



SPECIAL COMMISSION OF INQUIRY INTO CHILD PROTECTION SERVICES IN NEW SOUTH WALES

PUBLIC FORUM

ASSESSMENT MODEL AND PROCESS

18 APRIL 2008

FACTS SHEET

1. The *Children and Young Persons (Care and Protection) Act 1998* identifies the Department of Community Services (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.
2. Section 30 of the Act provides that where DoCS receives such a report:
 - a. *the Director-General is to make such investigations and assessment as he or she considers necessary to determine whether the child or young person is at risk of harm, or*
 - b. *the Director-General may decide to take no further action if, on the basis of the information provided, he or she considers there is insufficient reason to believe that the child or young person is at risk of harm.*
3. Where children and young people are assessed by DoCS as being in need of care and protection, s 34 of the Act outlines actions that can be taken by the Director-General:
 - (1) *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, welfare and well-being 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.*

Assessment framework currently used by DoCS

Initial assessment by the Helpline

4. When a child protection report is made to DoCS, a centralised intake point within DoCS, called the Helpline, makes an initial assessment on the information received. This service operates 24 hours a day, seven days a week.
5. The Helpline operates on a call centre model where child protection reports are recorded and assessed by trained caseworkers. The caseworkers operate in teams and are supervised by Team Leaders.
6. In addition to the general Helpline response teams handling incoming calls from reporters, there are a number of specialised teams operating. There is a dedicated education response team that takes calls from education mandatory reporters. The Helpline is also in the process of trialling a similar specialised team for health mandatory reporters.
7. When information concerning a child at risk of harm is received from a reporter this is recorded by the Helpline on the DoCS electronic database known as the Key Information and Directory System (KiDS). KiDS is a report/incident based, as opposed to client-centred, system. Reports or records on particular children and young people are linked together to form the case history.
8. The Initial Assessment is the first stage in the gathering and analysis of information, and is undertaken without direct contact with the child or family, unless the reporter is the child or a family member. The Helpline caseworker combines the reporter's concerns about the child, young person or unborn child with any child protection history recorded in KiDS.
9. The purpose of the Initial Assessment is to make a preliminary decision as to whether a child or young person is believed to be at risk of harm, or whether an unborn child is believed to be at risk of future harm. Depending on the outcome of this Initial Assessment, there are a number of possible actions that can occur:
 - a. the case is closed and information is retained on KiDS
 - b. referral to one of about 80 Community Services Centres (CSCs) located across the State or to a Joint Investigation Response Team (JIRT)¹ for further assessment
 - c. 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 Regional after hours response teams, will initiate an immediate field response.
10. The Helpline assigns a priority rating including a response time, based on the immediacy of the safety and risk of harm or the extent of harm that could reasonably be expected to occur to the child or young person. Response timeframes are:
 - a. within 24 hours (commonly known as a Level 1 report)

¹ In the Metropolitan region these are co-located teams of Police and DoCS together with Health. In rural areas these services are generally not co-located although provide the same joint response.

- b. within 72 hours (commonly known as a Level 2 report)
- c. within 10 days (commonly known as a Level 3 report).

Secondary assessment at the CSC/JIRT

11. The DoCS *Secondary Assessment - Risk of Harm Framework* is a guided practice risk assessment model 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 or young person's need for care and protection and subsequent case planning. Secondary Assessment - Risk of Harm is divided into two stages: Secondary Assessment Stage One (SAS1) and Secondary Assessment Stage Two (SAS2).

Secondary Assessment Stage One (SAS1)

12. An Intake Team/worker undertakes a SAS1 at the CSC. This means, where possible, additional inquiries including the gathering, recording, processing and consideration of 'other information' occurs to inform a decision about whether a matter proceeds to further assessment. This includes reviewing any previous child protection history known about the child, young person or family, local knowledge, and in some cases information gathered through a request under s 248 of the Act, usually to another agency such as Police, Health or Education. This is used to determine whether a visit to the child and family is required by the CSC (SAS2), or whether the case can be closed.
13. Closing the case may be due to insufficient information or because there are no resources in which to allocate the case (i.e. no caseworker resources). Information, referral or advice may be provided to the family prior to closure.
14. Factors that may signal high risk and therefore the need to proceed to a SAS2 include²:
- a. inability of primary caregiver 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. 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 people in the same household³
 - 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. family having transient lifestyle following contact by DoCS or another child protection agency

² DoCS Business Help Topic – Secondary Assessment – Risk of Harm.

³ DoCS Policy on Sibling Safety.

- j. pattern of multiple reports of a child under 5 years may suggest chronic neglect.⁴

Secondary Assessment Stage Two (SAS2)

15. A SAS2 is undertaken by child protection workers at the CSC and is a field based assessment. If a case proceeds to SAS2, it is allocated to a caseworker who will initiate face-to-face contact with the child, young person, the family and where indicated, other family members. The SAS2 includes an assessment of the child's safety, welfare and well-being and a decision about the need for protective action by DoCS. In urgent situations, where an immediate face-to-face assessment is required a report may go directly from the Helpline to a SAS2.
16. During a SAS2 the child or young person concerned must be observed and, where possible, interviewed. All children and young persons in the household (not subjects of the assessment) are to be identified and consideration is to be given as to whether they may be at risk of harm and should be included as subjects of the SAS2 in progress.
17. A SAS2 assessment can take up to 90 days. General principles and steps to be followed when completing this assessment include:
 - a. consultation between the caseworker and his/her line manager before a field visit
 - b. consideration of any relevant history of the child, young person or family
 - c. engagement of the family in the assessment process
 - d. information gathering through talking to and/or observing the child or young person identified as being at risk of harm as well as discussion with the parents and other relevant family members
 - e. contact with interagency partners.
18. Following completion of the SAS2 a determination is made by DoCS as to whether the child is found to be in need of care and protection. There are three possible decisions that can come out of 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 likely⁵ to be at future risk of harm.⁶
19. Where a child is found to be in need of care and protection a case plan is developed which is aimed at addressing the care and protection issues identified in the SAS2. Ongoing work with the child and family may be through intervention with parental agreement or through a care order in the Children's Court.

⁴ DoCS Policy on Neglect.

⁵ The analysis of likelihood of harm is focused on the adults in the life of the child or young person.

⁶ *NSW Interagency Guidelines for Child Protection Intervention 2006*, Chapter 3.

Case closure

20. 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:
 - a. relative priority of the report compared to other reports and current casework resources of the CSC
 - b. receipt of further information indicating that sufficient arrangements exist for the care and protection of the child or young person
 - c. assessment that the circumstances leading to the report being made have been resolved.

Brighter Futures – early intervention

21. DoCS operates an early intervention program called Brighter Futures. This program is designed for families who have children aged eight years or younger, with priority of access given to families with children less than three years of age. To be eligible for this voluntary program, families must have at least one vulnerability that, if not addressed, is likely to escalate and impact on a parent/caregiver's capacity to parent or on the well-being of the child/ren.
22. There are currently two entry pathways to the Brighter Futures program. The first involves a report of risk of harm or a request for 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 non-government service, called a Lead Agency, that is funded by DoCS for this program. Regardless of the pathway the CSC always makes the eligibility decision. A third pathway, a direct referral through the Aboriginal Maternal Infant Health Strategy, has commenced in one urban and one rural location.
23. A tool called the Case Streaming Tool, is applied by the Intake Team at the CSC when a report is received from the Helpline that meets the following criteria:
 - a. an immediate safety response is not required
 - b. there is low or medium risk
 - c. the criteria for the target group, such as age of the child/ren and identified vulnerabilities (as well as service needs if known) are met.
24. CSCs determine whether referrals received from Lead Agencies through the community pathway are eligible for the program. This is done by the CSC checking KiDS (to assess whether there are any relevant child protection concerns that may preclude the family) and whether the referral meets the criteria for the program. They are not subject to a SAS1.
25. When a family consents to be part of the Brighter Futures program, a different assessment model (i.e. not the child protection assessment), called the Family Strengths and Needs Assessment (FSNA), is used by DoCS early intervention caseworkers. This model is part of the Structured Decision Making suite of tools developed by the Children's Research Centre (Wisconsin, USA). The FSNA takes a holistic approach to identifying family's strengths, needs, resources and concerns, and uses an assessment score for each category on the tool to ensure that critical areas of family functioning are assessed for each family, using consistent and objective criteria. The FSNA covers areas for both the child (child development, emotional/behavioural, physical health, education, family relationships) and the parent/caregiver (substance use, household relationships, domestic violence, parenting skills, coping skills, social support, physical health).

Joint Investigation Response Teams

26. JIRTs comprise DoCS, NSW Police and NSW Health officers who undertake joint investigation of allegations of sexual abuse, serious physical harm and neglect where criminal conduct may be involved.
27. Reports from the Helpline or CSC are referred to a JIRT if they meet a set of criteria.
 - a. Physical abuse criteria includes:
 - i. intentional burns
 - ii. non-accidental fractures, serious lacerations, internal injuries
 - iii. symptoms consistent with 'shaken baby syndrome'
 - iv. serious bruises of varying ages of a non-accidental origin
 - v. attempted strangulation or suffocation.
 - b. Sexual abuse criteria is as follows:
 - i. disclosure and/or evidence of sexual assault
 - ii. any reports of sexual abuse of a child or young person under the age of 18 years where the alleged offender is over the age of criminal responsibility (i.e. 10 years)
 - iii. presentation of physical indicators consistent with sexual abuse such as venereal diseases, pregnancy, unexplained bruising or bleeding from genitals, presence of semen on a child, unexplained bruises to breasts⁷.
28. In order to accept a referral, JIRT officers must be satisfied that there is/will be sufficient evidence to commence criminal proceedings against the perpetrator.
29. If a case is accepted by JIRT, the DoCS officers undertake a secondary risk of harm assessment as outlined above.
30. If a case is rejected by JIRT, the matter is referred back to the CSC.

Assessment models in child protection

31. Currently, there is a national trend away from the 'one-size-fits-all' system of dealing with cases, towards a differential, customised response to reports of child abuse and neglect. Many child protection systems worldwide are undergoing reform, with a general move towards a second, non-investigative 'family assessment' pathway where alternative responses for certain categories of reported children and families have access to services without risk of harm needing to be substantiated first.
32. The pressure on the statutory child protection system has created an impetus to develop ways of diverting children from this system, both in Australia and elsewhere. Much of the work is at an early stage, with some States now actively pursuing this strategy. A common element in several of the projects is the diversion of referrals to small, multi-disciplinary, initial assessment teams.
33. The frameworks for assessment vary between jurisdictions in Australia. Some rely on frameworks based on professional judgement whilst others use an actuarially based assessment process.
 - a. The risk of harm assessment framework (called secondary assessment) in NSW and the ACT is based on the Victorian Risk Framework, which relies on professional judgement in determining a child or young person's need for care

⁷ The CSC assesses reports of sexualised behaviour and allegations where the offenders are 10 years and under.

and protection. Essentially this framework provides a template of guiding questions for caseworkers to determine how a case should be managed.

- b. South Australia and Queensland use a suite of actuarial tools called Structured Decision Making (SDM), referred to above. SDM offers an alternative assessment framework. Unlike the professional judgement model, it is an actuarial tool that places pre-determined weights on the answers to questions collected by caseworkers and quantitatively determines a level of risk of harm based on information collected. It comprises a set of assessment tools that structure key decision points, from the moment a report is received to a case being closed. It is based on empirical studies of child protection service cases and future abuse/neglect outcomes and provides a basis for subsequent actions on the part of the child protection agency.
 - c. There are a number of differential response models that although slightly different share common principles:
 - i. emphasis on engaging with 'at risk' children and families
 - ii. where referrals are made but are not considered a child protection notification, services can be offered to the child and family and accepted on a voluntary basis.
34. While there is a strong body of research favouring actuarial approaches⁸, each approach has its weaknesses. The inflexibility of the actuarial model may lead to the exclusion of critical 'left field' factors in assessing risk in a family. On the other hand, the flexibility of the professional judgement could have the same effect, because subjectivity could lead to inadvertently 'selecting out' critical factors.
35. Nationally and internationally, child protection systems can be grouped into the following two broad categories:
- a. Child Protection orientation
 - i. This approach characterises the United States, United Kingdom, New Zealand and Australian systems. These systems generally use a more legalistic and investigative approach in response to child protection concerns (e.g. the need to protect children from harm).
 - ii. Generally these systems are characterised by:
 - a single entry point; report or notification by a third party
 - a separation from family support services
 - resources that are concentrated on families where risks of abuse and re-abuse are high and immediate
 - out-of-home care is mainly involuntary.
 - b. Family service orientation
 - i. Sweden, Germany, Belgium and the Netherlands systems focus on broader welfare service provision (i.e. based on the premise that abuse is a result of family conflict or dysfunction stemming from social, economic and psychological difficulties).
 - ii. This approach assumes that children are best cared for within their family. The emphasis is focused on working with families as a whole to support and strengthen the parent-child relationship and family well-being.
 - iii. The underlying philosophies of the systems are related to providing supportive and voluntary interventions that are a normal part of every day life

⁸ *Risk assessment in child welfare: an issues paper*, DoCS Centre for Parenting and Research, September 2006

and not stigmatised or adversarial. This approach is embedded within and normalised by broad child welfare or public health services. Resources are available to more families at an earlier stage. Within this approach, the invocation of statutory powers is an intervention of last resort.

iv. Generally these systems are characterised by:

- a range of entry points and services
- a supportive or therapeutic response to meeting the needs of children and families to resolve problems
- a partnership approach with the family
- use of the legal system as a last resort with more alternate dispute mechanisms and informal mechanisms in place
- mainly voluntary out-of-home care services.

Victorian child protection system

36. Victoria has introduced a differential response to reports of concerns about the safety and well-being of children. As part of these reforms additional resources have been provided to Family Services (non-government services) to create a greater system capacity to provide prevention and early intervention services, and confidential referrals can now be made directly to those services. As a result it is intended that the Child Protection service will be able to focus more exclusively on children at risk of significant harm⁹. The model comprises two pathways for making reports:

- a. Child Protection Crisis Line (8 regional intake locations) - a report to the Child Protection arm of the Department is only considered if, after consideration of the available information workers are more inclined toward a view that:
 - i. the concerns currently have a serious impact on the child's immediate safety, stability or development, or
 - ii. the concerns are persistent and entrenched and likely to have a serious impact on the child's development.
- b. Child First Family Service stream for lower level concerns for family and parenting support (31 intake centres)¹⁰. The Child First Family Service stream co-locates Departmental child protection workers and non government family support staff, with the intention of diverting families from the statutory child protection system to community based support services.
- c. This is a voluntary assessment and service orientated response for lower risk families where it is considered that a family is facing severe stresses and problems that are impacting on the child's welfare, and there are concerns about the parent's capacity to deal with them. The characteristics of families referred to Child First include:
 - i. where there are significant parenting problems that may be affecting the child's development
 - ii. family conflict, including family breakdown
 - iii. families under pressure due to a family member's physical or mental illness, substance abuse, disability or bereavement
 - iv. young, isolated and/or unsupported families

⁹ Page 78, Productivity Commission Report 2008

¹⁰ Victoria's 2002/03 child protection reform Innovation Projects, now called Child FIRST.

The 2006/07 budget provided for a Child FIRST to be established in every local government area.

- v. significant social or economic disadvantage that may adversely impact on a child's care or development.

Queensland child protection system

- 37. The Department of Child Safety was established in 2004 following the Queensland Government's reform agenda for Queensland's child protection system and to implement the recommendations of the Crime and Misconduct Commission Report, *Protecting Children: An Inquiry into Abuse of Children in Foster Care*. This department is solely focused on child protection, while a second department, the Department of Communities is responsible for funding prevention and early intervention activities through the non-government sector.
- 38. State-wide Child Abuse and Neglect Teams (SCAN) are operational in Queensland and provide a formal mechanism to co-ordinate the activities of the various government departments in relation to child abuse and neglect. The SCAN system is mandated in legislation (*Child Protection Act 1999*, Part 3), however SCAN Teams do not have distinct decision-making authority. The individual agencies retain responsibility for actions in accordance with their legislative authority.
- 39. The SCAN Team provides a forum for formal consultation on child protection matters where there is a need for a multi-disciplinary approach. The SCAN system includes 21 Assessment and Management Teams staffed by professionals from Police, Health and Child Safety Agency. These teams focus on:
 - a. holistic assessment and management, not just investigation
 - b. systems for formal information sharing.

Statistics

- 40. Of the 286,033 reports to the Helpline in 2006/07, 201,208 reports (approximately 70 per cent of all reports received) on 102,098 children and young people were referred to a DoCS CSC or JIRT for further assessment/investigation.¹¹ The vast majority of these reports were referred to CSCs, with 1.1 per cent referred to JIRTs.¹²
- 41. The required response time allocated to the reports referred to a CSC/JIRT in 2006/07 for further assessment was as follows:
 - a. Less than 24 hours (Level 1) -19,193 (9.5 per cent of reports referred to CSC/JIRT)
 - b. Less than 72 hours (Level 2) - 73,687 (36.7 per cent of reports referred to CSC/JIRT)
 - c. Less than 10 days (Level 3) - 96,657 (48.0 per cent of reports referred to CSC/JIRT)
 - d. No response required/not stated – 11,112 (5.5 per cent of reports referred to CSC/JIRT).
- 42. Of the 286,033 child protection reports to DoCS in 2006/07:
 - a. 29.7 per cent (84,825) were assessed at the Helpline as not requiring any investigation by DoCS. Of these:
 - i. 18.0 per cent (51,546) were forwarded to a DoCS unit as information only¹³

¹¹ *DoCS Annual Report 2006/07*

¹² DoCS Child Protection System Overview briefing - 30 November 2007 (Table 5)

¹³ Defined by DoCS 'when there is an open case plan, not necessarily an allocated one, for that child at the CSC.....'and may constitute a new report about a child or young person being at risk of harm, a request for assistance or additional information related to current casework'. 18 February 2008.

- ii. 8.1 per cent (23,299) were provided with information, advice or referral to appropriate services
- iii. 3.5 per cent (9,980) received no further assessment as there were no significant risk of harm issues identified.
- b. 27.1 per cent (77,567) involving approximately 34,000 children and young persons were referred to a CSC/JIRT for assessment. No action was taken by the CSC/JIRT and nearly all were closed due to 'competing priorities' (77,386).
- c. 26.9 per cent (76,884), involving 49,589 children and young people, were referred to a CSC/JIRT and received a SAS1 only.
- d. Of the reports where a SAS1 only was completed the assessed outcomes were as follows:
 - i. 8,582 (3.0 per cent) were assessed as being eligible for early intervention
 - ii. 49,265 (17.2 per cent) were provided with other information and referred and closed
 - iii. 18,348 (6.4 per cent) had no further assessment required or possible, which included 17,705 that were closed due to competing priorities or no casework resources available
 - iv. 689 (0.2 per cent) were referred back to the Intake worker at the CSC and closed.
- e. 15.1 per cent (43,295), involving 15,346 children and young people, were referred to a CSC/JIRT and had a completed SAS2.
- f. 14.1 per cent (40,472) of all reports received by DoCS, which involved 11.3 per cent (14,010) of children and young people reported to DoCS, had actual harm or risk of harm substantiated. Of these 40,472 reports:
 - i. psychological abuse or risk of psychological harm comprised 39.5 per cent (16,003) of these reports
 - ii. neglect or risk of neglect comprised 31.7 per cent (12,827) of these reports
 - iii. physical harm or risk of physical harm comprised 18.5 per cent (7,497) of these reports
 - iv. sexual harm or risk of sexual harm comprised 10.2 per cent (4145) of these reports.
- g. 1.2 per cent (3,462) of all 286,033 reports were subject to ongoing secondary assessment/investigation at 30 June 2007.
- h. In 2006/07, there were 5,363 referrals made to JIRT with 56 per cent of these referrals (3,023) accepted by JIRTs.¹⁴

Multiple reporting

- 43. In 2006/07 the 286,033 reports concerning 123,690 children and young people averages at 2.3 reports for every child or young person reported¹⁵.
- 44. The number of children reported each year has increased and certain groups of children and young people, in particular, infants and Aboriginal children and young people are over-represented in child protection reports. In 2006/07, the average rate of children and young people reported per 1,000 population, was 78.8.¹⁶

¹⁴ DoCS handout at briefing of 11 December 2007 –Police JIRT database.

¹⁵ Document produced by DoCS. Reference no D1.

¹⁶ DoCS data: A.9 Summons 2.

- a. In 2006/07, the rate of child protection reporting for infants was 135 per 1,000 with an average of 2.6 reports per infant.
- b. In 2006/07, the rate of child protection reporting for Indigenous children and young people was 251 per 1,000 with an average of 3.1 reports per child or young person.¹⁷
- c. The number of individual children reported each year from 2001/02 to 2006/07 has increased by 46 per cent¹⁸. The annual number of 'new' children (i.e. those where there has never been a risk of harm report to DoCS previously) is increasing at a relatively low rate, while proportionately more children with a child protection history are being re-reported.
- d. The occurrence of multiple reports per child has increased over time. In 1999/00, the 1 per cent of children with the highest number of reports accounted for 4.8 per cent of total reports, whereas in 2006/07 this top 1 per cent accounted for 8.9 per cent of reports. In 2006/07, the top 20 per cent of children made up just over half of all reports¹⁹.
- e. Statistical analysis provided by DoCS of a cohort of children first reported to DoCS in the September quarter 2004 shows that increased re-reporting (within 12 months) is significantly associated with:
 - i. child protection or OOHC history
 - ii. young age
 - iii. adolescence
 - iv. Indigenous status.
- f. Information provided by DoCS shows that around 7,500 families accounted for 48 per cent of the total child protection reports to DoCS in 2006/07. Around 2,100 distinct family groups accounted for 24 per cent of reports to DoCS in one year²⁰.
- g. A recent analysis of children reported to DoCS that were part of a sibling group showed that 3 per cent of families reported to DoCS account for approximately one quarter of all reports in a year, while 11 per cent of these families account for almost half of the reports.²¹

Domestic Violence

45. In NSW in 2006/07, domestic violence was the most frequently reported issue. It was the primary reported issue in 26.0 per cent (74,283) of all reports to DoCS. Of these reports:
 - a. almost three-quarters of all domestic violence reports were made by Police.²²
 - b. almost one-third were closed at the Helpline, and a further one-third were closed at the CSC/JIRT prior to a secondary assessment
 - c. 8.7 per cent (6,451) of all domestic violence reports received a SAS2 and in 97.3 per cent of these cases, harm or risk of harm was determined.

¹⁷ Page 7, Handout from DoCS Briefing to the Commission of Inquiry into Child Protection services in NSW – Characteristics of DoCS child protection client base.

¹⁸ Page 1, Handout from DoCS Briefing to the Commission of Inquiry into Child Protection services.

¹⁹ Page 9, DoCS report: to Commission 2007 - *A closer look: recent trends in child protection reports*.

²⁰ Page 7, Handout from DoCS Briefing to the Commission of Inquiry into Child Protection services in NSW – Characteristics of DoCS child protection client base.

²¹ Page 2, DoCS 'Statistical Analysis of the child protection system – a summary' September 2007.

²² DoCS data – March 2008.

Neglect

46. In 2006/07, neglect was the primary reported issue in 14.7 per cent (41,947) of all reports. Of the 41,947 reports:
- a. almost one-quarter were closed at the Helpline, a further one-quarter were closed at the CSC/JIRT prior to any secondary assessment
 - b. almost one-third of the reports were closed after a SAS1
 - c. 20.3 per cent (8498) of all neglect reports received a SAS2 and in 94.2 per cent of these cases, harm or risk of harm was determined.

Physical abuse

47. In 2006/07, physical abuse was the primary reported issue in 14.2 per cent (40,559) of all reports. Of these:
- a. almost one-quarter were closed at the Helpline and over one-quarter were closed at the CSC/JIRT prior to any secondary assessment
 - b. over one-quarter were also closed after a SAS1
 - c. 18.0 per cent (7,299) of all physical abuse reports received a SAS2 and in 90.7 per cent of these cases, harm or risk of harm was determined.

Carer drug/alcohol use

48. In 2006/07, carer drug/alcohol use was the primary reported issues in 9.9 per cent (28,295) of all reports. Of these:
- a. almost one-quarter were closed at the Helpline and over one-quarter were closed at the CSC/JIRT prior to any secondary assessment
 - b. over one-quarter were also closed after a SAS1
 - c. 20.4 per cent (5766) of all carer drug/alcohol reports received a SAS2 and in 95.1 per cent of these cases, harm or risk of harm was determined.

Psychological abuse

49. In 2006/07, psychological abuse was the primary reported issues in 8.9 per cent (25,589) of all reports. Of these:
- a. more than one-third were closed at the Helpline, and over one-quarter were closed at the CSC/JIRT prior to any secondary assessment
 - b. almost one-quarter were closed after a SAS1
 - c. 11 per cent (2,894) of all psychological reports received a SAS2 and in 93 per cent of these cases, harm or risk of harm was determined.

Carer mental health issues

50. In 2006/07, carer mental health issues were the primary reported issues in 7.5 per cent (21,418) of all reports. Of these:
- a. one-quarter were closed at the Helpline, and one-third were closed at the CSC/JIRT prior to any secondary assessment
 - b. one-third were closed after a SAS1
 - c. 17.3 per cent (3,708) of all carer mental health reports received a SAS2 and in 95.3 per cent of these cases, harm or risk of harm was determined.

Sexual abuse

51. In 2006/07, sexual abuse was the primary reported issue in 7.1 per cent (20,204) of all reports. Of these:
 - a. over one-quarter were closed at the Helpline, and one-fifth were closed at the CSC/JIRT prior to any secondary assessment
 - b. over one-quarter of the reports were also closed after a SAS1
 - c. 21.8 per cent (4,407) of all sexual abuse reports received a SAS2 and in 87.9 per cent of these cases, harm or risk of harm was determined.