.³⁹⁴ Enhancements such as group sessions or cognitive retraining appear to increase the effectiveness of home visiting.
- 7.34 There are significant debates about the characteristics of successful home visiting programs concerning: the nature of the program; the problems that home visiting might influence; the nature of the relationship that should be established; and the qualifications, training and support required for home visitors.

³⁹⁰ For example, P Svanberg, "Attachment, resilience, and prevention," *Journal of Mental Health*, 7(6), 1998, p.555.

³⁹¹ *ibid.*

³⁹² M Wise, D Bennett, G Alperstein and P Chown, "Better futures for young people-a discussion paper," prepared for the NSW Centre for the Advancement of Adolescent Health, The Children's Hospital at Westmead, 2003; Commonwealth Attorney-General's Department, *Pathways to prevention: developmental and early intervention approaches to crime in Australia*, 1999 cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.5.

³⁹³ J Higgins, L Bromfield, N Richardson, "Child abuse prevention: What works? The effectiveness of home visiting programs for preventing child maltreatment." *National Child Protection Clearing House, Australian Institute of Family Studies*, 2006.

³⁹⁴ S Packer, "Good practice in responding to children in a medical setting," *Journal of Interpersonal Violence*, 10, 1, pp.3-25, cited in DoCS, "Domestic violence and its impact on children's development," edited version of presentation delivered at the Fourth Domestic Violence Forum, 24 September 2002, p.6.

- 7.35 Watson and Tully conclude that the evidence for the effectiveness of home visiting is mixed, particularly as a stand alone strategy to improve outcomes for children from vulnerable families.³⁹⁵

*Some of the reason so little can be gleaned about home visiting is that the evaluations are based on 'satisfaction' type rating scales with a few open-ended questions added. This approach only provides clues as to what might or might not work rather than the harder evidence base that more rigorous research would deliver. More data is needed on the practicalities of how to enrol and engage families and the reasons behind high attrition rates. Closer examination, of which families are helped, how many visits are needed, and to which home visitor qualities parents respond, is required.*³⁹⁶

- 7.36 Nevertheless, they further state that home visiting may be an excellent platform in identifying those families who need extra support.³⁹⁷

- 7.37 It has been suggested that parenting interventions that have the strongest evidence base:

*send nurses into the homes of high risk families, focussing on the improvement of prenatal health, the child's health and development, and parent's own economic self-sufficiency.*³⁹⁸

- 7.38 A program of prenatal and early childhood visitation by nurses can reduce the number of subsequent pregnancies and the risks of child welfare intervention, child abuse and neglect, and criminal behaviour on the part of low income, unmarried mothers for up to 15 years after the birth of the first child.³⁹⁹

- 7.39 Research suggests that in the Australian context positive outcomes are most likely to be gained from home visiting with the following characteristics:⁴⁰⁰

- a. programs for mothers from low socio-economic groups, some of whom may be identified on the basis of membership of a population group such as teenage or unmarried mothers, or by race
- b. home visiting by nurses commencing antenatally where a broad range of outcomes is desired, with a focus on improving both maternal and child outcomes

³⁹⁵ DoCS, *Prevention and Early Intervention Update: Trends in Recent Research, Literature Review*, June 2008, p.44.

³⁹⁶ *ibid.*, p.17.

³⁹⁷ *ibid.*, p.44.

³⁹⁸ D Olds, L Sadler, and H Kitzman, "Programs for Parents of Infants and Toddlers: Recent Evidence from Randomized Trials," *Journal of Child Psychology and Psychiatry*, 48(3-4), 2007, p.383.

³⁹⁹ D Olds, J Eckenrode, C Henderson, H Kitzman, J Powers, R Cole, K Sidora, 1997, *op. cit.*, p.637.

⁴⁰⁰ H Aslam, L Kemp, "Home Visiting in South Western Sydney – an Integrative Literature Review, Description and Development of a Generic Model," *Centre for Health Equity Training and Research*, April 2005, p.6.

- c. highly targeted interventions by psychologists/counsellors for mothers with post-natal depression
 - d. programs that include child development, parenting skills, parent-infant interaction and direct and indirect provision of resources
 - e. programs of long enough duration to impact on parenting or risk factors that contribute to child maltreatment.
- 7.40 A greater emphasis on understanding how to best work with Aboriginal, refugee and non-English speaking groups is required, as is developing better strategies to reach clients with complex needs and under-served groups such as grandparent and non-parental care-givers.⁴⁰¹

Sustained health home visiting

- 7.41 The NSW Miller Early Childhood Sustained Nurse Home Visiting (Miller) trial is the first longitudinal Australian randomised control trial to determine the impact of a comprehensive sustained nurse home visiting program in a population group living in an area of known disadvantage.
- 7.42 Mothers allocated to the Miller intervention receive a program of at least 20 home visits in total primarily by the same nurse during the remainder of their pregnancies and the first two years post birth. Mothers also have access to early childhood health services, volunteer home visiting services, family support services and group activities including parenting groups within the area.
- 7.43 Preliminary analysis shows that when compared with the control group, the children and mothers who received the intervention have achieved better outcomes in knowledge of 'sudden infant death syndrome,' breastfeeding, respiratory illness, child mental development and maternal health, including a positive impact on depressed mothers.⁴⁰² Results of the trial are due in December 2008.
- 7.44 South Australia is the only jurisdiction in Australia which has a population based sustained nurse home visiting program. A major evaluation of the outcomes is underway.

Early childhood education programs

- 7.45 The developmental gains associated with attending high quality early childhood education and care programs are well documented.⁴⁰³ High quality child care is

⁴⁰¹ Ibid., p.10.

⁴⁰² Sydney South Western Area Health Service, NSW Health, *Improving Outcomes of vulnerable children through Sustained Home Nurse Visiting*, www.archi.net.au.

⁴⁰³ DoCS, *Prevention and Early Intervention Literature Review*, May 2005, pp.18-24.

associated with improvements in school readiness, expressive and receptive language, positive social behaviour and a reduction in behaviour problems.⁴⁰⁴

- 7.46 Conversely, where the quality of child care is low, detrimental effects are apparent.⁴⁰⁵ The critical factor in the provision of child care programs is quality. Quality is referred to as being 'structural' (for example, staff to child ratios, staff qualifications, group sizes and staff stability, physical space) or 'process' (for example, warm, attentive care-givers, positive discipline, appropriate and varied activities) in nature.⁴⁰⁶
- 7.47 The longer the duration and the higher the frequency of access to high quality child care, the greater the associated gains in IQ and school achievement.⁴⁰⁷
- 7.48 Research evidence suggests that of all single strategy interventions, high quality child care is the most effective in improving child outcomes and providing children with a chance to start school on a more equal footing. To be effective child care does not have to be all day or all year but it must be high quality and programs need to be goal oriented. Centre based care can provide greater quality assurance than home based care, which is likely to be more variable in the quality of its delivery. Availability and affordability are critical.

School readiness programs

- 7.49 Recent studies have found that children from disadvantaged backgrounds tend to be less 'ready' for school and that: "the cost of beginning school significantly behind one's peers is substantial and a deficit from which children may never recover."⁴⁰⁸ It is recognised that it is better to prevent these deficits occurring and to eliminate the need for these children to catch up with their peers.⁴⁰⁹
- 7.50 There have been some positive results from school readiness programs but only a small number have been studied.⁴¹⁰

⁴⁰⁴ D Vandell and B Wolfe, "Child care quality: Does it matter and does it need to be improved?" 2000, cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.18.

⁴⁰⁵ A Hausfather, A Toharia, C La Roche and F Engelsmann, "Effects of age of entry, day-care quality and family characteristics on preschool behaviour," *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 38(4), 1997, pp.441-448, cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.18.

⁴⁰⁶ D Vandell and B Wolfe, 2000, op. cit., cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.23.

⁴⁰⁷ DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.23.

⁴⁰⁸ D Stipek and R Ryan, "Economically disadvantaged preschoolers: ready to learn but further to go," *Developmental Psychology*, 33(4), 1997 cited in DoCS, *Prevention and Early Intervention, Literature Review*, May 2005, p.34.

⁴⁰⁹ V Halfon, C Sutherland, M View-Schneider, M Guardiani, Kloppenburg, J Wright, K Uyeda, A Kuo and E Shulman, 2001 cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.34.

⁴¹⁰ N Richardson et al, "Making the right choices about child protection programs," 2005, cited in C Peltola and P Testro, *Towards a better future for children: preventing child abuse and neglect*, prepared for the National Association for the Prevention of Child Abuse and Neglect, 2006, p.9.

Parenting programs

- 7.51 A parenting program is “a focused short term intervention aimed at helping parents improve their relationship with their child, and preventing or treating a range of problems including behavioural and emotional adjustment.”⁴¹¹
- 7.52 There is little research into the long term effects of attending these programs. However, programs for specific groups of parents tend to be included in the literature as ‘promising programs.’
- 7.53 There are three key empirically supported behavioural parenting programs that have built an evidence base over recent years: Triple P (Positive Parenting Program); Incredible Years; and Parent Child Interaction Therapy.⁴¹² These programs were originally developed to reduce child behavioural problems but have been adapted as interventions for the child protection context.
- 7.54 Parenting programs can usefully be offered as a population intervention. This reduces stigma around seeking help⁴¹³ and helps to target children who are at risk of poor outcomes.⁴¹⁴ The effects of parenting programs appear to be long term⁴¹⁵ and ‘booster’ sessions seem to be important in maintaining or increasing outcomes from parenting programs.⁴¹⁶

Multi-component interventions

- 7.55 Meta-analyses show that programs using multiple interventions work better than those using a single intervention strategy.⁴¹⁷ Where these services are easily

⁴¹¹ J Barlow and J Parsons, “Group-based parent-training programmes for improving emotional and behavioural adjustment in 0-3 year old children,” *The Cochrane Library*, 2, 2004 cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, pp.29-30.

⁴¹² DoCS, *Prevention and Early Intervention Literature Review*, May 2005, pp.29-30.

⁴¹³ A Williams, S Zubrick, S Silburn and M Sanders, *A population based intervention to prevent childhood conduct disorder: the Perth Positive Parenting Program demonstration project*, paper presented at the Ninth National Health Promotion Conference, Darwin, Northern Territory, Australia, 1997; D Offord, H Chumera Kraemer, A Kazdin, P Jensen and R Harrington, “Lowering the burden of suffering from child psychiatric disorder: trade-offs among clinical, targeted and universal interventions,” *Journal of the American Academy of Child and Adolescent Psychiatry*, 37(7), 1998; S Zubrick, *Forecasting the mental health futures of Australian children*, presentation to Third International Conference on Child and Adolescent Mental Health, 15 June 2002, Brisbane Australia, 2002, cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.33.

⁴¹⁴ M McCain and J Mustard, *The early years study three years later: from early child development to human development*, prepared for Toronto: The Founders Network, 2002 cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.33.

⁴¹⁵ P Long, R Forehand, M Wierson and A Morgan, “Does parent training with non-compliant children have long term effects?” *Behaviour research and therapy*, 32(1), 1994, A Kazdin, “Practitioner review: psychosocial treatments for conduct disorder in children,” *Journal of Child Psychology and Psychiatry*, 38(2), 1997, pp.161-178, cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.33.

⁴¹⁶ S Eyberg, E Schuhmann and J Rey, “Child and adolescent psychotherapy research: developmental issues,” *Journal of Abnormal Child Psychology*, 26(1), 1998, pp.71-83, J Durlak and A Wells, “Primary prevention programs for children and adolescents,” *American Journal of Community Psychology*, 25(2), 1997, pp.233-243, cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.33.

⁴¹⁷ J Marshall and P Watt, *Child behaviour problems: A literature review of its size and nature and prevention interventions*, prepared for Interagency Commission on Children’s Futures, Perth, Western Australia, 1999 cited in DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.3.

accessible to the parents, for instance through co-location, the benefit to families increases.⁴¹⁸

*The service model consisting of a multi-component, co-located, accessible, affordable community based intervention, and which incorporates high quality child care as a key feature has retained its effectiveness when rolled out as public policy.*⁴¹⁹

- 7.56 No single strategy is as effective as a combined approach, which targets both child and parent.⁴²⁰

Family preservation services

- 7.57 There is no clear definition of the term ‘family preservation services.’ However, they are generally considered to be intensive, short term, in-home crisis intervention services that teach skills and provide supports for families in which a child is at imminent risk of OOHC placement.⁴²¹ While OOHC placement prevention is a major goal, the safety of children and improvement in functioning of parents, children and families is of primary importance.
- 7.58 The term ‘family preservation’ was originally applied to the US Homebuilders Model. Key characteristics include:
- a. contact with the family within 24 hours of the crisis
 - b. small caseload sizes for workers
 - c. flexible service delivery
 - d. service duration of four to six weeks
 - e. intensive service delivery.⁴²²
- 7.59 Overall, there is a lack of good quality research about the effectiveness of family preservation services.
- 7.60 Positive outcomes are thought most likely to be gained from family preservation services that:
- a. adhere to the Homebuilders Model
 - b. target families at imminent risk of the children being placed in OOHC
 - c. target families with all vulnerabilities, except where sexual abuse has occurred

⁴¹⁸ DoCS, *Prevention and Early Intervention Literature Review*, May 2005, p.3.

⁴¹⁹ J Temple and A Reynolds, “Benefits and costs of investments in preschool education: Evidence from the Child-Parent Centres and related programs” *Economics of Education Review* 26(1), 2007 cited in Submission: DoCS, Evidence Base for Effective Service Models, p.13.

⁴²⁰ Submission: DoCS, Evidence Base for Effective Service Models, p.14.

⁴²¹ National Family Preservation Network, “Intensive family services protocol,” 2003 cited in DoCS, *Family preservation services, Literature Review*, January 2008, pp.iii.

⁴²² DoCS, *Family preservation services, Literature Review*, January 2008, pp.iii-iv.

- d. offer a combination of concrete assistance (such as payment of bills, housing assistance) and clinical services that meet the assessed needs of families.

Early intervention with older children

- 7.61 The importance of intervening in late childhood and early adolescence (that is, 8-14 years) has been largely overlooked in research.⁴²³ However, an 'early in the pathway' approach has relevance across all life stages, including middle childhood and adolescence.⁴²⁴
- 7.62 Interventions delivered during the transition to adolescence are necessary in order to capture three groups of vulnerable children and young persons, that is:
- a. those who are currently experiencing problems but who did not receive an intervention during early childhood
 - b. those who received an intervention in early childhood but who continue to experience problems
 - c. those who are not currently experiencing problems but are at risk of developing problems during adolescence. Given the high rates of mental health problems, substance use and child protection notifications for 8-14 year olds, there is a critical need to provide early intervention for this age group.⁴²⁵
- 7.63 Research suggests that 'school connectedness' is an important protective factor for behavioural, emotional and school related problems and there is evidence that multi-component interventions that specifically target school connectedness improve children's academic, behavioural and psychological outcomes.⁴²⁶
- 7.64 There is mixed evidence to support the effectiveness of extracurricular activities, after school programs and mentoring programs as a strategy for high risk children and young persons, although these approaches may be beneficial for low risk children. Community programs appear to be effective when delivered as part of a multi-component intervention.⁴²⁷

Inter-jurisdictional models

- 7.65 The Inquiry has learned of a number of examples of multi-agency services delivering early intervention programs both nationally and internationally.

⁴²³ DoCS, *Early Intervention Strategies for Children and Young People 8 to 14 Years, Literature Review*, November 2007, p.iii.

⁴²⁴ A Hayes, "Why early in life is not enough: timing and sustainability in early intervention and prevention," in A France and R Homel, *Pathways and crime prevention*, 2007, p.205.

⁴²⁵ DoCS, *Early Intervention Strategies for Children and Young People 8 to 14 Years, Literature Review*, November 2007, p.2.

⁴²⁶ *ibid.*, p.v.

⁴²⁷ *ibid.*

- 7.66 Multi-agency working is a key component of the new approach to service design and delivery in the UK. The *Children Act (2004)* obliges all local authorities to have multi-agency Children's Trusts in place by 2008. Initiatives such as Sure Start Children's Centres and extended schools have been set up to provide services to meet this early intervention, integrated family support remit.
- 7.67 Sure Start Children's Centres are one stop places that aim to support young children and their families by integrating early education, child care, health care and family support services in disadvantaged areas. They provide services to children under five years and their families who can access help from multi-disciplinary teams of professionals. A recent evaluation found positive outcomes for children and parents living in Sure Start program areas.⁴²⁸
- 7.68 The Quebec model of integrated perinatal and early childhood services for vulnerable families aims to intervene early with mothers and families to encourage optimal development of the children, improve the family living conditions and reduce social problems including child abuse and neglect. The program targets two identified major predictors of risk: a maternal age of 20 years or less; and maternal educational attainment below the level of a high school diploma. This translates to a target group comprising about five per cent of births in Quebec.⁴²⁹
- 7.69 The program involves intensive nurse home visits weekly throughout pregnancy until the child is six months old, reducing to monthly for up to two years. The primary intervention during the home visits, which last about half a day per visit, is instruction in and modelling of parenting skills. It is complemented by provision of free long day care.
- 7.70 Quebec has also established 95 new 'one stop shop' community centres that build on a well resourced system of child, youth and family services.⁴³⁰
- 7.71 Dr Richard Matthews, Deputy Director-General, Health, told the Inquiry that the system operating in Quebec:
- has some very solid outcomes, not just in that broad area of health but in other measures such as high school completion rates, which are secondary measures but very good proxies for community functioning through life.*⁴³¹
- 7.72 In Victoria, Best Start, is an example of a multi-service, universal program administered by several agencies and delivered to specific areas. It is based on a range of core activities and service delivery principles, with regional

⁴²⁸ The National Evaluation of Sure Start Evaluation Research Team (UK), *The Impact of Sure Start Local Programmes on Three Year Olds and Their Families*, March 2008.

⁴²⁹ Correspondence: NSW Health, 14 August 2008, Attachment: Quebec, p.1.

⁴³⁰ Submission, Department of Premier and Cabinet, Appendix A, p.59.

⁴³¹ Transcript: Public Forum, Interagency Cooperation, 4 April 2004, p.42.

differences in programs based on identified need. The program commenced in 2002 and is being progressively implemented.⁴³²

- 7.73 The South Australian Government is in the process of establishing 20 Early Childhood Development Centres by 2010. These centres will offer integrated child care, preschool, early years of school, child health and family support services and will be located on school sites.⁴³³
- 7.74 Queensland is in the process of establishing four Early Years Centres under a new strategy, The Best Start – Supporting Families in the Early Years. The centres will offer universal and targeted services for children from pre-birth to eight years of age and their families, and will operate as part of an integrated prevention and early intervention service system.⁴³⁴

NSW Framework

- 7.75 In 2006 the Government released its *State Plan: A New Direction for NSW*, a 10 year plan for improving service delivery in NSW, in which addressing child abuse and neglect is specifically identified as a priority along with a range of other issues (for example, domestic and family violence) that can have a bearing upon the incidence of child abuse and neglect.
- 7.76 The Inquiry agrees with the comments made in the submission to the Inquiry from Premier and Cabinet:
- Most vulnerable families have chronic, not simply acute, problems. This has profound implications, making it essential that the whole range of health, education and social agencies stay involved with families and children at risk, including after a referral to child protection. It is not sufficient for other service agencies to consider that their involvement with a family should cease once a child protection agency has accepted a referral. Agencies should, as a matter of policy, remain involved with families they refer for child protection interventions.*⁴³⁵
- 7.77 That submission accepts that prevention and early intervention strategies should be shared more broadly across government and with the non-government sector. The Inquiry agrees.
- 7.78 Priority F4 of the State Plan commits the Government to embedding the principle of prevention and early intervention into agency decision making.

⁴³² Australian Research Alliance for Children and Youth, *Early Childhood Services: Models of Integration and Collaboration*, November 2007, p.27.

⁴³³ *ibid.*, p.33.

⁴³⁴ *ibid.*, p.36.

⁴³⁵ Submission: Department of Premier and Cabinet, p.24.

- 7.79 The NSW Government's Policy Framework on Prevention and Early Intervention 2007 is being trialled and strategies include the following:
- a. Every year two public sector agencies will each review an 'acute' program that accounts at least five per cent of the agency budget, with a view to identifying ways to reduce demand. In 2008, the agencies are DoCS and Health.
 - b. Premier and Cabinet will develop an assessment tool for agencies to use in developing capital and recurrent proposals to examine whether prevention and early intervention alternatives offer a better buy for the investment made.
 - c. Chief Executive Officer (CEO) clusters will develop a research and analysis agenda, to be initially led by the Human Services and Justice Cluster which will include focusing on Aboriginal children aged less than one year to five years and domestic and family violence. These groups will also be used as a vehicle for cross agency collaboration in this area.
 - d. Premier and Cabinet and NSW Treasury, together with relevant agencies will explore innovative funding mechanisms to mobilise resources for prevention and early intervention initiatives including measures for attracting contributions from the Commonwealth and private/not for profit sectors.⁴³⁶
- 7.80 Getting the balance right between the acute and supportive roles of a broad child protection system is a key policy dilemma that NSW and other jurisdictions face. In this context, there are a number of associated policy challenges:
- a. ensuring that primary responsibility for rearing and supporting children continues to rest with families and communities, with government providing support where it is needed
 - b. facilitating sustained system wide responses to families' chronic problems
 - c. building an evidence base for prevention and early intervention practice.
- 7.81 Premier and Cabinet offers a number of possible responses to improve prevention and early intervention approaches, including strengthening and quarantining prevention and early intervention resources and personnel, promoting evidence based interventions and creating stronger models of interagency service delivery.
- 7.82 The Inquiry supports the directions of the current NSW approach to prevention and early intervention although, it suspects that delivering and measuring its performance will be a challenge. However, as the CEO of UnitingCare Burnside said at the Inquiry's Public Forum on Early Intervention:

⁴³⁶ Department of Premier and Cabinet, Premier's Memorandum No. 2007-20 – State Plan Priority F4: *Embedding the principle of prevention and early intervention.*

*I don't think that we yet as a State in New South Wales have agreement about what it is that we want prevention and early intervention to achieve. When we read your fact sheet, it becomes very apparent that everything is described in terms of a program, and that program has, by definition, inclusions and exclusions.*⁴³⁷

- 7.83 The Inquiry acknowledges that a fundamental issue that appears to characterise NSW prevention and early intervention is the focus on programs rather than on what children and families need. As Professor Ilan Katz, Director, Social Policy Research Centre, University of NSW, stated at the same Public Forum:

*If you are a family in difficulties, or you are a woman who is being beaten by your partner, et cetera, where would you go for help in different circumstances? ... I am a very strong believer in multi-agencies working at all levels - at the planning level, at the delivery level, and at the management level. Your briefing paper really illustrates to me the range of different programs available - and there are 30, or even more programs, that are not in this briefing document - but none of them join up together. If I were a family, which one of these 10 or 12 different programs would I access and how would I know how to get into them?*⁴³⁸

- 7.84 The CEO of NSW Family Services advised the Inquiry:

*When I first came into this job seven years ago, I went to learn about Families First [now Families NSW] from the person who was then in charge of it. She made it very clear that it wasn't a funding program. It wasn't just a funding program; it was a way of viewing families and children, and I agree. I think it is a terrible shame that that has been lost. But some of the processes it brought in are still working beautifully at a local level.*⁴³⁹

- 7.85 The NSW Government's whole of government prevention and early intervention strategy for families expecting a baby or with children aged less than nine years is the Families NSW strategy. It is administered from DoCS and sits within the Communities Division of DoCS, which contains a raft of programs and functions which are also delivered as part of a whole of government approach and in partnership with the non-government sector.

⁴³⁷ Transcript: Public Forum, Early Intervention, 16 May 2008, p.6.

⁴³⁸ *ibid.*, p.17.

⁴³⁹ *ibid.*, p.28.

- 7.86 Families NSW is based on the premise that all families need support and assistance, and that some families need additional support because of their circumstances. The strategy is jointly run by DoCS, Health, Education, Housing, and DADHC, together with local government and community organisations. In 2007/08 the total Families NSW budget was \$40.4 million, of which \$29.6 million was managed by DoCS.⁴⁴⁰
- 7.87 The strategy provides a combination of universal and targeted support services in relation to supporting parents who are expecting or caring for a new baby or who are caring for infants and young children and assisting families who need extra support and linking families and communities.⁴⁴¹ Families NSW projects include supported playgroups, family workers, volunteer home visiting, early literacy projects, transition to school programs, toy libraries, parenting resources and family events.
- 7.88 Each DoCS region has a dedicated budget and resources, and through regular planning cycles, regions determine, identify and address local priorities. DoCS stated that:
- this allows agencies to move away from their traditional 'silos' and engage in more population based planning. Families NSW is informed by data and outcomes at a state and regional level, and by a robust research and evaluation agenda.*⁴⁴²
- 7.89 The effectiveness of Families NSW activities is measured against the following set of population level indicators:
- a. birth weight – proportion of babies born with a low birth weight (less than 2,500 grams)
 - b. prematurity – proportion of babies born before 37 weeks gestation, and fully breastfed at four and five months
 - c. child injuries – hospital separation rates for child injuries, children aged less than one year to five years
 - d. educational achievement – basic skills test scores in school years Three and Five
 - e. maternal health and well-being – rate of risk taking behaviours (smoking) during pregnancy
 - f. breastfeeding – babies exclusively breast fed at discharge from hospital.
- 7.90 Over the four years to 2011, Families NSW will focus largely on population groups such as Aboriginal mothers, teenage mothers and mothers in low socio-economic areas through the provision of antenatal and postnatal care. One of the key initiatives to be funded over the four years is the Triple P positive

⁴⁴⁰ DoCS, *Annual Report 2007/08*, p.25.

⁴⁴¹ NSW Government *Families First Outcomes Framework NSW Data Report*, June 2004, p.1.

⁴⁴² Transcript: Inquiry meeting with DoCS senior executives, 11 February 2008, p.8.

parenting program for families with children aged 3-8 years. The program aims to train up to 1,200 health, welfare and education professional to deliver the Triple P across NSW. Funding for the program is \$7.6 million over four years from 2007 to 2011.⁴⁴³

Universal service system

- 7.91 Universal services are provided by a number of government and non-government agencies, with health and the school/child care sector the key players.

Universal maternal and infant health services in NSW

- 7.92 Health provides a range of universal services:
- a. Antenatal care is available through maternity services, general practitioners and increasingly for Aboriginal women through specific Aboriginal Maternal and Infant Health Strategy services.
 - b. Safe Start – Integrated Perinatal and Infant Care is part of the Families NSW initiative. This involves a psychosocial assessment for postnatal depression to allow for women's early referral to appropriate intervention services. It is being progressively implemented statewide.
 - c. A Universal Health Home Visit from a child and family health nurse is available as part of Families NSW. Health reported that since 2001, the Universal Health Home Visit has been provided to over 260,000 families. A 2003 evaluation of the Universal Health Home Visit performed by the former Central Coast Area Health Service was positive.⁴⁴⁴
 - d. Health provides the Personal Health Record, known as the 'Blue Book' for all babies born in NSW. This parent held child health and development record holds details of the recommended screening and surveillance schedule of health checks for child health and development. Health advised the Inquiry that this tool had the potential to "be the instrument for every agency to pick up kids who are not meeting their milestones."⁴⁴⁵
 - e. Early Childhood Health Centres are located in all Area Health Services across NSW. They target families with children with a special focus on children aged 0-5 years. Child and family health nurses in these Centres offer primary health care, parent education, support, and child health and development services. Early Childhood Health Centre staff deliver a range of programs and services, including the universal home visit, parenting groups, supported playgroups, and the health checks.

⁴⁴³ DoCS, *Annual Report 2007/08*, p.25.

⁴⁴⁴ NSW Health, *Universal and Sustained Health Home Visiting*, p.2.

⁴⁴⁵ Transcript: Inquiry meeting with NSW Health senior executives, 12 December 2007, p.12.

- f. Domestic Violence Routine Screening. Under the program all women over 16 years of age and presenting to Health services are screened.

Early childhood education and care services in NSW

- 7.93 In NSW, DoCS has responsibility for regulating, licensing and setting standards for all children's services providers. Services that provide care or education for one or more children under the age of six years who do not ordinarily attend school, are required to be licensed by DoCS under the *Children's Services Regulation 2004*. The Regulation requires the licensee to develop policies that set out "the ways in which children will be assisted in the transition to other early childhood programs or to school."⁴⁴⁶
- 7.94 Services that provide before and after school and vacation care for children who have started school and are up to 12 years of age are not currently regulated by DoCS. However, under ss.42-46 of the Care Act, out of school hours services are now required to register with DoCS.
- 7.95 NSW does not appear to compare favourably with other states and territories in relation to participation rates in preschool services. According to the Productivity Commission, in 2006/07, 64.6 per cent of four year olds in NSW were enrolled in NSW government funded and/or provided preschool services.⁴⁴⁷ The average percentage of enrolment across Australia is 87.2 per cent, and is 96.8 per cent in Victoria.⁴⁴⁸ DoCS disagrees with the Productivity Commission's figures and provided a different statistic, stating that approximately 88 per cent of children in NSW accessed a preschool service prior to commencing school.
- 7.96 There is also a significant difference in the cost of preschool services in NSW compared with other jurisdictions. The Productivity Commission noted that, *inter alia*, after subsidies, the median weekly cost per child attending preschool in NSW in 2005 was \$40. The next most expensive jurisdiction was Victoria at approximately \$16. The average median cost in all other states and territories was less than \$10 a week.⁴⁴⁹ However, DoCS advised a cautionary approach to these figures as they do not take into account the number of hours a child is attending a preschool service, which is a key determinant in the average weekly cost.
- 7.97 Two factors seem to indicate that affordability may be a barrier for many NSW families wishing to access preschool services for their children. These are the significant proportion of 'for profit' services providing preschool services or programs and the high median weekly cost for preschool services in NSW. DoCS has advised that a key issue affecting affordability is that children

⁴⁴⁶ *Children's Services Regulation 2004* cl.64(1)(c).

⁴⁴⁷ This figure includes children attending child care services in recognition that in NSW age appropriate developmental programs are required by Regulation regardless of the child care setting.

⁴⁴⁸ Productivity Commission, *Report on Government Services, Volume 1*, 2008, Table 3A.11 and pp.3.19-20.

⁴⁴⁹ *ibid.*, Table 3A.11 and p.3.27.

attending, stand alone, limited hours preschools are not eligible for the Commonwealth Child Care Rebate or the Child Care Tax Rebate. However, this is a factor at play in all jurisdictions across Australia and therefore does not account for the differences in both the cost of, and the rate of participation in, preschool services between NSW and the other states and territories as advised by the Productivity Commission.

DoCS Children's Services Program

- 7.98 DoCS provides operational and capital funding to community based children's services through its Children's Services Program. The different service models that are funded under the Children's Services Program include: centre based long day care; occasional care; preschool services; mobile children's services; toy libraries; and vacation care.⁴⁵⁰ DoCS has projected that in 2008/09 it will fund 47,700 places per day in funded children's services and provide support for over 12,000 children from low income families.
- 7.99 In most circumstances, these services would be classified as universal services, as they are offered to whole communities. However, the blurring that can occur when attempting to classify these services in line with the public health model is evident. Children's services are also offered as part of a targeted secondary intervention such as the Brighter Futures program. The developmental gains associated with participation in high quality early childhood education and care programs, or children's services, are well documented.⁴⁵¹
- 7.100 The NSW Government has indicated that it will provide an additional \$85.5 million over four years to strengthen the community based preschool sector in NSW under the Preschool Investment and Reform Plan. The plan aims to bring levels of attendance at preschool programs in NSW to 95 per cent and give every four year old in NSW access to a preschool program two days a week.⁴⁵² Recurrent funding is however needed for its enhancement.
- 7.101 DoCS advised that there is no evidence of a reduction in demand for preschool services, and that the baby boom of 2005 will contribute to ongoing need.

COAG Early Childhood Development Agenda

- 7.102 The Commonwealth and the States have recently commenced work on developing implementation plans for the delivery of the Commonwealth Government's election commitments relating to early childhood education and care, including providing universal access to early learning programs for all Australian four year olds for 15 hours per week and establishing an additional

⁴⁵⁰ DoCS, *Annual Report 2006/07*, p.34.

⁴⁵¹ DoCS, *Early Intervention and Prevention, Literature Review*, May 2005, p.18.

⁴⁵² DoCS, *Annual Report 2006/07*, p.36.

260 child care centres on primary school grounds and other community land in areas where there are service gaps.⁴⁵³

- 7.103 A longer term reform program is also being developed in relation to Aboriginal early childhood development to ensure sustained engagement by all jurisdictions.
- 7.104 Other Commonwealth election commitments relating to early childhood development include establishing a National Health and Development Assessment System, specifically a 'Healthy Kids Check' upon starting school and the national rollout of the Australian Early Development Index in Australian primary schools.⁴⁵⁴
- 7.105 In the past, the division of responsibility between the Commonwealth and the States for child care and early childhood education "has been an obstacle to the most effective and efficient use of children's services across the system."⁴⁵⁵ So while it is still early days, the Inquiry recognises that this new Commonwealth-State collaboration on early childhood development has the potential to remove such obstacles. Premier and Cabinet advised:

*The emerging COAG agenda provides an opportunity to deliver significantly improved outcomes for children's early development, which will have flow-on benefits across the whole society. If the ambitious goals of the emerging COAG agenda can be achieved – strengthening families in need of support, giving children a healthy start to life and ensuring that they develop well - the flow-on effects for the child protection system will be significant. Stronger families and healthier children will mean a reduced demand for child protection responses, both in the short term (by supporting at-risk families) and in the long term by breaking intergenerational cycles of disadvantage).*⁴⁵⁶

Commonwealth initiatives

- 7.106 In addition to funding support for child care, the Commonwealth Government provides all eligible four year old children in Australia with a health check under Medicare to ensure they are healthy and ready for school. To be eligible, the child must be a permanent resident or be covered by a reciprocal agreement, and the parent must be in agreement with the child being immunised.⁴⁵⁷

⁴⁵³ Community and Disability Service Ministers' Conference, Agenda Item 3: COAG Early Childhood Development Agenda, 23 July 2008, p.1.

⁴⁵⁴The AEDI is a community-level measure of young children's development based on a teacher-completed checklist. It consists of over 100 questions measuring five developmental domains: language and cognitive skills; emotional maturity; physical health and well-being; communication skills and general knowledge; and, social competence. The Royal Children's Hospital Melbourne website is www.rch.org.au.

⁴⁵⁵ Submission: Department of Premier and Cabinet, p.40.

⁴⁵⁶ *ibid.*, pp.40-41.

⁴⁵⁷ Department of Health and Ageing, *Medicare Healthy Kids Check – Fact Sheet*, www.health.gov.au.

Targeted service system

- 7.107 NSW government agencies provide a range of secondary and tertiary services that, from a child protection perspective, have either a prevention or early intervention focus.

NSW Health services

- 7.108 Health, through its hospitals and Area Health Services, provides a range of targeted services to support children, young persons and their parents with health related needs.
- 7.109 Child and Adolescent Mental Health Services play an important role in the child protection system as a considerable proportion of children and young persons with developing mental health problems are likely to have experienced child abuse and neglect. These services include:
- a. 47 acute funded child and adolescent mental health beds
 - b. 56 non-acute funded child and adolescent mental health beds
 - c. day patient, outpatient and inpatient programs for children aged 5-12 years and their families at Redbank House, Westmead
 - d. an alternative care clinic providing mental health services specifically for children in OOHC, also at Redbank.
- 7.110 The Children of Parents with Mental Illness program, is a national program that targets children of parents with a mental illness. In relation to this program, Dr Josey Anderson of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) advised the Inquiry that “greater collaboration and perhaps even joint initiatives between DoCS and Health around children and parents with medical illness would greatly enhance that work.”⁴⁵⁸
- 7.111 The NSW School-Link Initiative aims to formalise partnerships between education providers and mental health services to improve the way in which they work together, to achieve better mental health outcomes for children and adolescents, to support child and adolescent mental health services and schools to work collaboratively to promote mental health, to prevent mental health problems and to facilitate early identification, management and support of students with mental health problems. An evaluation of the initiative was positive.
- 7.112 While drug and alcohol services focus on adults, they also have a role to play in the assessment and identification of children and young persons who may be at risk of harm as a result of their parents or carers having substance abuse problems.

⁴⁵⁸ Transcript: Public Forum, Health and Disability, 11 April 2008, p.60.

- 7.113 Similarly, adult Mental Health Services play a significant role in the support of parents with a mental illness. Northern Sydney Central Coast Health advised the Inquiry that a snapshot survey of their adult mental health service clients in April 2004 showed that 20 to 30 per cent of their clients were parents, a finding they said was consistent with national surveys. Further, they found that about 24 per cent of those clients who were parents had current or previous involvement with DoCS. For a further 13 per cent of those parents, it was not known if they had had a history of contact with DoCS.⁴⁵⁹
- 7.114 The Aboriginal Family Health Strategy is designed to address issues relating to the occurrence of family violence and sexual assault in Aboriginal communities. In addition, the Education Against Violence Strategy was funded in partnership with the Centre for Aboriginal Health to develop and run an accredited certificate for family/domestic violence and sexual assault course.
- 7.115 Aboriginal Medical Services deliver a range of primary health care services and host a number of specialist services. The funding of these Aboriginal specific primary health services is the responsibility of the Commonwealth Government. The services also work in partnership with NSW Health services to deliver services to Aboriginal children and families.
- 7.116 NSW Health also provides a network of sexual assault services that deliver medical examinations, crisis counselling and ongoing treatment to victims of child and adult sexual assault. These services provide an intervention for children displaying problematic sexualised or sexually abusive behaviours, where those children have disclosed that they have been the victim of sexual assault. These children who have not disclosed a history of sexual victimisation can be provided a service by Child and Family Health Teams (providing early intervention and health promotion programs delivered by a range of professionals including nurses, social workers, psychologists and psychiatrists) or by a Child and Adolescent Mental Health Team.
- 7.117 In addition, Health provides Physical Abuse and Neglect of Children (PANOC) services to children who have been abused or neglected, and who also display problematic sexualised or sexually abusive behaviours. Referrals to PANOC services must be made by DoCS.
- 7.118 While these services are intended to be available throughout NSW it appears from information provided to the Inquiry at the Public Forums and otherwise that they are not available in all locations.
- 7.119 The New Street Adolescent Service (New Street), based at North Parramatta, commenced operations in June 1998 under the auspices of the Sydney West Area Health Service. It provides a specialised, community based early intervention program for adolescents aged 10-17 years who display sexually abusive behaviours, which involves both the adolescent and family. Typically,

⁴⁵⁹ Northern Sydney Central Coast Health, *Parenting Mental Health Audit*, April 2004.

New Street, which is only available to adolescents who have not been charged with an offence, lasts for two years, and the service is overseen by an Inter-departmental Advisory Committee comprising representatives from DoCS, Education, Juvenile Justice, Health and Police. It is understood that with current resources it is able to accept approximately 25 per cent of the referrals made to it.

7.120 The first of the two planned evaluations delivered in May 2006 found strong evidence for the effectiveness of the New Street program both in reducing re-offending, and in protecting the target group from themselves becoming victims of crime and/or of abuse or neglect. The evaluation report made the point that, in addition to posing a risk to other children and young persons, the members of this group are themselves “an extremely vulnerable group whose needs should be highlighted within the child protection system.”⁴⁶⁰

7.121 The evaluation report further stated:

*The high cost of reoffending by untreated young people and young people who fail to complete treatment in terms of numbers of victims and level of severity of reoffending, presents a strong argument for the continuation and enhancement of the New Street treatment program and for its location within a coordinated interagency response that expedites referral to the program and supports the participation of the young people and their carers to complete the program.*⁴⁶¹

7.122 The evaluation report made a number of recommendations for expansion of New Street, and for the provision of additional resources to enable that to occur, as well as for a commitment by the interagency partners to expedite referrals to and assessment by the service.⁴⁶²

7.123 The New Street budget is just under \$500,000 per annum, and a cost benefit analysis undertaken by DoCS shows the total benefits of a “systemic community based program such as New Street” to be \$101,494 per client, outweighing the calculated total cost per client of \$27,010.⁴⁶³

7.124 A proposal for a similar service to be based in the Hunter New England area with an Aboriginal focus, was provided to the Inquiry.⁴⁶⁴ The proposed ‘Rural New Street’ program has been funded, the service manager commenced duties in Tamworth in February 2008, and clinical staff have been recruited with the expectation that the service would start taking referrals in September 2008. This service is also referred to in relation to the *NSW Interagency Plan to*

⁴⁶⁰ L Laing, J Mikulsky, and C Kennaugh, “Evaluation of the New Street Adolescent Service,” *Faculty of Education and Social Work, University of Sydney*, 2006, pp.5-6.

⁴⁶¹ *ibid.*

⁴⁶² *ibid.*, p.27.

⁴⁶³ NSW Health, *Service Proposal, Rural New Street program for adolescents who sexually abuse to be based in Hunter New England Area Health Service*, p.3.

⁴⁶⁴ *ibid.*

Tackle Child Sexual Assault in Aboriginal Communities 2006-2011. Action 56 of that plan deals with the establishment of the rural program (see Chapter 18 for further discussion of this plan).

- 7.125 It is understood that the new service is based on the same principles as New Street but with a particular emphasis on addressing issues within the families and communities of young Aboriginal offenders.
- 7.126 It may be noted that similar programs in New Zealand for Aboriginal child sex offenders, such as the Te Piriti Special Treatment Program have been the subject of positive evaluation. The experience with that program, it has been said, is that it provides support for designing and implementing a program that is attuned to the cultural background of those involved.⁴⁶⁵ Other community based programs in New Zealand have also reportedly shown a reduction in recidivism.⁴⁶⁶
- 7.127 The accepted wisdom that adolescents do commit a significant number of sexual offences, and that a sizeable proportion of all adult sex offenders against children began offending during their adolescent years⁴⁶⁷ strongly supports the need for the retention and development of programs based on the New Street model for those within the 10-17 year age group, who have not yet reached the stage of being charged with a sexual offence.
- 7.128 Although children under 10 years of age are conclusively presumed to be incapable of committing a criminal offence,⁴⁶⁸ and are therefore outside the JIRT process, it is of concern that NSW Health Sexual Assault Services data suggest that during 2002 and 2003 there were respectively 79 and 49 child sexual assault cases reported where the perpetrators were aged under 10 years.⁴⁶⁹
- 7.129 The incidence of mental health problems, learning difficulties, negative social interactions, and the increased risk of victimisation that these children are likely to experience, emphasises the need for Health to provide an effective therapeutic intervention for them, and for DoCS to be notified of any at risk issues for that child or other relevant children.

⁴⁶⁵ S Macgregor, "Sex Offender Treatment Programs: effectiveness of prison and community based programs in Australia and New Zealand," *Indigenous Justice Clearinghouse*, April 2008, pp.4 and 7.

⁴⁶⁶ *ibid.*, p.5.

⁴⁶⁷ Department of Juvenile Justice, *Profiling Australian Juvenile Sex Offenders: Offenders and offence characteristics*, p.1, 1999; D Lievore, "Recidivism of Sexual Assault Offenders, Rate, Risk Factors and Treatment Efficacy," prepared for the Office of the Status of Women by the Australian Institute of Criminology, May 2004, p.54.

⁴⁶⁸ *Children (Criminal Proceedings) Act 1987* s.5.

⁴⁶⁹ NSW Health, *Issues Paper, Responding to Children under ten who display problematic sexualised behaviour or sexually abusive behaviour*, 2005, p.8.

Department of Education and Training services

- 7.130 Education provides a range of targeted programs to support vulnerable students and students with additional needs across NSW. The aim of the majority of these programs is to establish protective factors and build resilience in children and young persons. The Federation of Parents and Citizens Association advised the Inquiry that “schools must be recognised as an essential sphere of influence for prevention and early intervention.”⁴⁷⁰
- 7.131 The Priority Schools Program is a targeted prevention and early intervention program which supports government schools in NSW with the highest concentrations of families from low socio-economic status backgrounds. Additional funding, staffing and consultancy support are provided to assist schools in the program to focus on improving the literacy, numeracy and participation outcomes for students. Currently, one quarter of the 2,216 NSW government schools receive funding under this program.⁴⁷¹
- 7.132 Education reported that over 200 breakfast programs operate at schools across NSW. The services vary from school to school and are often run either by, or in conjunction with, the parents and citizens association, charities and local businesses. The Red Cross was identified as a sponsor, participant or service provider in over 40 of the breakfast programs.
- 7.133 Education also operates programs targeting Aboriginal students with the aim of improving literacy and numeracy results, school retention rates and school attendance.
- 7.134 The Home School Liaison Program aims to provide “a supportive service to students, parents and schools to encourage the full participation of all students in education.”⁴⁷² There are currently 84 home school liaison officers and 11 Aboriginal student liaison officers located across the State on a needs basis. The liaison officers are authorised attendance officers who can provide intensive support for students and their families through a case management plan.
- 7.135 All government schools have access to the services of a school counsellor. School counsellors are experienced teachers with post-graduate training in school counselling whose work includes counselling students, assisting parents or carers to make informed decisions about their child’s education and liaising with other agencies concerned with the well-being of students. There are 790.8 equivalent full time school counsellor positions across NSW government schools.

⁴⁷⁰ Submission: Federation of Parents and Citizens’ Association of New South Wales, p.8.

⁴⁷¹ Department of Education and Training, *Priority Schools Program*.

⁴⁷² Department of Education and Training, *Home School Liaison Program Guidelines 2008*, p.3.

- 7.136 Education delivers a range of programs to support learning for children and young persons with additional needs. This includes children and young persons with learning difficulties, disabilities and/or with challenging behaviours.
- 7.137 Education has an OOHC program to support the learning needs of children and young persons in OOHC. There are 22.6 equivalent full time teacher positions funded as part of this program located within the regional student services teams.
- 7.138 As part of the Families NSW strategy, Education operates 47 Schools as Community Centres across the State. Local Schools as Community Centres facilitators, schools and interagency partners plan activities designed to develop capacity in young children up to eight years, their families and the local community. Activities include supported playgroups, play and learn groups for parents and children, transition to school programs, home literacy and transport programs, parenting workshops and support groups, information and resource services, nutrition and child health screening.
- 7.139 In recognition of the importance of a continuing involvement in education for the development of children, the Inquiry has recommended the addition of "habitual absence from school" as a risk factor requiring notification. It will be important for Education to have strategies available to respond to these cases, particularly where the report becomes a trigger for early intervention.

Housing NSW services

- 7.140 In 2006/07, Housing provided property and tenancy management for over 126,300 public housing homes and for more than 4,300 properties owned by the Aboriginal Housing Office. Through the Office for Community Housing, the Department also funded and regulated not-for-profit organisations to provide property and tenancy management for more than 15,600 homes.⁴⁷³
- 7.141 Housing has a Priority Housing Policy for applicants who are eligible for public housing, are in urgent need of housing and are unable to resolve their housing need through the private rental market. People approved for priority housing are housed ahead of most other public housing applicants on the Department's housing register.⁴⁷⁴
- 7.142 A factor that Housing considers when assessing an applicant's need for priority housing is whether the applicant, or a member of the applicant's household is at risk of harm due to domestic violence, sexual assault, child abuse, threatening behaviour by someone the applicant is living with or torture and trauma. Another factor considered is whether the applicant is homeless, at risk of homelessness or living in crisis or emergency accommodation.⁴⁷⁵

⁴⁷³ NSW Housing, *2006/07 Annual Report*, p.8.

⁴⁷⁴ NSW Housing, *Priority Housing Fact Sheet*, July 2008, p.1.

⁴⁷⁵ *ibid.*, pp.2-3.

- 7.143 Housing offers financial assistance to eligible low income clients to move to accommodation in the private rental market.⁴⁷⁶
- 7.144 People who need immediate housing assistance can seek help from Housing. Temporary accommodation is found in low cost motels, hotels, caravan parks or similar accommodation to assist people who are in housing crisis or homeless. Accommodation is provided for one or a small number of nights. Clients that need support are generally referred to supported crisis accommodation funded through the Supported Accommodation Assistance Program (SAAP) (see Chapter 17).⁴⁷⁷
- 7.145 The Housing and Human Services Accord was released in April 2007 and established “a framework for formal cross agency housing and support agreements to assist social housing tenants with complex needs to access support required to sustain their tenancies.”⁴⁷⁸
- 7.146 As with other statements of intent by way of MOUs and the like, the objectives are laudable, but whether they achieve any change for children and their families remains to be seen.
- 7.147 One of the schedules currently being trialled under the Housing and Human Services Accord is the Shared Access initiative. DoCS is participating in seven of the 14 Shared Access trials with Housing and other departments including Juvenile Justice and some NGOs. As part of these trials, DoCS identifies vulnerable people for priority access to public housing and provides ongoing case support for nominated clients. Examples include providing housing and support services to: young people leaving OOH in the Hunter Area who are assessed to be at risk of negative outcomes, without additional support; young women who are currently, formerly, or at risk entering or re-entering Juniperina Juvenile Justice Centre; families in Moree who are affected by domestic violence; and young persons who are homeless or at risk of homelessness and need support in Tamworth.⁴⁷⁹

Local government services

- 7.148 DoCS advises that 491 or 13.9 per cent of funded projects are delivered by local government. In 2007/08, about two thirds of the 152 local councils in NSW received a total of approximately \$20 million in DoCS funding for the provision of a range of services.
- 7.149 More than half of this funding was for the provision of children’s services. The extent of service provision by local councils in the children’s services area varies considerably across the State. For instance, in 2007/08, about one

⁴⁷⁶ NSW Housing, *RentStart Fact Sheet* July 2008.

⁴⁷⁷ NSW Housing, *After Hours Temporary Accommodation line*.

⁴⁷⁸ NSW Housing, *2006/07 Annual Report*, p.49.

⁴⁷⁹ DoCS, “Agency partnership boosts support for people with complex needs,” *Inside Out*, September/October 2008.

quarter of all local councils received DoCS funding to assist in the operation of long day care centres. Of these councils, most operated only one long day care service, while other councils operated multiple services. For example, in 2007/08, Blacktown City Council received DoCS funding for 21 long day care centres and Penrith City Council⁴⁸⁰ received DoCS funding for 17 long day care centres. In addition to long day care, DoCS provided funding to councils for preschools, vacation care and occasional care services.⁴⁸¹ Local councils operating children's services also receive funding from the Commonwealth through its Child Care Support Program.

- 7.150 Local councils were also funded by DoCS in 2007/08 to provide a range of services including family support services, supported playgroups, counselling services and refuges, and for family worker, community worker and youth worker positions.

Commonwealth targeted services

- 7.151 The Stronger Families and Communities Strategy is a Commonwealth initiative "giving families, their children and communities the opportunity to build a better future."⁴⁸² Currently funded under this strategy is Communities for Children, a place based early intervention and prevention approach to child protection and development under which NGOs are funded in 45 disadvantaged sites throughout Australia. It offers services that include: home visiting; early learning and literacy programs; early development of social and communication skills; and parenting and family support programs.⁴⁸³ The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) informed the Inquiry that the Communities for Children initiative was funded at \$37.45 million for 2007/08.
- 7.152 An evaluation of the Communities for Children program is underway. Overall the findings to date indicate that the program has had a significant impact on the delivery and configuration of services in the sites in which it is operating:

*There is universal agreement with the basic principle underlying this initiative - that coordination of services and community engagement are crucial for the effective provision of services to children in their early years and their families.*⁴⁸⁴

- 7.153 However, lessons learned from the implementation of Communities for Children initiatives include longer funding periods, longer lead-in times, more flexible use

⁴⁸⁰ DoCS, *Annual Report 2007/08*, pp.174-175.

⁴⁸¹ DoCS, *Annual Report 2006/07*, pp.176-200.

⁴⁸² Department of Families, Housing, Community Services and Indigenous Affairs www.facsia.gov.au

⁴⁸³ *ibid.*

⁴⁸⁴ Department of Families, Housing, Community Services and Indigenous Affairs, *Stronger Families and Communities Strategy National Evaluation Baseline Report on Communities for Children Process Evaluation*, www.facsia.gov.au/family/sfcs_report/sec6.htm

of resources, engagement of state and territory policy makers and a better understanding and communication of what is required in each site.⁴⁸⁵

- 7.154 The Responding Early Assisting Children Program is intended to improve the capacity of families and care-givers to respond appropriately to children's needs for care, development and safety through timely access to community resources that can support them in their parenting role. FaHCSIA reports there are 43 such funded projects throughout Australia.⁴⁸⁶

DoCS Brighter Futures early intervention program

- 7.155 A number of provisions under the Care Act provide a mandate for prevention and early intervention strategies. The objects in s.8 include, among other things:

(c) that appropriate assistance is rendered to parents and other persons responsible for children and young persons in the performance of their child-rearing responsibilities in order to promote a safe and nurturing environment.

- 7.156 The principles contained in s.9 provide that in the administration of the Care Act,

(d) ... in order to protect a child or young person from harm, the course to be followed must be the least intrusive intervention in the life of the child or young person and his or her family.

- 7.157 The legislation enables assistance to be sought by a child or young person⁴⁸⁷ or his or her parent.⁴⁸⁸ These provisions can be used to provide preventative and early intervention support to families, such as housing and referrals to a range of community based services.

- 7.158 In addition, under the *Community Welfare Act 1987*, the Minister and/or the Director-General can fund others to provide services including early intervention services.

- 7.159 Approximately 22 per cent (\$260 million) of the DoCS Reform Package was committed to expanding the NSW early intervention system with the establishment of the Brighter Futures program. It included an additional 350 caseworkers in CSCs and \$150 million to Lead Agencies and their partners to provide these services.

⁴⁸⁵ *ibid.*

⁴⁸⁶ Correspondence: Department of Families, Housing, Community Services and Indigenous Affairs, 15 September 2008.

⁴⁸⁷ *Children and Young Persons (Care and Protection) Act 1998* s.20.

⁴⁸⁸ *Children and Young Persons (Care and Protection) Act 1998* s.21.

- 7.160 Brighter Futures was established in an effort to address demands on the child protection system through intervening earlier with an integrated set of services to meet the needs of vulnerable children and families. DoCS informed the Inquiry:

The program is set up as a demand management for child protection reports but with associated benefits such as improving children's readiness for school, for parents, increasing their parenting skills in being able to look after those children and, of course, reducing the notification rates to the Department.⁴⁸⁹

- 7.161 Underpinning this model is the notion of integrated service delivery, whereby the full range of resources and services are accessible by families through a single entry point. This 'one stop' style service may not necessarily mean that all services are delivered under the one roof by a single service provider. Integrated service delivery arrangements, through consortia, alliances, sub-contracting or brokerage arrangements, can provide a mix of services in one or a number of locations via a coordinated single service access point. Research suggests that this style of service delivery has the potential to improve services delivered to children and families delivering benefits such as easier and more convenient access to services, and a reduced number of agency contacts which can assist families to navigate the maze of agencies.
- 7.162 The program commenced in 2003/04 in five CSCs. As at October 2008, there were 68 CSCs in NSW with Early Intervention Caseworkers and work continues in securing office accommodation and recruiting to the remaining positions, which DoCS advises will be complete by the end of 2008.
- 7.163 Nearly all Lead Agencies have started working with families with the remainder in the process of establishing their services. DoCS anticipate that all Lead Agencies will be providing services to families by the end of 2008.

Brighter Futures service model

- 7.164 Brighter Futures was developed following the merging of two early intervention projects in 2003/04:
- a. The Level Three Project which aimed to assist families who were the subject of reports assessed as Level Three by the Helpline or 'low risk' families (now the 80 per cent of families entering the Brighter Futures program through the Helpline referral pathway).
 - b. The Vulnerable Families Project which aimed to assist families with child protection risk factors that made them vulnerable to entering and then escalating in the child protection system (now the 20 per cent of families

⁴⁸⁹ Transcript: Public Forum, Early Intervention, 16 May 2008, L Mallett, Acting Deputy Director-General, Service System Development, DoCS, p.24.

entering the Brighter Futures program through the community referral pathway).

- 7.165 Brighter Futures is a voluntary, targeted program designed for low to medium risk families encountering problems that impact on their ability to care for their children. It provides a differential entry point for lower risk families with children, aged under nine years. In practice, however, DoCS largely limits entry to families with children aged under three years. The aims of this program are to:
- a. reduce child abuse and neglect by reducing the likelihood of family problems escalating into crisis within the child protection system
 - b. achieve long term benefits for children by improving intellectual development, educational outcomes and employment chances
 - c. improve parent-child relationships and the capacity of parents to build positive relationships and raise stronger, healthier children
 - d. break inter-generational cycles of disadvantage
 - e. reduce demand for services that otherwise might be needed down the track such as child protection, corrective or mental health services.⁴⁹⁰
- 7.166 Following an initial assessment of a report by the Helpline, and referral of the family to a CSC, caseworkers determine whether families will be allocated to a child protection worker or are eligible to be offered a voluntary service under Brighter Futures.
- 7.167 Families must have at least one vulnerability that, if not addressed, is likely to escalate and impact on a parent's or care-giver's capacity to parent, or on the well-being of the child/ren. Family vulnerabilities include:
- a. domestic violence
 - b. parental drug and alcohol misuse
 - c. parental mental health issues
 - d. lack of extended family or social support
 - e. parent(s) with significant learning difficulties and/or intellectual disability
 - f. child behaviour management problems
 - g. lack of parenting skills/adequate supervision.
- 7.168 Priority of access is given to:
- a. families previously participating in the Brighter Futures program who have moved and transferred to a new area
 - b. Aboriginal Maternal and Infant Health Strategy (AMIHS) referred families (see Chapter 18)
 - c. families with children under three years of age

⁴⁹⁰ DoCS, *Brighter Futures Caseworker Manual*, April 2007, pp.8-9.

- d. families who have been on the eligibility list the longest.
- 7.169 Families are initially assessed as eligible if the level of risk is low or medium and the required response time assigned to the child protection report is less than 72 hours, less than 10 days or 10 days or more.
- 7.170 Families participating in Brighter Futures are assessed as likely to need services of approximately two years duration and require case management and at least two of the following services:
- a. quality children's services which include any of the services that are licensed under the *Children's Services Regulation 2004*, such as long day care, preschools, and family day care
 - b. parenting programs which are designed to assist parents to enhance their parenting competencies by increasing their knowledge of child development and parenting practices.
 - c. home visiting which is a structured support program to help parents develop coping and parenting skills. This includes: both professional and volunteer home visiting; providing information, practical support and advice about the care of babies and children; modelling good parenting practices; and assisting families to develop supportive networks.
- 7.171 There are currently three entry pathways to the Brighter Futures program. The first involves a report of risk of harm or a request for Brighter Futures assistance to the Helpline that is then forwarded to a CSC for determining eligibility for the program. The second pathway is via a referral from a community agency or individual to a Lead Agency. A third pathway, currently being trialled, is a direct referral of families from AMIHS to this program (this service is outlined further in Chapter 18), some of whom will be referred by the community pathway and some by the Helpline.
- 7.172 Regardless of the pathway into the Brighter Futures program, DoCS always makes the eligibility decision. Lead Agencies can only begin working with families once they have received confirmation from DoCS that the family is eligible. As indicated earlier, it is necessary for a family to consent to participate in the program. A refusal to consent can be relevant to any assessment of the level of risk of children within that family.
- 7.173 Once the program reaches capacity under the current model:
- a. 80 per cent of families referred into the program will come via a report or request for assistance to the DoCS Helpline
 - b. 20 per cent of families referred into the program will come via the community referral pathway.
- 7.174 DoCS will provide case management, casework and home visiting services for 50 per cent of the total families in the Brighter Futures program. Lead Agencies will provide the other 50 per cent and also provide access to parenting programs and child care places for DoCS case managed families.

Role of DoCS

- 7.175 Once assessed as meeting the initial criteria for the program, the family either remains with DoCS Early Intervention team or the family's case is transferred (using s.248 of the Care Act) to a Lead Agency.⁴⁹¹

Table 7.2 **Reports assessed as eligible for Early Intervention at Secondary Assessment Stage 1, 2006/07 – 2007/08**

	2006/07	1 April 2007 – 31 March 2008
Total number of reports that were subject to a completed SAS1 only	76,884	98,656
Number of reports assessed as eligible for Early Intervention	8,108	15,965
Reports assessed as eligible for Early Intervention as a percentage of all reports receiving a SAS1	10.5%	16.2%
Reports assessed as eligible for Early Intervention as a percentage of total child protection reports	2.8%	5.4%
Reports assessed as eligible for Early Intervention as a percentage of reports referred to CSC/JIRT for further assessment	4.0%	7.8%

- 7.176 A more comprehensive assessment is then completed for each family following their referral to the Brighter Futures program, including contact with the family. This seeks to determine that referred families require, and will be appropriately supported by the range of services and supports offered through this program. As part of this assessment DoCS Early Intervention Caseworkers seek to identify that:
- a universal preventative service is unlikely to provide an intervention sufficient to alleviate current family concerns
 - the family is likely to require an intervention for two years, on average, to achieve lasting change
 - the family requires case management and at least two of the Brighter Futures funded services
 - the family requires sustained case management providing coordinated delivery of a range of support services and is not currently receiving this from another agency.
- 7.177 When a risk of harm report is made concerning a child participating in the program that does not warrant a child protection response, the DoCS Early Intervention Caseworker and Lead Agency Brighter Futures Caseworker should continue to provide services to the family. This work may involve modification of the plan to reflect the recommendations and advice of child protection staff.

⁴⁹¹ DoCS' Brighter Futures Teams only provide case management for families who enter the program via the Helpline pathway. Lead Agencies will case manage eligible families that enter Brighter Futures via the community referral pathway as well as some families who enter the program via the Helpline.

- 7.178 If a reported risk of harm to a child in the program is serious enough to warrant a child protection response, the current procedure contemplates that the family would be transferred to a Child Protection Caseworker and services to the family would be maintained, especially those services that are in the best interests of the child, such as, child care.

Evaluation of the Brighter Futures program

- 7.179 DoCS has appointed a consortium of academic institutions, led by the Social Policy and Research Centre at the University of NSW, to undertake a four year independent evaluation of Brighter Futures. The evaluation design began in 2006 and the evaluation will continue until 2010. The evaluation comprises a results and process evaluation, an economic evaluation and an intensive research study.
- 7.180 The first Interim report of the evaluation was completed for the period to October 2007.⁴⁹² This report provided a baseline, and while it drew no conclusions at that stage, it presented information on the outcomes of the referral process and the number and characteristics of the families entering the program:
- a. as at October 2007, 975 families had participated in the program with 882 families still in the program and 93 having left
 - b. 39 per cent were managed by DoCS and 61 per cent were managed by Lead Agencies
 - c. 59 per cent of the families entered through a report from the Helpline while 41 per cent of families entered the program through the community referral pathway
 - d. all community referrals were managed by the Lead Agency. For families that entered through a report to the Helpline, 32.5 per cent were managed by Lead Agencies
 - e. the main vulnerabilities recorded for families entering the program were lack of social support (51 per cent), parental mental health (47 per cent) and domestic violence (46 per cent). Seventy-four per cent of families had more than one identified vulnerability.⁴⁹³
- 7.181 Of the 975 families, 780 families (involving 1,711 children) had been reported⁴⁹⁴ to the DoCS Helpline with a total of 6,976 reports received by the Helpline for the period of 24 months prior to entering the program, with almost 90 per cent having a low to medium level of urgency. Of the 6,976 reports, the following is known:
- a. 11 per cent of these families were reported only once to the Helpline

⁴⁹² DoCS, *Brighter Futures Evaluation Program, Interim Report 1*, (Draft), March 2008.

⁴⁹³ *ibid.*

⁴⁹⁴ This figure includes families who were reported via the community referral route as they may have been subject to reports not associated with their referral into the program.

- b. the mean number of reports per child was 4.1 and the median was three reports
- c. almost seven per cent of children in the program accounted for more than 10 reports each
- d. ten per cent of reports were assigned a required response time of less than 24 hours, 42 per cent with a response time of less than 72 hours and 47 per cent with a less than 10 days response time⁴⁹⁵
- e. the most frequent primary reported issues were domestic violence (30 per cent), disability of carer (15 per cent), and risk of physical, psychological or sexual harm/injury (13 per cent). Inadequate clothing, nutrition, shelter or supervision made up 12 per cent of the reported issues.⁴⁹⁶

7.182 A greater proportion of families who entered the program from the Helpline, as compared with the community pathway, had identified vulnerabilities of domestic violence (50.8 per cent compared with 27.2 per cent) and parental drug and alcohol misuse (28.7 per cent compared with 16.8 per cent). Families with the vulnerability of parental mental health issues were more likely to have entered the program through the community pathway than through the Helpline (56 per cent compared with 44 per cent).⁴⁹⁷

7.183 For DoCS managed families, the most prevalent vulnerabilities were domestic violence, parental mental health and lack of social support. For Lead Agency managed cases, the vulnerabilities most prevalent were lack of social support, parental mental health and child behaviour management.⁴⁹⁸

7.184 The Inquiry, in agreement with most of those who made submissions on this topic, is of the view that Brighter Futures is a significant achievement that should continue and be expanded. As The Benevolent Society said:

*Brighter Futures really lays out that concern and they have a well designed program in terms of its components. It has set a benchmark in Australia about setting out provisions of child care in terms of an early intervention and prevention project. They have really led the way on that. It is a long term project that has sustainability and tries to meet those needs long term, and a lot of thought and good research has gone into it.*⁴⁹⁹

⁴⁹⁵ Note 2,016 of the 6,976 reports had missing data. DoCS, *Brighter Futures Evaluation Program, Interim Report 1*, (Draft), March 2008, pp.8-9.

⁴⁹⁶ DoCS, *Brighter Futures Evaluation Program, Interim Report 1*, (Draft), March 2008, pp.8-9.

⁴⁹⁷ *ibid.*, p.10.

⁴⁹⁸ *ibid.*, p.11.

⁴⁹⁹ Transcript: Public Forum, Early Intervention, 16 May 2008, p.8.

Issues arising

Gaps in the service system

- 7.185 Professor Graham Vimpani, Clinical Chair Hunter Children's Health Network, advised the Inquiry:

Fraser Mustard has always said that you shouldn't run early intervention out of spare parts repair shops. That applies equally to Health and to an agency that is providing welfare services. I think that we need to fill some of the gaps that currently exist in the suite of early intervention strategies, and sustained home visiting would be one of those. There are some programs of early intervention which need to be provided by health workers and therapists, just as there are some programs that are better provided by people with community development skills, and all those people need to be involved in the planning and implementation and evaluation of an early intervention service system.⁵⁰⁰

Gaps in the health service system

- 7.186 Dr Matthews informed the Inquiry that "there are significant resources available statewide. Whether they match the need or not, of course, is another matter."⁵⁰¹
- 7.187 The Inquiry heard that some services were lacking across the State. Sometimes the issue was that the services were staffed, but could not keep up with workload and had long waiting times for services. There were insufficient positions funded, or services were limited because they were provided by outreach part time and not based in the community. Sometimes there was exclusive criteria for access to services which meant that certain groups of children were not eligible for services. Very often the position was funded, but Health struggled to recruit and retain trained clinicians to the position.
- 7.188 The services most frequently cited as deficient were mental health, drug and alcohol services, sexual assault services, PANOC services, medical forensic services, counselling services for families and children (including domestic violence counselling), allied health services especially speech therapy, services for men, services for perpetrators, and assessment and treatment services for children in OOHC. The Inquiry also heard of the poor availability of parenting interventions in some parts of the State, especially for particular groups such as teenage parents in remote areas, and about a lack of culturally specific parenting programs for Aboriginal people despite courts requiring some

⁵⁰⁰ *ibid.*, p.16. Note: Dr. Fraser Mustard is a Canadian academic whose work on early childhood development and early intervention has gained international recognition.

⁵⁰¹ Transcript: Public Forum, Interagency Cooperation, 4 April 2008, p.37.

Aboriginal parents to attend courses. Regional areas reported greater difficulties in accessing health services of these kinds. It is of concern that these are the very services that are necessary for families that are struggling to raise their children, or who are likely to be involved in their abuse or neglect.

7.189 The Inquiry heard little about duplication of services, apart from the efforts made by agencies when developing services to avoid duplication.

7.190 Accessing services across state borders was also raised. In Boggabilla, the Inquiry heard that:

We have had lots of problems over the years with mental health issues. Goondiwindi will not accept our clients. We have to rely on Queensland Ambulance and the Police Service and an RN with a client who is medicated to get them to Moree. Once they're at Moree, they're transported by ambulance from there to Tamworth. There are a lot of people handling one client in something that could be quite easily fixed up if the person was scheduled in Queensland.⁵⁰²

7.191 Access to health services for children and young persons was an issue in a number of locations. The distance that children or young persons and their families had to travel to access such programs was a barrier to them starting and completing the programs.

7.192 A DoCS worker in a CSC in the Southern Region advised the Inquiry of the increasing severity of the issues facing families, and the interplay between drug use, domestic violence and mental health issues which required an increasingly complex service response.

7.193 For Aboriginal communities, the Inquiry heard that there were specific gaps in services to support healing, especially for men. The Director-General of Aboriginal Affairs stated that:

As to healing, people did mention psychiatric services, but the healing programs is another area that needs further development. They are not, I don't think, really hitting the road out there - the healing programs and mental health programs and men's groups. We do get a lot of call for men's groups to be supported, to take on these issues as well, but also for their own purposes and strength, doing some more work with men's groups.⁵⁰³

⁵⁰² Transcript: Public Forum, Communities of Toomelah and Boggabilla, 11 June 2008, Community Nurse, Toomelah, pp.5-6.

⁵⁰³ Transcript: Public Forum, Aboriginal Communities, 24 April 2008, pp.57-58.

- 7.194 The Inquiry was informed that there were specific communication issues contributing to poor child protection outcomes for young persons with a mental illness. The Ombudsman said that:

We have also found there to be inadequate interagency coordination in a number of matters concerning young people at risk where suicide or mental illness was known or documented ... In particular, we found that most of the young people who had committed suicide ... had had contact with a number of agencies, but in some cases there was limited communication or coordination between services, including between mental health services and DoCS.

...

Over the past three years we have made a series of recommendations directed to DoCS and Health regarding this issue of improving supports to young people with mental health problems. Our recommendations were firstly, for them to determine which of them should take the lead for ensuring ongoing improvement to the level of service provided to young people at risk of suicide and secondly, to consider strategies for improving:

- a. the systems for assessing the particular needs of individuals*
- b. effective and coordinated interagency responses to those needs*
- c. the systems for actually meeting the needs of individuals.⁵⁰⁴*

- 7.195 Perpetrator programs were raised as a separate issue requiring counselling interventions in a number of areas.

- 7.196 The availability of sufficient services is not a new issue and it is not one which can be solved alone by the injection of further funding. Attracting and retaining staff in rural and remote areas is a significant barrier to getting enough universal and targeted services throughout NSW. These matters are discussed in more detail in Chapter 10 where consideration is given to directions for the way forward.

Referrals to Lead Agencies in the Brighter Futures program

- 7.197 At the end of June 2008, there were 2,707 families comprising 6,515 children and young persons in the Brighter Futures program, of which 22.6 per cent

⁵⁰⁴ Submission: NSW Ombudsman, Young People at Risk, 26 May 2008, p.7.

(612) of the families were Aboriginal. DoCS was case managing 43.4 per cent (1,175) of these families and Lead Agencies was case managing 56.6 per cent (1,532) of these families.

7.198 The total planned contracted capacity to be provided by Lead Agencies is 2,757 families. As table 7.3 below shows, at the end of June 2008, Lead Agencies case managed just over one half of the target they had contracted to provide.

Table 7.3 **Number of Families case managed by Brighter Futures Lead Agency by Region and Referral pathway including contracted targets**

Region	Community Referral			Helpline Referral			Total LA Managed		
	No of Families	LA Target	% of Capacity	No of Families	LA Target	% of Capacity	No of Families	LA Target	% of Capacity
Hunter & Central Coast	92	178	52%	117	265	44%	209	443	47%
Metro Central	96	133	72%	105	199	53%	201	332	61%
Metro South West	73	179	41%	89	266	33%	162	445	36%
Metro West	73	134	54%	66	201	33%	139	335	41%
Northern	138	187	74%	171	285	60%	309	472	65%
Southern	83	103	81%	121	156	78%	204	259	79%
Western	158	188	84%	150	283	53%	308	471	65%
Total	713	1,102	65%	819	1,655	49%	1,532	2,757	56%

7.199 For cases being managed as at June 2008 by Lead Agencies, 54 per cent were families that have been reported through the Helpline and referred by DoCS and 47 per cent have come through the community pathway. If the program was operating as designed, it would be expected that Lead Agencies would be managing 60 per cent of the families that were reported through the Helpline and 40 per cent of those reported through the community pathway.

7.200 Further, as Table 7.3 above indicates, there is a 35 per cent vacancy rate in the Lead Agencies community referral pathway, with a much higher vacancy rate of 51 per cent for families, who following a report through the Helpline, should be referred by DoCS to Lead Agencies. These figures suggest that referral of families by DoCS is slow.

7.201 The total planned DoCS capacity is 2,757 families. Presently DoCS has a vacancy rate of 57.4 per cent (1,582 families). Nearly all of the 350 DoCS Early Intervention Caseworkers have been recruited and thus lack of staffing is unlikely to account for this high vacancy rate. The vacancies may be as a result of a reluctance by families to engage with DoCS Early Intervention teams or while recruited, staff may not have completed training, or it may be that the CSCs are slow at referring.

7.202 It is acknowledged that it is early in the program and that eight of the 34 Lead Agency services have not been operational for the full period (Metro South

West, Hunter/Central Coast and parts of Northern Region), equally not all CSCs have reached maximum caseloads. Nevertheless, the Inquiry suspects that CSCs are not referring families to Lead Agencies in circumstances where they are or should be aware of families who may or do meet the eligibility criteria.

- 7.203 This is supported by written submissions from Lead Agencies and information provided at Public Forums held during the Inquiry. The Benevolent Society said:

We have figures with regard to referrals that we get from DoCS compared to the referrals we get from the community, and I think that DoCS' families are something like four times less likely to get referred and four times less likely to engage in the service than the community referred services. So we don't think that DoCS should be in the business of trying to build that service component to its own suite of services.⁵⁰⁵

- 7.204 A key concern for many of the current Lead Agencies is the delay in referring and completing eligibility processes to enable these agencies to start working with families. In response to these concerns DoCS said:

I think there is a large volume of reports, as we've indicated, coming through our system from the Helpline to our CSCs, and they get a number of reports that they will have to go through each day ... Yes, it is workload. We have said to our CSCs for a while, until we get better at doing that, some of the Early Intervention Caseworkers need to come and sit on the intake teams and go through those as well – so taking them off direct service delivery and putting them into an intake team to try to speed up the process.⁵⁰⁶

- 7.205 DoCS informed the Inquiry that in March 2008 it agreed to some of the DoCS Early Intervention Caseworkers being used to assess users and refer families to Lead Agencies to increase the number of referrals.

- 7.206 It may be the high volume of reports being referred to CSCs that is inhibiting the capacity of CSCs to fully assess all appropriate cases that could be referred. It may be that the process itself is impeding referrals. In some areas hubs⁵⁰⁷ determine eligibility and in others, caseworkers perform the task.

- 7.207 The Inquiry sees merit in equipping the Helpline to refer families to Brighter Futures after determining eligibility. This may reduce the vacancy rates and relieve CSCs of performing the task for families who can be identified earlier in

⁵⁰⁵ Transcript: Public Forum, Early Intervention, 16 May 2008, p.8.

⁵⁰⁶ *ibid.*, p.26.

⁵⁰⁷ Hubs have been established in some regions to undertake this function on behalf of groups of CSCs where Early Intervention caseworkers have not yet been recruited.

the process, namely at the time of reporting. This will be addressed further in Chapter 10.

Inconsistent practices by DoCS in the Brighter Futures program

- 7.208 Whether the child protection histories of families or children render them eligible or ineligible for Brighter Futures is not clear from DoCS' various policies and procedures. Families do not appear to be excluded on the basis of the *number* of Helpline reports made, rather that seems to relate to their *type and severity*; which, it must be said, makes sense.
- 7.209 Even allowing for the exercise of discretion by caseworkers when examining a child's history, there would appear to be an inconsistent application of the DoCS' policies by caseworkers. A number of Lead Agencies also raised this concern. From its case file audit, the Inquiry identified the case set out below.

Case Study 2

A was born on 10 April 2007. A's mother, B, who was 17 years old at the time, had an extensive child protection history with DoCS. Over 50 reports had been received on B concerning domestic violence, non-attendance at school, running away, drug abuse of carers and sexual assault.

When B became pregnant DoCS received eight prenatal reports. When A was born reports continued to be made regarding both A and B, primarily regarding domestic violence.

Reports were streamed to the Early Intervention program on 17 April 2007 and 1 May 2007. In response to a further report on 13 May 2007, the Helpline noted that "14 reports for a 12 month old child is extensive. This and the previous reports indicate that A is at serious risk of harm/abuse." The Helpline recorded its disagreement with the practice at the CSC: "The records for A advise that this matter is allocated to Early Intervention. This report and the history advise that this matter in accordance with Departmental Early Intervention Policies does not meet the considerations for allocation to Early Intervention. This matter should be given allocation to full child protection intervention."

The CSC however, streamed the report to Early Intervention.⁵⁰⁸

B commenced participating in the program on 15 May 2007. A further report received was streamed to Early Intervention on 7 August 2007. B withdrew from the program on 3 December 2007 and the Early Intervention file was closed.

⁵⁰⁸ DoCS advised that the CSC can override the Helpline rating in accordance with the *Brighter Futures Caseworker Manual*.

A further report was received on 29 December 2007 regarding another incident of domestic violence but there is no documentation on file regarding further action.⁵⁰⁹

- 7.210 Reviews undertaken by DoCS also identified inconsistency in early intervention casework practice in a number of areas including the development of case plans, documentation, the completion of the required assessments within defined timeframes, the use of s.248 of the Care Act and the success with engaging families to participate in the program.⁵¹⁰ This is illustrated by the following case.

Case Study 3

The file showed that DoCS had assumed care of an 11 month old girl, T, and placed her back in the care of her mother with Parental Responsibility to the Minister. Interaction between the mother and an older child “raised ongoing concern about mother’s parenting capacity, which is currently being addressed through caseplan.”

T was placed in the care of her father by the following year, and lived with him, his wife, and his wife’s two children, with access to her mother weekly. After having T in their care for about two years, T’s father and stepmother began to raise concerns about her sexualised behaviour, the possibility she was at risk of sexual harm while with her mother, and requested assistance in dealing appropriately with T’s behaviour from DoCS and other service providers who made reports.

The file also holds reports expressing concern about the parenting T was receiving from her stepmother and the stepmother’s parenting of her own children. After a report about conflict and violence between T’s father and step mother, the case was referred to Brighter Futures.

The file notes that the “natural father appears to have shown an increased interest in T. Natural mother failure to act as she had suggested she could indicate a concern, although it is predictable given her history of failure to engage unless compelled to.”

This appears to indicate that the parents being assessed are T’s natural parents, who do not live together. The family is referred to child protection with the notation that, “Given that the subject children and parents are known to the department it would appear that Brighter Futures would not be an appropriate program to offer this family. They already have child care in place and natural mother has been offered parenting program type

⁵⁰⁹ DoCS advised that the report of 29 December 2007 was an information only stage one report. The case was closed at the CSC on 14 January 2008 after B declined a transfer to another CSC.

⁵¹⁰ DoCS, Early Intervention Program steering committee, *Operational Consistency Review* August 2007.

assistance and home visiting in the past and will only engage if she feels she has to. Therefore as natural mother is primary carer and known to the local office as unlikely to be willing to engage in the services the program has to offer Early Intervention is not considered appropriate.”

There is no mention of a stepmother or step children, or of the domestic violence incident in the report just prior to referral of the family to Brighter Futures. The names of T and her two step siblings appear, but the case plan number is not the one which appears on the recent report concerning the three children, or anywhere on T's Personal History. It is not clear which parent(s) are being assessed in relation to which children. There is also no mention of services offered by Brighter Futures other than preschool and parenting support.

- 7.211 DoCS states that the lack of consistency is partly attributable to the limited length of the time that the teams have been operating, Lead Agency capabilities and client demographics.
- 7.212 The Inquiry notes that DoCS is monitoring implementation within the CSCs and has put in place a range of training and other strategies to address these inconsistencies. The Inquiry is of the view that there needs to be much greater clarity about the assessment process DoCS uses to rule families in or out of the program based on previous child protection history.

Needs too high for Brighter Futures but too low for child protection

- 7.213 Brighter Futures was initially developed to provide a service for those families who were reported and assessed as low risk, or as not requiring urgent attention, but who had factors present which, if left unaddressed, could escalate to the point where statutory intervention might be required. The experience of Lead Agencies, as described to the Inquiry, is that referrals to them under the Brighter Futures program are of children at a higher level of risk and in need of more urgent attention, than was originally envisaged. Their concern is twofold. First, other children and families in need of early intervention services in order to avoid entry into care are missing out because their risk level is too low. Alternately, their child protection history precludes referral into the program but does not reach the level of risk where child protection interventions are made. Secondly, Lead Agencies are effectively being required to carry out child protection work, which should have been reserved for DoCS staff.
- 7.214 Further, that if sufficient child protection concerns emerge for children while in the Brighter Futures program, they are either removed from the services which are offered under the program and, short of being removed from their families, then receive little attention from the Child Protection Caseworkers.
- 7.215 The Inquiry shares the concern that while Brighter Futures is meeting a previously unmet need, some children remain unprotected. The Inquiry also

shares the concerns of the Ombudsman that while there are procedures in DoCS to refer cases back to the Child Protection team, there is no requirement for these cases to be allocated for further secondary assessment by that team.⁵¹¹

- 7.216 The Inquiry is of the view that a different pathways model may provide some assistance to these children, which together with the changes recommended in Chapter 10, should result in more of these children being assessed and assisted.
- 7.217 In contrast to the comments of some NGOs, other agencies stated that they had considerable experience working with high risk families. Nevertheless, as the needs of families reported to DoCS become increasingly complex, NGOs should be assisted by DoCS to develop greater capacity to help prevent these families from becoming involved in the child protection arm of DoCS. This might require the provision of specialised training and possibly short term secondments of experienced DoCS caseworkers to the larger NGOs that could manage the more challenging cases.
- 7.218 DoCS' policies state that if a reported risk of harm to a child in the program is serious enough to warrant a child protection response, the family should continue to receive services after being transferred to Child Protection teams. However, it appears that this does not always occur.
- 7.219 The Inquiry understands that DoCS is conscious of each of these matters and has recently completed an expression of interest process for more intensive services, namely 'family preservation services,' to address some of the current gaps.
- 7.220 The Inquiry supports the view raised by many agencies, including DoCS that there are only limited family preservation and similar models currently in place in NSW to cater for the needs of this group of children and families, and that this deficiency should be addressed. In addition there is a need to ensure that there are ongoing services for some of these families after the intensive delivery of these services. Recommendations are made about these and related matters in Chapter 10.
- 7.221 DoCS informed the Inquiry that recurrent funding should be made available to enhance lower intensity family support services to meet the needs of more than 10,000 families assessed each year as requiring prevention and early intervention services, including an expansion of the current Community Services Grants Program (CSGP) and other early intervention services, such as those offered under the Brighter Futures program. The Inquiry accepts that this would be desirable, although it is critical of the current funding structure, as detailed in Chapter 25. Chapter 10 contains recommendations in relation to this aspect.

⁵¹¹ NSW Ombudsman, *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths*, December 2007, p.48.

DoCS role as a provider and gatekeeper to the Brighter Futures program

- 7.222 The NGOs have consistently submitted to the Inquiry that the Brighter Futures Program should be undertaken by NGOs and that DoCS should limit itself to funding, monitoring and evaluating the delivery of these services by NGOs. Highlighted in many, if not all NGO submissions, was the assertion that DoCS' role in direct service provision of the program creates fear in clients, makes them reluctant to engage, and represents a conflict of interest between the focus of Brighter Futures and the focus of child protection work. If the fear of becoming 'known to DoCS' because of its role in delivering an early intervention program is the reason for families declining the opportunity of participation, then this could amount to a serious and potentially insurmountable barrier to its success.
- 7.223 DoCS, on the other hand, states that it would be preferable to maintain a mixed government and non-government delivery of these services, particularly when there is a higher level of child protection risk, and to develop an integrated approach across both sectors. This was supported by Professor Katz who stated:

I profoundly disagree with a lot of my colleagues, unfortunately, about the question of whether DoCS should be involved. I feel very strongly that the idea that DoCS should not be involved in Brighter Futures is based on a misconception and an idea that child protection operates on Venus and family support or early intervention operates on Mars, and the two are completely different activities. I disagree with that. I think it is based on the view that child abusers are evil people who beat their children and, therefore, children should be removed, and that early intervention is so-called strengths based, et cetera... From my point of view, both those types of families, going to what Professor Vimpani said, you need trust to work with them both within the child protection system and in the early intervention system. So the relationship between the family and the service provider is crucial.⁵¹²

- 7.224 As noted in Chapter 3, DoCS informed the Inquiry that it undertook an exercise to examine data and to obtain information about caseloads in Brighter Futures. Findings from this exercise showed the following.
- 7.225 First, a number of Early Intervention teams, similar to other teams, reported very fluid staffing arrangements as a result of higher duties, staff absences, and transfers between teams. Some managers expressed a reluctance to backfill

⁵¹² Transcript: Public Forum, Early Intervention, 16 May 2008, pp.17-18.

Early Intervention Caseworkers when staff were absent for periods of time given the longer term nature of the program.

- 7.226 Secondly, while most DoCS Early Intervention teams reported positive working relationships with Lead Agencies, some teams stated that there was frequent turnover of staff in the Lead Agency, lack of communication, problems with the DoCS Connect system, misunderstanding of case management and casework methods, and Lead Agencies distancing themselves from DoCS and Brighter Futures.
- 7.227 Thirdly, some DoCS managers reported that they did not have confidence in the case management abilities of the Lead Agency staff and were therefore reluctant to transfer the more complex cases to the Lead Agency.
- 7.228 The Inquiry is of the view that effective early intervention with families requires a relationship of trust between providers and parents. The fear of child protection involvement can act as a major barrier to parents accessing the specialist services that they need, such as drug treatment and domestic violence services. Further, many families may not engage with DoCS as they fear their children could be taken away. Improving access to such services without involving DoCS is important.
- 7.229 However, families cannot neatly be categorised and their needs are not static. The continuum of care and support services discussed earlier in this chapter, does not only operate lineally and in one direction. Families can be coping, then a catastrophic event might occur which places the child or children at risk. For this reason, DoCS child protection workers will always need to be available to work with families receiving Brighter Futures services, and in some cases to work in conjunction with an NGO.
- 7.230 There are obvious tensions that have arisen in operating a parallel system with both Lead Agencies (and their partners) and DoCS caseworkers providing the Brighter Futures program. Different operating environments only serve to exacerbate these inevitable tensions.
- 7.231 The issue for the Inquiry is what arrangement is likely to lead to better outcomes for the children and families participating in this program.
- 7.232 In practice, the DoCS Early Intervention program operates within a CSC environment which will inevitably prioritise urgent child protection reports and staffing resources to meet these needs, despite best efforts by DoCS.
- 7.233 Research and information examined by the Inquiry highlights tensions in delivering a voluntary program in the same environment that also works with involuntary clients. For many families, engaging with DoCS will be viewed with suspicion and may not assist families in feeling safe to disclose the problems they are experiencing.

- 7.234 The Brighter Futures program aims to build a greater capacity to integrate services for children and families in the program as well as linking them in with other local services. Two key services within the Brighter Futures program, child care and parenting groups, are not provided directly by DoCS to the families it manages. These services are provided by Lead Agencies for DoCS families. As such this may lead to less well integrated services.
- 7.235 Many lead agencies contracted to provide the Brighter Futures program also provide a range of other services that potentially families could access once their needs have lessened. Thus it would be possible to maximise gains made through the program by establishing links to other services. This would assist in developing more integrated services for children and families at the local level.
- 7.236 It is preferable, in the Inquiry's opinion, that much of the early intervention work be carried out by the non-government sector. There will necessarily have to be a somewhat gradual transition from DoCS to NGOs, which would require, among other things, NGOs to build increased capacity and expertise to meet the needs of a diverse range of families. This will be addressed further in Chapter 10.
- 7.237 In addition to the role of delivering early intervention services, most submissions from Lead Agencies raised concerns about the DoCS gate keeping process in that families have to be reported or assessed by DoCS as eligible prior to accessing the Brighter Futures program. This, they stated, creates a great deal of red tape and in their experience, most families do not like their details given to DoCS.
- 7.238 DoCS argued that the gate keeping process was required as:

One of the key issues for us is if that is a high-risk child already receiving services from either our child protection program or is in out-of-home care, one of the things we need to do, when we check our KIDS system, is make sure that they are not in any of those programs.⁵¹³

The 80/20 split

- 7.239 As noted earlier in this chapter, 80 per cent of referrals to the program come via a referral/report to the Helpline, whilst 20 per cent come via a referral from a family or service provider to the Lead Agency without a report to the Helpline.
- 7.240 Many submissions from Lead Agencies stated that the current 80 per cent of Helpline referrals should be reduced to encompass a greater community pathway referral capacity. The Benevolent Society advised the Inquiry:

⁵¹³ *ibid.*, p.25.

*We do want this [Brighter Futures] to go to the families who most need it and who have critical vulnerabilities, but I think you can do that by a referral system.*⁵¹⁴

- 7.241 Research on engagement of families supports the assertion of the Lead Agencies, and indicates that to increase uptake of services, agencies should recruit families through the community rather than through statutory agencies. Many NGOs stated that families are more likely to engage well with the program if they have entered via the community pathway.
- 7.242 They argued that DoCS has inadvertently created a situation where once the Lead Agency has met its percentage of community pathway referrals, families who are eligible for the program but who have not been the subject of a report are effectively forced to wait months for a vacancy or, potentially, until their situation escalates into a report to DoCS before they have a chance of entry to the program. By the time that arises their problems may even have escalated to a point where they are only suitable for a statutory intervention, with the result that an opportunity for a timely intervention will have been lost.
- 7.243 DoCS argued that the current referral, screening and service delivery arrangements should be maintained. The program is in its infancy and there is no objective evidence at this time that the program or its policy settings are failing or unable to meet the objective set by government.
- 7.244 In contrast to the submissions by Lead Agencies, DoCS stated that some of the DoCS Early Intervention teams were reporting that their Lead Agency had advised them that they were not able to accept further transfers for case management, as they were experiencing recruitment difficulties and staff turnover.
- 7.245 As the data set out earlier in this chapter reveals, no region has yet reached its capacity for families referred through the community pathway or the Helpline. As at June 2008 there was a 35 per cent vacancy rate for families referred through the community pathway and a 51 per cent vacancy rate for families referred by the Helpline.
- 7.246 These data tend not to support the concerns expressed by the Lead Agencies, although, no doubt, in some CSCs, the trends differ.
- 7.247 In addition, these data and the preliminary evaluation, suggest that there has been no wholesale refusal to engage with DoCS.
- 7.248 One file examined by the Inquiry suggests that it is not the case that all NGOs always work effectively.

⁵¹⁴ *ibid.*, p.10.

Case Study 4

The first report on A's brothers (A unborn) was received at the Helpline on 27 April 2006 and entered onto the KiDS system on 10 May 2006. A's brothers were two years old and six months old at the time. A's mother was two months pregnant with A.

The report concerned domestic violence and was referred to Early Intervention on 12 May 2006. DoCS did an initial home visit on 9 June 2006 to facilitate the mother's participation in the Early Intervention program and the mother agreed. A referral was made to the Early Intervention Lead Agency on 15 June 2006.

The worker from the Lead Agency rang DoCS on 11 July 2006 stating that she had been unable to make contact with the mother and 'could not attend the family home unannounced' so the case would be closed. The DoCS caseworker asked the agency to keep the case open and indicated she would re-contact the mother.

The DoCS caseworker conducted another home visit on 25 July 2006 and the mother once again agreed to participate. This was passed on to the Lead Agency but they were again unable to make contact. The DoCS caseworker suggested a joint home visit.

The joint home visit was arranged for 31 August 2006 at which time the Lead Agency 'informed the caseworker that she has tried to contact (the mother) a few times on her mobile and has been unsuccessful. (She) advised that due to this she will not be able to attend the home visit.' The DoCS caseworker went ahead with the visit and rang the Lead Agency during the visit with the mother to make an appointment. An appointment was made for 5 September 2006.

On 5 September 2006 the DoCS caseworker transported the mother and her children to and from the appointment, which was held at the premises of the Lead Agency.

The Lead Agency's policy on 'unannounced' home visits meant that the DoCS caseworker needed to stay involved with the family for nearly three months after the referral had been made.

- 7.249 The Inquiry is of the view that the current referral and screening process should remain while the program is bedded down. Given the relative infancy of this program and the associated rigorous evaluation framework in place, the current gate keeping, eligibility criteria and quota should remain until evidence is provided which supports change. Once the NGO capacity is fully established and found to be delivering effective early intervention, the eligibility criteria and quota restrictions can be reviewed, and if necessary revised.

Brighter Futures – concluding observations

- 7.250 The Brighter Futures program has been well conceived and is based on the available research. It is too early to recommend changes to essential elements of its design including the referral pathways, the quotas and the determination of eligibility.
- 7.251 However, the Inquiry is concerned that DoCS has been too slow in referring families to Brighter Futures, that DoCS' policies are not clear as to what child protection history disentitles a family from the program and that DoCS' process is somewhat duplicative with the Helpline and CSC caseworkers considering eligibility.
- 7.252 The Inquiry is of the view that DoCS should take steps now to remedy these deficiencies by way of preparing guidelines.
- 7.253 Chapter 10 suggests a way forward whereby the Helpline would assume responsibility for determining eligibility and referring families to Lead Agencies.
- 7.254 DoCS should also gradually reduce its case management of families in the Brighter Future program and allow that responsibility to be transferred to the Lead Agencies.

Children aged 9-14 years not eligible for Brighter Futures

- 7.255 Currently there is no integrated, evidenced based statewide targeted early intervention program for this age group. The Inquiry understands that investment in the middle childhood years still gives considerable individual and economic returns, and that there are relatively high rates of reports for children in this age group, especially of Aboriginal children. Diversion from the juvenile justice system, educational attainment and delay of early commencement of child bearing / rearing would be objectives of this program.
- 7.256 One submission identified the need for early intervention services with a strong education focus which increases the family's understanding of the school culture in which the child or young person is involved.
- 7.257 As noted elsewhere in this report school based support is an excellent site for universal prevention and early intervention services. Targeted service provision through school counsellors and through support for children and young persons with intensive needs are important programs that need to be resourced and utilised.
- 7.258 DoCS has recommended the establishment of a targeted early intervention program with recurrent funding for vulnerable families with children aged 9-14 years, with priority of access to services for Aboriginal children and their families. The Inquiry agrees but notes that currently any such extension of Brighter Futures to this age group lacks funding. Evidence about what works from research, the literature and similar effective programs in other jurisdictions

should determine program settings. Chapter 10 contains relevant recommendations.

Responsibility for ‘whole of government’ early intervention and prevention

7.259 The Inquiry is aware of concerns about the transfer of responsibility for Families NSW from The Cabinet Office to DoCS in 2004. Professor Vimpani noted that:

*prior to it occurring, concerns were expressed about the capacity of a line agency to also act as an umpire, concerns that have been borne out by the less participatory style of decision making that has been evident in the governance of Families NSW since this occurred.*⁵¹⁵

7.260 In particular, Professor Vimpani believes there has been a lack of consultation with Health regarding the programs being implemented under the Families NSW strategy.

7.261 The Benevolent Society’s view is in line with that of Professor Vimpani, noting that Families NSW showed great promise in coordinating the delivery of services, but lost its momentum when it was transferred to DoCS. It recommended transferring the coordination of initiatives such as Families NSW back to Premier and Cabinet.

7.262 UnitingCare Burnside contended that DoCS is not in practice a ‘community services’ department and as a result, programs such as Families NSW, Better Futures and the Children’s Services Program “struggle to find a place with their universal prevention and/or early intervention focus.”⁵¹⁶

7.263 Health stated that Families NSW “provides the framework and mechanisms for Health and other human services to facilitate coordinated integrated services.”⁵¹⁷ This view is not shared by everyone working in the health sector. The Inquiry has been advised by senior health professionals that it is increasingly difficult for staff in human service agencies such as Health to see themselves as equal partners in Families NSW; it is a whole of government strategy in name only.

7.264 Concerns have also been expressed that the scope of Families NSW has narrowed over time. Professor Vimpani commented that the strategy was:

supposed to be a suite of early intervention services, universal through to targeted. What seems to have progressively happened is that the targeted services have been hived off and

⁵¹⁵ Submission: Professor Graham Vimpani, p.7.

⁵¹⁶ Submission: UnitingCare Burnside, Early Intervention, p.5

⁵¹⁷ Submission: NSW Health, p.11.

*become part of Brighter Futures, so there is now not an integrated set of early intervention strategies.*⁵¹⁸

- 7.265 UnitingCare Burnside stated that whilst there are a range of programs and services in place, there is not a strong prevention and early intervention framework.

*It is essential to move beyond the current view that NSW is doing well at prevention and early intervention because it has established Brighter Futures and before that Families NSW (formerly Families First). Both programs are valuable though Families NSW has never been fully implemented – it has a nurse home visiting component but this essential aspect of Families NSW is not widespread, and the Level Three services (for more vulnerable families) were never developed. The existing programs are necessary components of the range of services needed in NSW for a comprehensive and effective prevention and early intervention service system but without place based co-ordination and access to resources, we will continue to have people falling through the gaps, either because they do not receive basic assistance or because their needs escalate and will require more intensive intervention.*⁵¹⁹

- 7.266 NSW Family Services Inc. has reported that at a local level, the establishment of Families NSW has had a positive impact on relationships between service providers. Involvement in the strategy has meant attending more meetings, which, rather than being a negative consequence:

*has been a brilliant thing... because the people at local levels across all those very complex funding streams and programs and criteria and administrative arrangements know each other and they get to be able to identify the gaps.*⁵²⁰

- 7.267 Health noted that a key concern has been the current division of responsibility for parenting support services between NSW Health and DoCS. While not recommending where they should sit, NSW Health stated that “as a minimum these services need to be integrated or ideally provided by one agency.”⁵²¹

- 7.268 In the seven regional strategic overviews completed by DoCS prior to the Brighter Futures Expression of Interest process, all regions identified the need for Brighter Futures to be integrated into the existing service system and not run as a parallel service system.

⁵¹⁸ Transcript: Public Forum, Early Intervention, 16 May 2008, p.14.

⁵¹⁹ Submission: UnitingCare Burnside, Early Intervention, p.8.

⁵²⁰ Transcript: Public Forum, Early Intervention, 16 May 2008, p.28.

⁵²¹ Submission: NSW Health, p.39.

- 7.269 A related issue was whether NSW Health should take primary responsibility for the delivery of early intervention services. Dr Matthews told the Inquiry:

I don't think this is something that Health should take over. I think that Health has a central and pivotal role, but I see the role of DoCS, of the NGOs, of alternative maternal care, however supplied, and I think there is a range of ways in which that can be done, but one thing is for certain, it needs to be high quality, we need to develop a team approach, but our most critical impact can be if we work together to get in early on those that we predict, rather than waiting for those where a problem has occurred.⁵²²

- 7.270 Professor Katz advised the Inquiry that while Health services were important as a point of contact and coordination in the early years, in middle childhood and adolescence other agencies would be more appropriate to lead the whole of government response.

Obviously, if early intervention were going to straddle a wider range of ages, it would not necessarily be appropriate for Health to deal with the eight to twelve or eight to fifteen age group and there, Education would probably be the most logical home for funding or coordination. So whatever you do, there would be breaks and the way to deal with those cracks breaks between different sectors is to have, as I said, multi-agency planning at all stages. I think this was the original concept of Families NSW.⁵²³

- 7.271 The problems facing families are often multi-faceted. While there are a range of strategies and programs in place within NSW, the Inquiry is of the view that there are significant gaps and fragmentation in the coverage of the services, including where they are located and their purpose. The Inquiry is of the view that attention needs to be given to identifying the outcomes for the varying level of needs of children and their families and developing one integrated prevention and early intervention framework. The Families NSW framework as originally intended appears to be a way forward. It uses population level indicators to measure the effectiveness of its services as outlined earlier. Chapter 10 advances the way forward proposed by the Inquiry to develop an integrated service model, an outcome that is consistent with its general support for enhanced interagency cooperation.

- 7.272 The Inquiry is not minded to recommend that the Communities Division, the umbrella for Families NSW and other whole of government functions, be re-located more centrally in Premier and Cabinet or otherwise in Health. The Inquiry makes recommendations for significant funding reform in Chapter 25

⁵²² Transcript: Public Forum, Early Intervention, 16 May 2008, p.13.

⁵²³ *ibid.*, p.18.

and is of the view that the Communities Division programs and functions would benefit from this reform and subsequently would be well placed in DoCS.

Proposed school attendance measures

7.273 Premier and Cabinet has advised the Inquiry that the preparation of a Bill to amend the *Education Act 1990* to strengthen compulsory attendance at school has begun.

7.274 If enacted, the legislation would give courts the power to make school attendance orders to require parents to take positive action to ensure school attendance, that could include requirements to attend mediation or counselling. Stronger options for prosecuting a parent in the Local Court are understood to be under consideration including the imposition of increased fines, imprisonment and alternative sentencing options to imprisonment. Education estimates that approximately 250 parents could be prosecuted in the first year under the proposed amending legislation. This is an increase on the average prosecution rates under the current legislative framework of between 60 to 100 per year.

7.275 Education states that imprisonment would only apply in extreme cases for repeat offenders: "in such extreme cases, it may be that the parent's presence in the child's home is the very thing preventing the child from attending school."⁵²⁴

7.276 The Ombudsman has been critical of Education in the past for failing to take decisive action regarding habitual non-attendance of children at school. The Ombudsman raised concerns about the high rates of non-attendance by Aboriginal children in particular locations. He stated:

*The issue is of particular significance to young people because they are not only being deprived of a fundamental right relating to their development but they also lose the social support network and structure that the school community can provide.*⁵²⁵

7.277 The Inquiry shares concerns that frequent and habitual non-attendance at school jeopardises future development and for that reason it has recommended that this should be a risk factor for reporting, as noted earlier. Imprisoning the offending parent or parents may, however, result in increased child protection concerns without addressing the underlying issues. More appropriate options might include the imposition of bonds subject to conditions requiring counselling or participation in parenting courses, the breach of which could attract more serious sanctions.

⁵²⁴ Correspondence: Department of Premier and Cabinet, 22 May 2008; Correspondence: Department of Education and Training, 2 April 2008.

⁵²⁵ Submission: NSW Ombudsman, Young People at Risk, p.13.

- 7.278 The Inquiry, however, recognises that wilful or persistent refusal to send children to school should attract sanctions such as imprisonment.
- 7.279 The Inquiry also cautions that the imposition of increased fines can be counter productive for the reasons identified by the NSW Sentencing Council in its Report, *The Effectiveness of Fines as a Sentencing Option: Court Imposed Fines and Penalty Notices*. By reason of the fact that many people in this group will have reduced economic circumstances the burden of a fine and the sanctions for non-compliance may serve to increase the family's stress and lead to further disengagement. Effective intervention to bring the children back to school and to deal with the underlying problems that are causing truancy or non-attendance, would involve a more positive approach.

Enhanced role for school counsellors

- 7.280 The Federation of Parents and Citizens Association called for additional school counsellors in schools because they "open more windows of opportunity to address problems before the child is in immediate danger."⁵²⁶ The NSW Secondary Principals' Council also called for additional school counsellors.
- 7.281 The situation at Bourke High School provides an example of how school counsellors are thinly spread across the State. The Inquiry has been advised that the school has the services of a school counsellor one day a week. The same counsellor services Bourke Public School and the schools in Cobar, Nyngan and Brewarrina.
- 7.282 UnitingCare Burnside also called for additional school counsellors, and recommended:

*That the NSW Government increase access to school counsellors for children and young people in the middle years by reducing the student to counsellor ratio significantly, particularly in disadvantaged areas.*⁵²⁷

- 7.283 Education, on the other hand, does not see the need to expand the role of school counsellors and views such a move as being likely to cause a duplication of services provided by other human service agencies. The Inquiry is unable to determine what these other services might be, given their overall shortage, and in any event sees no reason why any possible duplication cannot be addressed on the ground, by reserving counselling for those families who are not otherwise receiving relevant support.
- 7.284 The Inquiry agrees that the Government needs to fund additional school counsellor positions, and sees potential in an enhanced role for school

⁵²⁶ Submission: Federation of Parents and Citizens' Association of New South Wales, p.8.

⁵²⁷ Submission: UnitingCare Burnside, Early Intervention 9-14 years, p.5.

counsellors in supporting the child protection system, including undertaking regular home visits in the case of students who are known to be experiencing difficulties at home, or who are not attending school on a regular basis.

Availability of and criteria for social housing

7.285 From advice received by the Inquiry, it would appear that while there is a shortage of public housing in some parts of the State, there is capacity in other areas. The two main reasons for there being capacity in some areas appears to be due to the fact that some locations, particularly those within housing estates are not popular or to the fact that the quality of the available housing stock is poor. For instance, the Inquiry was informed by Housing staff that the public housing estate in East Nowra was not popular. It is in a socially disadvantaged area with a high Aboriginal population and it has: “very poor stock, yes, ageing 30 year old, you know, flat fibros.”⁵²⁸

7.286 The Inquiry has been further advised that:

*in the far south coast, in Eden in particular where Aboriginal clients are not presenting now because they don't want to live in our stigmatised estates, in our 40 or 50 year old houses, even though you suspect there's an underlying demand.*⁵²⁹

7.287 The Inquiry also heard of areas where there is a lack of public housing stock that is suitable for the requirements of those who need it. A Housing officer in Wagga Wagga noted “our major needs are for two bedroom accommodation whereas 65 per cent of our stock is three and four bedroom. We have an oversupply.”⁵³⁰ If this is the case, then it would seem that consideration could be given to a sale of excess stock and to the purchase of more needed housing.

7.288 The Housing criteria for priority housing includes assessing whether there is affordable and available “private rental accommodation that matches your basic housing requirements in your preferred area as well as other suitable areas.”⁵³¹ Concerns have been raised with the Inquiry as to the proof required. UnitingCare Burnside cited a recent case where a young mother with four young children who was moving between motel rooms and refuges was told she needed proof that she had unsuccessfully applied for private rental ten times before she would be considered eligible for priority housing.

7.289 When the Inquiry raised the circumstances of this particular case at a number of interagency meetings, the responses from Housing staff were equivocal. During these meetings, the Inquiry was not able to elicit a clear response from

⁵²⁸ Transcript: Interagency meeting, Nowra, 12 May 2008, Manager, Housing NSW, p.33.

⁵²⁹ *ibid.*, Area Director, Housing NSW.

⁵³⁰ Transcript: Interagency, Wagga Wagga, 11 March 2008, p.14.

⁵³¹ Housing NSW, *Priority Housing Fact Sheet*, December 2006, p.2.

Housing staff about the specific eligibility criteria that must be met when a person applies for priority housing. The most specific advice given was:

*We have policy guidelines around things like that. If clients have family or they have other capacity of their own, as I said, we would look at every other aspect of the case like that.*⁵³²

- 7.290 Affordable, accessible and liveable housing is essential for families, particularly women and children escaping violence. Its provision is a necessary component of a universal response to supporting families and in ensuring child safety.

Local government service provision

- 7.291 While many submissions to the Inquiry highlighted the need for local organisations to identify and meet local needs, there was no specific reference to the role of local councils.
- 7.292 The Inquiry recognises that councils play an important role in community capacity building and support through the provision of facilities such as community halls, community centres, neighbourhood centres, libraries, swimming pools and sports playing fields. The Inquiry is particularly mindful of the role many councils play in supporting the child protection system in locations where there is limited existing infrastructure. For example, the Central Darling Shire Council received DoCS funding in 2007/08 for the Wilcannia Women's Safe House. If Central Darling Shire Council did not provide this emergency accommodation, the nearest alternative safe house for women and children in Wilcannia escaping domestic violence would be 200 kilometres away in Broken Hill.
- 7.293 While Central Darling Shire Council would appear to have stepped in to fill a service gap, it is not a common action taken by councils in the west, central west and north west of the State. The majority of these councils did not receive funding from DoCS in 2007/08 for the provision of community services. Nevertheless, the Inquiry sees the potential for these councils to take on an expanded role in community service provision, particularly in locations where NGOs do not have the capacity to provide services.

Conclusion

- 7.294 The principles which the Inquiry believes should underpin the provision of universal, secondary and tertiary services to children, young persons and their families to reduce the likelihood of, ultimately their entry into OOHC are developed in Chapter 10, along with recommendations relevant to this chapter.

⁵³² Transcript: Interagency, Newcastle, 31 March 2008, Area Director, Housing NSW, p.38.

- 7.295 The outcomes for the varying level of needs of children and their families must be identified and an integrated prevention and early intervention framework developed. In short, the government and non-government sector should deliver an integrated, coordinated suite of services to these families.

Recommendations

Recommendation 7.1

DoCS should revise its Brighter Futures Guidelines to clarify the account to be taken of child protection history in determining eligibility.

8 Assessment and response

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NSW Assessment Framework

Introduction

- 8.1 The Care Act identifies DoCS as the agency responsible for the assessment of reports concerning a child or young person who is suspected of being at risk of harm.
- 8.2 There are different points in the assessment pathway for determining which children or young persons require a statutory service from DoCS. The test at the Helpline is whether the child or young person may be at risk of harm, and the decision about referral to a CSC or a JIRT centres on whether the child or young person may be in need of care and protection. The secondary assessment process undertaken by CSCs and JIRTs tests that hypothesis. 'Risk of harm' and 'in need of care and protection' are related but separate concepts that are explored at different points in the DoCS assessment process.
- 8.3 Section 24 of the Care Act allows for a report to be made to the Director-General when there are reasonable grounds to suspect that a child or young person is at risk of harm. Section 27 of the Care Act requires a report from certain people where they have current concerns about the safety, welfare or well-being of the child, and have reasonable grounds to suspect the child is at risk of harm. Under s.30 of the Care Act, on receipt of such a report, the Director-General is to make such investigations and assessment, as the Director-General considers necessary, to determine whether the child or young person is at risk of harm or may no take further action if, on the basis of the information provided, he or she considers that there is insufficient reason to believe that the child or young person is at risk of harm.
- 8.4 Then, in relation to taking action, s.34(1) of the Care Act, states that if the Director-General forms the opinion, on reasonable grounds, that a child or young person is in need of care and protection, the Director-General is to take whatever action is necessary to safeguard or promote the safety, well-being and welfare of the child or young person.
- (2) *Without limiting subsection (1), the action that the Director-General might take in response to a report includes the following:*
- (a) *providing, or arranging for the provision of, support services for the child or young person and his or her family,*
- (b) *development, in consultation with the parents (jointly or separately), of a care plan to meet the needs of the child or young person and his or her family that:*

- i. *does not involve taking the matter before the Children's Court, or*
 - ii. *may be registered with the Children's Court, or*
 - iii. *is the basis for consent orders made by the Children's Court,*
- (b1) *development, in consultation with one or more primary care-givers for a child or young person, of a parent responsibility contract instead of taking a matter concerning the child's or young person's need for care and protection before the Children's Court (except in the event of a breach of the contract),*
- (c) *ensuring the protection of the child or young person by exercising the Director-General's emergency protection powers as referred to in Part 1 of Chapter 5,*
- (d) *seeking appropriate orders from the Children's Court.*

8.5 Section 35 of the Care Act states that:

- (1) *The Director-General may decide to take no action if the Director-General considers that proper arrangements exist for the care and protection of the child or young person and the circumstances that led to the report have been or are being adequately dealt with.*
- (2) *If the Director-General decides to take no action, the Director-General must make a record of the reasons for the decision.*

8.6 Section 36 of the Care Act outlines the following principles that should guide intervention:

- (1) *In deciding the appropriate response to a report concerning a child or young person, the Director-General must have regard to the following principles:*
 - (a) *The immediate safety, welfare and well-being of the child or young person, and of other children or young persons in the usual residential setting of the child or young*

person, must be given paramount consideration.

- (b) Subject to paragraph (a), any action must be appropriate to the age of the child or young person, any disability the child, young person or his or her family members have, and the circumstances, language, religion and cultural background of the family.*
- (c) Removal of the child or young person from his or her usual care-giver may occur only where it is necessary to protect the child or young person from the risk of serious harm.*

8.7 DoCS stated that:

information on [the] care plan, [and] emergency protection and orders from the Children's Court are recorded in the Legal Record in KiDS for which certain data are not remediated. Data quality cannot be ascertained, hence information is not available for reporting.⁵³³

8.8 DoCS further stated that while there is the capacity to record support services provided by external organisations, it is often the case that details of these services are recorded in text fields in KiDS, and cannot easily be extracted. In addition, while there is a place in KiDS to record whether the client referred by DoCS was accepted by an external organisation, "it's not possible to tell whether the client actually took advantage of the services offered."⁵³⁴

8.9 Thus, little is available in the way of reliable data from DoCS as to the actions it has taken and the services offered to children, young persons and their families.

8.10 The Care Act does not prescribe the methods by which DoCS investigates or assesses a report about a child at risk of harm. DoCS, in its submission to the Inquiry identified the following principles as underpinning best practice assessment in child protection:

- a. The use of integrated/holistic information on status of the child, which is up to date (that is, aggregation of all reliable sources that will provide accurate and timely information regarding the child in their family/carer in their environment, which is revised when new/different information is available)*
- b. Assessment that is culturally relevant*

⁵³³ Correspondence: DoCS, 5 June 2008, p.6.

⁵³⁴ *ibid.*, p.5.

- c. Accurate documentation of the process (including clear logic about how conclusion is reached)*
 - d. The use of a single assessment that is available to all practitioners (that is, minimise multiple assessments and improve efficiency of system)*
 - e. Assessment that is solution-focussed, with intervention linked to assessment.*⁵³⁵

- 8.11 DoCS incorporates a consensus based Risk Assessment Framework (a modified version of the Victorian Risk Framework) in child protection, and the Structured Decision Making Family Strengths and Needs Assessment in the Brighter Futures program for the purpose of identifying required early intervention services.

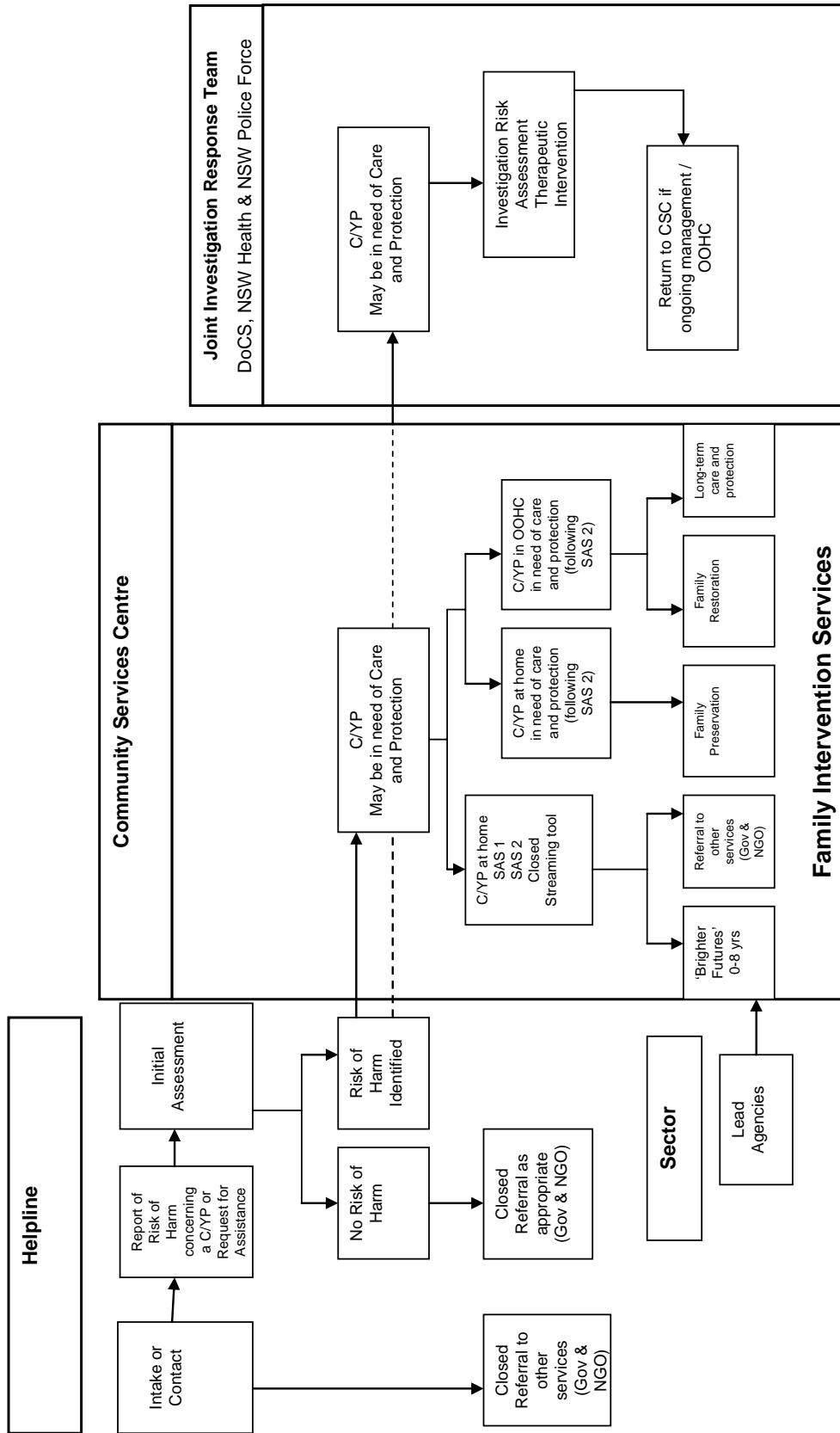
- 8.12 The current DoCS system can be classified as a guided professional judgement model which after the initial contact stage can be divided into two broad components: Initial Assessment and Secondary Assessment. These two components are each divided into two stages. Therefore five key steps make up the current risk assessment system:
 - a. Contact
 - b. Initial Assessment Stage One
 - c. Initial Assessment Stage Two
 - d. Secondary Assessment Stage One
 - e. Secondary Assessment Stage Two.

- 8.13 At each of these stages the process can be stopped and the case closed if the conclusion is reached that there is insufficient risk of harm to continue assessment. Whilst KiDS provides guiding questions for caseworkers during the initial assessments there is no formal weighting of the variables that are investigated.

- 8.14 In this chapter the Inquiry identified the current framework for assessment, and the range of casework interventions that are available. In the following chapter the issues arising and possible solutions are examined.

⁵³⁵ Submission: DoCS, Child Protection Assessment Models and Process, p.38.

Figure 8.1 Overview of Child Protection Intake, Investigation and Assessment Process



Assessment by the Helpline

- 8.15 The Contact and Initial Assessment stages occur at the DoCS Helpline. The Helpline is a 24 hour a day, seven days a week service that handles over 5,200 contacts a week including inquiries, requests for assistance, comments and complaints, and child protection reports. It also provides an after hours response service for the Sydney metropolitan area, and directs the work and exercises statutory casework delegations for the after hours response in non-metropolitan areas.
- 8.16 The Helpline was established in December 2000 in response to a recommendation of the Police Royal Commission and the recommendations of a number of prior reviews that DoCS improve its child protection intake services.⁵³⁶ The opening of the Helpline coincided with the commencement of the Care Act, which also broadened the definition for a report of a child at risk of harm. The Helpline was initially staffed with 54 caseworkers.⁵³⁷ Prior to that time, child protection concerns were directed to CSC intake teams, with no prior triage and no prior recording of the total workflow to each CSC.
- 8.17 More than 95 per cent of reports are made to the DoCS Helpline, where staff record the details of contacts and initial assessments into KiDS. The Helpline is required to answer calls in an average of three minutes. In 2007/08, calls were answered in an average of two minutes and 56 seconds, which was a slight improvement on the 2006/07 average of two minutes and 59 seconds.⁵³⁸
- 8.18 Child protection reports are recorded and assessed at the Helpline by caseworkers. The Helpline has over 250 staff working in shifts. There are 30 caseworker teams each comprising a Team Leader and six caseworkers. Six teams make up a Unit, which is led by a Manager Helpline. There are six Managers at the Helpline. They report to the Director Helpline who is accountable to the Executive Director Statewide Services for the day to day operations of the Helpline and the Domestic Violence Line. Supporting the frontline work are first, teams of Community Service Officers that handle general inquiries, secondly, subject matter experts and finally, business support staff.

Contact

- 8.19 The first point of communication between DoCS and a person or agency is documented in a contact record. At the Helpline a caseworker or a Community Service Officer gathers information from the reporter and records it on the KIDS contact record. Reasons for contact are classified as one of the following:

⁵³⁶ Performance Audit of the Helpline, *Auditor-General's Report*, June 2005, p.6.

⁵³⁷ *ibid.*, p.11.

⁵³⁸ DoCS, *Annual Report 2007/08*, p.45.

- a. report of concern for a child, young person or unborn child (risk of harm or homelessness)
 - b. request for information, advice or assistance about DoCS business (for example, adoption or fostering).
- 8.20 At this point a decision is made on whether an Initial Assessment is required. The Care Act identifies the separate situations when an Initial Assessment should be carried out:
- a. suspected risk of harm (Chapter 3, Part 2)
 - b. report of homelessness (Chapter 7, Part 2)
 - c. request for assistance from a child, young person or parent/care-giver (Chapter 3, Part 1), although this is a very small proportion of DoCS work
 - d. request for assistance by a child, young person, a parent or another person regarding serious and persistent family conflict or parental inability to adequately supervise a child or young person (Chapter 7, Part 1).
- 8.21 If the information gathered at the Contact stage does not meet any of these criteria then the matter is closed and no further action is taken.

Initial Assessment Stage One

- 8.22 This is the first stage in the gathering and analysis of information to determine if a child, young person or unborn child is at risk of harm. A plan in KiDS is created to document the information. Generally situations requiring this assessment fit into two types – requests for assistance and risk of harm.
- 8.23 The key action for a request for assistance is to determine whether it does or does not constitute a risk of harm. If it does not, information and advice is provided as required.
- 8.24 The caseworker makes an assessment of whether the child or young person is at risk of harm by taking into account age, development and vulnerability of the child or young person. Risk of harm is defined in s.23 of the Care Act. If, after assessing the information and after consultation and approval by a Helpline Team Leader, the caseworker determines that no safety concerns exist or that the child is not at risk of harm then the Initial Assessment is closed at Stage One. However if risk is identified the report proceeds to Stage Two of the Initial Assessment.

Initial Assessment Stage Two

- 8.25 This stage is undertaken without direct contact with the child, young person or family, unless the reporter is the child or young person or a family member.

- 8.26 Where there is an open case plan recorded in KiDS,⁵³⁹ the Helpline caseworker will determine if the information received constitutes a new report or whether it should be forwarded to the CSC for information only. If it is determined that the information received constitutes a new report, the Helpline will open a new plan and undertake an Initial Assessment.
- 8.27 Information retrieved from a history search undertaken by the Helpline caseworker is considered in conjunction with the reporter's concerns. This is an important step because consideration of previous reports and/or protective action taken by DoCS may change the significance of the information provided by the reporter. Information that is of particular relevance includes:
- a. previous episodes of abuse and neglect and any patterns arising from these
 - b. previous or current Children's Court orders and placements in OOHC
 - c. previous assessments or actions by DoCS
 - d. any complicating parenting issues such as domestic violence, parental misuse of drugs or alcohol or mental health concerns.
- 8.28 The Helpline caseworker is then required to undertake an analysis of the issues. Decisions are then made about the safety of the child or young person (extremely unsafe, moderately safe, safe or unknown); the degree/severity of the harm (high, medium or low); and the future risk of harm (highly likely, likely, unlikely, unknown).
- 8.29 If the Helpline assesses that a child or young person may be in need of care and protection, a case plan is generated and referred to a CSC or JIRT⁵⁴⁰ for further assessment. If it is determined the child or young person is at immediate risk of serious harm, and it is out of hours, the Helpline or the relevant regional after hours response team, will initiate an immediate field response.
- 8.30 A timeframe for a required response and an assessed level of risk is given in the plan. They are within 24 hours (commonly known as a Level 1 report), within 72 hours (commonly known as a Level 2 report) and within 10 days (commonly known as a Level 3 report).
- 8.31 In addition to the general Helpline response teams handling incoming calls from reporters, there are a number of specialised teams. There is a dedicated response team that takes calls from school/child care mandatory reporters. The Helpline is also in the process of trialling a similar specialised team for health

⁵³⁹ A 'case plan' is an accurate record of the plan that has been developed to address the needs of a child or young person that are identified through assessment. DoCS develops a case plan when the outcome of the Initial Assessment is referral to the CSC/JIRT for further assessment: DoCS, Intranet, *Case planning and casework practice*.

⁵⁴⁰ In the Metropolitan region these are co-located teams of Police and DoCS. In rural areas these services are generally not co-located although provide the same joint response.

mandatory reporters, and preliminary advice to the Inquiry suggests that this is working well.

I have information in front of me that two of the three Team Leaders and eight caseworkers have a very strong background working in the health system. They use that background to assist them when they are making assessments that come in from health professionals. We believe that we are making some improvements in that area already.⁵⁴¹

- 8.32 The then Executive Director, Helpline provided the Inquiry with the following case example:

I was informed about a call that involved a baby who was at an immunisation clinic. This was a child under 12 months. As the injection was given, the child was crying but very, very softly. Because that piece of information was heard by somebody who understood failure to thrive and some other indicators around that particular form of emotional abuse and developmental issues for that child, that information was picked up as a very high priority. The CSC intervened very quickly and got the child to the doctor. The child was assessed by that doctor as being almost life threateningly ill. I know that is one story, but I don't think that before November last year we would have been as confident that we would regularly pick up and be able to recognise those signs because we didn't have a cluster in place with the specialised expertise working on calls to the Helpline.⁵⁴²

- 8.33 CSCs generally have dedicated child protection staff whose specific role is to manage the receipt of reports from the Helpline at the point of intake. The number of staff dedicated to this function in each CSC is determined by the number of child protection casework staff in the CSC and the average annual reports sent through to the CSC.⁵⁴³

Assessment and response by CSCs

- 8.34 The primary function of caseworkers performing an intake function at the CSC is to manage the receipt of all plans from the Helpline and to prioritise matters requiring a field response. This process builds on, or clarifies, the information obtained by the Helpline during Initial Assessment and takes local knowledge into account for the purposes of analysis.

⁵⁴¹ Transcript: Public Forum, Assessment Model and Process, 18 April 2008, A Gallard, Deputy Director-General, Operations, DoCS, p.34.

⁵⁴² *ibid.*, p.35.

⁵⁴³ DoCS, *CSC Intake Discussion Paper*, Tab C, Intake at a CSC, pp.1-2.

- 8.35 As discussed earlier, DoCS uses a guided professional judgement model known as Secondary Assessment – Risk of Harm Framework that includes the collection and analysis of information and the exercise of professional judgement. The outcome is a professional opinion about safety, risk and harm that informs a decision about a child's or young person's need for care and protection and subsequent case planning. For this purpose Secondary Assessment - Risk of Harm is divided into two stages: Secondary Assessment Stage One (SAS1) and Secondary Assessment Stage Two (SAS2).

Case allocation

- 8.36 The December 2002 report of the Kibble Committee found that the allocation rate across all reports, that is the number of reports which were allocated to a caseworker at a CSC was around 30 per cent.
- 8.37 As discussed in Chapter 2, at that time, the allocation rate of reports with a required response time of less than 24 hours was 55 per cent, for reports with a required response time of less than 72 hours it was 26 per cent and for reports with a required response time of less than 10 days it was 12 per cent.⁵⁴⁴ The findings of the Kibble Committee were influential in relation to the NSW Government's decision to increase the DoCS budget and therefore substantially increase DoCS caseworker numbers.
- 8.38 DoCS has advised that, based on KiDS data, recent statewide allocation rates for child protection reports referred to CSCs/JIRTs for further assessment are as follows:

Table 8.1 **Allocation rates for child protection reports**

<i>Required response time</i>	<i>Allocation rate (%) 2006/07</i>	<i>Allocation rate (%) 2007/08</i>
Less than 24 hours	97.2	98.0
Less than 72 hours	66.3	75.5
Less than 10 days	45.9	55.9

- 8.39 At first blush it appears that, on this indicator, remarkable improvements have occurred. However, the Inquiry is of the view that these figures should be viewed with caution. DoCS defines the allocation rate as "the proportion of all reports referred to a CSC/JIRT for further assessment that had a secondary assessment (SAS1 or SAS2 recorded as completed or ongoing)." This means that DoCS allocation rates do not equate to the number of cases that receive a field response (that is, a face to face visit) or are subject to ongoing case management.

⁵⁴⁴ Information provided to Government by DoCS, March 2008.

- 8.40 If the definition of case allocation were to mean that a case received a field response, then allocation rates would have to be calculated using data on the number of reports that proceeded to a SAS2 (including those reports that were subject to an ongoing secondary assessment at the time the data was captured). If this were the case, then DoCS 2007/08 allocation rates for reports with a response time of less than 24 hours would be much lower than 98 per cent.
- 8.41 It is not clear what counting rules were used by the Kibble Committee. At the time of the Kibble Committee's deliberations, DoCS Priority One Policy was in force. While allocation was not formally defined under Priority One, the policy does refer to determining "priorities for allocation and field action response,"⁵⁴⁵ which seems to indicate that allocation involved a field response. The Kibble Committee report appears to take a similar view, distinguishing between action taken after a case is allocated and initial action taken prior to allocation. An indication that the allocation rate in 2002 may have been calculated using different counting rules from those in 2007/08 is found in the advice DoCS provided to government in 2002:
- DoCS is only able to allocate 55 per cent of Level 1 Reports to a caseworker. Of the 45 per cent unallocated, six per cent are closed under the Priority One policy...The other 39 per cent receive a minimal level of assessment and some telephone follow-up and monitoring.*⁵⁴⁶
- 8.42 This 'initial investigation or action' or 'minimal level of assessment' could refer to the Initial Assessment at the Helpline or it could refer to the office based investigation/assessment undertaken at the CSC (currently known as the SAS1). Therefore, given the lack of clarity over the definition of allocation rates in 2002, the Inquiry is of the opinion that it is of little value to compare 2002 allocation rates with 2007/08 allocation rates. It may be a case of comparing apples and oranges.
- 8.43 The Inquiry has found that there is a difference between CSC staff perception of case allocation and the way DoCS counts the allocation rate centrally. Many but not all CSC staff the Inquiry spoke with appeared to equate case allocation with a field response and therefore a SAS2.
- 8.44 The Inquiry is of the view that DoCS should adopt a more realistic approach to reporting on its allocation rates which differentiates between SAS1 and SAS2.

⁵⁴⁵ DoCS, *Priority One Policy*, February 2002, p.4.

⁵⁴⁶ Information provided to Government by DoCS, March 2008.

Secondary Assessment Stage One at the CSC

- 8.45 At a CSC an Intake team/worker undertakes a SAS1, which generally does not involve face to face contact with the child or family. The key objectives of CSC intake through a SAS1 are to:⁵⁴⁷
- a. ensure all relevant information held by DoCS about reported children and young persons and their parents/carers is reviewed – this includes the most recent approved SAS1 or SAS2 that contains an analysis of prior child protection history, recent assessments or information on file from agencies and other professionals that informs the child protection history and reference to whether or not there have been recent reports without a secondary assessment
 - b. confirm or change the initial rating of safety as assessed by the Helpline and commence the process of reviewing risk
 - c. provide the groundwork for an assessment where the resulting professional opinion provides a rationale to support decisions by DoCS to intervene in the life of a family where necessary to stop harm, reduce risk of harm and provide increased safety
 - d. assign priority for any further intervention as required including making a decision about further CSC intervention.
- 8.46 The Manager Casework⁵⁴⁸ with responsibility for intake, reviews the plans received from the Helpline, and either:
- a. refers the plan to the Early Intervention team following application of a case streaming tool to determine eligibility
 - b. refers the plan to the OOHC team (if the child or young person is in OOHC and the issue does not appear to require a child protection investigation)
 - c. refers the plan directly to the Child Protection team for a SAS2 which involves a field based assessment
 - d. closes the plan because there is information, which indicates that the reported child or young person is no longer at risk of harm, or there are other, more urgent or higher risk, 'competing priorities.'
- 8.47 Presently (as a result of different practices and inconsistency) DoCS is in the process of standardising its intake function within CSCs.⁵⁴⁹ New procedures to bring about greater consistency include the following:

⁵⁴⁷ DoCS, *CSC Intake Discussion Paper*, p.4.

⁵⁴⁸ In CSCs, caseworkers report to a Manager Casework who generally manages one of the DoCS program areas: Early Intervention, Child Protection or OOHC. Depending on the size of the CSC, there may be either a dedicated Intake Child Protection team or in the case of smaller CSCs, one of the managers will be given responsibility for Intake. Typically, this may be the Child Protection Manager or the Early Intervention Manager. DoCS, *CSC Intake Discussion Paper*, p.4.

⁵⁴⁹ DoCS, *CSC Intake Discussion Paper*, p.4.

- a. intake roles will not be rotated amongst other teams as is presently the case in some CSCs
- b. larger metropolitan/regional CSCs will have a team of intake caseworkers reporting to the Manager Casework (Intake)
- c. for smaller CSCs, the intake caseworker will be part of the Child Protection team at the CSC.

Secondary Assessment Stage Two at the CSC

- 8.48 In determining which matters proceed to a SAS2, consideration is given to the immediate safety factors and the potential harm impacts for the child or young person. Where there have been multiple previous reports about a child or young person, the DoCS policy states that potential for cumulative harm impacts for the child or young person must be also taken into account.⁵⁵⁰ Consideration must also be given to the characteristics of the child or young person such as the child's or young person's age, functioning or special needs that can increase reliance on a parent/carer, and any protective factors that may exist for the child or young person, such as a supportive school or the involvement of other services.
- 8.49 Specific factors that may signal high risk and therefore the need to proceed to a SAS2 include:⁵⁵¹
- a. inability of the primary care-giver to function due to alcohol, other drug misuse or mental illness
 - b. a history of suspicious death within the family, or injury to the child or other siblings
 - c. a report of serious injury
 - d. any history of parent/carer delay in seeking necessary medical attention or failure to meet health care needs for a child/young person in their care
 - e. current access to the child or young person by a person known to DoCS as a Person Causing Harm
 - f. previous protection action by DoCS for the subject child/young person, siblings other children/young persons in the same household
 - g. a pattern of recurring harm or risk and an escalation in the seriousness and/or frequency of reports
 - h. a history of parent/carer not providing adequate supervision relative to the age of the child or young person
 - i. the family having a transient lifestyle following contact by DoCS or another child protection agency

⁵⁵⁰ Submission: DoCS, Assessment Model and Process, p.40.

⁵⁵¹ DoCS, Intranet, *Secondary Assessment – Risk of Harm, Casework Practice*.

- j. a pattern of multiple reports of a child under five years that may suggest chronic neglect.
- 8.50 As part of a SAS2, the caseworker makes contact with and visits the reported child or young person and his or her family, conducts investigative interviews, gathers information from other sources such as schools, Police and relevant non-government services, and arranges for assessments from doctors, psychologists and other professionals, as necessary. Once the information is compiled, an assessment is made regarding the child's or young person's safety and well-being. This information is recorded on the KiDS system.
- 8.51 Following completion of the SAS2 a determination is made by DoCS as to whether the child or young person appears to be in need of care and protection. There are three possible decisions that can result from a completed secondary assessment:
- a. actual harm substantiated: where there is sufficient information to indicate on reasonable grounds that the child or young person has been harmed physically, sexually, psychologically or through neglect
 - b. risk of harm substantiated: where there is sufficient information about the likely harm consequences and harm probability to enable a judgement on reasonable grounds about the level of risk for the child or young person
 - c. unsubstantiated: where the secondary assessment has determined that there are no reasonable grounds to suspect that the child or young person had experienced actual harm or is likely to be at future risk of harm.⁵⁵²
- 8.52 Where a case is substantiated and the child or young person is found to be in need of care and protection a case plan is developed which aims to address the care and protection issues identified in the SAS2.
- 8.53 Where risk of harm or actual harm has been identified, immediate court action may be considered to ensure the safety of the child or young person. Ongoing work with the child or young person and family may be through intervention with parental agreement or through a care order in the Children's Court.⁵⁵³ Otherwise, case planning, in conjunction with the child or young person and family, commences. Case management incorporates ongoing assessment of the child's or young person's safety and well-being, coordinating service provision, monitoring, reviewing outcomes and case closure when a child's or young person's ongoing safety is secured.
- 8.54 DoCS has a statewide review of secondary assessment practice underway to identify supports that need to be put in place to improve practice, such as whether any streamlining of the secondary assessment framework is required.

⁵⁵² The analysis of likelihood of harm is focused on the adults in the life of the child or young person. *NSW Interagency Guidelines for Child Protection Intervention*, 2006, Chapter 3, at 3.3.5.

⁵⁵³ See Chapters 11 and 13 for actions in the Children's Court.

Case closure

- 8.55 In principle, all plans transferred from the Helpline to a CSC for further assessment should receive a secondary assessment. However, the level of demand for further assessments has often exceeded the available CSC resources. Community expectations are that most reports to DoCS will result in allocation of the report to a caseworker for a comprehensive assessment and intervention. The reality of the current system is that while all reports receive a level of preliminary assessment by the DoCS Helpline, DoCS prioritises its child protection casework services to those children who are most at risk with a particular focus on children with specific vulnerabilities.
- 8.56 Case closure can occur at any stage during the various child protection assessment processes, including after commencement of a SAS2. Reasons for case closure include relative priority of the report compared with other reports and current casework resources of the CSC.
- 8.57 DoCS' new Intake Assessment Guidelines have recently been implemented and aim to increase consistency by assisting Managers Casework responsible for intake in deciding which matters to allocate and when to close cases.
- 8.58 According to the guidelines:
- 1.1 *All Plans transferred from the Helpline to a CSC for further assessment/investigation should receive a Secondary Assessment. However, where the level of demand for further assessments exceeds the available CSC resources, the Manager Casework will exercise professional judgement in determining relative risk/priority amongst plans.*
 - 1.2 *All Plans must receive secondary assessment OR be closed within 28 days of receipt at the CSC.⁵⁵⁴*
- 8.59 High priority cases which will not normally be closed without a secondary assessment are those where a response is required within 24 hours and the child is under five years of age and those where a response is required within 24 or 72 hours and one or more of the following factors exist:
- a. The primary (or significant) care-giver's functioning or ability to parent is impaired due to: current alcohol and/other drug use; unmanaged mental illness; intellectual disability; emotional state of the carer; persistent care-giver hostility; and/or suicide risk/attempt of carer.
 - b. Reported issues relate to neglect, such as: necessary medical care not arranged; basic physical or psychological needs not met or at risk; non-

⁵⁵⁴ DoCS, *Intake Assessment Guidelines*, November 2007, p.3.

organic failure to thrive; inadequate supervision for age; inadequate shelter/homeless; and/or children abandoned in the car.

- c. Reported issues relate to domestic violence involving injury or use of a weapon where the child or young person is exposed to the violent incident and is likely to have suffered physical or psychological harm.
- d. The child has high support needs, such as, disability or illness.
- e. Within the past six months, there have been two or more plans for the child (or sibling living in the same circumstances) closed without a SAS2 completed.
- f. The child has siblings with a significant⁵⁵⁵ DoCS history of abuse or neglect, or have been removed, or are in care.⁵⁵⁶
- g. The plan concerns an allegation against an 'authorised carer', DoCS employee or employee who works with children in a non-government or government agency.

8.60 The guidelines state that plans should be closed immediately without secondary assessment where either:

- a. the child or young person is deemed safe and not in need of care and protection
- b. the plan does not meet the high priority criteria and/or is of lower risk/priority relative to other plans on hand and the Manager Casework determines that it will not be possible to conduct a SAS1 with existing resource levels within the required 28 day period (in such plans the reason should be recorded on KiDS as 'Current Competing Priorities' in the 'Plan Closure Reason' field).

8.61 The guidelines state that at a minimum a weekly case allocation meeting should occur with the Manager Casework responsible for the intake function, and one other Manager Casework, to review the plans listed as unallocated or listed for immediate closure. Where high priority cases cannot be allocated they are to be referred to line management to see if there is the possibility that another team or CSC can assist.⁵⁵⁷

8.62 The Ombudsman in a review of a child death raised concerns about these guidelines stating:

It is apparent to us that allocation decisions which are made on the basis of relative risk will, under the proposed guidelines as now, favour young children and those who are at immediate risk

⁵⁵⁵ Significant means history of serious abuse and neglect.

⁵⁵⁶ Including all children with siblings who have a significant history of risk of harm reports and/or DoCS intervention that may or may not include Children's Court proceedings, and/or a history of placement in short or long term OOH as a result of DoCS intervention. This also includes all children with siblings who are or have previously been subject to a Temporary Care Agreement.

⁵⁵⁷ DoCS, *Intake Assessment Guidelines*, November 2007, pp.9-11.

of harm. Whilst at one level this appears reasonable, it remains unclear to us how the system will ensure children reported to be neglected over time, will receive timely child protection intervention. This is even more so given that the department's practice rules for streaming reports to early intervention teams exclude reports assessed by the Helpline as high risk.⁵⁵⁸

- 8.63 The Ombudsman has correctly noted that there is a need to give appropriate weight to the urgency of the response required as well as the assessed risk level. This is particularly so for cases involving neglect.
- 8.64 Child protection work will always involve prioritising resources which will affect the allocation of cases. These guidelines seek to do so based on available research. Elsewhere in this report, suggestions and recommendations are made designed to ensure that more families receive assistance, not just from DoCS, and that caseworkers become more skilled and have access to the necessary expertise to assess reports and families. The particular position of adolescents is also addressed, since it is they who are most likely to suffer from the application of these guidelines.

NSW casework practice

Case management

- 8.65 Case management is a strategy that aims to mobilise, coordinate and maintain a diversity of services for the individual child or young person and his or her family.⁵⁵⁹ It has been described as the “glue that holds the system together,”⁵⁶⁰ or the “lynchpin for an effective interagency system.”⁵⁶¹
- 8.66 Case management performs a range of functions. It ensures that services are suited to the individual child and family, are clinically and culturally appropriate, and lead to desired outcomes.
- 8.67 The Interagency Guidelines describe case management as the process of assessment, planning, implementation, monitoring and review that aims to support families and decrease risks to children and young persons. The

⁵⁵⁸ NSW Ombudsman, *Investigation into the death of a child, Provisional Statement*, 2008. At the time of writing the guidelines had not been fully implemented.

⁵⁵⁹ BA Stroul and RM Friedman, “A system of care for children and youth with severe emotional disturbances (revised edition),” *Georgetown University Child Development Center*, 1986, cited in DoCS, *Models of service delivery and interventions for children and young people with high needs, Literature Review*, 2006, p.35.

⁵⁶⁰ *ibid.*

⁵⁶¹ M J England and R F Cole, “Building systems of care for youth with serious mental illness,” *Hospital and Community Psychiatry* 43(6), 1992; pp.630-633; E M Z Farmer, S Dorsey and S A Mustillo, “Intensive home and community interventions,” *Child and Adolescent Psychiatric Clinics of North America*, 13(4), 2004, pp.857-884, cited in DoCS, *Models of service delivery and interventions for children and young people with high needs, Literature Review*, 2006, p.35.

process should have an emphasis on ongoing analysis, decision making and record keeping.

- 8.68 The Interagency Guidelines state that where there are no risk of harm concerns, or where these have been sufficiently resolved, and other agencies continue to provide services to a family, any agency can assume the role of case manager.⁵⁶²
- 8.69 For child protection matters, case management remains with DoCS, primarily because of the Department's statutory responsibilities, which include investigation, decision making regarding removal and court work. However, interventions with children, young persons and families are often achieved without the need for a care order.⁵⁶³
- 8.70 Case planning is a key component of the case management process and is the mechanism for decision making and directing DoCS work with children and their families and/or their carers. The case planning process in child protection should be informed by ongoing assessment of the circumstances of the child or young person in the context of the family and/or carers.⁵⁶⁴ A case plan is developed to address the assessed needs of the child, young person or his or her family. DoCS' policy states:

*A case plan is an accurate and up-to-date record of the plan for DoCS action to address the needs of the child identified through assessment. Case planning ensures that all parties are clear about the goals and objectives of DoCS involvement, the issues to be addressed and responsibilities of all parties for the tasks involved.*⁵⁶⁵

- 8.71 Most of the casework decisions, which have been delegated from the Minister or Director-General rest with the caseworker's supervisor, the Manager Casework.

Referral, monitoring and supervision of families in statutory child protection

- 8.72 Referrals within the context of casework are made in accordance with the legislative requirements and principles as contained in the Interagency Guidelines and include:
- a. Requests for services (s.17 of the Care Act) which authorises DoCS to make a request to another government department or a community partner

⁵⁶² NSW Interagency Guidelines for Child Protection Intervention, 2006, 3.7 at p.15.

⁵⁶³ DoCS, *Child and Family and Out-Of-Home Caseworker Manual (draft) Chapter 5, Ongoing Casework Interventions*, 2007, p.60.

⁵⁶⁴ DoCS, Intranet, *Case Planning Policy*.

⁵⁶⁵ *ibid.*

in receipt of government funding to provide services to promote the safety, welfare and well-being of the child or young person.

- b. Best endeavours (s.18 of the Care Act) means using a genuine and considered effort by a government department or agency to respond to a request for service. The service does not have to be provided if it is out of the range of the service provider's expertise or responsibility.

- 8.73 DoCS' policy states that referrals for current DoCS clients involve:

*making contact with the service provider for or on behalf of the client. The referral process is followed by seeking information from the service provider as to whether or not the client engaged the service and discussion about outcomes of service provision.*⁵⁶⁶

The policy also states that referrals need to be monitored for various reasons including their uptake, the ability of an agency to provide a service, and the immediate and ongoing safety, welfare and well-being of children, young persons and adults. Details of the agency providing the service and the type of service should also be recorded.

- 8.74 DoCS' policies and procedures also stipulate that monitoring is a key element of case planning and requires regular feedback from the child, carers, and service providers as to whether services are being provided in the manner determined by the case plan and whether the needs of the child have changed.

- 8.75 DoCS advised the Inquiry that it has introduced a portal, which now enables Brighter Futures Lead Agencies to receive electronic referrals from DoCS and provide information on casework services. This however is limited to Brighter Futures but DoCS states that over time this could be expanded to non-government services for child protection and OOHC. Presently KiDS has the capacity for caseworkers to record information about referrals to services but DoCS advised that follow up relies on the caseworker establishing contact with the service provider on a regular basis.

Casework interventions

- 8.76 Some of the key strategies in NSW follow.

Prenatal reports

- 8.77 In 2006/07 for every 1,000 children in NSW, around 78 were reported to DoCS. The rate of reporting about children aged less than one year is considerably

⁵⁶⁶ DoCS, Intranet, *Information and Referral Policy*.

higher than for all other age groups.⁵⁶⁷ For every 1,000 children aged less than one year in NSW, 136 were reported to DoCS.⁵⁶⁸

- 8.78 The evidence base indicates that the period of pregnancy and the period immediately following the birth of a child are among the most vulnerable periods in human development. It is critical that at risk pregnant women are identified and engage with appropriate support services to reduce the risks to children in utero and at birth. The research also suggests that pregnancy is a key life stage where a pregnant woman may be more inclined to make positive changes for her child.⁵⁶⁹
- 8.79 In NSW, research undertaken by the Ombudsman as part of his review of child deaths, has also highlighted the need for an improved health and statutory child protection response to prenatal reports. For example, the *Report of Reviewable Deaths in 2004* found that 11 of the 72 children who died and who were known to DoCS were the subject of a prenatal report and that maternal substance use during and after pregnancy was a factor in most of the deaths. The report also found that prenatal reports are commonly given a low child protection response level, closed at the CSC without undergoing any further assessment (of future risks or relevant history) and rarely involve interagency meetings with Health staff or others.⁵⁷⁰
- 8.80 The *Report of Reviewable Deaths in 2005*, noted similar concerns to the 2004 report and stressed the particular importance of improving protection for children born into a family where serious parental drug use is occurring. Of the total 117 reviewable child deaths in 2005, 51 per cent of the children were aged less than 12 months.⁵⁷¹ The report noted that in at least 10 of the 69 deaths of children known to DoCS, there were prenatal reports that raised concerns about substance abuse on the part of the mother.⁵⁷² In reviewable death cases where parental substance abuse was evident, almost two thirds of the children were under 12 months of age when they died.⁵⁷³ In 2006, 59 per cent of reviewable deaths were children less than 12 months, of which 48 per cent were children aged less than one month.⁵⁷⁴
- 8.81 Amendments were made to the Care Act which came into effect in March 2007, to extend the circumstances in which a child or young person is taken to be at risk of harm. Section 23 now includes as a risk circumstance the fact that the child was the subject of a prenatal report under s.25 and that the birth mother

⁵⁶⁷ The rate for children aged less than one year is likely to be artificially inflated by small amount because DoCS data contain prenatal reports, whereas the base population only includes born children: DoCS, *A closer look: recent trends in Child Protection Reports*, December 2007.

⁵⁶⁸ DoCS, *A closer look: Recent trends in Child Protection Reports*, December 2007.

⁵⁶⁹ M Butler, "Pregnancy, opportunity or invasion," *Of Substance, Volume 5 (1)*, 2007 cited in DoCS, *Responding to Prenatal Reports Policy Draft*, August 2007, p.7.

⁵⁷⁰ NSW Ombudsman: *Report of Reviewable Deaths in 2004*, December 2005, p.83.

⁵⁷¹ NSW Ombudsman: *Report of Reviewable Deaths in 2005, Volume 2: Child Deaths*, November 2006, p.6.

⁵⁷² *ibid.*, p.18.

⁵⁷³ *ibid.*, p.9.

⁵⁷⁴ NSW Ombudsman: *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths*, December 2007, p.14.

did not engage successfully with support services to eliminate or to minimise the risk factors that gave rise to the report to the lowest level reasonably practical. The note to s.25 clarifies that prenatal reports are to enable assistance and support to be provided to the expectant mother to reduce the likelihood that her child when born will need to be placed in OOHC, and to provide early information that a child who is not yet born may be at risk of harm subsequent to his or her birth, and in conjunction with ss.23(f) and 27 to provide for mandatory reporting if there are reasonable grounds to believe that the child will be at risk of harm subsequent to his or her birth.

- 8.82 DoCS, together with Health have developed a Responding to Prenatal Reports Policy in response to the need for DoCS to provide clearer policy guidance for caseworkers to help them respond to prenatal reports. This was endorsed in March 2008. NSW Health currently provides services for drug and alcohol of misuse in pregnancy and mental health issues, such as Safe Start, which, as outlined earlier, includes psychosocial assessment and depression screening for pregnant and postnatal women.
- 8.83 A two tier system forms part of the prenatal policy:
- a. After receiving a prenatal report DoCS will issue a s.248 direction for information relating to the safety, welfare and well-being of an unborn child. This direction will be issued via the Area Health Service Section 248 Central Contact Point and will act as notification of a prenatal report to the specific health service to which it is directed.
 - b. In high risk cases DoCS will issue an Unborn Child High Risk Birth Alert form to s.248 Central Contact Points. The Central Contact Points will distribute the form to relevant health services within their auspices and this will act as notification of a prenatal report to those services.
- 8.84 The policy provides directions to caseworkers at the Helpline and CSCs about the required response to prenatal reports of risk of harm to an unborn child. This may reduce the likelihood that the child, when born, will need a child protection response. Health is currently consulting with its Primary Health and Community Partnerships Division about discharge options and follow up services for mothers whose babies develop Neonatal Alcohol Syndrome.
- 8.85 A trial of the policy commenced in June 2008 in three CSCs and the Helpline, and will be evaluated externally. A list of antenatal and maternity services across the State has been developed. This service mapping across NSW Area Health Services and DoCS regions provides a picture of service availability not previously collated by either DoCS or Health, and it is an initiative that this Inquiry fully supports.
- 8.86 It is intended that the prenatal reports policy will impact on the expanded AMIHS, which is outlined in Chapter 18, as Aboriginal women are likely to be strongly represented in the target group of prenatal reports. Along with the mainstream antenatal and maternity services mapped in the policy, the mapping

of current and planned services under the strategy should ensure caseworkers are aware of this service stream.

Intensive support and family preservation services

- 8.87 Family preservation programs are a key part of the service spectrum in many Australian and overseas jurisdictions. The most well known family preservation program is the Homebuilders Program, developed in 1974 through the US Institute for Family Development as an alternative to unnecessary out-of-home placements.
- 8.88 Family preservation services are primarily designed to maintain children aged from 0-15 years with their family and/or extended family and to encourage engagement with appropriate support networks to prevent these children from entering OOHC.
- 8.89 DoCS recently conducted an expression of interest process to establish this model across NSW. Under the new service model family preservation services will target families where children are reported at risk of harm and are most likely to escalate into OOHC without this service intervention. The model also includes provision of intensive support services to restore children in OOHC to their family or to better engage older children (12-15 years) with appropriate support networks where they may be living with their family or living independently of their family but not in formal OOHC.
- 8.90 Health notes in its submission to the Inquiry that:
- ... other Australian States also have models for intensive family treatment that may be useful for informing future service planning in this area. Queensland has established 'Evolve' Interagency teams which provide therapeutic and behaviour support services for children on child protection orders and in out-of-home care who have significant behavioural and psychological issues and/or disability behaviour support needs. Mental health professionals and psychologists, speech and language therapists work in collaboration with school guidance officers and child safety officers.⁵⁷⁵*
- 8.91 The Inquiry is aware that, in comparison with Victoria, Queensland, ACT and Western Australia, NSW has significantly fewer children and young persons accessing intensive family support services.⁵⁷⁶
- 8.92 The Inquiry supports the establishment of this model and the extension of these services in NSW. A recommendation is made to this effect in Chapter 10.

⁵⁷⁵ Submission: NSW Health, 3 March 2008, p.13.

⁵⁷⁶ Australian Institute of Health and Welfare, *Child Protection Australia 2006-07*, Child welfare series no. 43, 2008, p.66.

Aboriginal Intensive Family Based Services

- 8.93 DoCS Intensive Family Based Service (IFBS) is a child protection intervention program primarily for Aboriginal families in NSW. Presently there are six Aboriginal IFBS and one generalist IFBS operated by UnitingCare Burnside.
- 8.94 Families at risk of having their children removed, or families requiring intensive intervention so that reunification can occur, are eligible for IFBS. The IFBS aims to protect children, prevent potential OOHC placement and build on family skills and competencies working in partnership with the family and community.⁵⁷⁷
- 8.95 IFBS is delivered primarily in the home or in a community setting with caseworkers available to families 24 hours a day, seven days a week, for the time limited 12 week intervention. IFBS is provided by a small service team, comprising a manager, and up to four caseworkers each with a caseload of two families.⁵⁷⁸
- 8.96 The service comprises a mix of concrete and clinical supports. Skills development such as parenting, self-management, household management and budgeting, hands on assistance in areas such as house cleaning and transport, provision of basic furniture, white goods, and assistance to organise government benefits and other needs are among the concrete supports provided by IFBS.
- 8.97 IFBS was funded in 2007/08 to a total of \$3.2 million. This included \$1.98 million funded through DoCS operating funds, plus \$1.22 million through *Two Ways Together*⁵⁷⁹ in 'special initiative' funds.
- 8.98 In 2006/07, 265 children were receiving IFBS services, and one half of these children were aged under 10 years.
- 8.99 A 2008 evaluation of the DoCS IFBS program demonstrated that families receiving IFBS received significantly fewer reports on average in the three, six and 12 month post-intervention periods and in the three, six and 12 month pre-intervention periods.⁵⁸⁰ The impact on reported issues of carer drug and alcohol, carer mental health and neglect were found to be significant.
- 8.100 The program was described by stakeholders participating in the evaluation as a "highly appropriate service for Aboriginal client families"⁵⁸¹ and the evaluation recorded client families as providing positive views about their involvement with

⁵⁷⁷ DoCS, *Aboriginal Intensive Family Based Service (IFBS) (Family Preservation Service) Principles and Service Model Description*, October 2007, pp.4-5.

⁵⁷⁸ DoCS, *Draft IFBS Evaluation Report*, March 2008 p.9.

⁵⁷⁹ *Two Ways Together* is the NSW Government's ten year whole of government Aboriginal Affairs plan (see Chapter 18).

⁵⁸⁰ DoCS, *Draft IFBS Evaluation Report*, March 2008, p.29.

⁵⁸¹ *ibid.*, p.11.

the program, indicating that IFBS “provided a holistic intervention in which they did not feel threatened.”⁵⁸²

- 8.101 Economic evaluation was also positive, demonstrating a net average benefit per family of \$44,712 in the long term, which showed that the program benefits outweighed program costs and provided value for money to the community.⁵⁸³
- 8.102 The evaluation identified strategies to improve the referral rates to IFBS and also to improve post-intervention support, including funding a step down worker, the use of Brighter Futures services and greater use of CSGP funding to assist these families.⁵⁸⁴ DoCS informed the Inquiry in June 2008 that the Aboriginal Services Branch within DoCS had commenced work on an action plan to address these recommendations, to be progressed under the Child Protection Major Project.⁵⁸⁵
- 8.103 However, DoCS states that the capacity of Brighter Futures to absorb post-IFBS intervention clients is currently limited, given that the largest single age range (40 per cent) represented in the IFBS client population is 9-14 years, which is outside the current Brighter Futures program range. In addition, a number of families require more intensive ongoing support than that which can be provided through the Brighter Futures program.⁵⁸⁶
- 8.104 DoCS recently approved a strategy for enhancing post-intervention support pathways to ensure IFBS families receive between three months to two years support following the intervention. Key components of the strategy include:
- a. a structured pathway into the Brighter Futures program for eligible and suitable IFBS families post-intervention
 - b. funding of new case management, family and specialist support services within the CSGP for IFBS families post-intervention.
- 8.105 The Aboriginal Legal Service advised the Inquiry that:

A handful of Aboriginal Legal Services clients have been on the IFBS program with mixed success. The issues are that, back from the IFBS agency, people are now seeing IFBS as another arm of the Department of Community Services, and possibly as an evidence-gathering exercise to bring the matter before the court and have somebody in the home for a longer period than a DoCS worker can possibly be, to gather that evidence, view them, and then remove the child. That evidence is then used

⁵⁸² *ibid.*

⁵⁸³ *ibid.*, p.36.

⁵⁸⁴ *ibid.*, p.37.

⁵⁸⁵ DoCS, *Child Protection and Out-of-Home Care Major Projects Update June 2008*, p.2.

⁵⁸⁶ DoCS, *Draft IFBS Evaluation Report*, March 2008, p.38.

*as prior alternative action, which is something that has to be satisfied through the court process.*⁵⁸⁷

- 8.106 The Benevolent Society expressed concern about the fact that the IFBS services were only available in particular localities:

*Part of our concern would be that they are not statewide; they are very localised, and they are very short term. So you can't build a service system around a few services here and there; you need a service system where these are fully embedded in the continuum of services.*⁵⁸⁸

- 8.107 UnitingCare Burnside concurred with The Benevolent Society regarding concerns over the short term nature of the services, and stated that post-intervention, families needed to have continued, less intensive support available over a longer period to consolidate the benefits of the intensive intervention.
- 8.108 The UnitingCare Burnside IFBS provided services to 114 children in 2006/07 of whom 100 were non-Aboriginal.
- 8.109 In 26 February 2008, the Inquiry visited UnitingCare Burnside's North Campbelltown Family Centre at Minto. The agency informed the Inquiry that they had run an IFBS, funded by DoCS as a pilot, since 1994, taking referrals from Campbelltown and Ingleburn CSCs only. The Inquiry was informed that families often make 'amazing gains' while in the program, but that families often 'slipped back' after the intensive intervention finished. As a result, UnitingCare Burnside used their broader family support services to provide a continued intervention to families once the six week intensive program was over.
- 8.110 It appears that the IFBS is a successful service model, especially for Aboriginal people. The evaluation appears to have identified two of the three main concerns about IFBS that were raised with the Inquiry, and DoCS has told the Inquiry that it is planning ways to address the problems with referrals to IFBS, and the issues identified with a lack of post-intervention support.
- 8.111 The remaining issue is the negative impact of the association between IFBS and DoCS statutory child protection role for some participants, and the perception of some families raised by Aboriginal Legal Service that the IFBS is more about the collection of evidence to remove children than it is about preventing removal and keeping children safe with their family.
- 8.112 A potential solution of separating IFBS from DoCS has been suggested. However, as the families referred to IFBS are the subject of serious child protection concerns and are at the point of having children removed, or have had children removed, separating the program from the child protection arm of DoCS may not be appropriate.

⁵⁸⁷ Transcript: Public Forum, Aboriginal Communities, 24 April 2008, pp.61-62.

⁵⁸⁸ Transcript: Public Forum, Early Intervention, 16 May 2008, p.35.

- 8.113 The Inquiry notes that the evaluation of the IFBS program found evidence that the program was having positive impacts on subsequent OOHC placements for children, and specifically, had reduced the likelihood of placements by up to one third where children and young persons had a prior placement in the OOHC system in the 12 months prior to the intervention.
- 8.114 The Inquiry supports DoCS' strategies for enhancing post-intervention supports as well as those related to improving referrals from CSCs to these services. As outlined in Chapter 5, Aboriginal children and young persons are over represented in reports to DoCS and in OOHC. Services such as IFBS are critical to providing the services and support that are needed to prevent unnecessary entry of those within this group into care.

Parental drug use

- 8.115 Parental Drug Testing Guidelines for DoCS child protection staff commenced in April 2007. These are being trialled in seven CSCs. Drug use by parents is a prevalent feature in the risk of harm reports DoCS receives and drug testing is used to verify that a person is drug free or that their drug use is reducing over time.⁵⁸⁹ Whether they remain drug free or not can be important for restoration.
- 8.116 An external evaluation of the parental drug testing policy has begun and will assess the effectiveness of the policy, the implementation of the policy's trial and the outcomes achieved, thereby helping to guide statewide implementation.
- 8.117 Parental responsibly contracts, or an undertaking as part of a court order are necessary to secure formal parental consent to drug testing.⁵⁹⁰ A parent that does not consent to undergo drug testing is advised that refusal will be interpreted as a presumption of ongoing (serious and persistent) drug use and will be viewed as evidence to support removal.
- 8.118 An information sharing protocol regarding clients receiving opioid treatment was developed by Health and DoCS and implemented statewide in July 2007. The aim is to improve interagency cooperation and information sharing for parents and carers on methadone or buprenorphine opioid treatment programs. It relates to the exchange of information between public and private prescribers and permits caseworkers to discuss with the prescriber the parent/carers compliance with treatment, whether children have been sighted and whether there are concerns for the child and whether parenting is compromised as a result.
- 8.119 A review was undertaken by the DoCS Drug and Alcohol Expertise Unit in September 2007 to examine the effectiveness of the protocol. The review indicated that even with a limited time for implementation, 65 per cent of the

⁵⁸⁹ 'Drug' includes all illicit drugs and the misuse of prescription drugs: DoCS, *Parental Drug Testing Guidelines*, p.2.

⁵⁹⁰ *Children and Young Persons (Care and Protection) Act 1998*, s.38A and 73.

caseworkers were already aware of or had some knowledge of the protocol, almost 60 per cent could identify how to access information on the protocol and 15 per cent had already implemented the protocol. Ongoing promotion of the protocol is continuing via the unit staff in consultancies and relevant staff training courses. The unit is also working with regions to facilitate the establishment and running of interagency meetings when required.

- 8.120 The Inquiry considers it important that caseworkers are able to have better access to health expertise, and that the significant role of health in child protection work is acknowledged. As the research set out earlier indicates, women entering treatment earlier and spending more time in treatment, results in children being more likely to be reunited. Parental drug testing policies are positive in this respect. Chapter 10 sets out the Inquiry's views on a model for better integrating health workers with DoCS work.

Siblings

- 8.121 The DoCS policy on siblings commenced in 2006 and states that all reports to DoCS involving a recent child death⁵⁹¹ or a report on siblings or any other children or young persons in a household where a child or young person has recently died should usually result in a home visit. The policy states that at this home visit the caseworker is to:
- a. check that the family has the support and assistance they need in relation to the care and protection for other children or young persons in the home
 - b. sight the remaining children to ascertain they are safe and well
 - c. determine whether a secondary risk of harm assessment of siblings and other children in the household is required.
- 8.122 This is a sensible policy which the Inquiry understands, followed on from a number of deaths of children. There is no evidence available to the Inquiry that it is or is not being implemented. It clearly should be. An awareness of siblings should permeate all of DoCS work, not just when a child has died.

Permanency planning

- 8.123 One of the most contentious and difficult issues in child welfare policy and practice is achieving some certainty and permanence in the lives of children. As can be seen in Chapter 16, significant numbers of children are moving in and out of care. It is also clear that a number of children entering care are doing so for a second or even third time.⁵⁹² The consequence of children moving in and out of care, or remaining at home in unsafe and inadequate care

⁵⁹¹ A 'recent death' is defined as the child having died less than 90 days before the Department received the report: DoCS, *Sibling Safety Policy*.

⁵⁹² See Chapter 5.

for too long, means that when they do come into care they bring with them significant levels of disturbance and attachment difficulties.⁵⁹³

- 8.124 Research shows that the timeframe for decision making is critical for placement stability.⁵⁹⁴ The initial six months emerges as a crucial period for restoration and therefore decisions about reunification should be a priority.⁵⁹⁵ Specialist expertise is needed in an increasing number of cases to determine the prospects of a parent being able to manage their substance dependence or other issues and provide appropriate parenting. This work also needs to be informed, the Inquiry was advised, by an evidence base and good longitudinal research and monitoring of outcomes.
- 8.125 Section 78A of the Care Act defines permanency planning as the making of a plan that aims to provide a child or young person with a stable placement that offers long term security that:
- (b) *meets the needs of the child or young person*
 - (c) *avoids the instability and uncertainty arising through a succession of different placements or temporary care arrangements.*
- 8.126 As soon as child protection intervention commences with a child or young person and his or her family, consideration must be given in case planning to the issues of stability and permanency. Section 83 of the Care Act provides that where DoCS applies for a care order (other than an emergency order) for the removal of a child or young person, an assessment must be made about whether there is a realistic possibility of restoration. This is to avoid the detrimental impact on children and young persons of failed attempts at restoration with birth parents, which can lead to children and young persons being adrift in the care system and experiencing unplanned multiple placements.
- 8.127 A permanent placement may be achieved by:
- a. restoration to the care of a parent or parents
 - b. placement with a member or members of the same kinship group as the child or young person
 - c. long term placement with an authorised carer
 - d. placement with an authorised carer (after two years continuous care) under an order for sole parental responsibility under s.149
 - e. adoption.

⁵⁹³ A Osborn and PH Delfabbro, "National comparative study of children and young people with high support needs in Australian Out-of-Home Care, Final Report," *University of Adelaide, South Australia*, 2006 cited in DoCS, *Models of Services Delivery and Interventions for children and young people with high needs, Literature Review*, 2006, p.1; Submission: Cashmore, Scott and Calvert, 10 March 2008, p.43.

⁵⁹⁴ DoCS, Intranet, *Permanency Planning Policy*, p.3.

⁵⁹⁵ DoCS, *Permanency planning: A review of the research evidence related to permanency planning in out-of-home care*, 2006 cited in Submission: DoCS, Evidence base for effective services, May 2008, p.25.

- 8.128 Where restoration is the goal, appropriate resources should be directed to its achievement from the outset and maintained. If the case plan determines that restoration of the child or young person to the birth family is not a viable option, a Care Plan which outlines the permanency plan for the long term care of the child or young person must be prepared for the Children's Court. The Care Plan needs to be approved by the Manager Casework.
- 8.129 The DoCS Permanency Planning Policy requires that a decision about the realistic possibility of restoration must be made within six months of the Children's Court action being initiated for children less than two years of age, and within twelve months for all other children and young persons.
- 8.130 Twelve specialist permanency planning caseworkers have been employed to facilitate permanency planning in four CSCs⁵⁹⁶ and a further 21 specialist caseworkers are currently in the process of being trained and recruited. It is intended that these permanency planning caseworkers will provide mentoring and support for caseworkers when assessing the needs of children and young persons, working with families and planning for and managing permanent placement outcomes.
- 8.131 DoCS acknowledges that at present, practice in the field on early case planning that focuses on issues of permanency is variable,⁵⁹⁷ and is attempting to address this through its Permanency Planning Project.
- 8.132 As at 30 June 2008, there were 467 children in the Permanency Planning Project, because of parental dual diagnosis, drug and alcohol misuse, neglect, and parental mental illness.⁵⁹⁸ By the end of June 2008, there were 83 final orders recorded for children in the project, most of whom had parental responsibility placed with the Minister (to 18 years) or with a relative.
- 8.133 Project data for children with final court orders over a six month period from July 2007 to January 2008, showed a trend towards more children being placed with relative carers compared with other long term placements.⁵⁹⁹
- 8.134 The results evaluation of the Permanency Planning Development Project Stage 1 suggests that decisions about the realistic possibility of restoration are being made within the policy timeframes for children aged 0-2 years. The report states that 12 months into the project, a higher proportion of children are in permanent placements compared with children in the comparison sites (where this project was not in place), and the data indicate that these children are safer as measured by child protection reports.⁶⁰⁰

⁵⁹⁶ Penrith, Campbelltown, Eastern Sydney and Central Sydney. A further 12 sites commenced in July 2007 a further 12 CSC commenced permanency planning, St George, Sutherland, Ingleburn, Fairfield, Blacktown, Mt Druitt, Goulburn, Yass, Wagga, Albury, Lismore and Tweed Heads. Further implementation commenced in 2008 for 26 further sites: Submission: DoCS, OOH, p.48.

⁵⁹⁷ DoCS, Intranet, *Permanency Planning Policy*, p.7.

⁵⁹⁸ DoCS, *Annual Report 2007/08*, p.60.

⁵⁹⁹ *ibid.*, p.60.

⁶⁰⁰ DoCS Report, *Evaluation of the Permanency Planning Development Project Stage 1*, December 2007, p.3.

- 8.135 Restoration Guidelines have been also developed to assist caseworkers in making decisions about whether restoration is a viable option for a child or young person. These guidelines have been incorporated into training for caseworkers in the Permanency Planning sites.
- 8.136 In Chapter 11 the report addresses the tension referred to by DoCS between the least intrusive principle and permanency planning.

Responses to Aboriginal children, young persons and families

- 8.137 There are two particularly impressive examples in Victoria and the Northern Territory of interventions with Aboriginal children, young persons and their families.

Lakidjeka Aboriginal Child Specialist Advice and Support Service

- 8.138 Lakidjeka Aboriginal Child Specialist Advice and Support Service (Lakidjeka) is an Indigenous specific response to child protection intervention in Victoria. The service has been profiled in the Human Rights and Equal Opportunity Commission *2007 Social Justice Report*, and in a 2007 publication from the AIFS and the Secretariat of National Aboriginal and Islander Child Care (SNAICC) examining Indigenous responses to child protection issues. The Inquiry visited Lakidjeka in Victoria to gain further insight into its role and function.
- 8.139 Lakidjeka is provided through a partnership between the Victorian Aboriginal Child Care Agency and the Victorian Department of Human Services. The 2007/08 partnership agreement provides \$2.5 million for Lakidjeka, which the Inquiry was informed funds 28.5 positions. The positions are primarily caseworkers. Lakidjeka covers all of Victoria except for the Mildura Local Government Area where another Aboriginal service performs a similar role.
- 8.140 Lakidjeka aims to provide an Aboriginal perspective into child protection risk and safety assessment, planning processes and decision making about Aboriginal children. It aims to improve case planning and decision making about Aboriginal children and young persons who have been notified to child protection services, and to improve the engagement of those children and young persons and their families with the support services they need. It also aims to improve the involvement of Aboriginal family and community members in the support of Aboriginal child protection clients. This in turn is expected to improve Aboriginal children's connection with their community and to strengthen their cultural identity.
- 8.141 Lakidjeka staff provide a 24 hour on call response to notifications made to child protection services about a child or young person identified as Aboriginal. Lakidjeka staff are then involved in and/or consulted about the Department's decisions about that child or young person.

- 8.142 In response to a child protection report, Lakidjeka workers undertake joint visits with child protection workers to help child protection workers understand Aboriginal child rearing practices and to help Aboriginal families understand child protection concerns and processes. Lakidjeka workers also attend case conferences, case planning meetings, family group conferences and court, where they can provide verbal and written evidence and assistance at pre-hearing conferences.
- 8.143 Lakidjeka workers have a role in advising child protection staff of the most culturally relevant referrals. They also provide input into departmental cultural support plans, and help families to be more involved in decision making about their children. Lakidjeka workers are consulted about OOHC placements and provide advice to mainstream OOHC service providers about how to improve community and cultural connections for Aboriginal children in their care.
- 8.144 Higgins and Butler reported that:

*Lakidjeka workers have status to act as a 'friend of the court' during court hearings and are able to give unsworn statements in the court room ... This means that Lakidjeka workers are recognised by the court as having a legitimate role in the proceedings, and having expertise in Indigenous child and family welfare matters.*⁶⁰¹

- 8.145 Lakidjeka has been formally evaluated although the report has not been made public and the Inquiry understands that Lakidjeka has reservations about its methodology. The Social Justice Report and the work of Higgins and Butler claim that the staff believe that the program has resulted in fewer Aboriginal children being removed from their families because child protection workers have a better cultural understanding, with the result that there are more referrals to family support services, which has in turn resulted in higher compliance with the Aboriginal Child Placement Principles for those cases where children are removed.

The establishment of Lakidjeka has had a significant impact on reducing the number of placements of Aboriginal and Torres Strait Islander children outside their communities. There is an increasing number of Indigenous children who now remain more connected to their families and communities, which strengthens positive cultural identity.

As Indigenous people with connections in their local communities, Lakidjeka staff are often able to identify family members with whom the child can be placed and engage key

⁶⁰¹ J Higgins and N Butler, "Indigenous Responses to Child Protection Issues", Promising Practice in Out-of-Home Care for Aboriginal and Torres Strait Islander Children and Young People and their Carers," Booklet 4, Australian Institute of Family Studies, 2007, p.11.

*people in the family who can participate in the planning and decision-making process regarding a child's well-being.*⁶⁰²

- 8.146 However, Lakidjeka informed the Inquiry that from the data kept by it (the quality of which may be reduced by some reluctance or dilatoriness on the part of caseworkers to keep file notes) there had not been a reduction in the removal of Aboriginal children from their families over the last few years, and that there may have had been an increase. That is not necessarily a negative outcome, since it may be that some of these children had been inappropriately left in positions of risk in the past.
- 8.147 Unpublished data provided to the Inquiry by Lakidjeka included the following:
- a. in 2006/07, a total of 2,306 reports were received, 2,034 through the day services, 272 through the after hours service
 - b. of these reports, 1,155 were investigated
 - c. of the possible 1,038 first home visits, 856 were attended by Lakidjeka
 - d. the service reported 91 per cent attendance at Best Interest Planning meetings, and 77 per cent attendance for planning reviews in 2006/07.⁶⁰³
- 8.148 Higgins and Butler claim that Lakidjeka has built a reputation for providing sound advice about the child's Aboriginal community to the child protection department, as well as valuable information to promote the child's cultural identity. Lakidjeka has been reported to be successful partly due to the willingness to take a collaborative approach on child protection issues rather than being adversarial in their approach.⁶⁰⁴
- 8.149 Lakidjeka staff are also regularly involved in providing advanced training courses to child protection workers and other child and family welfare staff on working with Aboriginal families and organisations. Lakidjeka's success in this training is significant because it can have a real influence on informed decision making by child protection services and other child and family welfare services. Lakidjeka's involvement in child protection service provision is said to have resulted in a more flexible and creative response to addressing risk issues.⁶⁰⁵

*Fundamentally, the program has been instrumental in assisting child protection staff to make more informed decisions about Indigenous children.*⁶⁰⁶

- 8.150 Lakidjeka has also reported a number of challenges to the implementation of the program. These have included: recruiting Aboriginal staff; ongoing education of child protection staff about understanding the role of the program;

⁶⁰² *ibid.*

⁶⁰³ Lakidjeka Aboriginal Child Specialist Advice and Support Service, *Annual General Meeting Report*, July 2006-June 2007, pp.5-7.

⁶⁰⁴ J Higgins and N Butler, 2007, *op. cit.*, p.12.

⁶⁰⁵ *ibid.*

⁶⁰⁶ *ibid.*, p.13.

understanding the role of cultural and community connections in the promotion of children's best interests,⁶⁰⁷ and in some cases suspicion that they represent the welfare.

- 8.151 Lakidjeka informed the Inquiry that its staff understand their role as advising the Department on how to act in the best interests of Aboriginal children. Lakidjeka staff do not provide case management. Their interactions with families are focused on helping families to understand why they have come to the attention of child protection agencies.
- 8.152 The model appears promising and provides an alternative model for compliance with the requirements for consultation contained in the Aboriginal Placement Principles of the Care Act. However, the data available from Lakidjeka are currently not sufficient, in terms of quality or quantity, to definitively demonstrate the success of the program.
- 8.153 NSW Aboriginal community controlled services appear to be at an earlier stage of development than those in Victoria in terms of the volume of service provision, the level of coordination in the sector, and their capacity to undertake statutory work. So far as the Inquiry can see, there is no single organisation in NSW which is sufficiently skilled or resourced, at this time, to carry out a similar role to that of Lakidjeka. It would appear accordingly that NSW would require a planned, consistent and long term approach to building capacity in Aboriginal organisations before the introduction of a similar program could be considered. It is an initiative that should form the basis for a greater involvement of Aboriginal input into child protection work in the widest sense of that term. A recommendation is made to this effect at the end of this chapter.

Safe Families

- 8.154 Safe Families is a Northern Territory based program that takes an Indigenous family inclusive, community centred approach to responding to child protection issues. It aims to keep Aboriginal children and young persons out of the care system. The program is an initiative of the Tangentyere Council in Alice Springs. Safe Families provides services to Aboriginal people living in Alice Springs and the 18 town camps on the town's fringes.⁶⁰⁸
- 8.155 Safe Families helps children up to 14 years of age who have been identified as being at risk, or who are the subject of child protection intervention and who present with multiple and complex issues. Safe Families can intervene early to help the family and prevent the need for statutory child protection involvement. This can include providing voluntary OOHC placements for children at risk within their kinship and community networks.⁶⁰⁹

⁶⁰⁷ *ibid.*

⁶⁰⁸ *ibid.*, p.19.

⁶⁰⁹ *ibid.*

- 8.156 The Safe Families model was developed in consultation with local Indigenous leaders, community groups and service providers.⁶¹⁰ The program aims to empower communities to become more skilled and to know more about child protection issues, so that they can develop the capacity to address protective concerns themselves and keep their children in their community.⁶¹¹ The program commenced in 2002. The Safe Families model includes a six step intervention strategy:
- a. referrals from the child protection service, police, youth services, youth night patrol and the courts
 - b. crisis accommodation, which may be town based, with the family of origin of the child, with identified community members or extended family, or in a town camp based accommodation
 - c. assessment, where the young person is referred to a youth service through participation in a family meeting
 - d. medium to long term accommodation through a family mapping process where the need for placement is identified and assessed
 - e. case management, where the need for support services for both the child and his or her family is identified and services are allocated. A broad range of services are available
 - f. review and assessment of placement and progress. At the end of the assessment the child may be returned to his or her natural family, or may remain in placement with an exit plan drawn up. A referral may be made to the Department of Health and Community Services where a placement has been unsuccessful and there are no other family placement options. Or, an ongoing case management plan may be drawn up where further involvement of the Safe Families service is required.⁶¹²
- 8.157 The Safe Families model is based on the idea that Aboriginal people working in an Aboriginal service have an advantage when working with Aboriginal families because they operate in a culturally appropriate way, and are likely to be trusted by the people with whom they are working. Workers may have known the family for many years and are likely to have known the child since they were small. Therefore they have background knowledge about the family and the issues that the child may be experiencing that departmental workers simply do not have:

Our greatest strength is our ability to provide clarity [about a case]: our workers have known the families for years. We've also become quality assurance for the department, because we see families in greater depth and greater detail.⁶¹³

⁶¹⁰ *ibid.*, p.20.

⁶¹¹ *ibid.*, p.19.

⁶¹² *ibid.*, pp.21-22.

⁶¹³ *ibid.*, p.23.

- 8.158 One of the strengths of Safe Families cited in the literature is its capacity to provide up to six weeks in residential care for children who need alternative accommodation so that they do not have to leave their community. Children may stay in the facility for longer than six weeks if no suitable alternative is available. The service takes the perspective that it is better to keep the child until a suitable placement is found, rather than placing a child in a situation that may not meet their needs in the longer term.⁶¹⁴
- 8.159 Safe Families aims to prevent children from being in physically unsafe placement, but also aims to keep them from being based in culturally unsafe placements. The service claims to have been successful in case managing Aboriginal children who could not be placed elsewhere, or where previous placements have broken down. According to the AIFS, the result of the Safe Families model is that children stay with Safe Families longer than they do with other services, and all of the children that have come through service and have not returned to their parent's care have ended up in a stable placement.⁶¹⁵

Responses to culturally and linguistically diverse children and young people

- 8.160 The Inquiry acknowledges the importance of child protection workers operating in a culturally sensitive and appropriate way. This is fundamental to good casework and to achieving the best outcomes for children.
- 8.161 NSW is a culturally diverse community. 23.3 per cent of the NSW population was born overseas with 16.1 per cent from non-English speaking countries. 18.9 per cent of the NSW population speaks a language other than English at home.⁶¹⁶
- 8.162 One of the objectives of the *Community Relations Commission and Principles of Multiculturalism Act 2000*⁶¹⁷ is to promote access to government and community services that is equitable and that has regard to the linguistic, religious, racial and ethnic diversity of the people of NSW.
- 8.163 The submission of the NSW Community Relations Commission to the Inquiry stated that reforms to the child protection system must take into account the cultural and linguistic diversity of NSW. The Community Relations Commission drew particular attention to the needs of newly arriving refugee communities and the wide range of parenting approaches, definitions of family and what constitutes acceptable or unacceptable forms of punishment that may exist in NSW.

⁶¹⁴ *ibid.*

⁶¹⁵ *ibid.*

⁶¹⁶ Community Relations Commission, *The People of NSW*, Section 2, NSW Overview, www.crc.nsw.gov.au.

⁶¹⁷ *Community Relations Commission and Principles of Multiculturalism Act 2000*, Part 3, S.12(b).

- 8.164 There is very limited research literature on the nexus between children and young persons of culturally and linguistically diverse (CALD) backgrounds and child protection, and very limited reliable data on the numbers involved in the child protection system. However, DoCS estimates that approximately one in five DoCS clients is from a family where a language other than English is spoken at home. Further, DoCS estimates that 15 per cent of children and young persons in OOHC are from a family where a language other than English is spoken at home and 25 per cent have a cultural identity of non-English speaking origin.⁶¹⁸
- 8.165 Section 9(c) of the Care Act requires that in all actions and decisions made under the Act that significantly affect a child or young person, account must be taken of the culture, disability, language, religion and sexuality of the child or young person and, if relevant, those with parental responsibility for the child or young person.
- 8.166 Section 9(e) stipulates that if a child or young person is temporarily or permanently deprived of his or her family environment, or cannot be allowed to remain in that environment in his or her own best interests, the child or young person is entitled to special protection and assistance from the State, and his or her name, identity, language, cultural and religious ties should, as far as possible, be preserved.
- 8.167 DoCS has acknowledged
- the urgency of DoCS establishing infrastructure to support the increasing number of families utilising its services from culturally and linguistically diverse backgrounds....CALD issues have assumed increasing importance, in both volume and sensitivity.*⁶¹⁹
- 8.168 Accordingly, DoCS has a number of initiatives underway, for example it has:
- a. implemented data procedures to collect data on CALD clients for evaluation and planning and provision of services for DoCS' CALD clients
 - b. developed cultural competencies and provided advice about effective practice in relation to CALD clients to caseworkers
 - c. developed a CALD foster carer recruitment strategy
 - d. an Ethnic Affairs Advisory Group and a Multicultural Staff Reference Group,⁶²⁰ is finalising a five year Multicultural Strategic Commitment and is funding a three year collaborative research project on child protection practice with CALD clients to identify good practice strategies

⁶¹⁸ Cultural identity is broader than language spoken, for example a second or third generation migrant may only speak English at home, but their cultural identity may still be of non-English speaking origin.

⁶¹⁹ Information provided to Government by DoCS, March 2008.

⁶²⁰ DoCS, 2007/08 Annual Report, pp.129 and 131.

- e. established a Multicultural Caseworker Program, with 61 identified positions covering 22 languages. It is expected that this program will be fully operational in 2008/09
 - f. developed a draft Contact Policy Guidelines that stress that “particular efforts should be made to promote the child’s sense of identity and belonging to their culture”
 - g. funded 211 projects for CALD clients
 - h. developed a Good Practice Guide for caseworkers on working with CALD people and communities. This includes information on cross cultural practice, assessment and casework and guidance about the use of interpreters and language services. DoCS also has a practice resource for secondary risk of harm assessment with migrant and refugee families and a practice guide for funded OOHC services on assessing the needs of CALD children and families in OOHC.
- 8.169 At the casework level, the Inquiry’s case file audit included examples of files where caseworkers inconsistently identified or confused the language and cultural backgrounds of clients. For example, the following list details the different ways four people had their cultural identity described in case files viewed by the Inquiry:
- a. Middle Eastern even after the mother has identified as Sudanese
 - b. Maori, Anglo, Samoan, Islander
 - c. Dutch, Polish, Australian
 - d. Greek, Australian, Lebanese.
- 8.170 There was also one instance where no interpreter was used despite notes on file that an interpreter be used as the mother’s English was limited, particularly under stress.
- 8.171 There were no submissions to the Inquiry from particular communities of CALD backgrounds and very few submissions raised this issue, except in generic terms.
- 8.172 The Inquiry is concerned that the submissions and representations received were almost silent on this issue. It is possible that the cultural and related factors, recognised in the Care Act as being so important to a sense of self and identity, are being largely ignored by the broader child protection system. If so that is unacceptable, and it is a matter that should be addressed by the research project mentioned above.

Interagency work

- 8.173 In addition to the work carried out by DoCS, other agencies contribute to the assessments conducted on at risk families and the interventions which then

occur. Of particular significance is the work of Health and the interagency work undertaken in the JIRTs.

Child Protection Units

- 8.174 Child Protection Units offering specialised multidisciplinary assessment of children referred with child protection concerns are located in the three specialist children's hospitals: Sydney Children's Hospital at Randwick, The Children's Hospital at Westmead and John Hunter Children's Hospital in Newcastle. Each offers a specialist response to children and young persons who have experienced abuse, and to their families. These services include 24 hour crisis counselling and medical services, specialist assessment, forensic medical assessment, ongoing therapeutic and counselling services, medical treatment, complex consultation and expert testimony in court.
- 8.175 The Inquiry was informed that these services provide statewide 24 hour specialist consultation and support to DoCS and Health workers.

The Education Centre Against Violence

- 8.176 The Education Centre Against Violence was established in 1985 and provides training to health workers and their interagency partners on sexual assault, domestic violence, and child abuse. The centre delivers over 180 training programs annually, and has developed a range of resources for training and working with children and their families, including DVDs, CD-Roms and training manuals.
- 8.177 The Inquiry also learned of the centre initiative *Weaving the Net*, which has been developed for Aboriginal communities wanting to promote community and family based solutions to child abuse and family violence.

Joint Investigation Response Team

The Model

- 8.178 A joint investigative model, then called a JIT, involving Police and DoCS was first established in the early 1990s to achieve a more coordinated approach to investigating sexual assault, serious physical assault and neglect. During the following decade, co-located teams which ultimately became Joint Investigation Response Teams (JIRTs) were established in a number of areas in NSW.
- 8.179 There are currently 12 non co-located and 10 co-located JIRTs in NSW.
- 8.180 JIRT services are provided under two models: Co-located (metropolitan) and non co-located (rural). In the co-located model, DoCS and Police officers are located and respond to matters together, undertaking joint decision making. In the non co-located model, DoCS and Police officers are located separately, but still provide a joint response. DoCS trained JIRT caseworkers undertake both

general and JIRT casework, and are located within a CSC under the supervision of the Manager Casework (general position).⁶²¹

- 8.181 Rural JIRT coordinators provide support to non co-located DoCS JIRT caseworkers in the Regions. JIRT Coordinators organise training, and liaise between DoCS and the other JIRT agencies.
- 8.182 As a result of the recommendation of a recent JIRT Review, Health is now also a joint decision maker in JIRT matters along with DoCS and Police. A new centralised management structure is being implemented so that all JIRTs whether co-located or non co-located, will have a direct reporting line to the centrally located Director JIRT rather than the Regional Directors.
- 8.183 The current JIRT process essentially involves the following steps:
- a. referral to a JIRT from the Helpline or from a CSC after initial consideration of whether the risk of harm report qualifies for the JIRT process
 - b. a decision to accept or reject made on the basis of the referral, after consideration by the DoCS and Police team members, with Police having the final say
 - c. referral back to a CSC of rejected cases, or to a Police Local Area Command for further investigation or action
 - d. engagement with Health for forensic examination and a therapeutic response via a sexual assault service or PANOC service as required, for accepted cases; rejected cases will only receive such services if, after further assessment by a CSC, a referral is made.⁶²²
- 8.184 Acceptance of the referral has depended upon JIRT being satisfied that there is, or will be, sufficient evidence to commence criminal proceedings against an alleged perpetrator.
- 8.185 The Police team members have had the responsibility of initiating any necessary protection action by way of an Apprehended Violence Order (AVO), of deciding whether to charge the perpetrator and of preparing the brief for the Office of the Director of Public Prosecutions (DPP) and dealing with that office during any prosecution that follows. In the course of the process they generally take the lead in the interview with the child or young person, although normally with the assistance of a DoCS caseworker. They also interview the perpetrator and other witnesses.
- 8.186 The interview is routinely recorded by video, and back up audio, and the electronic recording of the interview is admissible in evidence, subject to the provisions of the *Criminal Procedure Act 1986*.⁶²³

⁶²¹ DoCS, *Overview of the JIRT program structure and governance arrangements, September 2008*, p.1.

⁶²² DoCS, NSW Health and the NSW Police Force, *JIRT Policy and Procedures Manual*, 2001.

⁶²³ *Criminal Procedure Act 1986* ss.76, 306Q-306Z.

- 8.187 Guidance is provided in relation to the interview process in the manual which is provided to participants in the training course for JIRT staff.⁶²⁴
- 8.188 The DoCS caseworkers have the responsibility of undertaking a secondary risk of harm assessment, and of determining whether action should be taken for removal of the victim and of any other relevant children or young persons, for whom the perpetrator presents a risk of harm.

DoCS statistics

- 8.189 The preliminary data for 2007/08 set out in Chapter 5 indicate that 6.7 per cent of total reports to DoCS had sexual abuse as the primary reported issue, rising to 8.3 per cent when taking primary, secondary and third reported issues into account. The corresponding figures for physical abuse for 2007/08 were 14.2 per cent rising to 22.9 per cent. A slightly higher percentage of reports about each issue was referred to a CSC or JIRT than for total reports. In the period 1 April 2007 to 31 March 2008, sexual abuse reports were less likely to be closed at the CSC/JIRT before any secondary assessment, whereas physical abuse cases were slightly more likely to be closed at this stage.
- 8.190 In the period 1 April 2007 to 31 March 2008, sexual abuse and physical abuse reports were more likely to receive a SAS2 than the average across all reports. However, these reports were less likely to be substantiated.
- 8.191 The data for accepted and rejected referrals appears in the tables below.⁶²⁵

Table 8.2 Accepted and rejected JIRT referrals

<i>Financial Year</i>	<i>Referral</i>	<i>Accepted</i>	<i>Rejected</i>
2006/07	5,363	56.4%	43.6%
2004/05	6,456	56.1%	43.9%

Table 8.3 JIRT co-located data only

<i>Financial Year</i>	<i>Referral</i>	<i>Accepted</i>	<i>Rejected</i>
2006/07	3,352	53.8%	46.2%
2004/05	3,823	50.4%	49.6%

Table 8.4 Non co-located data only

<i>Financial Year</i>	<i>Referral</i>	<i>Accepted</i>	<i>Rejected</i>
2006/07	2,011	60.7%	39.3%
2004/05	2,633	64.4%	35.6%

- 8.192 These figures suggest that there has been a successive reduction in the annual referrals over the period 2004/05 to 2006/07, notwithstanding the upward trend in child protection reports over that period.

⁶²⁴ NSW Police Force, *Joint Investigative Interviewing of Children Course – Audio Recording and Video Recording of Investigative Interview with Children and Young People*, May 2007.

⁶²⁵ Data for 2005/06 has not been included due to data quality issues.

- 8.193 It is clear from Police data in 2005/06 that the majority of the referrals have involved allegations of child sexual assault.⁶²⁶
- 8.194 In addition, the data indicate relatively low referral and acceptance rates for physical abuse and neglect cases which is of concern, and may have been due to the vagueness of the original criteria as well as a level of uncertainty among paediatricians and Emergency Departments as to the aetiology of injuries or appearance in a child of malnutrition or illness. Unfortunately, DoCS was unable to provide data on the nature of the referrals to JIRT.

Some statistics on child sexual assault

- 8.195 Some information in relation to the incidence of substantiated child sexual abuse is provided by the recent report on the evaluation of the Cedar Cottage Program run by Health, which noted:

In 2004, 3,752 child sexual offence incidents were reported to the police in NSW (Fitzgerald, 2006). Of these incidents, 1,042 (27.8%) were cleared up by the police within 180 days of reporting. In the NSW Local and Higher Courts 547 persons were charged with at least one child sex offence. Of these, 243 (44.4%) were found guilty of at least one child sex offence. Of all the persons found guilty, 138 (56.8%) received a sentence of full-time imprisonment and once received periodic detention. One thousand and fifty-seven individual charges of child sexual offences were finalised, of which 481 (45.5%) were proven.

Whereas child sexual abuse cases constitute a significant proportion of all criminal trials (16% in the Sydney District Court and 42% in regional District Courts)(Gallagher & Hickey, 1997), only approximately eight percent of all reported cases result in a conviction (Fitzgerald, 2006).

The rate of guilty pleas in child sexual assault cases increased between 2004 and 2006 according to BOCSAR (Cossins, 2008). However, defendants are less likely to plead guilty to a sex offence compared to other offences and less likely to be found guilty at trial (Fitzgerald, 2006; Taylor, 2007). Accordingly, a steadily decreasing conviction rate of child sexual abuse compared to convictions for all other criminal offences combined was observed during the 1990s. More recent data confirm this trend, with the likelihood of conviction in the NSW higher courts for a child sex offence falling between

⁶²⁶ DoCS, NSW Health and the NSW Police Force, *NSW Joint Investigative Response Team Review*, November 2006, p.87.

*one fifth and one quarter, where the accused pleads not guilty (Cashmore, 1995; Cossins, 1999).*⁶²⁷

2006 review

- 8.196 A number of reviews of the JIRT model have been conducted, with the most recent being undertaken in 2006. That review identified the following problems:
- a. the wide variations in the rates of acceptance of referrals between different JIRTs, and the emphasis that was being placed on the immediate incident, rather than on the context in which it occurred, or on the broader history of the relationship between the perpetrator and victim
 - b. the focus that was placed on success in prosecution, rather than on the safety and well-being of the victim
 - c. the delays that were occurring in interviewing children
 - d. an under representation in the acceptance of physical abuse cases
 - e. an over dependence on the need for disclosure by the victim of sexual abuse before acceptance and investigation
 - f. the difficulties in engaging Aboriginal children and their families, associated with insufficient cultural awareness and local knowledge on the part of JIRT staff, when working with these communities, as well as a limited involvement of Aboriginal staff in the JIRTs and, in turn with a lack of understanding by Aboriginal Communities in the JIRT model
 - g. an imperfect coordination of the input of members of the teams, and the absence of Health as a full partner contributing to decision making or planning
 - h. a lack of timely referral to forensic medical services and allied health services, including counselling
 - i. imperfect communications between the agencies, particularly in the sharing and exchange of information, and difficulties in establishing an integrated regional approach to governance because of the differing geographical boundaries of all three agencies
 - j. a lack of reliable and accessible data on JIRT processes and outcomes.⁶²⁸
- 8.197 The recommendations which were made by that report have been endorsed and are the subject of an implementation plan.

Internal audit review in 2006

- 8.198 An audit of JIRT rejections carried out by Ernst & Young in 2006 also identified a number of deficiencies in the management of referrals to JIRTs across the

⁶²⁷ J Goodman-Delahunty and J Pratley, 2008, op. cit., pp.5-6.

⁶²⁸ DoCS, NSW Health and the NSW Police Force, *NSW Joint Investigative Response Team Review*, November 2006, pp.4-5 and see also pp.14-15, 17, 19, 20-21.

several regions, and in the way that the rejected referrals were processed. This audit noted several persistent failures in relation to the adequacy of the documentation for the rejected matters, and also identified several cases where there had been:

- a. delays by the JIRTs in the assessment of referrals
- b. a lack of review of rejected matters by Managers Client Services and of referral to the Director Child and Family
- c. delays in the management of cases referred back to CSCs
- d. some lack of understanding by the staff involved of the relevant procedures.⁶²⁹

Reforms post 2006

8.199 As a result of the findings of the 2006 review, there has been significant change to the operations of JIRT. The key outcomes from the reform process are as follows:

- a. A trial commenced on 10 September 2008 to implement a Central Decision Making team titled the JIRT Referral Unit (JRU), involving senior representatives of the three agencies, responsible for the decision to accept or reject a referral, and for undertaking the further inquiries needed in the case of a matter regarded as appropriate for provisional acceptance. This takes this function away from local JIRT Units.
- b. A new structure has been established which removes operational reporting responsibilities from the seven regions and establishes a single reporting and accountability line from JIRT caseworkers through to the Director JIRT in DoCS Head Office.
- c. Revised Operating Procedures have been developed including those relating to the sharing of information and the development of safety and welfare and well-being plans.
- d. A Rapport Building Project has been taken over by Health employing a consultant.
- e. There is a JIRT at Tamworth which is co-located.
- f. A revised MOU is under consideration for the exchange of information between Police and DoCS.
- g. Revision of the physical abuse criteria has occurred; and consideration is being given to the suggested revision of the sexual abuse criteria.
- h. JIRT governance has been revised.
- i. The new JIRT structure includes a Director Practice JIRT

⁶²⁹ Correspondence: DoCS, 20 March 2008, Ernst and Young Audits: Regional Operations, Metro Central, April 2006; Metro West, April 2006; Western, June 2006; Metro South West, June 2006; Northern, August 2006; Southern, August 2006; Hunter and Central Coast, August 2006.

- j. Forensic medical services have been reviewed, although the implementation of this review awaits further consideration and approval by Health, and additional work may be required in relation to its costing.
- 8.200 The JRU is of particular importance. It has a DoCS Manager Client Services, a Zone Coordinator from Police, a Health Services Manager from Health, and a staff comprising a DoCS Caseworker, a Police Team Leader, a Police Constable, a Health Service worker and administration staff.
- 8.201 During the trial, the JRU will receive referrals, decide whether the referral meets the JIRT criteria, undertake any additional inquiries, distribute accepted matters to a local JIRT and refer rejected matters back to a CSC after completing a SAS1.
- 8.202 The Inquiry supports the JRU initiative, which could assist in overcoming the problem brought to its attention in several submissions, concerning the incomplete and sometimes inaccurate information obtained via the Helpline and passed to a JIRT, which has either resulted in a need for further work by the JIRT, or a rejection of the referral which has commonly been followed by case closure without any field visit.
- 8.203 There is however an imperative to avoid delay in these cases, given the relatively brief window available to obtain forensic evidence, and the possibility of witness collaboration or pressure on a complainant to retract an allegation of abuse. The adoption of a central gate keeping team should be contingent upon it not being a cause for delay in the commencement of investigations.
- 8.204 Rejected cases have been referred back by the DoCS Manager Casework to a DoCS CSC for further management; or by the Police Team Leader to a Local Area Command for further investigative action if there is reason to suspect that a criminal offence outside the JIRT criteria has occurred. This procedure will continue pending the further trial of the Central Decision Making team.
- 8.205 In addition, and in response to the Ernst & Young review, DoCS has advised the Inquiry of a number of changes made to reports and procedures and has introduced an audit process.
- 8.206 The reform process following the 2006 JIRT Review may result in at least some of the issues previously noted becoming more of historic interest. However, the fact is that they have caused problems in the past, and unless suitably addressed, they are likely to re-appear.
- 8.207 An illustration of a key problem can be seen in the following case which the Inquiry considered.

Case study 5

Over a period of several years, DoCS received 27 reports about one or more of three children with the same mother. Taken together these reports raised concerns about the family's itinerancy, the domestic violence the children were exposed to, and the impact of parental drug and alcohol abuse on them. The children were also variously reported to be neglected. The girl, on more than one occasion, was reported to be subjected to physical assault by the people variously caring for her. At the age of three years she was exposed to the alleged rape of her young aunt by a partner of her mother. At the age of five years she herself was allegedly indecently assaulted by a family member. JIRT became involved but responded to the sexual assault allegations only, and appears to have focused exclusively on the criminal aspects of the case.

Subsequently, the girl's sibling died. DoCS accepts that the JIRT investigation was too narrow.

DoCS advises that this example highlights the difficulties that rural areas have with access to trained JIRT staff.

A number of initiatives have been put in place since these events to address the issues raised by this case.

Acceptance of referral

- 8.208 As was noted in the 2006 JIRT Review earlier there has been a wide divergence between individual JIRTs as to the proportion of cases accepted.
- 8.209 The additional physical assault and neglect training now to be provided, and the revised physical assault criteria, should help to reduce any inconsistency in practice in relation to these forms of abuse.
- 8.210 They should also assist in increasing the limited number of physical assault cases that have been referred and accepted to date. That low level of referral and acceptance is of concern having regard to the possibility of these cases escalating and resulting in the infliction of more serious injury or even in a death, unless addressed at an early stage.
- 8.211 It was suggested to the Inquiry that a problem for physical abuse and neglect cases has been the fact that the focus for JIRT has been on the current incident, without reference to the context and history of the relationship between the victim and the alleged perpetrator including evidence of earlier abuse. If so this appears to have been an inappropriate practice, which risks missing escalating and potentially serious cases. The Inquiry understands that work is being done to identify patterns of abuse in cases referred to a JIRT.

- 8.212 The problem identified may have been due to some misunderstanding of the law in relation to the circumstances in which evidence can be introduced in a trial of events that go beyond the incident which has led to a referral, investigation and possible prosecution. If that be the case, then training is required for JIRT officers about the circumstances in which relationship or context evidence can be adduced, and in relation to tendency and coincidence evidence.⁶³⁰
- 8.213 Until the sexual assault criteria are clarified, problems are likely to persist with their application. It is important that the trial of the JRU be completed and that a clear set of criteria be finalised to assist in the assessment of cases for referral to a JIRT, both at the Helpline, and at the JRU if that model is adopted.
- 8.214 It is recognised that JIRTs will always face a difficulty where the victim is young and fails to make a sufficient disclosure of sexual or physical abuse that would provide a basis for a prosecution. Premature closure of these cases without an informed understanding by JIRT members of the dynamics of disclosure of abuse, including the fact that it will often be delayed or emerge progressively, and that it will depend upon the establishment of a relationship of trust and confidence on the part of the child with the interview team, may well have contributed, in part, to the high rejection rate in these cases.
- 8.215 The relatively low conviction rate in defended cases and earlier decisions of the High Court concerning the reliability of delayed disclosures, and of a need for corroboration⁶³¹ may also have contributed to the reluctance of some JIRTs to accept these referrals. However the law has caught up with accepted professional knowledge in relation to the sexual abuse of children, and relaxed the need for some of the warnings that were previously needed.⁶³²
- 8.216 In some instances the choice of interviewer may be critical as is illustrated by the following case study.

Case Study 6

A 14 year old child whose allegation of a sexual assault was referred to a JIRT, was reluctant to speak to male detectives, but was able to make a disclosure once the interview was conducted at her request by female officers.

⁶³⁰ *Evidence Act 1995* ss.97 and 98.

⁶³¹ For example, *Longman v The Queen* (1989) 168 CLR 79; *Crampton v The Queen* (2000) 2006 CLR 161; *Doggett v The Queen* (2001) 208 CLR 343; *Crofts v The Queen* (1996) 186 CLR 427.

⁶³² *Evidence Act 1995*, ss.165A and 165B and the unproclaimed *Evidence Amendment Act 2007* Schedule 1 (34) which will allow expert evidence to be given in relation, *inter alia*, to the development and behaviour of children who have been victims of sexual offence; as well as the *Criminal Procedure Act 1986* ss.294 and 294AA.

Response to rejected referrals

- 8.217 Of concern has been the experience of rejected referrals being sent back to a CSC without any ongoing case plan, and then closed without a secondary assessment or other action. Police raised this as a matter that could lead to repeat referrals and it was also an issue that was raised at several of the rural interagency meetings, including those at Dubbo, Ballina, Newcastle and Wagga Wagga.
- 8.218 It was similarly raised in the draft report of the Ombudsman's investigation into the response by DoCS and JIRT to risk of harm reports concerning the death of a child.⁶³³ In that report, several problems were identified concerning the management of the case by the relevant CSCs following a JIRT rejection, particularly in relation to its transfer, the lack of a sufficient secondary risk of harm assessment, and inappropriate management and review following the rejection, as well as problems in record keeping.
- 8.219 DoCS has responded to these issues by way of the revised Casework Practice document for rejected JIRT referrals, and the revised Intake Assessment Guidelines. It has also pointed to the JRU Trial which should improve record keeping and ensure at least a SAS1 occurs.
- 8.220 The experience with the earlier audits, and the introduction of the revised practice document points to the desirability of an ongoing audit, at suitable intervals, to ensure that there is compliance with current JIRT policies and procedures, either by the Ombudsman, or in the course of DoCS Internal Audit Program.
- 8.221 Additionally it means that cases rejected by JIRTs by reason of insufficient disclosure, where suspicion remains as to the occurrence of sexual assault should not be closed without attention being given to referral for counselling and a therapeutic response.

Full participation of Health

- 8.222 Clearly there are advantages in including Health as a full partner in the JIRT process, in so far as that could:
- a. permit an improvement in the sharing of information held by Health concerning any history of injury or neglect known to it
 - b. facilitate the prompt development of a safety welfare and well-being plan for accepted cases as well as for rejected cases
 - c. assist in securing immediate access to counselling and other therapeutic assistance for the victim and family.

⁶³³ NSW Ombudsman: *Investigation into the death of a child*, July 2008.

- 8.223 The Inquiry accepts that, in principle, it is desirable for Health staff to be involved as a full partner in the JIRT process from the time of referral, and to be in a position to contribute to the assessment, investigation and planning process.
- 8.224 While Police supports the full involvement of Health it has also raised some concerns from past experience, as to the consistency of its involvement, and its capacity to contribute to the initial decision making process and consequent planning.
- 8.225 Clearly there would be considerable resource implications for Health generally, as well as logistic difficulties for some Area Health Services, in recruiting sufficient staff and in making them available to individual JIRTs, as well as a need for some change in the culture of Health workers if they are to become more closely involved in an agency that has, among its principal objectives, a criminal investigative function.
- 8.226 Otherwise, the Inquiry considers that the potential input from Health into the development of safety, welfare and well-being plans can be achieved through the other strategies discussed in this report, including placing Health workers within CSCs, and the JRU where they can have a wider role in assessing cases for JIRT referrals, or for care and protection or early intervention.

Quarantined or co-located?

- 8.227 As a general principle, and as discussed elsewhere in this report, the Inquiry supports the concept of locating staff from DoCS and from other relevant human services agencies within the same general location, for example in a state government office centre, so as to facilitate cross agency client access to services.
- 8.228 This is likely to be more necessary in rural and remote areas of the State than it is in the larger metropolitan centres.
- 8.229 JIRT units have been located separately from Police Stations and from DoCS offices, for reasons that are obvious and are not questioned by this Inquiry. This does, however, raise the question whether JIRT staff from DoCS and Health should be co-located with the Police team, or remain in the premises of their respective agencies and be available when required.
- 8.230 The advantages of co-location are obvious, although in the more remote areas of the State there may not be enough JIRT work, and too much work for DoCS and Health in their core responsibilities to justify co-location.
- 8.231 The Inquiry considers that this will need to be worked out on a case by case basis depending on the availability of local staff, and on how well the boundaries of the JIRT coverage match those of the DoCS CSCs and Area Health Services involved. The lack of alignment between agency boundaries was identified by Detective Superintendent Begg, the former Commander of the

Sex Crimes and Protection Squad, as creating some inflexibility in the ability of a co-located worker to respond to some of the referred cases.⁶³⁴ The Inquiry acknowledges the validity of this concern.

- 8.232 The associated question which arises is whether there should be a large pool of DoCS workers, in particular, trained for JIRT work, who can be called up from their normal duties for JIRT referrals as and when required, or whether there should be a smaller pool of specialists quarantined for this form of work. Again this seems to be a matter for which there is no single answer. It will depend on the potential caseload, the location of each JIRT and of the relevant CSC or Area Health Service, and the level of their staffing and demand for their core services. In general, the Inquiry believes that co-location is preferable for those JIRTs that have a consistently heavy work load, and that otherwise the quarantined model is preferable. In each case this will permit deployment of the specialisation and acquired expertise that is needed for this work, and will enhance a consistency of and stability in the management of ongoing cases, including the support of the victim and family. However, it is recognised that in some instances, the level of demand and resources will not permit or justify either course.
- 8.233 What is required, accordingly, is a process that will match, as far as possible, DoCS and Area Health Service staff with JIRTs, on a regional demand and resourcing basis, with preference being given in descending order of priority to co-location, quarantining of JIRT specialists, and secondment of JIRT trained casework managers or caseworkers as required.

Staffing and training

- 8.234 The Inquiry has been informed of the difficulties that each of the agencies has experienced, or expects to experience in providing and maintaining the staffing required for JIRT units particularly in rural and remote areas, of the resulting lack of stability in key positions and of the need to rely on the provision of services on an outreach basis. This difficulty was raised with the Inquiry at a number of the rural interagency meetings, including those at Inverell, Dubbo, Broken Hill, and Coonamble.
- 8.235 Clearly, the employment and training of suitable staff is necessary, as is the engagement of Aboriginal workers for JIRTs that are likely to receive referrals involving Aboriginal victims and families. This has been recognised by the reform process, the objectives of which, in this respect, are endorsed by the Inquiry.
- 8.236 It is however a problem that will require innovative strategies for all agencies that may require the provision of incentive packages, and a positive program for recruitment and training.

⁶³⁴ Transcript: Inquiry meeting with NSW Police Force senior executives, 8 January 2008, pp.17-18.

- 8.237 The Inquiry considers that these strategies and particularly that of rotation are sensible occupational and health strategies, that should be extended, with any suitable modifications if not already in place, to all JIRT staff, to address the special demands and stresses of this work.

Sharing of information

- 8.238 The requirements of confidentiality and the perceived restrictions on the exchange of information between the JIRT members, and the need to deploy the DoCS worker to act as an intermediary and to initiate action under s.248 of the Care Act, in order to obtain and exchange information have been identified as an ongoing problem.
- 8.239 The ability of JIRT members to share the information that is contained within their databases and that is relevant for the investigation of a possible criminal offence concerning a child, or for managing a care and protection issue is critical.
- 8.240 This is addressed in more detail in Chapter 24 in which the Inquiry discusses the need for a legislative scheme that will permit the provision and sharing of information, by and between human service agencies, where that is consistent with the paramount interest of securing the safety, welfare and well-being of a child or young person, within which could be included its provision and sharing where that is reasonably required for the purpose of a JIRT.
- 8.241 So far as the Inquiry can ascertain the Privacy Commissioner has not issued a Privacy Direction in relation to the JIRT model, with the consequence that the general privacy principles, outlined in an annexure to this report, apply subject to the several exemptions for which they provide.
- 8.242 The JRU Casework Practice document notes that:
- As full Partners in JIRT, DoCS, Health and Police are able to share information relevant to the safety, welfare and well-being of a child without the need for a s.248 request.*
- 8.243 This appears to have given rise to an assumption that there is no need to continue with a process which had been commenced for the preparation of a Privacy Direction.
- 8.244 The Inquiry understands that there have been conflicting opinions of law expressed in this respect. If doubt does persist then this needs to be addressed either by the issue of a Privacy Direction or by a broader amendment of the law, which is addressed later in this report. Pending legislative amendment, a Privacy Direction would seem sensible to ensure that current work is not prejudiced by privacy concerns.
- 8.245 A specific problem has been identified by Health in relation to its system for the collection and retention of data, in respect of which it noted:

*Implementation of the JIRT recommendations in four trial sites in November-December 2007 has flagged the significant impediments to the three agencies working together well as a result of the lack of standardisation of and timely access to clinical information within the NSW Health system. Many components of the health system continue to rely on manual systems of information storage and retrieval. Health workers in the decentralised NSW Health system are frequently unable to access information as readily as their interagency partners in Police and DoCS.*⁶³⁵

- 8.246 This can obviously be a problem in the case of mobile families who may reside from time to time in locations covered by different Area Health Services, as well as for those families who deliberately access different services, or move residence, to avoid reporting by Health or DoCS scrutiny. One such case was brought to the Inquiry's notice concerning a child with serious malnutrition who had been presented at each of the Children's Hospitals, in circumstances where the treatment recommended was not provided, as the treating paediatricians at each hospital were prevented by the child's mother from obtaining access to the medical records at the other hospital.
- 8.247 As the recent JIRT Review also revealed, an issue of law arises concerning the ability of a Health worker from one Area Health Service, working in a JIRT Unit, to obtain health information from another Area Health Service.
- 8.248 The Inquiry recognises that there are substantial issues arising as a result of the absence of any central or universal electronically based system within NSW Health for the collection and retrieval of data. This is attributable to the Area structure under which it operates, and to the *Health Records and Information Privacy Act 2002*. The benefits, and consequences, of any wholesale revision of systems for Health data management are beyond the scope of this Inquiry, beyond noting that consideration needs to be given to the development of a means whereby Health workers can provide the information that is needed by JIRTs, for individual cases.

Availability of forensic and sexual assault and PANOC services

- 8.249 A network of 55 Sexual Assault Services across NSW provides services to adults and children who have experienced sexual assault. Forty-six of these services see children and young persons. The services offer free counselling, information and access to medical services. Most services are funded through Area Health Services, and a small number are funded under the CSGP specifically to provide counselling to child sexual assault victims. Details of the DoCS funded programs are discussed in Chapter 25.

⁶³⁵ Submission: NSW Health, 3 March 2008, p.44.

8.250 Health also provides required medical examinations and treatment for children who are suspected or known to have been abused or neglected. The service includes a full physical examination and brief behavioural and developmental assessment in addition to the taking of the history regarding the sexual assault. The service is restricted to medical practitioners working with the sexual assault service unless training has been provided or they are experienced in these examinations.⁶³⁶ An estimated 475 examinations were provided to children in 2004/05.⁶³⁷

8.251 Health informed the Inquiry that a review of these services was commissioned in January 2007, in response to:

*concerns that arrangements to secure medical officers for forensic and medical services for sexual assault and child physical abuse and neglect are variable across NSW in regard to the timeliness, consistency, and quality of services available. The availability and willingness of medical officers to provide these services was of particular concern.*⁶³⁸

8.252 The report of the review was delivered in August 2007. It found that forensic and medical examination of children who report sexual assault is a highly specialised medical activity that rarely produces conclusive findings, and that medical care and forensic examination must be provided by medical practitioners trained in child sexual assault and child development and conducted in a child focussed and friendly environment. The consultations by the review team with stakeholders revealed a similar range of issues with the forensic and medical services to those found by the Inquiry, including the following:

- a. Victims were choosing to opt out of having a forensic examination due to time delays or the need to travel to access the service, limiting the opportunities for Police to proceed with a criminal justice response.
- b. Many medical practitioners were not interested in providing a forensic and medical response to victims of sexual assault because of inadequate pay, training and support. There were very few paediatricians available and willing to examine children who may have been sexually abused especially in rural and regional areas.
- c. There was limited coordination between the health response and that of other services, which led to confusion about the roles and responsibilities for the three key agencies. There were also limited numbers of trained medical practitioners available to conduct examinations. This was reported to be due to a shortage of paediatricians and general practitioners in rural

⁶³⁶ NSW Health, *Sexual Assault Services Procedures*, 9.8 and 9.18.

⁶³⁷ NSW Health, *Review of Forensic and Medical Services for Victims of Sexual Assault and Child Abuse, Part 2*, August 2007, p.75.

⁶³⁸ Submission: NSW Health, 3 March 2008, p.42.

and regional areas. It was also reported that doctors found the system an unattractive one in which to work.

- d. Provision of culturally appropriate and accessible services for Aboriginal victims needed to be addressed, in order to overcome barriers to disclosure and reporting.
- e. Data systems for sexual assault needed strengthening, while data systems for forensic and medical responses to child physical abuse and neglect did not exist.⁶³⁹

8.253 The review examined the concepts of 'one-stop shops' and networked responses to victims of abuse and neglect, that involve a coordinated and/or co-located response across agencies such as DoCS, Health and Police, and found that they improve outcomes for victims.⁶⁴⁰

8.254 The review recommended a whole of government approach to the provision of these services, with the Health aspects including the establishment of clinicians within each Area Health Service with a responsibility to provide leadership, coordination and direction to practitioners, the establishment of forensic and medical hubs in each Area Health Service, and the training and employment of accredited, trained medical and nursing personnel to conduct examinations. Examinations of children would not be conducted by nurses in the recommended model.⁶⁴¹

8.255 Health advised the Inquiry that a staged implementation of the review was currently being examined, and that it was in the process of developing a business case and an implementation plan in response to the KPMG review report.

8.256 PANOC services were established in 1997 to provide a dedicated counselling response to children who are victims of physical or emotional abuse or neglect, where abuse has been substantiated.⁶⁴² Children can be referred to these services through DoCS, JIRT, and the Children's Court. The Inquiry was informed that PANOC services are located in each Area Health Service across NSW.

8.257 The need for prompt access to forensic services, sexual assault and PANOC (or Child Protection Counselling) services in relation to JIRT referrals is obvious.

8.258 Not all of the available positions in the Child Protection Units at the three Children's Hospitals, or in the PANOC and Sexual Assault Service Units within the Area Health Services across the State, have been filled, with the result that

⁶³⁹ NSW Health, *Review of Forensic and Medical Services for Victims of Sexual Assault and Child Abuse, Report 1 – A new approach*, August 2007, p.19-29.

⁶⁴⁰ *ibid.*, pp.23-24.

⁶⁴¹ *ibid.*, p.34.

⁶⁴² NSW Health, *Child Protection Counselling Services Policies and Procedures 2007* (DRAFT).

there are delays, while some victims find it necessary to travel significant distances to attend a relevant service.

8.259 This has been identified as a factor that can cause victims to disengage from the JIRT process, and it can leave them without the support and therapeutic response that is needed to address the harm occasioned by the assault.

8.260 In this regard the Police informed the Inquiry that:

The system in relation to the delivery of forensic medical examination currently in place is not working. NSW Health have recently completed a significant review of these services however there would need to be significant financial resources and time invested before the recommendations come to fruition. There needs to be immediate access to forensic, counselling and medical services in rural and remote areas. This may be able to be achieved via the appointment of a Government Medical Officer in local areas who is trained to provide these services to victims.

Currently a child may pass many medical officers en route to a 'major' medical location for the examination. The other challenge linked to this is the transport of such victims. If taken in Police vehicles there is a potential risk of cross contaminations. Confusion currently exists regarding who has the responsibility for transport to and from forensic medical examinations.

A major issue for rural-based medical practitioners is the challenge presented in giving evidence in court. This requires them to disrupt their practice and travel to the location of the court with limited financial compensation. An alternative and more efficient method would be the use of audio visual links for rural medical practitioners in giving evidence in child sexual assault matters, (thus limiting) the time they are absent from their practices and eliminating many logistical issues.⁶⁴³

8.261 The difficulties that were experienced in obtaining forensic examinations were identified in several rural interagency meetings including those at Dubbo, Moree, Bourke, Wagga Wagga, Coonamble and at Newcastle.

8.262 Police in its submission noted that:

JIRT teams and specialised investigators could also benefit from improved access to experts in the field of child abuse matters, rather than relying on paediatricians, where and when

⁶⁴³ Submission: NSW Police Force, Regional Interagency Forums, February 2008, p.2.

*available, whose expertise in determining how injuries are caused is often limited. One approach might be to establish a "register of experts", whose advice is considered, robust and tested, who are able to be appointed as JIRT consultants to assist any JIRT team and to provide expert testimony in Court proceedings.*⁶⁴⁴

8.263 The problems with the lack of expertise in this area were also identified by The Children's Hospital at Westmead in its submission, which noted that there is no adequate training in NSW in forensic medicine, particularly in injury identification, and that practitioners interested in working in this area need to gain the necessary expertise through the Victorian Institute of Forensic Medicine. It made the point that "mediocre reports" from doctors in Emergency Departments can lead to a poor presentation of evidence and to an unsatisfactory outcome.⁶⁴⁵

8.264 The Inquiry was informed of widespread concerns as to the insufficiency of Sexual Assault Services or PANOC services, at its rural interagency meetings including those held at Griffith, Inverell, Dubbo, Coonamble, Moree, Nowra, Bourke and Wagga Wagga.

8.265 The difficulties in filling positions for these services were also of concern to Health. Dr Matthews advised the Inquiry:

*Take, for instance, the PANOC services in Greater Western Area Health Service, only 50 per cent of those funded positions are filled, despite fairly desperate attempts by the Area Health Service. It is extremely difficult to get workforce in those places.*⁶⁴⁶

8.266 Health informed the Inquiry that as part of the interagency response to child sexual assault in Aboriginal communities, funding had been allocated for an additional six specialist Aboriginal sexual assault counselling positions, with four of those positions established to date, two of which have been filled.

8.267 The lack of sufficient staff in Child Protection Units and in the Sexual Assault and PANOC units will lead to undesirable waiting lists, particularly for those needing longer term support, since priority needs to be given to acute crisis interventions, counselling and forensic services for both adults and children.

8.268 The Inquiry's attention was drawn to the existence of waiting lists by The Children's Hospital at Westmead, in its submission, which also invited

⁶⁴⁴ Submission: NSW Police Force, 19 May 2008, p.47.

⁶⁴⁵ Submission: The Children's Hospital at Westmead, pp.9 and 11.

⁶⁴⁶ Transcript: Public Forum, Health and Disability, 11 April 2008, pp.17-18.

consideration to the establishment of additional Child Protection Units at other public hospitals, located in areas of high demand.⁶⁴⁷

- 8.269 It is noted in this respect that Health has in the past funded or supported a range of non-government sexual assault programs, some of which have been co-located with Area Health Services, with additional support from Neighbourhood Centres. The possibility of engaging these services, where they continue to be funded, merits consideration, at least for longer term specialised therapeutic intervention.
- 8.270 Whatever approach is taken, the absence of readily accessible expert forensic services, and of counselling and support through Sexual Assault and PANOC services, is a serious obstacle to the successful operation of the JIRT model, and consequently for the provision of an acceptable care and protection system. As such it needs to be addressed by Health.
- 8.271 The Inquiry also heard that for a child to be seen by a PANOC worker, policy required that the case be open and have an allocated DoCS caseworker. One health service coordinator informed the Inquiry:

*I think it's perhaps one of the changes that we would like to see within Health, that our PANOC services are able to see children and able to accept referrals direct other than through the DoCS process, because that is a bit of a barrier, I think, and hindrance.*⁶⁴⁸

- 8.272 The Inquiry was informed that sexual assault counselling has not normally been provided to children under the age of 14 years until they had been interviewed by a JIRT team and their disclosure confirmed. The justification for that approach is understandable in that it was designed to avoid the risk of an allegation of contamination in the event of a subsequent disclosure being made. The Inquiry learned that this has presented a problem in those cases where, despite the absence of a disclosure or sufficient disclosure to JIRT, there was some evidence supportive of the report, yet the case was closed without any secondary assessment or additional investigation by the CSC.
- 8.273 The Inquiry understands, that as presently structured, children and young persons who are subject to physical assault or neglect, require a referral from a JIRT or DoCS, or from the Children's Court, in order to access a PANOC service. This can prove problematic in the case of JIRT rejections where the case is closed without an ongoing care or well-being plan, which includes a referral to such a service.
- 8.274 The Inquiry expects that this problem should be solved by the revised Health policy that would allow counselling to take place, but to be suspended in the

⁶⁴⁷ Campbelltown cited as one such area, for which a response could be provided through a Child Protection Unit located at Liverpool Hospital, Submission: The Children's Hospital at Westmead, p.11.

⁶⁴⁸ Transcript: Public Forum, Inverell, 20 March 2008, p.11.

event of a disclosure being made in the course of that counselling, followed by a referral to the Helpline and on to a JIRT.

- 8.275 In one regional Public Forum, a private psychologist working with Life Without Barriers informed the Inquiry:

*The other issue I wanted to address is sexual assault. That is a really huge issue and it is ongoing. For any child under 10 to get sexual assault counselling, it is usually very, very difficult because, especially in foster care, they do not trust adults. If they make a disclosure, it is usually to the foster carer. Then when DoCS interviews or JIRT interviews, they won't say anything, they won't make another disclosure; therefore, the referral can't be made for a sexual assault and the counselling doesn't happen. That is the most appropriate counselling for a child who makes a disclosure. You can send them to a private psychologist, you can send them to another service, but that's not necessarily the most appropriate. What they need at that time is skilled workers to work with them.*⁶⁴⁹

Engagement of Aboriginal Communities

- 8.276 The difficulties in engaging Aboriginal children and their families in the JIRT process are acknowledged.⁶⁵⁰
- 8.277 The Inquiry was also informed during the rural Public Forums of the extent to which investigations into allegations of sexual assault within a community on the North Coast had caused serious divisions within that community.
- 8.278 A consequence has often been the subsequent retraction of a disclosure, and, in many cases, an insufficiency of evidence to justify interviewing a suspected perpetrator. The development of a culturally appropriate JIRT model, for which work has been undertaken may help to address this problem. It envisages making a support person available to a victim during a JIRT intervention, utilising Aboriginal agency staff for a JIRT consultation, improving JIRT staff cultural awareness, and informing JIRT engagement with Aboriginal communities through a community awareness and education package and other strategies.
- 8.279 The initiatives of DoCS and Police in response to the 2006 Review are positive and need to be supported and maintained. In this respect probably the most important element is engagement with the community and building an understanding of and confidence in the JIRT system. The Toomelah/Boggabilla Project and the further projects considered for other communities, including

⁶⁴⁹ Transcript: Public Forum, Nowra, 13 May 2008, p.22.

⁶⁵⁰ According to the JIRT Review in 2006 Aboriginal children represent 3.4 per cent of accepted JIRT cases, a percentage of well below the proportion of such children reported to the Helpline (11.8 per cent). DoCS, NSW Health and the NSW Police Force, *NSW Joint Investigative Response Team Review*, November 2006, p.21.

Nowra, need to be monitored for lessons about how the JIRT process can be made more relevant for Aboriginal families. Additionally agencies need to demonstrate that they are committed to tackling child abuse in these communities by ensuring that they have specifically trained staff available, and that they will follow through with prosecutions.

Support facilities

- 8.280 Police drew attention to the fact that while considerable capital expenditure has been incurred in acquiring suitable JIRT facilities away from Police Stations and DoCS offices, and in constructing interview suites with up to date equipment for the recording of interviews, in rural areas particularly those involving Aboriginal communities JIRTs generally have to travel to the location of the victim to interview them.
- 8.281 It identified that further work was needed to develop practical options for effective portable recording facilities, beyond the current hand held videos mounted on a tripod, that are currently used in these situations.
- 8.282 The Inquiry acknowledges the force of this submission since the quality of the audio and visual recording of any interview that is to be tendered in Court as the evidence of a child, is vital to the success of a prosecution.

Safe houses and alternative accommodation

- 8.283 Police also drew attention to the fact that:

When a child discloses a sexual assault, particularly those in small Aboriginal communities, there is a need to be able to secure safe accommodation immediately. If a child is placed in an alternative home in an Aboriginal community, they may still be at significant risk.

In rural areas there is generally a lack of alternative emergency accommodation available for children at risk.⁶⁵¹

- 8.284 Again the need for this kind of facility is critical given the risks of reprisal and pressure which can be exerted upon a complainant and his or her family in a small community, within which particular problems are likely to arise, in practice, in maintaining confidentiality as to the fact of disclosure and investigation.

Conclusion

- 8.285 The Inquiry accepts that there are strong reasons in principle, and in practice, for the use of the JIRT model. They lie in its ability to:

⁶⁵¹ Submission: NSW Police Force, 19 May 2008, p.4.

- a. provide a timely and comprehensive investigative process, drawing upon the combined expertise and experience of the team members
 - b. enhance the quality of investigations and the preparation of briefs of evidence
 - c. pave the way for the victim and non-offending family members (where the case involves intra familial abuse), to have timely access to therapeutic interventions and counselling
 - d. lessen the stress for victims by providing a more focussed interview structure that should avoid the need for repetitive interviewing
 - e. allow, in conjunction with the investigative process, case planning for the well-being and welfare of the victim
 - f. provide an effective basis, subject to the changes considered elsewhere in this report in relation to privacy and confidentiality issues, for a more comprehensive exchange of information
 - g. provide a platform for greater interagency cooperation and cross jurisdictional training in the complex and challenging issues that arise in relation to child sexual and physical abuse, and neglect.
- 8.286 In the light of these considerations and of the experience with the JIT and JIRT process since it was first trialled in 1994/1995, this Inquiry supports its continuation and action to complete the reform process that was instituted following the 2006 Review.
- 8.287 It is recognised that full involvement of Health as a JIRT partner, enhancement of the Forensic Medical Service, and implementation of the strategies designed to make the JIRT process more accessible and productive in relation to the Aboriginal community, will involve a substantial commitment of resources on the part of all partners, that will have financial implications. The Inquiry, however, considers that there is no alternative other than to complete the reform program, and to maintain an auditing and monitoring process in order to identify whether any of the issues mentioned above continue to emerge, or whether new problems arise that need to be solved.
- 8.288 In Chapter 9 consideration is given to the issues that arise in relation to the assessment and casework processes outlined in this chapter, and in Chapter 10 recommendations are made to deal with those issues.
- 8.289 In relation to JIRT, the Inquiry makes the following recommendations.

Recommendations

Recommendation 8.1

The JIRT Reform Program, as set out in the Implementation Plan should be completed.

Recommendation 8.2

JIRT should be regularly audited.

Recommendation 8.3

Pending amendment of the privacy laws as recommended in Chapter 24, a Privacy Direction should be issued in relation to the JIRT process so as to facilitate the free exchange of information between the NSW Police Force, NSW Health, each Area Health Service, The Children's Hospital at Westmead and DoCS.

Recommendation 8.4

NSW Health should provide an appropriately trained workforce to provide forensic medical services where needed for children and young persons who have suffered sexual assault and physical injury.

Recommendation 8.5

The NSW Government should develop a strategy to build capacity in Aboriginal organisations to enable one or more to take on a role similar to that of the Lakidjeka Aboriginal Child Specialist Advice and Support Service, that is, to act as advisers to DoCS in all facets of child protection work including assessment, case planning, case meetings, home visits, attending court, placing Aboriginal children and young persons in OOHC and making restoration decisions.

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Assessment tools

Current debate

- 9.1 In recent decades, child protection practice has become increasingly risk adverse. This is partly as a consequence of intense scrutiny and the fear of the public fall out if a 'wrong' decision is made.⁶⁵² In response many child protection systems have had a tendency to resort to increasing proceduralism with a heavy emphasis on risk assessment and investigation processes.⁶⁵³

It has led to an emphasis on identifying abuse to the detriment of developing services to offer constructive help to families which might enable them to offer a safer and more nurturing environment. In addition, practitioners have been required to devote their efforts to determining whether or not a case meets the threshold for child protection to the detriment of a wider assessment of the family's functioning and consideration of whether the child's needs are not being met for reasons other than serious parental abuse.⁶⁵⁴

- 9.2 The factors leading to reports to child protection agencies, such as carer drug and/or alcohol abuse, domestic violence and mental illness, are usually long term issues requiring sustained intervention and support. Research evidence and practice in the USA reveal that in such circumstances a 'family assessment' and support approach tends to be more effective than an investigative approach.⁶⁵⁵
- 9.3 Predicting whether a child needs to be removed from an unsafe home, or which families would benefit from the provision of services to assist them to parent more effectively, underpins the decisions that a child protection worker makes daily. The task of gathering information, making sense of this information and deciding what action to take are all dependent on the skills that child protection staff have in developing relationships with families to elicit this information.⁶⁵⁶
- 9.4 A key challenge in child protection services is the identification of effective tools and models that assist caseworkers, managers and organisations to ensure that decisions are based on evidence.

⁶⁵² P Gillingham, "Risk assessment in child protection: Problem rather than solution?" *Australian Social Work*, 59(1), 2006 pp.86-98 cited in L Bromfield and P Holzer, "A national approach for child protection-Project report" *National Child Protection Clearinghouse, Australian Institute of Family Studies*, 2008, p.14.

⁶⁵³ A Cooper, R Hetherington and I Katz, "The Risk Factor: Making the child protection system work for children," *DEMOS*, www.demos.co.uk, June 2003, p.23.

⁶⁵⁴ Correspondence: E Munro, *Can you design a safe child welfare system*, p.1.

⁶⁵⁵ See, for example, US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Alternative Responses to Child Maltreatment: Findings from NCANDS," July 2005; L A Loman and G D Siegal, "St Louis, Missouri: 'Differential Response in Missouri after Five Years: Final Report,'" *Institute of Applied Research*, February 2004.

⁶⁵⁶ Correspondence: E Munro, *Can you design a safe child welfare system*, p.3.

- 9.5 The Inquiry notes that this task is complicated by the knowledge that expecting complete accuracy in child protection risk assessments, regardless of the model, is unrealistic.⁶⁵⁷
- 9.6 The accuracy of any risk assessment instrument is determined by three variables:
- a. the sensitivity of the instrument (how many high risk families are correctly identified – true positives)
 - b. the specificity of the instrument (how many low risk families are correctly identified – true negatives)
 - c. the base rate or prevalence of the problem being measured (child maltreatment).⁶⁵⁸
- 9.7 Risk assessment approaches can be over inclusive and generate a high number of false positives and on the other hand they can be insufficiently sensitive and generate a high number of false negatives. There are fiscal costs in assessing families who were not at risk for maltreatment as well as in responding to those families who abused their children but were then not identified as being at risk. Personal costs to the families who are labelled incorrectly as abusing their children can also lead to unintended consequences.⁶⁵⁹
- 9.8 It is important to note that:
- there is no present risk assessment system that defines, in quantitative terms, 'high', 'medium' or 'low risk.' For example, we do not know if classifying a family as 'high risk' means there is a 10 per cent, 30 per cent or an 80 per cent probability that a family will, in fact, re-abuse children ... The best that can be said for existing instruments is that they are able to rank cases, more or less accurately, along a risk continuum, without specifying how close the case is to either end of the continuum, or how much difference there is between cases with different rankings.*⁶⁶⁰
- 9.9 Risk assessment instruments are in essence risk classification tools rather than abuse prediction tools.⁶⁶¹ Thus, instead of predicting what will occur,

⁶⁵⁷ E Munro "Common errors of reasoning in child protection work," *Child Abuse and Neglect*, Vol 23, No 8, 23 August 1999, pp.745-758.

⁶⁵⁸ E Munro, "The Impact of Audit on Social Work Practice," *British Journal of Social Work*, No. 34, 2004, cited in Submission: DoCS, Structured Decision Making, p.7.

⁶⁵⁹ RA Caldwell, GA Bogat and WS Davidson, "The assessment of child abuse potential and the prevention of child abuse and neglect: a policy analysis," *American Journal of Community Psychology*, 16, 1988, pp.609-624 cited in Submission: DoCS, Structured Decision Making, p.8.

⁶⁶⁰ MS Wald and M Woolverton, "Risk assessment: the emperor's new clothes?" *Child Welfare*, 73, 1990, pp.483-511 cited in DoCS, "Risk Assessment in Child Welfare: An Issues Paper," September 2006, p.10.

⁶⁶¹ A Shlonsky and D Wagner, "The next step: Integrating actuarial risk assessment and clinical judgment into an evidence-based practice framework in CPS case management," *Children and Youth Services Review*, 27(4), 2005, pp.409-427; D DePanfilis and SJ Zuravin, "Assessing risk to determine the need for services," *Children and Youth Services review*, 23(1), 2001, pp.3-20 cited in DoCS, "Risk Assessment in Child Welfare:

classification of greater or lesser degree of risk simply informs practitioners and agencies about which cases are more likely than others to be high risk. As a result, the professional judgement of workers is still crucial. Consequently, the use of risk assessment instruments is not seen as replacing the need for professional and well trained staff.

- 9.10 Munro concludes that “analytical tools are needed to supplement intuitive skills and shift practice reasoning along the continuum towards the analytical end”⁶⁶² and that risk assessment instruments have the potential to improve practitioner reasoning and decision making.
- 9.11 Dale et al observe, “the application of systematic thinking and analytical skills are notoriously lacking in assessments.”⁶⁶³ Assessments can be susceptible to significant cognitive and emotional bias:

*In this context, a requirement to record the thinking processes behind the taking of fundamental decisions would instigate practitioners, supervisors and managers to take much more consistent and carefully considered decisions. An audit trail of rationale could have a crucial effect on many key decisions and reduce inconsistency in decision making. To record the rationale for these decisions would focus thinking in a systematic way and ensure that the evidence base of the decision would be transparent and available as a contemporary record in any subsequent dispute.*⁶⁶⁴

- 9.12 The frameworks for risk assessment vary between jurisdictions. Some rely on frameworks based on professional judgement while others use an actuarially based assessment process or a mixture of both processes.
- 9.13 Recent debates concern the relative merits of these models for assessing risk. However, numerous analyses of risk assessment instruments have identified the lack of agreed definitions of risk as a fundamental problem, affecting both the empirical validation of these instruments and their implementation in the field.⁶⁶⁵ No method of risk assessment will have 100 per cent reliability. Citing relevant research, DoCS informed the Inquiry:

An underlying problem is two different approaches to human reasoning: analytical and intuitive. Analytical reasoning is described as ‘a step-by-step, conscious, logically defensible

An Issues Paper,” September 2006, p.8; B Saunders and C Goddard, “A Critique of Risk Assessment Procedures: Instruments of Abuse? A review of the literature,” *Australian Childhood Foundation*, June 1998, p.22.

⁶⁶² E Munro, 1999, op. cit., p.754.

⁶⁶³ P Dale, R Green, and R Fellows, *Child protection assessment following serious injuries to infants – fine judgments*, November 2005, pp.194-195.

⁶⁶⁴ *ibid.*, p.195.

⁶⁶⁵ MS Wald and M Woolverton, 1990, op. cit., pp.483-511; T McDonald and J Marks, “A review of risk factors assessed in child protective services,” *Social Service Review*, 65, March 1991, pp.113-132 cited in DoCS, *Risk Assessment in Child Welfare: An Issues Paper*, September 2006, p.10.

process' as opposed to intuitive reasoning which is 'a cognitive process that somehow produces an answer, solution or idea without the use of a conscious, logically defensible, step-by-step process.'⁶⁶⁶ In child protection practice, many professionals rely heavily on intuitive skills⁶⁶⁷ despite the evidence that 'intuition is a hazard, a process not to be trusted, not only because it is inherently flawed by 'biases' but because the person who resorts to it is innocently and sometimes arrogantly overconfident when employing it.'⁶⁶⁸

9.14 Further:

The literature on human reasoning and decision making indicates that personal judgement is often influenced by contextual factors such as the representativeness of the case, the availability or vividness of information, and the presumed relevance of the available information to the decision being made.⁶⁶⁹ Munro found that most determinations of risk were based on a limited range of data, often with the most memorable cases (those that aroused emotion or were most recent) factoring into the assessment of risk more than the 'dull, abstract material in research studies, case records, letters and reports.'⁶⁷⁰ Subsequently, even with evidence contrary to the workers initial case disposition, revision of judgement about cases was slow or non-existent.⁶⁷¹

9.15 There is a strong body of research indicating that actuarial approaches are superior to clinical judgment approaches in assessment of risk,⁶⁷² particularly in relation to the classification of families at risk for child maltreatment.⁶⁷³ Current estimates of the accuracy of actuarial instruments in predicting child

⁶⁶⁶ KR Hammond, "Human Judgement and Social Policy: Irreducible uncertainty, inevitable error, unavoidable injustice," *New York: Oxford University Press*, 1996, p.60, cited in Submission: DoCS, Structured Decision Making, p.4.

⁶⁶⁷ E Munro, 1999, op. cit., pp.745-758 cited in Submission: DoCS, Structured Decision Making, p.4.

⁶⁶⁸ KR Hammond, "Human Judgement and Social Policy: Irreducible uncertainty, inevitable error, unavoidable injustice," *New York: Oxford University Press*, 1996, p.88 cited in Submission: DoCS, Structured Decision Making, p.4.

⁶⁶⁹ L Cicchinelli, "Risk assessment: expectations and realities," *The Apsac Advisor*, 8(4), 1995, pp.3-8 cited in Submission: DoCS, Structured Decision Making, p.4.

⁶⁷⁰ E Munro, 1999, op. cit., p.754 cited in Submission: DoCS, Structured Decision Making, p.4.

⁶⁷¹ Submission: DoCS, Structured Decision Making, p.4.

⁶⁷² J Ruscio, "Information integration in child welfare cases: an introduction to statistical decision making," *Child Welfare*, 3(2), 1998, pp.143-156; RM Dawes, D Faust and PE Meehl, "Clinical vs Actuarial Judgement," *Science*, 243(4899), 1989, pp.1668-1674; AW Leschied, D Chiodo, PC Whitehead, D Hurley and L Marshall, "The empirical basis of risk assessment in child welfare: the accuracy of risk assessment and clinical judgement," *Child Welfare*, 82(5), 2003, pp.527-540 cited in DoCS, "Risk Assessment in Child Welfare: An Issues Paper," September 2006, p.7.

⁶⁷³ D DePanfilis and SJ Zuravin, "Assessing risk to determine the need for services," *Children and Youth Services review*, 23(1), 2001, pp.3-20; C Baird and D Wagner, "The relative validity of actuarial and consensus based risk assessment systems," *Children and Youth Services Review*, 22(11/12), 2000, pp.47-64 cited in DoCS, "Risk Assessment in Child Welfare: An Issues Paper," September 2006, p.7.

maltreatment range from around 70 per cent to 80 per cent⁶⁷⁴ compared with 64 per cent for clinical decision making.⁶⁷⁵ Anglin contends that accuracy of such tools is not likely to exceed 80 per cent.⁶⁷⁶

- 9.16 Actuarial methods are not infallible.⁶⁷⁷ These models have considerably less accuracy in determining which moderate risk families are most likely to become high risk, or which families are at risk for tragic outcomes such as child death.⁶⁷⁸ There is also recognition that there has been little work done on whether the factors that predict abuse are the same as those predicting re-abuse.⁶⁷⁹
- 9.17 While there is a strong body of research favouring actuarial approaches, a number of criticisms have been voiced. Dr Leah Bromfield, Manager of the National Child Protection Clearinghouse, AIFS advised the Inquiry:

*key criticism of actuarial models is that, over time, they will de-skill your workforce. The workforce will, over time, look to the tool and not trust their own professional judgement.*⁶⁸⁰

- 9.18 Other limitations of actuarial approaches include implementation difficulties, where risk assessment scores may be inflated by child protection workers, often with the best intentions of ensuring ongoing services for select families. Results from these tools can also be ignored due to doubt about the psychometric properties of the instrument. As Doueck and colleagues conclude without good quality control and worker supervision, the system can be used to support potentially poor decisions.⁶⁸¹ This problem is shared with professional judgement models.
- 9.19 In a literature review undertaken by the Australian Childhood Foundation the authors outline various concerns about actuarial based risk assessment tools noting that “the haste with which they are being designed and adopted does not...reflect the sudden availability of valid knowledge based on scientifically rigorous research findings.”⁶⁸² The authors argue that these tools are seen as

⁶⁷⁴ AW Leschied, D Chiodo, PC Whitehead, D Hurley and L Marshall, 2003, op. cit., pp.527-540; HJ Doueck, Dj English, D DePanfilis and GT Moore, “Decision making in child protective services: a comparison of selected risk-assessment systems,” *Child Welfare*, 72(5), 1993, pp.441-453 cited in DoCS, “Risk Assessment in Child Welfare: An Issues Paper,” September 2006, p.10.

⁶⁷⁵ Submission: DoCS, Structured Decision Making, p.10.

⁶⁷⁶ JP Anglin, “Well-being and paramountcy in child protection: the need for transformation,” *Child and Youth Care Forum*, 31, 2002, p.233-255 cited in Submission: DoCS, Structured Decision Making, p.7.

⁶⁷⁷ J Ruscio, 1998, op. cit., pp.143-156; RM Dawes, D Faust and PE Meehl, “Clinical vs Actuarial Judgement,” *Science*, 243(4899), 1989, pp.1668-1674 cited in DoCS, “Risk Assessment in Child Welfare: An Issues Paper,” September 2006, p.7.

⁶⁷⁸ B Saunders and C Goddard, 1998, op. cit., cited in DoCS, “Risk Assessment in Child Welfare: An Issues Paper,” September 2006, p.7.

⁶⁷⁹ P Lyons, HJ Doueck and JS Wodarski, “Risk assessment for child protective services: a review of the empirical literature on instrument performance,” *Social Work Research*, 20(3), 1996, pp.143-156; MS Wald and M Woolverton, 1990, op. cit., pp.483-511 cited in DoCS, “Risk Assessment in Child Welfare: An Issues Paper,” September 2006, p.7.

⁶⁸⁰ Transcript: Public Forum, Assessment Model and Process, 18 April 2008, p.57.

⁶⁸¹ HJ Doueck, D English, D DePanfilis and GT Moore, 1993, op. cit., cited in Submission: DoCS, Structured Decision Making, p.6.

⁶⁸² B Saunders and C Goddard, 1998, op. cit., p.22.

'quick fixes' by child protection systems that are under increasing stress⁶⁸³ and as a means of protecting the organisation from blame when tragedies occur.⁶⁸⁴ They conclude by recognising that risk assessment tools may be useful aides to professional judgement but not as predictive tools.

- 9.20 Another criticism is that the inflexibility of the actuarial model may lead to the exclusion of critical 'left field' factors in assessing risk in a family. Dr Bromfield advised:

*If we take mental health, though, as an example, most parents who have a mental health problem will not abuse their children. What an actuarial tool is not sensitive enough to do is to tell us why some parents who have that risk factor will and other parents won't, need child protection involvement.*⁶⁸⁵

- 9.21 On the other hand, the flexibility built into the professional judgement model could have a similar effect, because subjectivity could lead to inadvertently 'selecting out' critical factors.
- 9.22 In summary, the risk assessment debate accepts that there will always be some inaccuracy associated with risk assessment tools. Recent discourse has begun to move away from an 'either/or' approach and to recognise that whilst some tools more accurately classify risk, this does not rule out the need to use other approaches (consensus based, clinical judgement) in conjunction with risk assessment tools in working out what services will help to ameliorate risk and to engage families with services.

Assessment frameworks used in other Australian jurisdictions

- 9.23 Australia, like the USA, the UK and Canada, has traditionally adopted an investigative approach to child protection, which focuses on investigating and responding to discrete episodes of reported risks to the child.
- 9.24 Child protection legislation in each jurisdiction prescribes the role and scope of child protection services and guides child protection practice. Many jurisdictions are currently reviewing how they assess and respond to child protection reports with an emphasis on the importance of assessing both 'risks' and 'needs' at all stages of child protection involvement (that is, intake, investigation, case planning and management).⁶⁸⁶
- 9.25 Recently, Victoria has developed a Best Interests Framework that has built on its existing Victorian Risk Framework, a professional judgement model, by

⁶⁸³ *ibid.*

⁶⁸⁴ *ibid.*, p.34.

⁶⁸⁵ Transcript: Public Forum, Assessment Model and Process, 18 April 2008, pp.56-57.

⁶⁸⁶ L Bromfield and P Holzer, "A national approach for child protection-Project report" *National Child Protection Clearinghouse, Australian Institute of Family Studies*, 2008, p.40.

introducing differential categorisation for statutory and non-statutory reports. Reports are classified as either: a Child Wellbeing Report; a Protective Intervention Report; an Unborn Child Report; or as having Inappropriate/Insufficient information. An outcome of an intake assessment has also been expanded so that a Child Wellbeing Report is referred to a Child and Family Information, Referral and Support Team (Child FIRST) for family support services.⁶⁸⁷

- 9.26 In 2006, the ACT's assessment process was broadened to include a risk assessment tool and a needs assessment framework. In assessing risk, the ACT uses a Risk Assessment Tool based on the Victorian Risk Framework and the Manitoba Risk Estimation System. In determining a family's needs, the UK Framework for the Assessment of Children in Need and their Families is used.⁶⁸⁸
- 9.27 Western Australia introduced the Child Safety Assessment Framework in 2005, which is a modified version of the previous assessment tool employed by the Department (the Risk Analysis and Risk Management Framework). The new framework adopts a strengths based approach to safety assessment, and has two elements: an initial assessment framework and a comprehensive analysis of information.⁶⁸⁹
- 9.28 South Australia and Queensland use a suite of actuarial tools called Structured Decision Making (SDM), developed by the US based Children's Research Center (CRC). The CRC has customised these tools for use in a number of jurisdictions in the USA and Australia. Queensland has adopted the whole suite of SDM tools in a staged approach.⁶⁹⁰

Structured decision making

- 9.29 The SDM case management model, an actuarial model, is designed to improve decision making in child welfare cases. It identifies multiple decision points and guides workers through each discrete decision point with a structured assessment. The principle behind SDM is that decisions can be improved by clearly defined and consistently applied decision making criteria and readily measurable practice standards, with expectations of staff clearly identified and reinforced. Key factors that are known to have a strong association with future abuse or neglect are included in the risk assessment and are score based on pre-determined rating.
- 9.30 One of the criticisms of the research on SDM is that in most cases it has been undertaken by the US based CRC. However, the key issue relates to the extent

⁶⁸⁷ *ibid.*, p.39.

⁶⁸⁸ *ibid.*, pp.33-34.

⁶⁸⁹ *ibid.*, pp.39-40.

⁶⁹⁰ Submission: DoCS, Structured Decision Making, p.9.

to which it conforms to acceptable standards of research quality and rigour.⁶⁹¹ In any event, there has been a recent review of the research literature on different instruments for assessing risk and safety in child welfare focusing on instrument reliability, validity and outcomes by researchers at the University of California.⁶⁹² It found that the SDM has a stronger predictive validity than consensus based instruments.

Use of structured decision making within DoCS

- 9.31 When asked to explain the difference between the two approaches, the then Executive Director, DoCS Helpline advised:

An actuarial system would be embedded in KiDS, so you would put information in and there would be some algorithms running in the background that would weight the information. So what is the combined composite weight that you might put on domestic violence and particular kinds of drug and mental health? In a professional judgement model, which is the one we run, the caseworker does all of that in their head and then tests their perceptions with a third party, their supervisor, and they come up with a judgement together.⁶⁹³

- 9.32 While DoCS uses professional judgement to guide its assessments at the Helpline, it appears that there is little written guidance or criteria that are provided to Helpline staff to assist them in making judgements about required response times and urgency. DoCS in its own internal review of a child death found poor assessment of history at the Helpline and noted that there is currently no clear procedural protocol in place guiding the level of response.⁶⁹⁴
- 9.33 In 2005, DoCS reviewed the viability of incorporating SDM into the DoCS assessment process. This review concluded that there was not a strong case for immediate or full implementation of SDM as its benefits were not sufficiently significant to warrant investment at that time. A key issue identified was that full information was not available to measure the 'errors' in the current DoCS process. Because not all reports receive a secondary assessment, the actual incidence of 'false positives' and 'false negatives' arising from the current process could not be accurately determined. According to DoCS, this is still the case. DoCS decided that work would occur to improve its current assessment system, while at the same time monitoring the implementation of SDM in other jurisdictions.

⁶⁹¹ C Baird and D Wagner, 2000, op. cit., pp.47-64 cited in Submission: DoCS, Structured Decision Making, p.10.

⁶⁹² D'Andrade, Austin and Benton, "Risk and Safety Assessment in Child Welfare: Instrument Comparisons," 2008, p.31. <http://jebsw.haworthpress.com>.

⁶⁹³ Transcript: Inquiry meeting with DoCS senior executives, 30 November 2007, p.77.

⁶⁹⁴ DoCS, *Child Death Review Report*, 2008.

9.34 In its submission to the Inquiry, DoCS stated:

Based on recent experience in other jurisdictions which have introduced SDM™ approaches, DoCS has concluded that there would be benefit in examining the introduction of a structured analysis approach, involving clearly defined and consistently applied decision making criteria, to assist initial assessment at the Helpline of a child's safety.... As in all such systems, caseworkers would be expected to complement the structured analysis outcomes with the exercise of their professional judgement.⁶⁹⁵

9.35 DoCS further stated that the SDM tools would fit into a revised child protection framework as follows:

1. *At Helpline intake a decision-tree such as SDM's Response Priority Assessment would assist with determining the urgency and prioritising action once transferred to the CSC – immediate, within 24 hours, or within 10 days. The less urgent cases are likely to proceed down a family assessment path, pending confirmation through subsequent safety and risk assessments, while more urgent cases have a higher likelihood of investigation and statutory intervention.*
2. *At CSC first point of contact with families, a Safety Assessment would determine the 'threat' and extent of 'protective' mechanisms. This would further assist in determining the initial response and the likely recommendations of services.*
3. *After the Safety Assessment has instigated immediate intervention where necessary, a Family Risk Assessment, in combination with the Safety Assessment, would confirm the likely path for the family.⁶⁹⁶*

9.36 DoCS stated that while SDM could fit into a reformed child protection system, the tools would need to be tailored and tested within the DoCS environment, and DoCS would need to work closely with the CRC and with the two Australian jurisdictions who are presently implementing SDM. A key issue identified by DoCS is the impact on the workload of CSCs if all cases that meet the criteria are to be assigned a field response, as is part of the SDM model. DoCS recognised that an SDM model would need to build in some alerts or overrides to pick up members of those groups likely to be at high risk, for example, Aboriginal children, children under one year of age, and children whose siblings

⁶⁹⁵ Submission: DoCS, Assessment Model and Process, pp.23-24.

⁶⁹⁶ Submission: DoCS, Structured Decision Making, p.11.

have been the subject of high risk reports. Such cases would then be streamed for immediate assessment.

- 9.37 Dr Raelene Freitag, Director of the CRC, in evidence to the Inquiry, stated that to develop SDM for DoCS, a workload analysis would need to be undertaken, involving a random sample of cases. The analysis would identify the standards for which a worker was accountable and would keep track of the time spent on assessment of a case.
- 9.38 DoCS recommended to the Inquiry that further analytical work be undertaken before SDM is tested within DoCS. The Ombudsman in his submission to the Inquiry supported the adoption of a structured decision making assessment tool of the type recommended by DoCS. Support for such a tool, he states, can be found in the argument that it may provide caseworkers, particularly those at the Helpline, with much greater clarity in relation to making assessments about the relative risk of certain matters over others.
- 9.39 Dr Bromfield told the Inquiry there is a very limited independent evidence base against which to assess the effectiveness of SDM. She indicated that the preliminary results of an evaluation by Deakin University into the implementation of SDM in Queensland suggest that overall "... it did not promote consistency in decision making."⁶⁹⁷ In light of this evidence, the Ombudsman is in favour of an initial testing of the tool to ascertain whether it improves assessment, and addresses some of the fundamental weaknesses associated with the current assessment system.
- 9.40 The Inquiry agrees that such a testing is warranted at the Helpline and at CSCs in relation to assessments and interventions, including restorations.

Common assessment tools

- 9.41 In a number of jurisdictions, such as England, there is a move towards other services, including all child health and education services, using a 'common assessment framework' to identify and respond to the needs of a child and family, and to refer only those cases requiring a more specialised statutory child protection assessment to statutory child protection services. This common risk assessment framework is thought to enable potential reporters to make more balanced judgements so that the cases reported are those more likely to reach a threshold for statutory investigation and intervention. Such a system if effective is likely to prevent the waste of the scarce resource of child protection workers and to provide earlier assistance to families.
- 9.42 Research and information provided to the Inquiry suggests that there is merit in exploring the development of common assessment tools, for example through the current project between Health, DoCS, Attorney General's, Police and non-government services to develop a cross agency risk approach on domestic

⁶⁹⁷ Transcript: Public Forum, Assessment Models and Process, 18 April 2008, p.57.

violence. Similar work is being progressed for mental health, for drug and alcohol between DoCS and Health.

- 9.43 As many families present with multiple issues there is also a need to consider an assessment framework that provides tools for all key workers within the child protection system and that encompass all risk factors for the purpose of referral to DoCS. As noted earlier each agency within the system brings different levels of expertise and knowledge to the task. Understanding how risk factors impact on a child is critical to this assessment framework. The common assessment process would operate across agencies, and cases referred to DoCS would then be subject to SDM if adopted, or to its current procedures for assessing risk and for deciding whether to exercise the statutory intervention powers.

Work at the Helpline

- 9.44 Key issues before the Inquiry have concerned the work of the Helpline. They include the accuracy of the information which is recorded and the completeness and accuracy of history checks undertaken by caseworkers. DoCS has identified the inconsistent use of the category of 'information only',⁶⁹⁸ inconsistent classification of risk levels,⁶⁹⁹ and delay in entering data and referring reports to CSCs.⁷⁰⁰ In addition, it has found significant variation between CSCs and the Helpline as to whether a report meets the threshold of risk of harm⁷⁰¹ with the result that 21 per cent of reports referred to a CSC in 2006/07 may have been unnecessary.⁷⁰²
- 9.45 The existence of these issues is illustrated by the findings of the NSW Auditor-General in his 2005 performance audit of the Helpline, and in reviews undertaken by the Ombudsman.
- 9.46 In his *Report of Reviewable Deaths in 2006*, the Ombudsman noted:
- a. In some cases it was not clear whether the Helpline's recommendation adequately reflected the risks to the child indicated in the information at hand, or in information previously held on previous reports in DoCS.⁷⁰³
 - b. In some cases, reports sent as information only contained, at least in part, additional information that raised new concerns not previously identified to DoCS, meaning that new information was not subject to analysis by the CSC. Other reports considered to be 'information only' were closed at the Helpline and some of these cases contained information from the reporter

⁶⁹⁸ DoCS, *Frequently Reported Families Project*, 29 August 2008, p.8.

⁶⁹⁹ *ibid.*

⁷⁰⁰ DoCS, *Child Death Review Report*, 2008.

⁷⁰¹ DoCS, *Analysis of the decision to refer child protection reports to a CSC for secondary assessment*, September 2007.

⁷⁰² DoCS, *Statistical analysis of the child protection system – a summary*, September 2007.

⁷⁰³ NSW Ombudsman, *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths*, December 2007, p.42.

about the level of risk and for some children there was also a recent child protection history.⁷⁰⁴

- c. There were cases where history checks were wrong or did not sufficiently capture relevant family background, including long term parental substance abuse, or mental health issues or where they did not establish significant links to previous incidents or relationships, including where children of a previous relationship had been removed.⁷⁰⁵
- d. Factual errors in the assessment of a report were sometimes carried over either wholly or in part, resulting in assessments for subsequent reports replicating an inaccurate history.⁷⁰⁶
- e. Multiple reports at times appeared to be assessed on an incident basis, although records indicated escalating risk.

9.47 As an example, the Ombudsman stated in relation to the death of one child, whose sibling was already in OOHC, there had been nine reports made to DoCS concerning the child and her siblings. Of these reports, the Helpline completed history checks, but only three of the reports identified that the child's sibling was in care, and none of the reports identified that her other siblings were the subject of care applications previously. Only in relation to one of the reports is there any evidence of Helpline staff analysing the reported concerns against the children's child protection history in terms of determining the possibility of serious harm, given the cumulative risks from the reports over time.⁷⁰⁷

9.48 DoCS in its own internal review of this case identified that two of the reports took between five and six weeks to be transferred to a CSC and that Helpline history checks were not thorough and did not adequately detail the child protection history.⁷⁰⁸

9.49 The Ombudsman reported that: "Under the current KiDS system, for a user to apprise themselves of a family's child protection history, they may need to spend hours navigating their way through numerous data fields."⁷⁰⁹

9.50 Similar issues were also identified in cases reviewed by the Inquiry where children and young persons had not died. The Inquiry undertook a review of 75 case files to examine casework practice compliance against DoCS policies and procedures.⁷¹⁰ These files included children and young persons from all

⁷⁰⁴ *ibid.*, p.45.

⁷⁰⁵ *ibid.*, p.46.

⁷⁰⁶ *ibid.*, p.46.

⁷⁰⁷ NSW Ombudsman, *Investigation into the death of a child, Provisional Statement*, 2008.

⁷⁰⁸ DoCS, *Child Death Review Report*, 2008.

⁷⁰⁹ Submission: NSW Ombudsman, Assessment and Early Intervention and Prevention, p.12.

⁷¹⁰ The 75 files reviewed represented cases from 41 CSCs of which 63 files were of children and young persons who had been the subject of eight reports to DoCS under Part 2, Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998* between 1 January 2007 and 30 June 2007; two files of children and young persons who on 14 November 2007 were reported to DoCS for the first time and that report was referred to a CSC and directly allocated for a SAS 2; seven files representing 20 children who in the week beginning 1 July were referred to and accepted by a Brighter Futures team; and three files of

program areas (Child Protection, OOHC and Brighter Futures), all age groups, 37 female and 38 male children and young persons, 30 Aboriginal children and young persons and nine children from CALD backgrounds. The files were from 41 CSCs representing all regions.

- 9.51 The Inquiry's case file audit findings were consistent with those of the Ombudsman.
- 9.52 In relation to reports assessed at the Helpline, the Inquiry's case file review found that only half of the files reviewed had substantial information on the file to show that the child's history of previous reports had been reviewed, with about 40 per cent having some information to indicate that their history had been reviewed.
- 9.53 The variability of the assigned responses was reflected in one file reviewed by the Inquiry. In that file, between 29 March 2007 and 7 July 2007 nine reports were made about inadequate supervision of a child, specifically a 10 year old child playing on a busy road. The first report was assigned a response of less than 72 hours, it was then transferred to a CSC and allocated. Subsequent reports about the same issue were variously assigned responses of less than 24 hours, less than 72 hours and less than 10 days. It was unallocated and then a later report received a response of less than 72 hours. At some stage, a report was assigned a response of 'information only'.⁷¹¹ It appears that whether or not the child was actually on the road at the time that the reporter telephoned the Helpline, also affected the assigned response.
- 9.54 In July 2007, DoCS undertook a root cause analysis, to examine the ongoing concerns regarding history searches conducted at the Helpline.⁷¹² Not surprisingly, one of the key findings of the root cause analysis was that the current structure of KiDS did not support caseworkers when conducting history checks.
- 9.55 A 2007 business process review also identified the need for tools to assist in identifying risk patterns, in prioritising cases and in ensuring adequate history checks.

Case Study 7

Health workers made eight reports about risk to a child concerning the mother's mental illness and the parents' capacity to care for their child. DoCS performed three SAS1 and one SAS2 before a caseworker from the CSC called the mother's mental health nurse, S, after a report from the

children and young persons who were referred by the Helpline to a JIRT. The sample was not intended to be representative of DoCS clients or statistically significant but rather to provide information on casework practice compliance with DoCS policies and procedures and the outcomes achieved by DoCS for children and young persons.

⁷¹¹ All reports raised concerns that child was playing on road – one assigned a level 1, 5 were given a level 2 and 1 was given a level 3.

⁷¹² Correspondence: DoCS, 5 June 2008.

Mental Health Unit had been received and allocated a Stage 1 response. The caseworker recorded the conversation in a file note, the last paragraph of which states:

S was very concerned for the welfare of V and relayed again Dr's [psychiatrist] fear of the baby dying if left in the care of the parents. As we were speaking I looked up the Helpline report on V. The report was labelled as Information Only and did not contain the doctor's fear of the baby dying and did not fully relay the concerns of the doctor and S. I informed S of this who was very upset as she felt this information was important. S stated that Dr – told the Helpline Caseworker several times about her grave concerns for the baby being left in the care of her parents and her fear of the baby dying.

The next document in the file was a removal order for the child, made the same day.

- 9.56 Work has been done at the Helpline to address a number of these issues and the Inquiry is conscious that there have been delays in replacing technology which has impeded the effectiveness of the Helpline. However, of considerable concern is that criteria have still not been established for caseworkers to use in screening all contacts before proceeding to an initial assessment. Further, no written guidance is given to caseworkers in determining the response time which should be assigned to a report and there is no requirement for reports to be placed on the KiDS system and referred within a specified period of time.
- 9.57 A range of measures are needed to address these deficiencies. They include testing SDM at the Helpline, redesigning KiDS to enable it to be an effective tool rather than the impediment it has increasingly become, clarifying the procedures for referral for 'information only' and the circumstances in which particular response times are assigned and encouraging caseworkers through training and professional development to adopt a more holistic approach. Recommendations have been made in earlier chapters about the first three matters, and recommendations appear at the end of this chapter concerning the remaining matters.

Work at the CSC

- 9.58 The Inquiry acknowledges that the work done by caseworkers and their managers is difficult, challenging and requires them to be inordinately resourceful to achieve gains with children and their families. The stress of the position is compounded by their inability to effectively engage with all of those who need their services.

We read the reports every week. We cringe because we have to close them. We know that we should be getting out there. We know that we will get out there because another report will

*come through and that report that we have unallocated will then become a higher priority than the current priority that week.*⁷¹³

*I see the two Managers Casework juggling their red in-trays which has got the new unallocated high needs children in it daily, looking at "Who can I change? What is happening for these children? Can I now allocate it?"*⁷¹⁴

*I'm faced with five Managers Casework who each have 70-odd cases on their caseload. I'm thinking "How? How am I going to manage in the way that I think is best practice when there's 300-odd cases here ... How am I going to sit down with these managers in supervision and ask them to tell me what they have done in the last month when they have got 40 cases in court?" ...if you want best practice, if you want a level of analytical reflective casework and decision making, that is not the environment where it will happen.....We only see the red flashing lights. The amber we just miss. We are set up to be a system that is in crisis, and we have developed a way of responding that is highly formulaic and highly prescribed, and anything outside of that we are likely to miss.*⁷¹⁵

9.59 As one DoCS employee informed the Inquiry:

*It is not so much the amount of work given to each individual (caseworker)...., it is the inability as a human being to help those cases that are screaming out for help but do not fit into the 'emergency category' and therefore need to be passed over in order to work with those needing immediate assistance.*⁷¹⁶

Sufficiency of assessments

- 9.60 The data indicate that between 2006/07 and April 07/March 08 there has been a significant increase in the number and proportion of reports receiving a SAS1. Over the same period, however, there has been a 10 per cent decrease in the number of reports receiving a SAS2. The number of children and young persons involved in reports receiving a SAS2 has also decreased by 5.9 per cent.
- 9.61 In addition, multiple reporting in relation to the same child or young person has significantly increased over the last five years and most children and young persons now reported have a history of prior reports to DoCS.

⁷¹³ Transcript: Inquiry meeting with DoCS staff, Hunter and Central Coast Region, p.9.

⁷¹⁴ Transcript: Inquiry meeting with DoCS staff, Western Region, pp.19, 27-30.

⁷¹⁵ Transcript: Inquiry meeting with DoCS staff, Metro Central, p.16.

⁷¹⁶ Submission: current DoCS staff member.

- 9.62 The average number of reports per child per year has increased which suggests that there is an increased likelihood of continued contact with DoCS; that is, of being reported and then re-reported.
- 9.63 There has been a significant increase over time in the percentage of children who were the subject of a substantiated report and a further substantiation within the following 12 months.
- 9.64 It appears that the most likely outcome for children who received multiple SAS2s was to be reported multiple times in the 12 months following the last SAS2. Children who did not receive a SAS2 and who did not have a report allocated were most likely not to be reported again within the following 12 months.
- 9.65 Of the children with multiple SAS2s, approximately one quarter entered an OOHC placement in the assessment period, indicating an increasing level of seriousness of the risk to these children and young persons.
- 9.66 The Inquiry sought to explore whether children and young persons entering OOHC did so after a pattern in which reports increasingly received a more urgent response level. DoCS carried out a preliminary analysis, at the Inquiry's request, which revealed that children and young persons follow many different pathways before entering care – some have a long history of child protection reports, some have only a few reports or one serious report and some have no child protection history. However, a preliminary conclusion that may be drawn, is that children and young persons entering care were more likely to have had previous reports with the same or less urgent response levels compared with their last report before entering care.
- 9.67 There may a number of reasons which explain the data summarised in paragraphs 9.60-9.65. First, the response by DoCS to the initial and even subsequent reports may not have resulted in a decreased risk of harm. This may be because of no action or ineffective action, or the assessment may have been incident based rather than holistic. As noted in some cases reviewed by the Ombudsman, DoCS action has resolved immediate risks – such as homelessness or safety in the context of domestic violence – but has failed to address the serious and ongoing chronic child protection concerns.
- 9.68 Secondly, it may reflect that DoCS' intervention has resulted in more mandatory reporters becoming aware of the plight of the children and their families and thus making further reports. Thirdly, there may have been an unpredictable change in the families' circumstances.
- 9.69 Finally, as the Ombudsman has noted cases may be closed after a report has been referred for further assessment, in circumstances where the record indicates that a secondary assessment has taken place, without any work having been done.

We also identified some cases where secondary assessment records appear to have been created for purposes other than assessment. This included 'data remediation purposes only', that appears in the child's history as completed assessments, although there is no information to indicate assessment of risk. In other cases we saw SAS1 records that appear to have been created as a tool to close a case, without any apparent gathering or assessment of information. In one record, the only information documented in the record of assessment is CSC will not be responding due to workload and other cases having a higher priority.⁷¹⁷

- 9.70 The Ombudsman also noted that many of the completed SAS1 records contained an effective analysis of risk and safety and provided an adequate basis for a decision on the need for further assessment. However, he also noted that there were instances where SAS1s were very limited in the information gathered, leading to poorly informed decisions not to proceed to a comprehensive assessment. In addition, there were instances where SAS1 information gathering was adequate, but the information gained did not appear to inform decisions about case closure.
- 9.71 From information available to it, the Inquiry concludes that assessments carried out at the CSC tend at times to be incident based, sketchy and without sufficient regard to potentially relevant information held by other agencies
- 9.72 The Inquiry has also found that assessments do not always reflect all the available information and do not accurately record the information contained on the file or in KiDS and the decisions made are not always consistent or supported by the available information.
- 9.73 These findings are supported by reviews by the Ombudsman and DoCS of the following cases.

Case Study 8

Following the death of an 11 month old child, DoCS' review found that the majority of the workers involved in the child's care, though experienced, had failed to consider all of the information available about the characteristics of the child and her family. The case involved the Helpline, two CSCs and a JIRT and the assessment practice was characterised by DoCS as fragmented.

Other problems identified by DoCS included first, a disagreement regarding the case management responsibility between two CSCs which caused unnecessary delay in the assessment, secondly, delays and omissions in

⁷¹⁷ NSW Ombudsman, *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths*, December 2007, p.52.

interagency communications, and finally the fact that new concerns about the child were advised to each of the CSCs but were not added to KiDS appropriately.

Case Study 9

In another case, the DoCS review acknowledged that while there were limited caseworker resources, the risk assessment was generally superficial and of poor quality, it lacked rigour and there was an absence of known facts recorded over time. A critical fact in this case was that the child the subject of an assessment by DoCS over a period of six months was not sighted as part of this process.

Case Study 10

A report was made to the Helpline on 2 June 2006 by the de facto of the maternal grandmother of a 13 year old girl. This was the fifth report received on this child. The assessment recorded that "the caller said A hates her father and she has been sleeping with knives in her bed and not attending school." The case was open and allocated.

There were four further reports over the next 3 months where callers repeated the assertions that A had 'knives' or a 'fork' to be used as a weapon or to protect herself from her father.

The case was open and allocated at the CSC but there is no record of these statements being followed up by the caseworker with the child.

A year or so later, in a referral to PANOC after an alleged rape, under 'DoCS action to date' the history of reports and action is detailed. In the description of one of the reports which included the assertions regarding 'knives', forks' and/or 'weapons' the referral records that "A made allegations that she had been bashed up by her natural father and she goes to bed with weapons." A had never been recorded as making any such allegations herself - they had all come from other reporters.

9.74 From its examination of families who were the subject of the Frequently Reported Families Project, DoCS has identified the following issues relevant to work at CSC level:⁷¹⁸

- a. 66 per cent of the 50 cases reviewed were allocated cases within CSCs. Thus, notwithstanding work being done by a caseworker, fresh reports were still being made.

⁷¹⁸ DoCS, *Frequently Reported Families Project*, 29 August 2008, p.6.

- b. Most of the children whose cases were reviewed had siblings who had also been reported. This may suggest a response by DoCS on the child reported, rather than the family as a whole, including siblings.
- c. All of the reviewed cases included at least one type of repeat report with most including two or three. All of the cases reviewed included a risk of harm. This suggests a pattern of repeat reports plus risk, not a pattern of repeat reports without risk.

9.75 From this review DoCS identified some suggested strategies at a CSC, Helpline and service system level, including the following:

The most commonly suggested strategy is unsurprising: more comprehensive Secondary Assessments leading to targeted intervention which is clearly communicated to, or jointly delivered with the family and interagency partners.⁷¹⁹

9.76 The Inquiry agrees that this should be the goal.

9.77 Further, the review identified a “lack of timely, child focused and holistic assessments for some of the reviewed matters.”⁷²⁰ This further supports the need for reviews (audits) to be undertaken in CSCs to monitor the quality and compliance of casework practice with what are essentially sound policies.

9.78 This is particularly needed as DoCS has tried to respond to these problems through policy and training initiatives, which have included specialised training in critical areas such as substance abuse and neglect as well as revising its secondary assessment procedures. How well these are implemented and monitored in CSCs has been identified by the Inquiry as variable in quality. The need to regularly review the systems and practices within CSCs is critical to improving the quality of services. This is even more necessary where, as noted in Chapter 3, there are significant workforce capacity issues.

9.79 Recommendations about these matters appear in Chapter 3 and at the end of this chapter.

Communication with families

9.80 DoCS’ casework policy states that engaging families is an interactive process that is fundamental to all casework with children, young persons and their families.⁷²¹ However, a number of submissions and cases reviewed by the Inquiry raised concerns about the lack of effective communication and engagement by DoCS caseworkers and their managers with families. In some circumstances the level of communication was reported as demeaning, overly judgemental and not such as to encourage cooperation.

⁷¹⁹ *ibid.*, p.7.

⁷²⁰ *ibid.*, p.8.

⁷²¹ DoCS, Intranet, *Engaging Families Policy*.

- 9.81 Many families stated they have had multiple caseworkers over a year, that caseworkers are difficult to access and that monitoring and supervision of families is minimal.
- 9.82 In addition, the clarity of communication between caseworkers and clients and the challenges posed in engaging with families when the 'welfare' is held by some in poor regard, were raised.

Case Study 11

At a meeting between the family and DoCS the family was informed "that a rehab entry and participation was the only way that the department felt the family was able to care for the child, otherwise the dept would look at a care application."

The mother agreed and entered a rehabilitation facility. She was due to complete her program on 15 June 2007. DoCS provided support to her during this time, liaised with the facility and assisted with transport to and from medical appointments for her child.

On 14 June 2007 DoCS called the rehabilitation facility to see 'if it was deemed appropriate for her to stay longer' as the mother had requested to leave the program. The rehab worker is recorded as saying:

N/M is able to stay longer, that there is nothing that would be classed as overt in regards to n/m behaviour and (she) is on time in relation to picking up her methadone, that they (rehab facility) are trying to assess (that) if n/m goes home is it a safe environment?

The DoCS worker then spoke with the mother who stated she was clear she would be going home the following day as she had completed the program. She became abusive towards the DoCS caseworker and hung up the phone.

DoCS then assumed care of the child and removed him from the facility on 15 June 2007 due to concerns about the impact of the parents' drug use on their ability to parent and because of the high medical needs of the infant. The notes of the removal record the mother saying:

No, you're not taking him, where's A (caseworker), I want to talk to A.....I want to talk to her and tell her she's a fucking liar, she told me all I have to do is stay here for 21 days that's it and that's all I'd have to do, she's a fucking liar.

DoCS' noted to the Inquiry that the rehabilitation centre (after an initial assessment period of around 21 days) determines the length of time individual clients need to remain in the facility.

Case Study 12

A and B are Aboriginal and were four years old and one year old when they were removed from their mother and placed in foster care on 16 May 2007. There had been 12 reports to DoCS prior to their placement regarding inadequate shelter/homelessness, inadequate nutrition and concerns about physical and psychological harm.

Their mother had been a 'state ward' and it had been acknowledged that she had issues dealing with 'the welfare.' She also had mental health issues, lacked stable accommodation and was not managing her epilepsy. The mother was resistant to DoCS intervention and DoCS was not able to successfully negotiate a working relationship with her. For instance, there was a breakdown of contact visits and contact with extended family.

This breakdown in communication resulted in a lack of inclusive care planning for the children and a potentially unsafe placement with the father.⁷²² DoCS initial care plan (6 July 2007) proposed an Order of restoration to the mother over two years and recommended participation in the Intensive Family Based Service Program and comprehensive strategies which would assist the mother and support restoration. However this care plan was never able to be discussed and negotiated with the mother. An addendum to the care plan (24 September 2007) records that the 'mother has refused to work with the Department hence the Department is unable to ascertain if restoration is a realistic option'. The Department then proposed an order allocating Parental Responsibility to the father until the children are 18 years old with a 12 month s.76 supervision order. This was the Final Order made by the Court on 8 January 2008.

- 9.83 Clear communication is essential, although not always attainable when families will not engage. Strategies to provide caseworkers with enhanced supervision, reduce the pressure of work by diverting cases not requiring statutory intervention and improving the tools available to them are set out at the end of this chapter and in Chapter 10.

Documentation

- 9.84 Maintaining accurate and up to date records is an essential component of effective casework practice and is stipulated in DoCS' policies and procedures:

case planning processes, including assessments, case plans, minutes of case plan meetings, and reviews, must be recorded and documented in an organised way that is easily accessible

⁷²² Serious allegations had been made against the father regarding sexual assault of A.

*to anyone taking part in these processes. Records should also note when case plan actions are completed and objectives achieved so that this information is taken into account during ongoing planning and reviews.*⁷²³

- 9.85 Organised recording of decisions and plans ensures that information is documented and communicated in a logical and sequential way which promotes a coordinated and integrated response to the child's or young person's needs. It also allows for some accountability to children, birth families and carers (as well as other stakeholders) for decisions that have been made.
- 9.86 There was significant evidence before the Inquiry that the documentation of decisions and actions taken by DoCS staff was at best inconsistent. A number of DoCS own internal reviews identified that there was poor documentation of the reasons for decisions. This affected the completeness and accuracy of information on the file/KiDS and impeded making holistic assessments.
- 9.87 The DoCS audit of 20 cases in two CSCs undertaken in 2007 identified a number of issues in relation to documentation:

*There were some files that were very well kept and included almost all of the records from KiDS and other information ... there were also some that were quite poor. There were records on KiDS that were not present on files; handwritten information on the files that was not reflected in KiDS; information that was not in chronological order. This made it difficult in some cases to understand the progress of the case and why particular actions took place.*⁷²⁴

- 9.88 In this same audit the reviewer found that in many of the cases reviewed there were not well articulated case plans and it was difficult to assess whether or not the actions planned reflected assessed risks.
- 9.89 DoCS Frequently Reported Families Project found that there was difficulty in "accurately commenting on the actions and decisions of CSCs due to inconsistent or lack of documentation of decision making in relation to case closure and un-allocation."⁷²⁵
- 9.90 The Ombudsman's *Group Review Report: Children Under Five in OOHC* found that DoCS failed to obtain health records detailing children's health histories for a significant number of children, and documented action relating to medical assessments by specialists was often not contained on the child's file.⁷²⁶

⁷²³ DoCS, *Child protection and OOHC caseworker policy manual*, p.36.

⁷²⁴ DoCS, Audit report, *Review of casework practice at Glenn Innes and Inverell CSCs*, p.5.

⁷²⁵ DoCS, *Frequently Reported Families Project*, 29 August 2008, p.7.

⁷²⁶ NSW Ombudsman, *Group Review Report: Children Under Five in OOHC*, November 2007, p.5.

- 9.91 In the Inquiry's review of the 75 DoCS case files there was inconsistent documentation of investigation, assessment, planning, analysis and casework evident in many of the files. This made it difficult to determine how well the case management policy was implemented in practice. Documentation of the reasons for decisions and actions was sometimes unclear or absent in the files.
- 9.92 There were also many examples in the Inquiry case file audit where the file was chronologically out of order, contained many duplicates, had missing pages and/or significant gaps in information. This would make it very difficult for a caseworker to build a holistic or sequential picture, particularly if there was not sufficient time to review the file. This could have a major impact on the adequacy of the assessment and subsequent action.
- 9.93 There were also examples where up to date information concerning an allocated matter was not recorded on KiDS by CSC staff. As DoCS operates a 24 hour, seven day a week service it is critical that information is recorded in one place so that in the event of an after hours report all available information is accessible.
- 9.94 An internal review by DoCS of a particular file following the death of a child also highlighted these risks:

The paper file and KiDS records for this case suggest the case was allocated in April 2006 but no casework was undertaken until after [the child's] death in July 2006, a period of more than two months.....this means that when the matter was viewed on KiDS, by both the Helpline and other staff within the office, the matter appeared to be allocated when in fact no casework was being done and no staff were assigned the tasks of monitoring the matter in the absence of the allocated caseworker.⁷²⁷

- 9.95 The risks associated with operating a dual system (both KiDS and paper files) for recording information about children, young persons and their families are obvious and significant.
- 9.96 KiDS should be the only system used by casework staff. This is even more critical when reports are made after hours to the Helpline. Decisions based on full access to all information may make a difference to whether a response is made to the report.

Case Study 13

The Inquiry requested the files on a particular Aboriginal child, who was a member of a large family. DoCS provided the Inquiry with three volumes of hard copy file information, one volume of KiDS records, and a KiDS Person History. The file contained records of 17 reports, including contact records

⁷²⁷ DoCS, *Child Death Review Report*, 2007.

and the related initial assessments. The KiDS Person History listed 30 Initial Assessments. Of these 30, 11 appear to have no corresponding reference material in the file.

From the history section of some reports, it appeared that there were additional reports concerning this child that did not appear in the file, or the KiDS Person History. One report in 2003 referred to 15 prior reports dating from 1993. The KiDS Person History listed 10 reports, and commenced in 2000. The Child Protection History section of another report in 2003 stated that in the preceding 15 months there were 17 previous reports for this child. For this period, the KiDS Person History listed 10, and the file contained five of these.

The file was difficult to follow, as the reports and other material did not always appear in chronological order. The third volume contained information in chronological order for 2007, however some of the information for 2007 was not in this file, and appeared in a different volume between paperwork from 2005.

Of the reports listed on the KiDS Person History, seven appeared to have been given a response time of less than 24 hours, requiring caseworkers to quickly access and assimilate the child protection history to inform their decisions. While it is possible that some of the missing information is listed in the files of this child's multiple siblings, it is difficult to see how a worker can effectively and swiftly access the relevant information to inform practice from a disorganised and disjointed file such as this one. It is of concern that the files refer to reports and information that is not referenced in the Person History.

Changes in caseworkers and CSCs

- 9.97 The Inquiry's audit demonstrated problems when caseworkers change and where a case needs to be moved between CSCs. In some of the files reviewed by the Inquiry a change of caseworker resulted in inconsistent approaches. One case had 11 different caseworkers assigned from 2003 to early 2008. In another case, initial work was positive, and a case plan was developed for handover to a new caseworker when the initial caseworker was transferred. However, after this good start the case could not be re-allocated due to staff shortages and the case plan was not implemented.
- 9.98 As is evident from Chapter 3, the issue is not so much retention of staff but movement within the organisation. While there can be clear benefits to staff and to DoCS from this flexibility, clients can suffer. As has been noted by the Ombudsman, good handover procedures are essential.

Case closure

9.99 The 2002 Kibble Committee report found that:

The ongoing dilemma at the CSC is how to find a balance between addressing as many cases as possible with limited service levels, with addressing fewer cases with a higher level of service. The vast majority of work undertaken at a CSC is reactive; that is, the incident has usually already occurred by the time DoCS are involved. The triage approach and management focus on a satisfactory response to level 1s appears to favour an allocation of resources to as many cases as possible.... The triage approach and emphasis on Level 1s may have inadvertently caused a number of more serious Level 2s and 3s to have escaped the attention of Caseworkers. There does not appear to be clear guidelines for Casework Managers as to how they weigh up the significance of risk and probability against the matter of urgency, and allocate work accordingly.⁷²⁸

9.100 While there are now guidelines that provide some greater direction for CSCs and for the Brighter Futures program, the picture remains similar to that of 2002 as described above. The Inquiry visited a number of CSCs whose staff provided concerning examples of cases that they were not able to allocate, even though the risks were high, due to other more serious matters. Examples of such cases provided by a CSC in Metro South West Region follow.

Case Study 14

One case involved two children aged eight and 11 years who live with their mother. Since 2004, there have been 16 reports received with 15 of these occurring in 2007.

The reports concerned a suicide attempt by the mother, drug and alcohol abuse of the mother resulting in alleged physical abuse, and inadequate nutrition of the children. Mother has a 20 year intravenous drug use habit and approaches her daughter's friends to sell them drugs. Mother is bipolar and is currently not being treated and not taking her medication. There is verbal and physical abuse between the mother and her new boyfriend. Mother drinks every day and the eldest child gets breakfast and makes lunch herself.

Recently the mother was found by one of the children unconscious with blood coming from her eyes and frothing at the mouth. It is suspected that drug users attend the home to shoot up in the garage. The last report

⁷²⁸ Joint DoCS/Public Service Association, Working Party Report, June 2002, p.49.

stated that the mother's care of the children was deteriorating and the children are described as depressed, reacting badly to any loud voice and at times covered and hid.

None of the reports that were received have been able to be allocated by the CSC.

Case Study 15

A second case concerned a family where there have been 13 reports since July 2003 to DoCS.

The parents both seem to have a long history of drug use and have been in and out of jail for several years. Both parents have been on the Drug Court program and are still using. The children do not appear to have any stability in their lives and are constantly exposed to drug use by their parents as well as domestic violence incidents.

Four other children have been removed from the mother's care. The reason for removal of these children was due to physical abuse, severe verbal abuse, exposure to domestic violence and neglect.

A report in 2005 was received regarding concerns about the mother's ongoing drug use (amphetamines and ecstasy) and the lack of insight that the mother showed regarding the effects of her drug use. There were also concerns over the mother's relationship with the child as probation and parole had witnessed the mother threaten to 'flog' the child for disobedience and continues to use inappropriate and explicit language.

The last report was received in January 2008 and was not able to be allocated at the CSC. This report was made by Police who had attended the family home after both parents called the Police. Mother alleged father assaulted the child by kicking him and making him fall in to the wall. Mother claimed the father head butted her. In the report Police stated the child did not say a single word but had no visible injuries. Both parents were aggressive towards each other and the Police.

Case Study 16

A third case relates to a family where there have been 22 reports from 8 June 2000 to 21 December 2007, 18 of which related to domestic violence. Mother has a reportedly significant problem with marijuana abuse.

A report received on the 22 May 2007 related to the mother being physically aggressive towards her child, which resulted in him falling over and sustaining an injury to his head. Other issues identified related to the mother being observed as being heavily under the influence of substances.

A report received on 26 October 2007 stated that one of the children had rotten decaying teeth with a large abscess forming. Parents had not sought medical treatment for this. This child also had a large patch of hair missing behind her left ear.

The most recent report on the 21 December 2007 stated that the father physically assaulted the mother in front of the children. The mother attended a refuge and was transported by police, the children remained with the father. Concerns were raised that the children have been left with their father.

Father uses heroin and deals and the children have reported to their teacher that they are scared of both of their parents. Other reports state that the children do not bring enough food for lunch and they are like scared 'rabbits.' Case closed unallocated.

Case Study 17

In 2006, five reports were received regarding issues of drug abuse by the carer, domestic violence and risk of physical harm.

In 2007, five reports were received about the same issues. None of the reports were allocated for ongoing casework and the only work that was conducted consisted of investigative phone calls. This was done at intake level.

In 2008, one report was received regarding issues of sexual harm, domestic violence and drug abuse by the carer. Of these reports only one is currently open.

That report relates to an 11 year old boy disclosing that the mother's partner sexually abused him. The child disclosed that his mother's partner was performing fellatio on him. The boy had also expressed concerns that his two sisters may also have been sexually abused. He no longer resides with the mother and her partner however the two sisters and a newborn child do.

He was interviewed by JIRT in January 2008 and made clear disclosures however his mother did not believe his disclosure and has maintained a relationship with the alleged perpetrator. Police attempted to arrest the perpetrator but he was not located although the mother said he visits on and off. The Police will be charging the mother's boyfriend with an act of indecency with a child under 16 years and aggravated sexual assault.

The CSC state they have strong concerns for the other siblings who still reside with the mother as a result of her not believing or minimising the seriousness of her son's disclosure. There is also concern that she seems to be hiding the perpetrator from Police or not disclosing his whereabouts.

The CSC could not allocate the case.

- 9.101 In reviewing 75 DoCS case files, the Inquiry gave attention to whether the case closure policy is routinely followed by in CSCs. In some cases there was evidence that the policy was fully implemented, with the non-allocation of the case properly and completely recorded. The reasons usually included the number of trained staff on leave, the number of staff at training, the number of staff awaiting training, and information concerning a full caseload for available staff such as the number of court matters and case allocations they had.
- 9.102 In one case, the file note provides similar information on caseworker and manager caseloads in the reasons for non-allocation, in conjunction with the observation that the “unit was instructed to function five per cent below budget.” In some cases, the file notes documenting case closure under this policy also noted that the case warranted a risk of harm assessment, although it was not possible to allocate the case. In some cases, Priority One review meetings were documented as having occurred, with the outcome that the case remained unallocated and was closed, or occasionally was allocated.
- 9.103 There were other examples, however, of instances where no reason for closure was provided. In the case of many of the cases closed under the policy, there was no response to the reporter on file.
- 9.104 In addition to the information gained through the Inquiry’s case file audit, the data indicate that, at the most, 0.4 per cent of reports which were closed before any secondary assessment due to competing priorities, had been subject of a s.248 direction. That percentage increased to 5.1 per cent of those closed after a SAS1 due to competing priorities.
- 9.105 This may suggest difficulties in obtaining information from other agencies, or inadequate assessment practices in DoCS in making inquiries of those agencies.
- 9.106 While CSCs have received an increase in the number of caseworkers under the Reform Package, there are at times significant periods when these new resources cannot be used to respond to reports being received. This is related in part to delays in the recruitment of new staff once vacancies occur, absences for the training required for new caseworkers, the relative inexperience of new caseworkers and casework managers, and leave arrangements. However, it is noted that the percentage of reports closed at CSCs or JIRTs before any secondary assessment, generally and by reason of competing priorities has reduced between 2006/07 and 2007/08. In addition, in the last financial year, more SAS1s were completed before closing the file due to competing priorities.
- 9.107 Recommendation 29 of the Legislative Council Standing Committee On Social Issues December 2002 report, *Care and Support: Final Report on Child Protection Services*, called for DoCS to establish a formal strategy to reduce the number of unallocated cases, both those which are requests for assistance and

those which are reports of children at risk of harm, and to also establish data collection systems to monitor levels of unallocated cases. It was recommended that the data be made public. This report makes that data public.

- 9.108 The Ombudsman stated that one of the predominant and ongoing issues identified in his reviews of child deaths is the number of reports closed due to current competing priorities once they reach a CSC, observing:

many of the cases closed on the grounds of 'competing priorities' is that they may still be matters relating to significant risk to a child at the time the decision is taken for the department to take no further action.⁷²⁹

- 9.109 The Ombudsman noted that the new Intake Assessment Guidelines provide an important tool for promoting consistent assessment and allocation decisions but is of the view that they do not deal with the problems of closing cases where significant risks have been assessed but for which DoCS is not able to provide a response. The Ombudsman has recommended previously that:

A key principle in child protection intervention should be that where a report raises issues of safety of a child, or a failure to adequately provide for a child's basic physical or emotional needs, it should not be closed until adequate steps have been taken to resolve the issues. In this context, DoCS should work towards a framework for case closure that includes a risk threshold above which cases should not be closed without protective intervention.⁷³⁰

- 9.110 DoCS has taken the position that all child protection systems require procedures to assist the agency to manage service demand when demand for assessment and casework services exceeds organisational capacity. DoCS' advice to the Ombudsman has consistently stated that it is not possible to identify a risk threshold beyond which a case cannot be closed.
- 9.111 The Inquiry has concerns in relation to the function of the DoCS Intake Assessment Guidelines as a second stage mechanism for prioritising cases for allocation within the CSC. Information provided to the Inquiry suggests that inconsistent practice in conducting thorough child protection histories at both the Helpline and during a SAS1 at a CSC are still evident leaving cases where there are at harm risks unaddressed. This together with the level of further reporting for children who have previously received some form of assessment by DoCS suggests that there may be a more fundamental issue related to the quality of assessment practice within CSCs (SAS1 and SAS2).

⁷²⁹ Submission: DoCS, Assessment and Early Intervention and Prevention, p.8.

⁷³⁰ NSW Ombudsman, *Reviewable Deaths Annual Report 2003/04*, December 2004, p.67.

- 9.112 In Chapter 10, the Inquiry addresses the need for the expanded use of universal, targeted and tertiary services, the adoption of different pathways for responding to risk of harm reports and a greater responsibility for other government and non-government agencies in providing services for families in need. Together the initiatives could help in addressing the current gap in those cases which have been closed due to a lack of resources, but which still pose risks for the children or young people concerned.

Restoration

- 9.113 The Inquiry has found that DoCS does not consistently carry out a comprehensive assessment before returning children to the parents from whom they were removed.
- 9.114 In 2007, the Ombudsman reported:

In one case we investigated, a child was removed from their parents and placed in temporary care, due to risks presented by domestic violence, homelessness, substance abuse and poor parenting capacity. After some months, the child was restored to the parents following DoCS advice to the Children's Court that the family had demonstrated significant changes in the circumstances that had led to the child's removal, and that the parents would continue counselling and had agreed to random drug testing. However, our review found there was inadequate assessment or verification of these changes. Records indicate the parents disengaged with support services following restoration of the child and closure of the case by DoCS.⁷³¹

- 9.115 One non-government service met with a number of their service users to canvass their experiences with the child protection system so as to inform the Inquiry. A consistent theme that was raised by service users included the following:

The operation of the system does not always result in better outcomes for children. This was particularly of concern where children were removed subject to a number of assessments that did not seem to be completed and returned to families with no real sense of anything being different.⁷³²

- 9.116 DoCS *Child Deaths Report 2006* similarly found cases where siblings were restored, notwithstanding the lack of evidence of changed practices to parental behaviour.⁷³³

⁷³¹ NSW Ombudsman, *Report of Reviewable Deaths in 2006, Volume 2: Child Deaths*, December 2007, p.57.

⁷³² Submission: UnitingCare Burnside, 20 May 2001, p.1.

⁷³³ DoCS, *Child Deaths Report*, 2006, p.29.

- 9.117 An audit of 20 cases in two CSCs undertaken by DoCS in 2007 identified a number of issues in relation to restoration practices:

In a significant number of the cases restoration occurred with comments about parents having being referred to other support services and therefore the safety of the children was increased. On these files there was little evidence that DoCS had actually assessed whether the parents were attending the services as required or on any regular basis, and whether or not the services were having any impact on the range of issues that were identified in reports as being risk issues for the children.

It is apparent however in many of them there is little evidence of continuing work from DoCS and significant change on the part of the parent which would indicate sufficient safety. It does appear that there is a tendency towards 'trying' restoration plans as a first move, and attempting to get consented care plans rather than considering and planning for permanency for the children.⁷³⁴

- 9.118 The same audit found that where restoration plans are agreed to in court, there is a significant drop off in the work caseworkers are able to do, or are asked to do, on the restoration plan. The audit found that in some cases a number of months pass without any indication of casework in the file other than organising contact visits.⁷³⁵
- 9.119 It should however be noted that a follow up review undertaken by the Ombudsman in 2007, into the adequacy of case management, including care planning and permanency planning of children under five years of age managed by DoCS, found that, *inter alia*, there were improvements in the quality of care planning for children who were the subject of short term orders.⁷³⁶
- 9.120 Ineffective casework practices in this respect poses a significant risk to children and young persons, who may be placed back in situations where the same risks that necessitated DoCS intervention have not been adequately addressed. In a cohort study undertaken by DoCS in 2007, an analysis of children aged 0-16 years reported in July-September 2004 showed that overall, children who had previously been in placement were more likely to be reported again than children with no placement history.⁷³⁷ This suggests that restoration practices may be a factor in both multiple reporting and re-entry into care. This matter is further addressed in Chapter 11.

⁷³⁴ DoCS, Audit Report, *Review of casework practice at Glenn Innes and Inverell CSCs*, p.7.

⁷³⁵ *ibid.*, p.8.

⁷³⁶ NSW Ombudsman, *Group Review Report: Children Under Five in OOHC*, November 2007, p.4.

⁷³⁷ DoCS, *A closer look: recent trends in child protection reports*, December 2007.

Referral to services for children and families

- 9.121 As indicated earlier, DoCS provided limited data to the Inquiry on the work done with families once an assessment has been completed, although some information was gained through the Inquiry's visits to CSCs. Many of the CSCs visited outlined significant issues with accessing external services for children and families, particularly health related services:

One of our biggest issues when we are working with families is finding other agencies or departments where we can refer, like, say for argument sake, families with alcohol or drug issues, there is no drug and alcohol counsellors in the area, so it is really difficult. Most of the follow up needs to be by caseworkers or an attempt to get services from outside the area to support the families or get the families to that support. That is not only with drug and alcohol, it is with sexual assault counsellors.⁷³⁸

All we can do is refer them to mental health and then when you go to mental health, there is no one really there to support them. The resources levels here are just unbelievable at the moment; there's nothing there to refer to half the time.⁷³⁹

There is a huge waiting list for PANOC counselling services and child and family counselling services.⁷⁴⁰

- 9.122 Many submissions from non-government service providers commented on the lack of referrals of children and families by DoCS to agencies and subsequent monitoring by DoCS. Barnardos informed the Inquiry:

We are also heavily involved in the child protection system through the provision of children's family centres - that is centres providing eight, nine, different practical programs in areas of high socioeconomic need. They receive a lot of referrals -sadly few from the department. The issue of referrals is a sore point with us. We have given evidence at previous inquiries into the department's functioning. There was a Senate inquiry about the department. We gave evidence there that the department is extremely poor at referring out. One arm of the department funds us to provide service delivery and the operational arm simply does not refer the children. We get to know them because they come to us from varieties of other sources.⁷⁴¹

⁷³⁸ Transcript: Inquiry meeting with DoCS staff, Western Region.

⁷³⁹ Transcript: Inquiry meeting with DoCS staff, Northern Region.

⁷⁴⁰ Transcript: Inquiry meeting with DoCS staff, Southern Region.

⁷⁴¹ Transcript: Inquiry meeting with Barnardos, CEO and Director of Welfare, 18 December 2007, p.3.

- 9.123 Further, The Benevolent Society told the Inquiry:

The DoCS workers are so backed up with responding to crises, they are not actually getting around to phoning us with the referrals. I used to manage a number of our services as a senior manager, and I'd be saying to my managers, "You have to be phoning them twice a week. We have room for 20 families. We have 15 and we know DoCS has the families." We actually assertively have to go to them and have meetings with them to get the families, which is remarkable. The PANOC services in Health, they certainly used to say that. It is another system issue where DoCS are so busy dealing with the reports that they can't get to the referrals.⁷⁴²

- 9.124 A related issue concerns the appropriateness of referrals and follow up the outcome. In a recent DoCS internal review of 20 cases at two CSCs it was noted:

In some of the cases there were interviews with parents regarding the risks and where they denied the allegations, or said they had stopped the behaviour (for example using drugs) their word was taken as proof of change. In one case where there were reports regarding physical abuse, drug and alcohol use and mental health issues including suicide attempts by the mother, the case was recommended for closure following a referral to mental health services. Prior to recommending closure there was no evidence that the referral had been taken up, despite evidence on the file that previous referrals to mental health had been unsuccessful.⁷⁴³

- 9.125 As is clear from Chapter 7 there are too few services, however in the view of the Inquiry, DoCS does not refer sufficient families to those services which do exist. Chapter 10 makes recommendations in this regard.

Aboriginal children, families and communities

- 9.126 Many of the initiatives being taken to improve DoCS caseworkers' capacity to make appropriate decisions about risk of harm, removal and placement of Aboriginal children are in the early stages of development or implementation. DoCS stated that this makes it difficult to assess the impact that these measures will have on practice and the service system, and ultimately on Aboriginal children and families.
- 9.127 DoCS identified in its submission to the Inquiry that while more formal consultation processes are in place in relation to placement and maintenance of

⁷⁴² Transcript: Inquiry meeting with The Benevolent Society senior representatives, 12 December 2007, p.17.

⁷⁴³ DoCS, Audit report, *Review of casework practice at Glenn Innes and Inverell CSCs*, p.6.

cultural identity, the processes in relation to investigation and the decision to remove are less clear. DoCS is currently developing a resource that will assist DoCS caseworkers to develop effective working relationships with Aboriginal children, young persons, families and communities.

- 9.128 In addition, there is work currently being implemented within DoCS to improve practitioner knowledge and skills in working with Aboriginal clients and their communities. Some of these projects include the development of cultural care plans; the Aboriginal Strategic Commitment and local plans for each CSC and region; as well as cultural training and increasing the number of Aboriginal staff within the organisation.
- 9.129 DoCS also identified some significant barriers in many rural and remote Aboriginal communities for implementing case plans to address risks for these children:

A lack of options in many of these communities for family support, services for children or possible placements can also lead caseworkers to more quickly remove children from the community back to a regional centre. An alternate response to these same conditions can lead some caseworkers to fail to act, by making a judgement that the child isn't in as much need as others.⁷⁴⁴

Case Study 18

Child B was born in 1992 in Campbelltown, the second child of two Aboriginal parents. His birth certificate, applied for and obtained when he entered voluntary temporary care in 2007, shows that his mother was born in Gilgandra NSW, and father was born in Taree NSW. It appears that the family history with DoCS commenced in May 1993.⁷⁴⁵ B was placed in care more than once before DoCS obtained the birth certificate, which is the only evidence on file of his mother's place of origin. There is one other reference to her being of a different origin to local Aboriginal people in Wyong, when she said she could not access services because she was of the 'wrong blood.'

Over B's history of involvement with DoCS, the exploration of family relationships reflected in the file concentrated on his nuclear family. In a report early in 2003, the mother of B made an unsolicited statement that the child's natural father had a child from a previous relationship. There is no indication on file that further information was sought, although names

⁷⁴⁴ Submission: DoCS, Aboriginal Communities, p.27.

⁷⁴⁵ In a report dated 29 May 2003, it is noted that fifteen prior reports exist dating from May 1993 to April 2003. Later in the file material interspersed with reports from different years are reports dating 3 January 2002 and 19 April 2002. The material prior to 2002 was not reflected in the files.

and addresses of a mother and child of a different surname are recorded in the report without a stated relationship.

This potential half sibling of B is not named in the relationships section of the person history. Nor is B's paternal grandmother named in this section, although DoCS had direct contact with her at least once, in 2002. Cousins, aunts and uncles appear in the person's history relationship section, but there is no information to show whether their relationship to B is through his mother or his father, or how meaningful those relationships are to him.

In an interview with the natural mother in 2007 a caseworker asked the mother "Have you got family in Sydney? Is your mother there?" The mother's recorded answer was "Mum passed away in '89. I come from a big family, five boys and five girls." The caseworker responded "Do you see your other children?" The narrative then says that the mother provided the children's names and ages details as follows: A 18, B 15, C 13, D 11, E 8, F 7, G 4.

Only B and child H, almost 12 months old, were in her care and she was expecting child I. One caseworker asked the mother whether the two sons that she has with her were full brothers. The mother said that they were step brothers. It appears from the file that they are in fact half brothers, as they both have the same mother. This was not clarified in the interview. The notes do not document any exploration of the mother's relationship with her four sisters and five brothers.

This mother is called CI, but also known as CBe. Throughout the file reports variously identify B as being born in 1991, 1992, or being twins with his older sister A or younger brother C. His first name is spelled several ways, and he seems to be identified under at least three surnames – BI, BBr, and BC.

Children A, B, C and D appear to share the same father. It is not clear from the file who the father of E is. F and G appear to share an unnamed father. In 2006, H was born followed by I in 2007, apparently to two different fathers named in the file. In an Initial Assessment in 2005 it is noted that there was a "previous record of a prenatal report for twins that were due in April 2005 and also a record showing a prenatal report for a baby due to be born in 2004. No further information about these pregnancies are clear." In terms of extended family, the only other person mentioned in the file is the paternal grandmother of A, B, C and D, with whom B and some of his siblings were placed informally or formally (it is not clear) for a period or periods of time.

In the 2005 initial assessment above, the Helpline quotes the reporter as saying that "mother said the rest of the children are "with their father, sort of", mother refused to explain further."

In the interview in 2007 referred to above, the mother volunteered the information about her family of origin, and the caseworkers did not seek any further information. There is no record in the file of any questions regarding the extended family of B's father, the presence of any siblings of the natural father, or any further information being sought about other children of the natural father.

At one point in 2007 B's father was not contactable, and the mother was observed to be intoxicated and then could not be located. The DoCS worker recorded "the only adult that I was able to access concerning this was B's sister – A who is 19 years old. She said to me that she was travelling to Tamworth tomorrow being 12 February 2007 to pick B up and see her mother. A was able to give me verbal permission to take B into temporary care until she arrives."

For B, who had four recorded entries into care, there was no genogram in the file, and it was a very time consuming process to sift through the file to find the relevant information. The aunts and uncles referred to in the KiDS Person History did not have contact details in the files provided to the Inquiry.

- 9.130 Clearly more needs to be done. In Chapter 18 of this report, recommendations are made.

Good casework

- 9.131 As is clear from this chapter, the quality of casework at CSCs is variable. However, the Inquiry was made aware of examples of good casework, including successful engagement with families, implementation of supportive casework practice, and appropriate use of mechanisms such as s.248 requests to access relevant information. Some files documented a clear case plan, regular case meetings with multi agency involvement, effective liaison with other agencies and case management review.

Case Study 19

Five prenatal reports had been received and the file was allocated at the birth of the child. There was clear evidence of a timely and ongoing response by DoCS and ongoing liaison with other agencies to coordinate services. The mother moved to WA and DoCS wrote to WA child protection services outlining their involvement with family (assistance with child and family health services, supported accommodation, parenting course, Alcohol and other Drug counselling). DoCS involvement recommenced when the mother returned to Sydney. The risks related to the mother's mental health issues and drug use. The risk of harm fluctuated but DoCS kept in regular, weekly contact, conducted home visits and worked with other agencies to ensure supports were in place.

- 9.132 It is not suggested that this is the only example of good casework seen by the Inquiry, but it is indicative of what can be achieved when there is an effective commitment to provide a follow up.

Supervision and professional development

- 9.133 Many of the casework practice issues identified in this chapter can be addressed by enhancing the supervision structures in place and ensuring that professional development is ongoing and targeted at areas of poor practice. It should specifically address the need for, and encourage and support the implementation of, policy and procedure.
- 9.134 The Inquiry is of the view that the establishment of the DoCS clinical structure comprising Casework Specialists and Directors Practice Standards should be retained to focus on coaching new frontline caseworkers and newly appointed managers, as well as to provide and facilitate access to other key clinicians, external to DoCS, so as to assist in managing complex cases.
- 9.135 For all caseworkers and managers there should be a structured program for ongoing professional development which is incorporated into annual PPR agreements. This should focus on the development of skills in evidence based assessment and intervention and on obtaining knowledge and skills from other key specialists, such as those practising in mental health, substance abuse and domestic violence.
- 9.136 In addition to individual supervision, there should be a facilitated monthly group case practice review of selected cases within each CSC, in which all caseworkers and managers, participate, and which may include specialists from other agencies, where the case requires.
- 9.137 DoCS should seek to develop models of professional support for novice caseworkers, such as those offered in other disciplines like medicine that require safety and risk factors to be taken into account in decision making. This may include a period of structured internship where new caseworkers (with limited experience and newly qualified) have the opportunity to engage in a range of supervised work activities. A cohort of experienced practitioners should be identified to support these staff.
- 9.138 DoCS should explore the establishment of specialised training in child welfare and child protection practice as part of key undergraduate courses in disciplines such as Social Work. Incentives could be considered for new recruits who complete this specialised component including placement with DoCS commence at a higher remuneration level. Under this model those without specialised prior training would start at lower grade and receive intensive induction support.

Inquiry's review of four CSCs

- 9.139 The Inquiry visited and met with the staff at a number of CSCs and subsequently collected and reviewed data concerning Campbelltown CSC, Eastern Sydney CSC, Shellharbour CSC and Moree CSC. The Inquiry also held Public Forums and interagency meetings at or near Shellharbour and Moree.
- 9.140 The demographics, staffing composition and capacity of these four CSCs vary significantly as do the number of reports they handle. The following table provides details of the number of casework staff positions in each of the four CSCs as at 30 April 2008.

Table 9.1 **Casework staff establishment numbers in Campbelltown CSC, Eastern Sydney CSC, Shellharbour CSC and Moree CSC, as at 30 April 2008.**

	Campbelltown	Eastern Sydney	Shellharbour	Moree
Managers Client Services	2	1	1	1 (shared- Narrabri)
Managers Casework	12	6	6	2
Caseworkers	74	36	33	13
Casework Specialists	2	2	2	1 (shared- Narrabri)
Total Casework Staff	90	45	42	17

Note: IFBS staff based at Campbelltown were not included in this table as their work involves intensive case management of specific families.

- 9.141 At 30 April 2008, the four CSCs were carrying varying numbers of vacancies. At Campbelltown 5.4 per cent of the above caseworker positions were vacant, at Eastern Sydney 19.4 per cent were vacant, at Shellharbour 12.1 per cent were vacant, and at Moree 46.2 per cent were vacant.
- 9.142 The supervision ratio for Managers Casework to caseworkers at 30 June 2007 ranged from 1:3 in Moree to 1:8 in Shellharbour. The State average for 2006/07 was 1:6.
- 9.143 At 30 June 2007, a significant proportion of caseworkers in all four CSCs had been employed by DoCS for one year or less. In Eastern Sydney they accounted for almost two thirds of all caseworkers, in Shellharbour they accounted for over 60 per cent, and in Campbelltown and Moree, they accounted for about half of all caseworkers.
- 9.144 Managers Casework had on average more experience working for DoCS than caseworkers, particularly at Eastern Sydney where all managers had six or more years experience as DoCS employees, and Campbelltown where all but two managers had four or more years experience working as DoCS employees.

- 9.145 At 30 June 2007, the average rate of separation for DoCS caseworkers was 7.18 per cent. The separation rates in Campbelltown and Shellharbour were below the average while in Moree and Eastern Sydney the rates were significantly higher than the average, at 16 per cent and 22.2 per cent respectively.
- 9.146 The table below shows that as at 30 April 2008, the caseworker capacity for all four CSCs was significantly lower than the number of caseworkers occupying positions. Given the significant proportion of caseworkers employed in all four CSCs who had been employed by DoCS for one year or less, it is assumed that many of these caseworkers had not completed CDC training and as a result were not counted when CSC caseworker capacity was calculated.
- 9.147 The impact of training on the caseworker capacity of CSCs should not be underestimated. During 2006/07 DoCS staff undertook 127,169 hours of CDC training, which averages at around 50 hours for every caseworker position. A further 83,160 hours of other training was undertaken by DoCS staff, which averages at just over 20 hours for each staff member.

Table 9.2 Caseworker capacity and caseloads for Campbelltown CSC, Eastern Sydney CSC, Shellharbour CSC and Moree CSC, as at 30 April 2008

	Campbelltown	Eastern Sydney	Shellharbour	Moree
Caseworker establishment	74	36	33	13
Caseworker positions filled	70	29	29	7
Caseworker capacity	36.94	11.70	8.26	4.27
Caseload per caseworker (on open plans)	8.55	17.10	8.31	16.28

- 9.148 As at 30 April 2008, caseworkers at Campbelltown and Shellharbour were carrying caseloads that were lower than the State average of 11.33 open plans per caseworker. Eastern Sydney and Moree were carrying caseloads that were higher than the State average.
- 9.149 In 2006/07, 7,748 reports were referred to Campbelltown CSC by the Helpline for further assessment. Shellharbour CSC received 4,889 such reports, Eastern Sydney CSC received 3,171 such reports, and Moree CSC received 1,262 such reports.
- 9.150 The proportion of referred reports involving Aboriginal children and young persons varied significantly across the four CSCs in 2006/07. Of all referred reports in NSW in 2006/07, 17.9 per cent involved Aboriginal children and young persons. In Campbelltown, Eastern Sydney and Shellharbour the proportion of reports involving Aboriginal children and young persons was below the State average at 10.5 per cent, 12.5 per cent and 13.1 per cent respectively. The opposite was true of Moree, where the proportion of reports involving Aboriginal children and young persons was much higher than the State average at 68.6 per cent.

- 9.151 Between 2004/05 and 2006/07, there was a 43.5 per cent increase in the number of reports referred to a CSC/JIRT for further assessment. The percentage increase in the number of referred reports to Moree over this period was close to the State average at 43.9 per cent. It was slightly higher than the State average at Campbelltown at 48.1 per cent and was significantly higher at Shellharbour, which experienced a percentage increase in referred reports of 64.2 per cent. At Eastern Sydney there was no increase in the number of referred reports from 2004/05 to 2006/07. In both years, 3,171 reports were so referred.
- 9.152 After a series of meetings with CSCs it became clear to the Inquiry that casework staff across the State were under considerable pressure as a result of the volume of reports flowing into their CSCs on a daily basis. Staff at the Campbelltown CSC described the backlog of reports with a response time of less than 72 hours and less than 10 days as “unmanageable.” During 2006/07, 7,748 reports were referred to Campbelltown, which averaged at about 150 reports every week.
- 9.153 The Inquiry does not have data on the caseworker capacity of the four CSCs for the years 2004/05 or 2006/07. However, as all CSCs have more caseworker positions now than they did in 2004/05, it is assumed that as the number of reports increased over the period (with the exception of Eastern Sydney), so too did caseworker capacity. This assumption would appear to be supported by the increase in the proportion of reports that were the subject of a completed SAS2 in all four CSCs between 2004/05 and 2006/07.
- 9.154 In 2004/05, 13.5 per cent of all referred reports were the subject of a completed SAS2. This increased to 21.5 per cent of all referred reports by 2006/07. While the proportion of referred reports that were the subject of a completed SAS2 also increased across all four CSCs over this period, the proportion of reports so assessed at Campbelltown and Shellharbour in 2006/07 was below the State average, at 17.2 per cent and 17.9 per cent respectively. Eastern Sydney was on the State average at 21.4 per cent and Moree was significantly higher than the State average with 34.8 per cent of all referred reports being subject to a completed SAS2.
- 9.155 The above data could suggest different levels of SAS2 assessment being undertaken on SAS2 across CSCs. Information that is missing from this picture is the percentage of cases that were subject to a SAS2 which required ongoing casework, and what that casework involved.
- 9.156 While the proportion of completed SAS2 reports at Eastern Sydney was about the same as the State average, what happened to the remaining reports does not align with the trend across the State. Proportionately more reports than the average were closed before any secondary assessment, and correspondingly, proportionately less reports were the subject of a SAS1 only.
- 9.157 The assessment path for reports referred to Campbelltown in 2006/07 more closely approximated the State trend, although proportionately, slightly more

reports were closed prior to any secondary assessment or after a SAS1 and proportionately fewer were subject to a completed SAS2.

- 9.158 At Shellharbour, proportionately less reports were closed prior to any secondary assessment, but proportionately more were closed after a SAS1. The proportion of reports that were subject to a completed SAS2 was lower than the State average.
- 9.159 At Moree, the assessment path for reports was quite different again. Very few reports were closed before any secondary assessment, although a significantly greater proportion were closed after a SAS1. However, the proportion of reports to receive a completed SAS2, at 34.8 per cent, was significantly higher than the State average.
- 9.160 In 2006/07, the substantiation rate varied, both across the four CSCs and with the State average of 93.5 per cent. At Campbelltown, there was a finding of harm or risk of harm in 94.5 per cent of reports that were the subject of a completed SAS2. At Shellharbour, the substantiation rate was higher again at 96.3 per cent and it was highest at Eastern Sydney at 98.1 per cent. At Moree, on the other hand, the substantiation rate was significantly lower than the State average at 86.8 per cent.
- 9.161 So even though reports at Moree were more likely to receive a completed SAS2, a greater proportion had a finding of no risk or harm than in the other CSCs. That said, however, 30.2 per cent of all reports at Moree resulted in a finding of harm or risk of harm, which was higher than for the other CSCs and higher than the State average.
- 9.162 The substantiation rates across three of the CSCs increased between 2004/05 and 2006/07, which is in line with the State trend. At Moree, however, the substantiation rate dropped slightly over the period, from 87.0 per cent to 86.8 per cent.
- 9.163 The proportion of referred reports assigned a required response time of less than 24 hours fell across all four CSCs between 2004/05 and 2006/07, which aligns with the statewide trend. In 2006/07, 9.5 per cent of all referred reports were assigned a response time of less than 24 hours. At all but Eastern Sydney, the proportion of referred reports so assigned was lower than the State average. At Eastern Sydney, the proportion of reports so assigned was slightly higher than the State average at 10 per cent.
- 9.164 Across the four CSCs, between 93.4 and 100.0 per cent of all reports with a required response time of less than 24 hours (often referred to by staff as Level 1 reports) were allocated for some level of secondary assessment, whether a SAS1 only or a SAS2. It was an inability to provide this level of assessment for reports with a required response time of less than 72 hours (often referred to by staff as Level 2 reports), particularly those that were considered high risk, that concerned many staff in the four CSCs. A staff member from Shellharbour stated:

...we rarely get to Level 2s. We seem to be getting quite a few coming through to Level 2 highs. They grade them. It's almost a Level 1, it doesn't quite get there, but you read the report and it's obviously extremely concerning, but it's a Level 2 high and pretty much because of the lack of resources and the staffing and the issues that we have here, we're only quite often responding to Level 1s.

- 9.165 This exercise reveals the differences between CSCs in terms of their capacity, the experience of their staff, the number and type of reports which they allocate and those which received little attention, and the significant periods of time spent in training.
- 9.166 As has been evident from this and preceding chapters, the Inquiry is concerned that the implementation in CSCs of policies and procedures developed by Head Office is patchy. This exercise suggests that the procedure to educate staff in one CSC about good practice should not necessarily be the same as in another. The Inquiry is of the view that Regional Directors and those who report to them, should be tailoring their support for CSC staff in understanding and applying practice changes, dependent on the particular needs and circumstances of the community which comes within the catchment of that CSC.

Involving other agencies in assessment and response

Health

- 9.167 In order to gauge the extent to which DoCS formally sought information from other agencies to assist in assessing families and determining the most appropriate response, the Inquiry sought information from DoCS and Health as to the number of requests for assistance or directions for the supply of information made by DoCS.
- 9.168 The Inquiry was surprised that the data provided by DoCS revealed that the number of directions made under s.248 of the Care Act equated to only 7.7 per cent of the reports which were referred to a CSC or a JIRT for further assessment. Health informed the Inquiry that it accounted for about 40 per cent of those directions.
- 9.169 DoCS does not collect data about requests made under s.17. However, Health reported to the Inquiry that it had received 93 such requests from DoCS in 2006/07 and 72 in 2007/08.
- 9.170 From that data and from submissions and the various audits and reviews available to the Inquiry, the Inquiry has concluded that caseworkers do not routinely involve other agencies in deciding and planning assessments or interventions nor do they routinely communicate with them or seek information

about their work with families. Of course, there will be cases where no other agency is involved, however, in many cases, Police, Education or Health will have had some involvement with the family and will hold relevant information which should be sought formally. In some cases, the relationships will be such that the information can be obtained informally, although the frequent reference to the impediments posed by the privacy legislation suggests this is not the usual approach.

9.171 In addition to formally or informally seeking information, there is the issue of communication about events relevant to agencies other than DoCS.

9.172 A number of health services identified that communication with caseworkers is a frequent problem and impacts on effective case management of children. For example, the Sydney Children's Hospital at Randwick stated that while its Child Protection Counselling Service only works with families where DoCS remain involved, it is not uncommon to have DoCS fail to return calls or emails sometimes for as long as six weeks. Multiple calls are made to managers and caseworkers that respond to some matters but not to others.

9.173 The Ombudsman's review of a child death found:

No secondary assessment was ever completed by Blacktown CSC to which the case was referred... they concluded there was no immediate risk of harm concerns and closed the file as SAS1. They did not advise the hospital of this action notwithstanding that the hospital had repeatedly asked for the child to be returned to the hospital for further assessment... The internal review concluded that the assessment by Blacktown CSC lacked holistic rigor. There was no information to suggest protective factors were in place or risks assessed.⁷⁴⁶

9.174 An issue which emerged early in the Inquiry and gave rise to frequent comment by mandatory reporters was the perception that DoCS did not give sufficient weight to the expertise of the reporter. This was of particular concern to Health.

9.175 The Ombudsman's review of a child death found:

DoCS risk assessment did not take into account the mother's history of drug addiction, gave insufficient weight to an opinion of a medical practitioner and did not make any assessment of the mother's home including sleeping arrangements for the baby. The focus of DoCS' attention appeared to be on securing supported accommodation for the mother.⁷⁴⁷

9.176 In this case the Ombudsman concluded that:

⁷⁴⁶ NSW Ombudsman, *Investigation into the death of a child, Provisional Statement*, 2008.

⁷⁴⁷ NSW Ombudsman, *Investigation into the death of a child*, 2006.

Despite the imperative set by the Government guidelines that agencies work together in relation to protecting children and young people in need of care and protection, there is little evidence that this effectively occurred in this case. Part of this failure can be linked to the inadequacies in DoCS's risk assessment and the Department's lack of appreciation of the relevant issues potentially placing the child at risk even when these were reported by the baby's specialist. While the Department sought information from Area Health Services, when this was provided it had little bearing on the case plan. There was sufficient reason for DoCS to request information from NSW Police, but this did not occur.⁷⁴⁸

- 9.177 Recently, DoCS and Health prepared a paper that examined practice and systemic issues for each Department arising from seven child deaths between May 2003 and August 2006.⁷⁴⁹ The paper considered the balance between a statutory child protection focus on ensuring the safety of children and the treatment/social rehabilitation perspectives where drug dependency was an issue. This revealed a number of practice, treatment, intervention and interagency issues for both agencies.
- 9.178 First, it was evident that there is a lack of information sharing between DoCS casework staff and Health staff and between staff in each agency, including hospital and drug and alcohol professionals. Also identified was a cultural divide between professionals from the two agencies with the stereotypical perception that "Health is there to support the parent and DoCS is there to support the child."⁷⁵⁰
- 9.179 The paper refers to a Canadian study which describes how historically the two delivery systems (health and child protection) have had different orientations, goals and organisational cultures which have led to fragmentation and a lack of coordination of services and case planning. The study also states that coordination of services can be further impeded when women fear that they may jeopardise custody of their children if they reveal the full extent of their substance abuse problems or enter substance abuse treatment.
- 9.180 Secondly, there was a need identified for child protection staff to regularly update their skills in engaging these families, and their knowledge about drug issues, and for drug and alcohol workers to have knowledge about child protection issues.
- 9.181 Thirdly, it was evident that there was confusion about the delineation of roles between Health and DoCS.

⁷⁴⁸ *ibid.*

⁷⁴⁹ DoCS and NSW Health, *Methadone related child deaths issues paper*, April 2008.

⁷⁵⁰ *ibid.*, p.33.

- 9.182 Confusion about service roles and responsibilities can result in a loss of focus on the child protection issues and impede effective case planning for the child and parent. A simple example is where a DoCS worker may need an interpretation of a toxicology screen or a drug and alcohol worker may have concerns that a child is not meeting developmental milestones.
- 9.183 Fourthly, the paper noted that liaison persons from each agency needed to be identified.
- 9.184 The DoCS Drug and Alcohol Expertise Unit is working with Health to scope a cross agency project that will identify how to better integrate service delivery across DoCS and drug and alcohol systems, with a view to trialling it in metropolitan and rural sites. Health is also developing a training package on child protection issues for all government and government funded drug and alcohol workers across the State. It is anticipated that this will strengthen cross agency practice and promote caseworker access to experts in drug and alcohol services in their region.
- 9.185 The Inquiry is of the view, which is shared by many participants in the NSW child protection system, that there is a need to bring the expertise of professionals from other non-government and government agencies more closely into the assessment process. As a senior doctor from Sydney Children's Hospital working in this area informed the Inquiry:

What we've been asking for a number of years is some dedicated staff within the Department of Community Services to investigate, not just the Helpline, but when they go to the next level of assessment and investigation of complex and serious medical matters.... one can't expect the average caseworker to be able to comprehend and work within that complexity.... We're not talking about multiple or many cases. It is a small but very complex and very time-consuming number of cases that obviously both Health and the Department of Community Services put a lot of resources into currently and they are not ideally managed from both our services.⁷⁵¹

- 9.186 The Inquiry is supportive of the Drug and Alcohol Expertise Unit and is of the view that a similar strategy should be developed for dealing with mental health issues and domestic violence. The greater involvement of Health in child protection work is addressed in Chapter 10.

Multi-agency response

- 9.187 A multi-agency systems approach involves identifying the underlying patterns in the work environments of the different agencies which support good practice, as

⁷⁵¹ Transcript: Public Forum, Mandatory Reporting, 15 February 2008, p.22.

well as those that create unsafe conditions in which poor practice is more likely, and then applying the lessons learned.

- 9.188 This approach would enable all agencies working with children, young persons and families to understand casework practice better in order to improve the quality of services. It could focus on the influence of different assessment practices, as well as an communication and collaboration practice that can affect and decision making. A recommendation to this effect is made in Chapter 10.

Different pathways

- 9.189 As is evident from the data, only a small number of children reported receive a detailed assessment and planned intervention from DoCS. Some children do not need statutory intervention and some families need some assistance, which could be equally or better provided by an agency other than DoCS.

DoCS view

- 9.190 Presently, NSW treats all information about a risk of harm to a child or young person as a report, and then a decision is made whether to refer the matter to a CSC or a JIRT. DoCS contended to the Inquiry that NSW is well suited to adopt a new differential child protection system and recommended an approach which combines the current Helpline function with a multi-track system whereby children and their families are streamed either to a statutory response or to family support and early intervention services.
- 9.191 This new approach would group current clients based on service needs and on the likelihood of needing statutory intervention. Its purpose would be to provide a better basis for assessment and for ensuring referral to the most appropriate services. This system would cover the needs of children and young persons in NSW requiring no DoCS action (though possibly support services from health and other social services) through to those requiring OOHHC services. DoCS recognised that the distinction between the groups was not always clear cut, that overlap existed and a family's need for services, and the intensity of service need, would vary over time. Further, assigning families to a specific classification (such as family support or child protection) and then proposing services that would most effectively meet their needs would depend on robust systematic assessment throughout the lifetime of the case.
- 9.192 In broad terms there are three groups of clients who are currently reported to the DoCS Helpline.
- 9.193 Group A comprises lower needs children and young who enter and exit the system quickly. These children and young persons are generally not referred to a CSC because they are assessed as below the current risk of harm threshold, or if referred to a CSC, are assessed at the CSC intake to be of a much lower

priority than others, and as requiring minimal attention within the child protection system (that is, no further secondary assessment).

- 9.194 DoCS estimated this group comprises around 25 to 35 per cent of children and young persons who are currently reported to DoCS in any year (in 2006/07 this would have equated to between 30,922 to 43,291 children). While some other government agency (for example, Health or Housing) or non-government family support services might be required, under a raised reporting threshold, there would be no need for DoCS intervention if the risk of harm threshold was not met.
- 9.195 Group B comprises children and young persons who enter the system and are generally reported several times, possibly over a long period of time. This group comprises around 45 to 60 per cent of children and young persons currently reported (in 2006/07 this would have equated to between 55,660 to 74,214 children). With the current level of resources within the system, a proportion of these children and young persons are assessed and prioritised for intervention, but a large number currently do not receive any further DoCS case management or any targeted services. A mix of services of varying intensity is required for these children and young persons. A large proportion would benefit from intensive early intervention services, such as those offered under the Brighter Futures program, while others would only require lower intensity, shorter term family services, delivered by the non-government service sector with support from other government agencies, and enhanced through expansion of the CSGP.
- 9.196 Group C comprises children and young persons who require immediate intervention (statutory child protection) to address their situation of child abuse and/or neglect and to protect them from harm or imminent entry into OOHC. This group is estimated to comprise 10 to 20 per cent of children and young persons reported (in 2006/07 this would have equated to between 12,369 to 24,738 children). These children and young persons require a full face to face assessment (currently SAS2), family preservation services (possibly followed by intensive early intervention, such as a Brighter Futures type service, in a step down approach) and/or OOHC. In April 07/March 08, 14,443 children and young persons were the subject of a completed secondary assessment (SAS2) by DoCS.
- 9.197 DoCS identified that:

Our whole system is organised by the triage principle where the most urgent, the most serious things do increasingly and very significantly I think get a response and we work very closely and well I think with our colleagues in Health and Police and Education in an interagency response to those matters. I think where issues collectively come is in those matters that fall below that threshold of immediate urgent seriousness where you have a range of concerns of risk that may fall just short of a

*threshold of seriousness, but you are at the limit of the system's capacity to provide a response.*⁷⁵²

- 9.198 DoCS anticipated that a new model would use the NGO sector to case manage Group B and some Group A clients who were assessed as requiring the lower intensity family support services, with DoCS retaining program funding. Alternatively, it noted that consideration could be given to Health managing the program funding for family support services, or at least co-locating those services with Health services, subject to a service level agreement and monitoring.
- 9.199 DoCS has recommended maintaining the Helpline for all contacts/receipt of information and continuing recording of this information on a centralised database, subject to improvements in KiDS. DoCS stated that a centralised model enables consistent recording of information about risk of harm to children, establishes consistent intake decision making processes that are transparent, and provides for case prioritisation that is the same across the State. This is important as families and children often move throughout the State between local DoCS regions, and it is critical that the information about child protection concerns can be accessed on a statewide basis and allow DoCS to respond to after hours child protection cases.
- 9.200 DoCS argued that:
- Decentralised, locally based contact and intake processes can result in fragmentation of child protection information and lower service capacity, due to logistical difficulties and cost benefit inefficiencies in providing 24/7 access in each location. In addition, although decentralised intake can appear to offer the attraction of more immediate linkages between reporters and local service providers, such a potential benefit is unlikely to be significant in very busy CSCs or, given the size of NSW, rural and remote locations such as Western Region.*⁷⁵³
- 9.201 DoCS also proposed an alternative pathway in which mandatory reporters could make a report to the Helpline at the same time as referring children and their families to locally based services. Most mandatory reporters, DoCS argued, are involved in local service networks. This approach would include mandatory reporters getting feedback from the Helpline.
- 9.202 DoCS advised that referral from the Helpline to one of the 14 Brighter Futures Lead Agencies would be possible, but would require amendment of the current Case Streaming Tool and clarification about those referrals which are not accepted by Lead Agencies. Referrals from the Helpline to other non-government services could operate in a similar manner, if non-government

⁷⁵² *ibid.*, pp.19-20.

⁷⁵³ Submission: DoCS, Assessment Model and Process, p.21.

agencies were prepared to aggregate referral points in a particular geographic community. Rather than DoCS referring families to hundreds of services across the State, it could refer to a smaller number whose role in a particular community (apart from any projects they manage) would be to refer on to services within the network of the community.

- 9.203 This approach would require:
- a. capacity for the Helpline to take on this additional function, and design of appropriate business processes with supporting technology, such as extension of the DoCS portal
 - b. identification through Initial Assessment of children and families for whom passive referral by DoCS was appropriate, including some clients who are currently lower risk needs clients and not likely to be reported again to DoCS
 - c. client consent to make referrals or some other arrangement for the exchange of information apart from consent. While passive service referrals by the Helpline in these circumstances are possible, the ability of this centralised contact centre to make active referrals would be constrained by its capacity to engage with families at the local level, many of whom would not be aware that a report had been made to the Helpline.

Other views on establishing different pathways

- 9.204 Other jurisdictions in Australia and overseas are attempting to move from an exclusively investigative child protection approach to alternative models that allow more flexibility for intake and service delivery.⁷⁵⁴ These 'differential response' systems (also known as 'dual' or 'multi-track') include a second non-investigative or family assessment pathway that provides assessment of the needs of the child and family and referral to appropriate services without first requiring a determination of risk of harm.
- 9.205 Some of these options include: promoting and enhancing referral pathways down from and between tertiary services; promoting and enhancing referral pathways directly into secondary/targeted services; creating a single visible entry point where families are assessed and referred to the most appropriate service response (for example, primary/secondary family services or tertiary child protection services); and/or not creating a specific visible referral point, but enabling community members and professionals to make referrals to those services that exist within the local area to meet the identified need.⁷⁵⁵
- 9.206 Health recommended to the Inquiry that integration of a needs assessment into the DoCS assessment processes should occur. Health argued that the current

⁷⁵⁴ J Waldfoegel, (Forthcoming 2008), op. cit., cited in Submission: DoCS, Assessment Model and Process, p.13.

⁷⁵⁵ L Bromfield and P Holzer, "A national approach for child protection-Project report" *National Child Protection Clearinghouse, Australian Institute of Family Studies*, 2008, p.57.

DoCS triage processes for accessing and maintaining access to specialist child protection services do not always capture those that are most vulnerable to harm due to family circumstances and the characteristics of the children and parents.

9.207 Priority allocation does not adequately address the risks to children and young persons who are vulnerable to future harm, who are experiencing lower levels of harm, or who are subject to neglect. As models of decision making are based on incidents of abuse or neglect rather than on holistic assessment of the needs of children and young persons in the context of their family and community, the systemic response is reactive not proactive.

9.208 Needs assessment, Health argued, addresses aspects of functioning, strengths and issues that may not be illuminated through the risk of harm assessment. Health is of the view that concurrent needs and risk of harm assessment by DoCS as a process of case management would best ensure that issues of safety and harm are addressed for children and young persons, with essential links made to aspects of welfare and well-being.

9.209 A number of submissions recommended the introduction of a differential system for responding to risk of harm reports. As noted by the Ombudsman:

Even if the Department is able to strengthen its assessment practices and adopt sophisticated intelligence based practices, it will not be able to meet demand...We also support the department's view that NSW would benefit from a differential system for responding to risk of harm reports. There will always be reports that require a forensic investigative approach by the department, however, for many reports, the best response will be one that is focused in providing support.⁷⁵⁶

9.210 Education identified the need for a stronger emphasis on early intervention and support and clear pathways for making referrals to support agencies. For example, a school may identify concerns for a child that relate to parenting capacity or need for support due to complex and challenging child care issues, which may lead to risk of harm if not addressed. Education stated it may be helpful to establish clear mechanisms for schools to refer such matters directly to relevant support services, which may assist families to access the support they need and engage with support services without the stigma of being 'reported to Community Services'.

9.211 The Ombudsman noted that there was merit in DoCS' grouping of the reports into the three categories (A, B, C), although he pointed out that a future system would need to test the accuracy of these estimates and have the flexibility to adjust the service mix should this be required. The Ombudsman also supported the Helpline model proposed by DoCS.

⁷⁵⁶ Submission: NSW Ombudsman, Assessment and Early Intervention, p.13.

- 9.212 Many non-government agency submissions supported a differential pathway stating that the current system lumps all reported children into the same harm category instead of differentiating between harm and need for assistance. Many submissions stated that there was a need to distinguish between children in need of support and children at risk of significant harm. The Benevolent Society said:

*The system does not respond favourably to parents who recognise they need support in their parenting role and would like help. Because of the policing nature of social services and the lack of services, parents know that the likely outcome of seeking help is an abuse report, in some instances followed by removal of the child. Clearly there needs to be a different approach to service provision.*⁷⁵⁷

- 9.213 Other submissions suggested amending the Care Act to create two entry pathways for services. One pathway would be for responding to children, young persons and families 'in need of support' with the second for reporting children and young persons at risk of significant harm. This approach would involve establishing a series of local/regional intake and referral centres for children, young persons and families in need of support which could be co-located with service providers. This is not dissimilar to the model in place in Victoria with its two pathways, under which lower risk families can be subject to a decentralised voluntary assessment and service orientated response through Child FIRST, and those with high risk who come within the statutory child protection regime.
- 9.214 Other versions of this model include introducing a community based intake and referral for cases that fall below the statutory reporting threshold. Both models support maintaining a centralised intake system while introducing a range of supplementary systems to improve intake (for example, a statewide advisory service, regional CSC support roles, community based intake).
- 9.215 Other suggestions to embed a differential response system include the placement of a child protection consultant in agencies to divert cases not requiring a statutory intervention. This position would be located in key government and non-government agencies and these positions would make a call as to whether to report to DoCS or refer the family to other services. DoCS would accredit these people.
- 9.216 The Commissioner for Children and Young People advised the Inquiry:

It is about helping them [agencies] really to send only those cases to DoCS that DoCS require a statutory intervention. Importantly, it is to say, "If DoCS are not going to be involved,

⁷⁵⁷ R Lawrence-Karski, "United States: California's reporting system in N Gilbert (ed) 'Combating child abuse: international perspectives and trends'," *New York, Oxford University Press, 1997*, pp.3-6 cited in Submission: Centacare, Broken Bay, p.10.

*what will we put in place? Who will we work with? How else can we get other agencies engaged to meet the needs of this child so that those needs are met? At the moment, our system seems to be that children are being reported to DoCS, but a lot of them do not end up with their needs being met. It is about reducing the demand on DoCS, so they can focus on those that only they can focus on; but at the same time where DoCS are not involved, it means those other agencies making sure that the children's case are met through designing case plans.*⁷⁵⁸

- 9.217 Health acknowledged that such a person within Health who could act as a central point to consider information gathered by Health workers may be of some value.
- 9.218 The Inquiry is of the view that a critical issue driving demand for child protection services is the need for appropriate responses for those families who fall below the threshold for statutory intervention, or whose cases have to be closed by reason of competing priorities or lack of resources, yet are families that would benefit from specific services to address their current problems and prevent escalation. Decisions regarding which referral pathways will be provided, and which of these will be promoted in the community can have a significant impact on the role that child protection services play in the child welfare continuum and demand on tertiary services.
- 9.219 Chapter 10 describes the model preferred by the Inquiry.
- 9.220 The Inquiry is not in favour of creating a separate department to manage those reports which do not require statutory intervention and matters of child development more generally. There is a continuum of services required for children and young persons, which is better coordinated from the one agency.
- 9.221 The creation of a separate department would have significant cost implications. It would risk duplication of effort, and increase the risk of children or young persons falling between the cracks. There could be significant problems attributed to inconsistent practices or policies. Overall the Inquiry is not satisfied that the establishment of a separate department would add value to the system.
- 9.222 The Inquiry agrees with the comments made in one submission that rather than organisational change, what is called for is a shift in the way in which the needs of children and young persons' are understood and services for children and young persons are delivered.

⁷⁵⁸ Transcript: Public Forum, Assessment Model and Process, 18 April 2008, p.52.

Conclusion

- 9.223 As can be seen from this and the preceding chapters, there is a deal of data available about the numbers of children and young persons by reference to DoCS processes. Thus, while the reader knows the number who have had SAS2s, it does not know what, if any service was provided to them or whether it was taken up and was beneficial. Were they referred to a mental health service, if so, did they receive counselling, did the parents access child care, did the mother attend a rehabilitation service and complete it, and what were the outcomes?
- 9.224 Of the children and young persons who were the subject of a finding of substantiated neglect or risk of neglect in 2005/06, around three quarters did not subsequently enter care. Even fewer entered care where the risk issues involved psychological harm, physical harm, sexual harm and risk of harm. The question as to what happened to these children and young persons is important and largely remains unanswered.
- 9.225 The data on the reporting history of children and young persons, particularly following a substantiation is the best evidence potentially available of the effect the child protection system has had on children and young persons who were reported. The data are of qualified use however for the reasons set out in Chapter 5.
- 9.226 The Inquiry's observations are therefore based on an analysis of the process data, the information obtained by other reviews and audits and the submissions made to the Inquiry.
- 9.227 The Inquiry concludes that the assessment and response work of DoCS is based on sound policies and procedures which are, in turn, reflective of current research. However, the implementation of those policies is inconsistent and too many assessments lack a holistic approach, lack rigour and do not take advantage of the expertise or information of others. Significantly a number of families are excluded from the intervention or services that they need because of the emphasis on prioritising the responses to the high risk cases that need urgent intervention.
- 9.228 Consistent with the Inquiry's findings, DoCS has identified five themes arising from its analysis of the deaths of children 'known to DoCS' in 2007. Those themes: are the importance of supervision of casework staff; maintaining a child focus in assessment work; use of medical opinion in assessment of serious abuse; working with hostile or aggressive clients; and the challenges of working with domestic violence.
- 9.229 It is acknowledged that DoCS has initiated or completed a number of projects designed to deal with the issues raised in this chapter. Each is dealt with elsewhere in this report. They include implementing the Professional Development and Quality Assurance project; requiring caseworkers, although

not Managers Casework, to possess a tertiary qualification; developing a significant research function within DoCS and working on a better way of communicating and embedding policies with caseworkers and their managers.

9.230 The Ombudsman noted that over the last five years the Department has sought to respond to these problems in a number of ways, including through policy and training initiatives. He noted that with the recruitment of a large number of new staff over the past five years, and the overhaul of its business practice, it was inevitable that there would be significant challenges in delivering high quality assessment decisions at the CSC level, at least in the short to medium term.

9.231 The way in which new policies and research are communicated to staff, the adequacy and quality of their supervision and the volume of material to be digested are significant matters to be addressed, as is the need for a differential response model. Recommendations are made in this chapter and in Chapter 10.

Recommendations

Recommendation 9.1

DoCS should test the use of Structured Decision Making tools at the Helpline and at CSCs in relation to assessments and interventions including restoration.

Recommendation 9.2

A common assessment framework should be developed for use by DoCS and other agencies in child protection work which encompasses all risk factors.

Recommendation 9.3

DoCS should develop a strategy to move to electronic record keeping and abolish the use of paper records.

Recommendation 9.4

DoCS should revise its case practice procedures to provide Helpline caseworkers with greater guidance as to determining response times for reports of risk of harm.

Recommendation 9.5

For all caseworkers and casework managers there should be a structured program for ongoing professional development which is incorporated into annual Personal Planning and Review agreements.

Recommendation 9.6

In addition to individual supervision, there should be a facilitated monthly group case practice review of selected cases within each CSC and at the Helpline, in which all caseworkers and managers participate and which may include specialists from other agencies, if the cases require it.

Recommendation 9.7

DoCS should develop models of professional support for novice caseworkers, such as those offered in other disciplines like medicine, which involve safety and risk factors in decision making.

Recommendation 9.8

The work of the Drug and Alcohol Expertise Unit should be expanded to include mental health and domestic violence.

10 Directions for the way forward

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- 10.1 This chapter collects together the principles which the Inquiry believes should underpin the child protection system in NSW, the goals to be reached, and what needs to be done to achieve these goals. The Inquiry has not costed the recommendations contained in this chapter, however, where DoCS has provided the Inquiry with a estimate of costs, that estimate has been included.
- 10.2 This chapter is focused on the broad system which encompasses all relevant government agencies and NGOs. Commentary and recommendations about the internal workings of DoCS can be found in the preceding chapters.
- 10.3 Specific comments and recommendations concerning OOHC appear in Chapter 16 while those concerning court processes and the statutory basis for intervention appear in Chapters 11 to 13.

Principles

- 10.4 Child protection is the collective responsibility of the whole of government and of the community.
- 10.5 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.
- 10.6 The child protection system should be child focused, with the safety, welfare and well-being 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.
- 10.7 Positive outcomes for children and families are achieved through development of a relationship with the family that recognises their strengths and their needs.
- 10.8 Child safety, attachment, well-being and permanency should guide child protection practice.
- 10.9 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.
- 10.10 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.
- 10.11 Assessments and interventions should be evidence based, monitored and evaluated.

Goals

- 10.12 The outcomes sought from the service system should be to ensure that, at the very least, children are able to grow up unharmed by their social, economic and emotional circumstances and are supported to do so by parents who are competent and confident.
- 10.13 The child protection system should comprise integrated universal, secondary and tertiary services, with universal services comprising the greater proportion.
- 10.14 There should be a mix of low, medium and high intensity services that are flexible to the changing needs of children, young persons, families, and of the communities in which they reside.
- 10.15 Universal, secondary and tertiary services for families who are, or may be, at risk of requiring statutory intervention, should be funded, monitored and/or regulated by the State and/or the Commonwealth, and, within NSW, principally by DoCS, Health, Education, Juvenile Justice, DADHC and Housing. The principles of performance based contracting should apply and there should be funding cycles that permit stability in the provision of services.
- 10.16 Universal and secondary services should be delivered by a mixture of the NGO sector and state agencies, the latter being primarily delivered by Health, with DoCS being a provider of last resort.
- 10.17 DoCS, and where necessary, Police, should remain responsible for interventions mandated under the Care Act.
- 10.18 Health related tertiary services such as sexual assault and PANOC services and other specialist assessment and therapeutic services should be delivered primarily by NSW Health, Area Health Services and the The Children's Hospital at Westmead with other non-Health tertiary services being primarily delivered by a mix of DoCS and NGOs.
- 10.19 All services should be integrated and, where possible, co-located or operated in 'hubs', with outreach capacity.
- 10.20 All services should be delivered as close as possible to where children and families live. For example, schools should be used as community centres, transport should be available and the hours of operation should be flexible.
- 10.21 There should be integrated locally based universal, secondary and tertiary services for Aboriginal communities which should include those services described above as well as healing programs and services for perpetrators.
- 10.22 Casework actions should connect the child, young person and family with other providers and community supports that can identify, and mutually commit to addressing the needs of the child and family through an integrated system of services and care.

- 10.23 There should be a consistent common framework for the evaluation of service outcomes.
- 10.24 Each human service agency should have a statutory obligation and a professional commitment to ensure interagency cooperation in the provision of child protection services.
- 10.25 Measures of the performance of agencies engaged in child protection work at the local, regional and state level, should be compatible, population and outcome based, as well as process focused.
- 10.26 Annual reporting requirements for all government agencies and NGOs should include reporting on their child protection functions and outcomes.
- 10.27 Data should be collected, shared and published so as to inform research and further the safety, welfare and well-being of children and young persons.
- 10.28 A research agenda should be developed across governments and should include NGOs.

What needs to be done

- 10.29 As has been shown in Chapter 5, while the numbers of child protection reports have continued to increase each year from 2001/02, the size of the increase follows no clear pattern. The volatility of the size of the variation from year to year makes it difficult to predict future trends. However, there are suggestions that reports in 2008/09 will stabilise, with possibly an increase on 2007/08 of no more than three per cent to six per cent.
- 10.30 Service availability, therefore, needs to take into account current demand, which is generally only being met for a fraction of those children and young persons at risk of harm, as well as modest, rather than significant, increases in reporting. The economic situation as well as the natural increase in population will also have an effect. While raising the statutory threshold will affect the number of reports, it may not significantly affect those families who need assistance and come to attention other than through a report to DoCS.
- 10.31 The Inquiry makes the following recommendations.

The creation of different pathways

Recommendation 10.1

Members of the community and mandatory reporters who are not those described below, who suspect that a child or young person is at risk of significant harm ("the statutory threshold") should report their concerns to the Helpline. Reports should be as comprehensive as the knowledge and professional or expert experience of the reporters permits.

Mandatory reporters from each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, the Department of Education and Training, the Department of Juvenile Justice and the Department of Ageing, Disability and Home Care who suspect that a child is at risk of significant harm, which is imminent, should report directly to the Helpline.

Mandatory reporters from each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, the Department of Education and Training, the Department of Juvenile Justice and the Department of Ageing, Disability and Home Care who suspect that a child is otherwise at risk of significant harm should report their concerns to a newly created position or Unit within their own agency ("the Unit"). That Unit should be staffed by specialists with knowledge of the work of the agency and knowledge of child protection work (see below).

That Unit should determine whether the report meets the statutory threshold, by use of a common assessment framework, and if so, make the report promptly to the Helpline.

If the report does not meet the statutory threshold, and the Unit considers that the child or young person is in need of assistance, one or more of the following should occur:

- a. The child or young person or family is referred by the Unit or the initial reporter to a newly created Regional Intake and Referral Service. That service should be located within an NGO and should determine the nature of the services required and refer the family to the appropriate NGO or other state or Commonwealth agency for services such as case management, home visiting, intensive family support brokerage, quality child care, housing and/or parenting education.
- b. Families who are assessed by the Unit as meeting the criteria for Brighter Futures should be referred directly to the Lead Agency contracted in the relevant area.
- c. A referral to the Domestic Violence Line should be made by the Unit or the initial reporter if the concern arises primarily from the presence of domestic and family violence and the non-offending parent (usually the mother) requires assistance.
- d. The agency works with the child or young person, alone or in combination with another appropriate agency or NGO.

Recommendation 10.2

Reports made to DoCS should be assessed at the Helpline with the use of Structured Decision Making tools (after being tested and applied). If a

report is assessed as meeting the statutory threshold, the report should be dealt with in one of the following ways:

- a. Families who are assessed by the Helpline as meeting the criteria for Brighter Futures should be referred directly to the Lead Agency contracted in the relevant area.
- b. Where a child or young person is:
 - i. assessed as in need of a response within 24 hours, or
 - ii. assessed as in need of a response within 72 hours and the risk is assessed as high, or
 - iii. under five years and the primary care-giver's functioning or ability to parent is impaired due to current substance abuse, unmanaged mental illness or intellectual disability, and:
 - the child has high support needs, or
 - the primary reported issue is neglect or actual injury, or
 - the child or a sibling has been previously removed from the family by reason of care and protection concerns

then such child or young person should be referred to a CSC that will apply the Structured Decision Making tools in assessing, intervening and, if ultimately found to be appropriate, removing the child or young person from his or her family.

- c. Children and young persons who are assessed as in need of a response within 72 hours with a risk assessed as less than high, or as in need of a response within less than 10 days and who do not meet the criteria for Brighter Futures, should be referred to the Regional Intake and Referral Service which should determine the nature of the services required and refer the family to the appropriate NGO or other state or Commonwealth agency for such assistance as may be reasonably available and likely to meet the relevant need.

The Regional Intake and Referral Service described above should be operated and staffed by an NGO, with one or more child protection caseworkers seconded from DoCS. Where the child protection caseworker forms the view that the child or young person may be at risk of significant harm, the caseworker should perform a history check on KiDS and, if in the caseworker's view, the statutory test is met, the caseworker should refer to the matter to the Helpline. There should be at least one Regional Intake and Referral Service in each DoCS Region.

DoCS structure

Recommendation 10.3

DoCS should remain as a single department with a centralised Helpline, it should be divided into regions which are aligned with other key

agencies and each region should contain such number of CSCs (see Chapter 23) as are appropriate for the level of demand within the region.

Service availability

Recommendation 10.4

Services should be integrated, multi-disciplinary and co-located, wherever practicable and child and family services should be established in locations of greatest need, by outreach if necessary.

NGOs and state agencies should be funded to deliver services to the children, young persons and families who fall within the groups listed in recommendations 10.1 a and b and 10.2 a and c above. These services should cover the continuum of universal, secondary and tertiary services and should target transition points for children and young persons. Such services should include:

- a. home visiting, preferably by nurses, high quality child care, preferably centre based, primary health care, school readiness programs, routine screening for domestic violence, preschool services, school counsellors, breakfast programs and early learning programs
- b. sustained home visiting, parenting education, supported playgroups, counselling services, the Home School Liaison Program and accommodation and rental assistance
- c. drug and alcohol counselling and rehabilitation services, sexual assault counselling, forensic services for sexual assault victims, PANOC services, services for adolescents aged 10-17 years who display sexually abusive behaviours, allied health services such as speech pathology and mental health services
- d. secondary and tertiary services that include intensive, short term, in house and crisis interventions and that provide links to other services following intensive support, where needed
- e. the availability of counselling or other similar services from other agencies should not be dependent upon a risk of significant harm report being made to DoCS, or DoCS having allocated the report/case.

Recommendation 10.5

- a. Brighter Futures should be extended to provide services to more children aged 0-8 years and integrated into the service system (DoCS estimates that this should assist an additional 1,200 families).
- b. Brighter Futures should be extended progressively to provide services to children aged 9-14 years with priority of access to

- services for Aboriginal children and their families (DoCS estimates that this should assist an additional 3,400 families).
- c. The number and range of family preservation services provided by NGOs should be extended. This should include extending Intensive Family Based Services to Aboriginal and non-Aboriginal families (DoCS estimates that this should assist an additional 3,000 families).
 - d. The Aboriginal Maternal and Infant Health Strategy should be delivered statewide (funds have been allocated for this service).
 - e. Young, first time, isolated mothers with low educational attainment should receive secondary services, particularly sustained home visiting where the focus should be on positive maternal and child outcomes.
 - f. One year of free early childhood education before school should be provided to low income families.
 - g. Co-located child and family centres servicing Aboriginal communities, involving health and education services should be developed.
 - h. In relation to domestic violence, the commitment to the Domestic Violence Court Intervention Model, Integrated Case Management, Non-government sector grants, Staying Home Leaving Violence, the Court Assistance Scheme, Indigenous Programs and police equipment should be implemented.
 - i. The commitment to establish the Safe Families Program – Orana Far West should be implemented.
 - j. The commitment to fund the Preschool Investment and Reform Plan should be implemented.
 - k. The implementation plans for the delivery of the Commonwealth Government's election commitments relating to early childhood education and care, including providing universal access to early learning programs for all Australian four year olds for 15 hours per week and establishing an additional 260 child care centres on primary school grounds and other community land in areas where there are service gaps, should be progressed.

Recommendation 10.6

The capacity of NGOs, Aboriginal and non-Aboriginal, to staff and deliver the services detailed in Recommendations 10.4 and 10.5 a, b, c, e, f and g to children, young persons and families, particularly those who present with a range of needs including those which are complex and chronic, should be developed. The principles underpinning performance based contracting should apply.

Working collaboratively

Recommendation 10.7

DoCS, each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, the Department of Juvenile Justice, the Department of Ageing, Disability and Home Care, the Department of Education and Training and NGOs should use a common assessment framework to identify and respond to the needs of children, young persons and their families, particularly in the areas of serious and chronic neglect, parental substance abuse, high risk adolescents, serious mental health issues and high risk domestic violence cases.

Each key agency, namely DoCS, each Area Health Service, The Children's Hospital at Westmead, the NSW Police Force, Housing NSW, the Department of Juvenile Justice and the Department of Education and Training should identify their high end users, referred to by DoCS as Frequently Reported Families and who, for DoCS are estimated to number between 2,500 and 7,500 families. An integrated case management response to these families, which includes participation by relevant NGOs should be provided including the adoption of mechanisms for identifying new families and for enabling existing families to exit with suitable supports in place.

Specialists in substance abuse, mental health, domestic violence and other similar areas should assist DoCS caseworkers in case allocation, planning, assessments and interventions by attending CSCs on a regular basis.

Agencies, including NGOs should be free to exchange information for the purpose of the safety, welfare and well-being of a child or young person (see Chapter 24).

A multi-agency systems approach to case review should be established (see Chapter 9).

Workforce needs

Recommendation 10.8

A workforce strategy should be established which takes into account the needs of NGOs to employ additional staff and to accommodate the progressive transition of early intervention and OOHC (see Chapter 16) casework to the NGOs.

NGOs should receive sufficient funding to develop the infrastructure needed to attract experienced staff, and be assisted in providing uniform training for caseworkers and carers.

Recommendation 10.9

A Unit of one or more positions, depending on the size of the agency, should be created in each Area Health Service, The Children's Hospital at Westmead, the Department of Education and Training, the NSW Police Force, the Department of Ageing, Disability and Home Care and the Department of Juvenile Justice to receive reports of risk of significant harm from staff of the agency and to take appropriate action for the protection of children and young persons, including reporting to DoCS. In addition, the Unit should ensure communication with other agencies, primarily the human services agencies and relevant NGOs, and provide advice to the Human Services and Justice CEOs Cluster about any problems or emerging trends concerning interagency collaboration.

The Unit in each agency should:

- a. report to the agency's CEO or a defined and consistent second tier within the agency
- b. use data systems and processes that are common across agencies
- c. meet regularly with the positions created in the same agency and with those in other agencies
- d. keep relevant data which is then shared across agencies
- e. be child protection trained
- f. be positively named.

Recommendation 10.10

Caseworkers should be employed on a temporary basis or re-assigned from Brighter Futures or OOHC work as case management is transferred to the NGO sector, to manage those reports meeting the criteria set out in 10.2 b above until Recommendations 6.2, 10.1 and 10.2 are implemented (DoCS estimates that 300 temporary caseworkers are required).

Brighter Futures**Recommendation 10.11**

Within three to five years, case management of all families in Brighter Futures should be by Lead Agencies.

Figure 10.1 Different response pathway

