

Appendix



Brief Guide to Reporting

Health workers have a responsibility to promote the safety, welfare and well-being of children and young people. If you have concerns on reasonable grounds that a child or young person is at risk of harm, you should:

- check the 'Guide to Making a Report to DoCS' in Appendix 4 of this manual
- read the detailed procedures for reporting in chapters 7 and 8.
- consult your supervisor or manager, if appropriate, to help you decide whether to make a report
- provide support and reassurance to the clients because disclosure of abuse is a difficult process for children and young people
- make a report to the DoCS Helpline on **133 627** giving your name, position and Health service
- make sure the child, young person and family are involved in making the report, if safe and appropriate
- if necessary, ensure the safety of the child or young person until contact from DoCS
- arrange for safe transport to a hospital emergency department if the child or young person has injuries
- inform DoCS if the parents or caregivers are unwilling to consent to a medical examination
- inform your supervisor or manager about the report, the action DoCS intends to take if known, and any arrangements for follow up with the child, young person or family
- document the relevant information outlined in chapter 10.
- continue to support the child or young person and, if appropriate, family members.

If you assess that a child or young person may be at risk of harm, irrespective of your supervisor or manager's opinion, you must make a report to the Department of Community Services.

If there are issues relating to a specialist area of work, such as mental health, drug and alcohol, community health or PANOC, please refer to the appropriate section in chapter 18 of this manual.

2

Appendix

NSW Health Circulars

- 92/21 Patient Information and Consent to Medical Treatment
- 96/73 Access to Department of Health Records by the Child Death Review Team
- 97/58 - Incidents reportable to the Department
- 97/80 - Procedures for recruitment and employment of staff and other persons -vetting and management of allegations and improper conduct
- 2000/100 – Protecting Children and Young People: Recognising and Reporting Suspected Risk of Harm and Responding to Requests from the Department of Community Services
- 98/29 Subpoenas
- 99/18 NSW Health Privacy Code of Conduct
- 99/65 - Ombudsman Amendment (Child Protection and Community Services) Act 1998 - Allegations of child abuse
- 2000/55 - Policy and procedure for employment screening of staff and other persons in child related areas
- 2000/69 - NSW Department of Health policy on employment screening using criminal record checks
- 2000/76 Policy and Procedures for Employment Screening of Staff and other persons in child related areas - amendment to attachments

Appendix

3

Level	Sexual Assault Services Description	
1	No planned service. Able to provide treatment or support prior to referral to designated sexual assault service. Able to assist with transport to referral centre. Formal link with a Level 4 Sexual Assault Service with Policies and procedures in place for referral developed in consultation with Level 4 service. Quality assurance activities(1). Interpreters as per Circular 94/10. Staff trained in relation to recognition and notification as per 97/14. Copies of Recognising and Notifying Child Abuse and Neglect, Procedures for Frontline Health Professionals & A Policy for Protecting Children and Young People from Physical Abuse, Sexual Abuse, Emotional Abuse and Neglect. Copy of Interagency Guidelines for Child Protection Intervention available and all relevant staff aware of and adhere to all documents.	
3	As Level 1 plus specialist counselling staff providing follow up counselling for victim and for non-offending family. This includes individual, group and family counselling. No after hours medical service. Able to assist with transport to Level 4. Formal links with Level 4 for 24 hours crisis counselling and medical care. May provide follow up medical care. Formal quality assurance program(1). Program of community education and professional training provided to other relevant health workers. Training and adherence to Child Protection Policy and Procedures Manual and/or Sexual Assault Service- Policy and Procedures Manual for Adults and relevant interagency protocols. Services without Coordinators must receive supervision and support from Level 4 or Area Sexual Assault Coordinator. May be based in hospitals or community health centre with access to hospital facilities. Pathology Level 1.	
4	As Level 3 plus 24 hour service with counsellor and medical officer on call. Designated coordinator of service. Has medical officer(3) trained in the care of sexual assault victims, including completing forensic protocol(2). Designated area in emergency department or elsewhere in hospital for crisis care, with support services as for Level 3 Emergency Services. Access to specialist care including mental health, surgery, gynaecology and Drug and Alcohol services. Program of community education and professional training. Adherence to Child Protection Policy and Procedures Manual and/or Sexual Assault Service – Policy and Procedures Manual for Adults and Interagency Guidelines for Child Protection Intervention and/or Interagency Guidelines for Responding to Adult Victims of Sexual Assault.	
6	As Level 4 plus conducts research. Extensive program of community education and professional training. Specialist medical staff available for consultation. Colposcopy for children available. Accepts referral from Level 4 for specialist medical assessment. Level 4 Pathology available. Medical officer and paediatric sub-specialists available for consultation. For child sexual assault services Paediatric Medicine and Paediatric Surgery Level 6 on site. For adults gynaecological surgery at Level 5. Provide peer review for medical practitioners.	
		(1) See 'Glossary'
		(2) Sexual Assault Referral Unit, Medical Protocol or Child Sexual Assault Medical Protocol, Division of Forensic Medicine, Department of Health.

Level	Child Protection Services (PANOC) Description		
1	Reporting and appropriate referral by medical practitioner and health professionals. Management of presenting health problem. Reporting to Department of Community Services (DCS) in accordance with Children (Care and Protection) Act, 1987 and Circular 97/14. Pathology Level 1 and access to Diagnostic Radiology Level 2. Referral for counselling/medical care to next level or appropriate local community health services. No planned PANOC Service. Formal link with Level 4 PANOC and Sexual Assault Service. Interpreters as per Circular 94/10. Staff trained in relation to recognition and notification as per 97/135. Copies of <i>Recognising and Notifying Child Abuse and Neglect, Procedures for Front Line Health Professionals</i> and <i>A Policy for Protecting Children and Young People from Physical Abuse, Sexual Abuse, Emotional Abuse and Neglect</i> . Copy of <i>Interagency Guidelines for Child Protection Intervention</i> available and all relevant staff aware and adhere to all documents.	4	As level 3 plus 24 hour crisis intervention service provided by paediatric/medical officer and health professionals- all with training in dealing with child abuse. Designated PANOC coordinator. Formal link with Level 6 PANOC Service. Designated area in Emergency Department or elsewhere in hospital for crisis care. Referrals from lower levels accepted. Paediatric Medicine Level 4 and Paediatric Surgery Level 3 on site.
3	As Level 1 plus links with on or off site specialist PANOC workers with experience and training in counselling intervention with child victims of physical or emotional abuse or neglect and their carers. Medical service provided by paediatrician/medical officer with paediatric experience. Ongoing medical treatment or monitoring as required. Access to and links with Emergency Departments. Formal link with Level 4 PANOC Service and Level 4 Sexual Assault Service (on or off site). Networks developed between social work department, obstetrics units, paediatric services, mental health, drug and alcohol and community health services. Link and regular meetings with local Department of Community Services and NSW Police Service.	6	As Level 4 plus designated multidisciplinary team consisting of medical services (paediatrician, medical officer), psychiatrist, social worker, psychologist, allied health professionals and nursing staff who will provide 24 hour crisis intervention rostered service from within the team. Has designated director. Has active undergraduate, postgraduate and professional teaching role and conducts research. Clinical pathology available. Medical officer and paediatric specialists available for consultation. Paediatric Medicine Level 6 and Paediatric Surgery Level 6 on site. Provide peer review for medical practitioners. Formal procedures for referring children and families for ongoing counselling intervention back to Level 3 and 4.

Appendix

4

Checklist for Making a Report to DoCS

A quick checklist is attached for you to go through. By the end of the checklist you should have a clear picture of concerns allow you to make a report under the Children and Young Persons (Care and Protection) Act 1998.

You will also have an understanding of whether you are a mandatory reporter and are obliged under the Children and Young Persons (Care and Protection) Act 1998 to report any child who is at risk of harm or homeless.

Ring 000 immediately if there is a life threatening situation

This checklist is to assist you if you want to make a report about a child or young person you believe is at risk of harm or who is homeless.

Remember – when making a report please have available all the information you or your organisation has on the child or young person's situation and their family structure.

1. If you answer **YES to any one of these age groups**, proceed to the next questions.

Do your issues of concern involve:

	YES
One child aged 0 to 15 years OR a group of children affected by the issues of concern (Class of children)	
A young person aged 16 or 17 years	
An unborn infant	

2. If you can answer **YES to all of the following questions you may** make a report to DoCS. Proceed to the next stage to find out if you are a mandatory reporter and **must** make the report. If you answer **NO** to any of the questions, discuss with your supervisor what other options there may be.

	YES
Is the child or young person residing in NSW OR did the issues of concern occur in NSW?	
Can you identify the child or young person? (Minimum: full name, age and home address) OR	
Can you describe them AND their current whereabouts OR give a place they regularly go to (eg: home, school, youth or sporting club etc.) OR can you identify who the class of children are?	
Do you suspect, on reasonable grounds that the child or young person is at risk of harm? (Definition of risk of harm is provided in guide notes) OR Is the child or young person homeless?	

3. You are classified as a Mandatory Reporter if you have any form of paid employment OR deliver a service as part of your professional work OR you are a manager in an organisation in the following fields which deals wholly or in part with children under 16 years:

	YES		YES
Children's Services		Police	
Education		Residential services	
Health care		Community Services	

4. If you can answer YES to any one or more of the following questions AND you are a Mandated Reporter (or you are required to report by your own employer's policies), you MUST contact the Department of Community Services to make a Report. If you are not a Mandated Reporter you may decide, as someone who is concerned about the child or young person, to make a Report.

Risk of Harm: (Definitions of the types of "risk of harm" are listed over page)	YES
Are the child or young person's basic physical needs NOT being met? OR at risk of not being met?	
Are the child or young person's basic psychological needs NOT being met? OR at risk of not being met?	
Does the child or young person require health care? AND Have their parents failed to arrange for necessary health care AND are unable or unwilling to?	
Is the child or young person being physically abused or ill treated? OR at risk of being abused or ill treated?	
Is the child or young person being sexually abused or ill treated? OR at risk of being abused or ill treated?	
Does child or young person live in a household where there is domestic violence? AND As a consequence, are they at risk of suffering serious physical harm OR serious psychological harm?	
Have the child or young person's parents/caregivers behaved in such a way towards them that the child or young person has suffered serious psychological harm? OR is at risk of suffering serious psychological harm?	
Is a child homeless and at risk of harm?	

5. If you answer Yes to the next question, you MUST make a report to DoCS, even if you are not a mandatory reporter:

	YES
Are you providing residential accommodation to a child living away from home without parental permission?	

6. If you answer Yes to the following question about the homelessness of a young person you MAY make a report to DoCS:

	YES
Is a young person homeless AND you have their permission to make a report?	

The following section gives a set of brief references to the Children and Young Persons (Care and Protection) Act 1998 and helps explain what risk of harm means.

Information from the children and young persons (Care and Protection) Act 1998

- Section 3:** Defines the specific ages of children (0-15 years) and young persons (16-17 years).
- Section 25:** Allows for reports to be made on unborn.
- Section 4:** Defines who the Act applies to. Section 4(c) clarifies that it covers any child or young person who is subject to an event or circumstances (issues of concern) that occurs in NSW.
- Section 27(2):** Notes that the reporter must include the child or young person's name or description.
- Section 27(1):** Classifies what groups of workers are mandatory reporters.

What is risk of harm?*

Section 23(a): Basic physical or psychological needs not being met (Neglect)

Neglect occurs where there is risk of harm or actual harm to a child or young person caused by the failure to provide the basic physical and emotional necessities of life. Neglect is characterised as a continuum of omissions in the care of a child or young person.

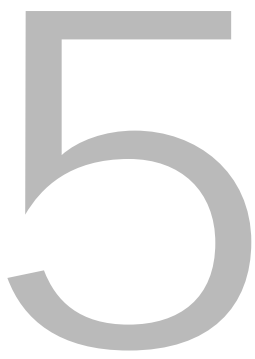
Neglect of Basic Physical Needs:

Occurs when a person, whether or not the parent of the child or young person fails to provide the basic staples of life to an adequate degree without reasonable excuse. These basic staples include the following:

- Food
- Safety from harm (which includes issues of adult supervision)
- Clothing
- Physical shelter from the elements
- Hygiene

Neglect of Basic Psychological Needs:

May be summarised as the child or young person not receiving sufficient or appropriate interaction or stimulation from their parents or caregivers to allow the child or young person to achieve appropriate attachments with primary carers and others, or allow for their ongoing intellectual, emotional and physical development.



Appendix

CONFIDENTIAL NSW Health

Recording Form for the Report of Suspected Risk of Harm Related to the Abuse or Neglect of a Child or Young Person

Name of child or young person _____ Age _____
 Date of Birth _____ Please tick: Male Female
 Home address _____ Postcode _____
 Home phone _____
 School/Campus/Centre attended by child or young person _____
 Names of parents or carers and their relationship to the child or young person _____
 Name _____ Name _____
 Phone No _____ Phone No _____
 Relationship _____ Relationship _____
 Aboriginal () Torres Strait Islander () NESB () Language _____

Report made to the Teleservice Centre:

Date ____ / ____ / ____ Time _____ AM/PM
 Name of intake officer _____

What are the concerns held of harm or risk of harm to the child or young person? _____

(Please attach additional information as required)

If this report is being made in relation to a young person, note whether the report has been discussed with the young person, and the views of young person about this report? _____

If this a report related to the homelessness of a young person, do you have the young person's permission to make this report? Yes No

Recommended decision of DoCS Helpline officer about action to be taken, if known _____

Call Reference number (allocated to report by the DoCS Helpline)

Health contact person _____ Telephone _____

Name and Position _____

Signature and Date _____

Appendix



CONFIDENTIAL NSW Health

Response to Request for Information from the Department of Community Services (Docs)

Name of child, young person or family member: _____

Date of birth ____ / ____ / ____ Please tick: Male Female

Name of DoCS Officer Requesting Information: _____

Relevant Information:

(Please attach additional information as required)

Is there another Health worker/Service approved for future contact in relation to this matter?

Yes No (Please tick)

If Yes, Name of Health worker/Service: _____ Phone: _____

Name of Health worker contacted/completing this form: _____

Position _____

Health Service Manager _____

Signature _____

Date _____

7

Appendix

Instructions for Completion of INTERIM Best Endeavours Forms Management Information Systems Unit

Contents	Page
Introduction	2
The Best Endeavours Intranet Data Collection	2
INTERIM Registration and Monitoring	2
Feedback about INTERIM system	3
Supply of Forms	3
Instructions for completion of the Response Form for Best Endeavours Requests from The Department of Community Services	4
Instructions for completion of the Update to Best Endeavours Requests for Service	16

Introduction

As part of its responsibility under section 17, 18 and 85 of the Children and Young Persons (Care and Protection) Act 1998, the NSW Health Department has undertaken a number of initiatives to ensure that Best Endeavour responses to Requests for Services from the Department of Community Services are effective and timely.

The Best Endeavours Intranet Data Collection

A data collection, registration and monitoring system will be implemented at the beginning of March 2001 to monitor the frequency with which Best Endeavour requests are made to Health Services and their effectiveness and impact.

This system will be Intranet based and will feature:

- Statewide central registry of all best endeavours requests.
- Point of contact data entry and updating.
- Coded menus.
- Prompts for key information.

Special features will be:

- Certain data entry triggers for email alerts to the relevant Area Health Service and Community Service Centre at crucial times in the response process.
- A suite of local and AHS based monitoring reports.

In addition, the system will have the capability to eventually:

- Participate in the Human Services Intranet Program.
- Accept direct data input from the Department of Community Services.

INTERIM Registration and Monitoring

Two forms serve as INTERIM methods for maintaining Area registration and monitoring functions until the Statewide Intranet collection is implemented.

- a) The Response Form for Best Endeavours Requests from The Department of Community Services to be completed at the time of acceptance of the Request for Service from the Department of Community Services.
- b) Update to Best Endeavours Requests for Service to be completed 6 weeks after the date of acceptance of the Request for Service from the Department of Community Services.

Together with the original Request for Service form from the Department of Community Services, they supply the set of information required for Registration and monitoring.

Feedback about INTERIM system

Comments about the INTERIM forms are encouraged. All feedback will be considered in the design of the Intranet system.

Please send comments to:

Josie Hudson
Project Officer
Best Endeavours Data Collection
Management Information Systems Unit

email: jhuds@doh.health.nsw.gov.au
Phone no. (02) 9391 9054
Fax no. (02) 9391 9070

Supply of Forms

1. The INTERIM Response Form for Best Endeavours Requests for Service from the Department of Community Services and the INTERIM Update to Best Endeavours Requests for Service are available on the Best Endeavours Data Collection Site on the NSWHealthNet – <http://internal.health.nsw.gov.au/iasd/dm/bedc/>
NB. A copy of these instructions are also available on this site.
2. Electronic copies are also available from the Department's Management Information Systems Unit. Contact Josie Hudson at jhuds@doh.health.nsw.gov.au
3. Faxed copies are also available: contact (02) 9391 9054

Instructions for Completion of INTERIM

Response Form for Best Endeavours Requests for Service from the Department of Community Services

Purpose of Form:

1. Provide information to the respective Area Health Service about the timeliness of immediate follow up of a certain Request for Service from the Department of Community Services to a particular Health Service within the Area.
2. Provide follow up information to the particular Community Services Centre about a certain Request for Service that has been received by the Health Service. In particular:
 - a) whether the Request for Service has been accepted or not and
 - b) contact details within the Health Service

Timeliness:

1. This form is completed as a result of a decision being made about the acceptance or otherwise of a Request for Service from the Department of Community Services to a particular Health Service.
2. This form is then relayed by email or fax to:
 - a) the Area Central Register of Best Endeavours and
 - b) the originating Community Service Centre.
3. The acceptance decision needs to be within 48 hours of receipt of Request for Service at the Health Service.

Question No.	Information Category	Data Element Name	Page No
1	Date	Today's Date	5
2	Details	Health Service Name	5
3		Health Service Type Requested	5
4		DoCS Reference Number	6
5		CIS No(s) of Child(ren) concerned	6
6		Client Date of Birth	7
7		Date of Request	7
8		Date and Time Received at Health Service	7
9		Date and Time Considered by Health Service	8
10		Source of Request	8
11		Outcome of Request: Request accepted	Estimated Time of Service provision
12	Outcome of Request: Request not accepted Service Contact Details	Reason why request not accepted.	9

1. Today's Date

Definition: The date on which the form is completed.

Guide for Use:

1. Henceforth, this date will be regarded as the date that the Request for Service was accepted or declined.
2. This is a key field.
3. It is one of the data items used to track the sequence of responses to Best Endeavours Requests.

2. Health Service Name.

Definition: The local name by which the provider of the Health Service is known.

Guide for Use:

1. This is a key field.
2. This is one of the data items used to track the sequence of responses to Best Endeavours Requests.

3. Health Service Type Requested.

Definition: The type of service requested by the Department of Community Services centre.

Guide for Use:

1. The types of service requested are listed below.
2. One service only to be entered.
3. Enter code only

Code Set:	01 Mental Health Assessment	30 Home Based Care Service
	02 Forensic Medical Examination	31 Indigenous Health Service
	03 Emergency Medical Treatment	32 Men's Health Service
	04 Other Crisis / Trauma Response	33 Mental Health Service
	21 Acute / Post Acute Care Services	34 Oral Health Service
	22 Aged Care Service	35 Palliative Care / Hospice Care Services
	23 Ambulance Service	36 Primary Care Health Service
	24 Child Health Service	37 Public Health Service
	25 Child Protection Service (PANOC)	38 Rehabilitation Service
	26 Counselling Service	39 Respite Care Service
	27 Disability Service	40 Sexual Assault Service
	28 Drug and Alcohol Service	41 Sexual Health Service
	29 Ethnic / Migrant Health Service	42 Women's Health Service
		43 Youth Health Service
		44 Other Health Service Specify

Source of Definition: Community Health Code Set

Source of Information: Request for Service form from DoCS.

4. DoCS Reference Number.

Definition: The number assigned by DoCS Helpline to identify a call.

Source of Information: Request for Service form from DoCS.

Guide for Use:

1. This is a key field.
2. This is one of the data items used to track the sequence of responses to Best Endeavour Requests.

5. CIS No(s) of Children concerned.

Definition: The CIS number is the number assigned to a child upon becoming a client of the Department of Community Services.

Guide for Use:

1. Each CIS number is unique to one child.
2. The client who is the direct subject of the Request for Service may or may not be the child identified at risk of harm.
3. There may be more than one child identified as at risk of harm in one family group.
4. Three spaces have been set aside for three numbers to be entered but if this is not enough, indicate other numbers on the page.

Source of Information: Request for Service form from DoCS.

6. Client Date of Birth.

Definition: The date of birth of the client.

Guide for Use:

1. The client is the person referred.
2. This may be a child at risk of harm or any member of that child's family group.
3. This is a key field.
4. This is one of the data items used to track the sequence of responses to Best Endeavours Requests.

Source of Information: Request for Service form from DoCS.

7. Date of Request

Definition: The Date the Service was Requested by DoCs.

Guide for Use:

1. This is a key field.
2. This is one of the data items used to track the sequence of responses to Best Endeavours Requests.

Source of Information: Request for Service form from DoCS.

8. Date and Time Received at Health Service.

Definition: The date and time that the Request for Service form is received at the office of the Health Service provider.

Guide for Use:

1. The mode of receipt of the form may be encrypted email or fax.
2. This is one of the data items used to track the sequence and timeliness of responses to Best Endeavours Requests.

Source of Information: The date stamp on the email or fax.

9. Date and Time Considered at Health Service.

Definition: The date and time that the request is discussed by the Health Service Manager with a potential worker with regards to timeframes of acceptance or reasons for non acceptance.

10. Source of Request.

Definition: The originating centre of the Request for Service form from the Department of Community Services.

Guide for Use:

1. The types of originating centres are listed below.
2. One type of centre only to be ticked in the box provided.
3. If the origin of the Request for Service form is from DoCS Helpline, the associated Health Service Type Requested is limited to codes 01 to 20.

List of Items:

1. Request received from CSC / JIT. Note: specify name.
2. Request received from Helpline.

Source of Information: Request for Service form from DoCS.

11. Estimated Time of Service Provision.

Definition: Having accepted the request for service, the estimated time delay between the date of receipt of request for service and the date when the service is most likely to be able to be offered.

Guide for Use:

1. Time periods and other options are listed below.
2. One option only to be ticked in the box provided.
3. If the origin of the Request for Service form is from DoCS Helpline, the associated Health Service Type Requested is limited to codes 01 to 20.

List of Items:

1. Service provided before written request
2. Immediately (within 2 days)
3. Between 3 to 7 days
4. Between 1 and 2 weeks
5. Between 2 and 4 week
6. Between 4 and 6 week
7. Between 6 and 8 weeks
8. If waiting time is outside this timeframe: Request has been prioritised on the waiting list for the next vacancy.
9. If waiting time is outside this timeframe: Request has been placed on the waiting list according to priority against other demands.

Source of Information: This decision is made at the time that the Health Service Manager and worker confer.

12. Reason why request not accepted.

Definition: Having not accepted the request for service, the reason why the request was deemed not acceptable.

Guide for Use:

1. One of the listed items only needs to be checked.
2. Specify reasons where prompted.

List of Items:

1. Service requested is not currently provided due to staff vacancy
2. Service requested is not consistent with the service responsibilities.
Note: specify inconsistency.
3. Providing the service would prejudice the discharge of the service functions.
Note: specify reason.
4. Service requested is not currently provided due to another reason.
Note: specify reason.
5. Request has been transferred to an alternate Health Service which has agreed to accept the request.
Note:
 1. Enter date transferred to alternate Health Service.
 2. Enter alternate service details in 'Service Contact Details' box.

Source of Information: This decision is made at the time that the Health Service Manager and worker confer.

Service Contact Details.

Guide for use: This information is provided to facilitate contact by DoCS.

Instructions for Completion of INTERIM

Update to Best Endeavours Requests for Service

Purpose of Form:

1. Provide information to the respective Area Health Service about the timeliness of service provision following the acceptance of a Request for Service from the Department of Community Services to a particular Health Service within the Area.

Timeliness:

1. This form is completed 6 weeks after accepting a Request for Service from the Department of Community Services to a particular Health Service.
2. This form is then relayed by email or fax to the Area Central Register of Best Endeavours

Question No.	Information Category	Data Element Name	Page No
1	Date	Today's Date.	11
2	Details	Health Service Name.	11
3		DoCS Reference Number.	11
4		Client Date of Birth.	11
5		Date of Request.	11
6		Planning Meeting / Process	Date of Planning Meeting / Process.
7	First Client Contact	Date Client First Seen.	12
8		Service Provided to.	12
9		Time between Request Received at Health Service and Client first seen.	12
10		Time between Planning Meeting / Process and Client first seen.	13
11	Where Service is Not Provided	Reason for Service Not Provided.	13

1. Today's Date

Definition: The date on which the form is completed.

Guide for Use: This date should be 6 weeks after completing the INTERIM Response Form for Best Endeavours Requests for Service from the Department of Community Services.

2. Health Service Name.

Definition: The local name by which the provider of the Health Service is known.

Guide for Use:

1. This is a key field.
2. This is one of the data items used to track the sequence of responses to Best Endeavours Requests.

3. DoCS Reference Number

Definition: The number assigned by DoCS Helpline to identify a call.

Guide for Use:

1. This is a key field.
2. This is one of the data items used to track the sequence of responses to Best Endeavours Requests.

Source of Information: Request for Service form from DoCS.

4. Client Date of Birth

Definition: The date of birth of the client.

Guide for Use:

1. This is a key field.
2. This is one of the data items used to track the sequence of responses to Best Endeavours Requests.
3. The client is the person referred.
4. The referred client may or may not be a child at risk of harm.

Source of Information: Request for Service form from DoCS.

5. Date of Request

Definition: The date the service was requested by DoCs.

Guide for Use:

1. This is a key field.
2. This is one of the data items used to track the sequence of responses to Best Endeavours Requests.

Source of Information: Request for Service form from DoCS.

6. Date of Planning Meeting / Process.

Definition: The date a planning meeting or a planning process in partnership with DoCS occurs.

Guide for Use: This is the meeting / process organised by DoCS after receiving an acceptance from a Health Service for a Request for Service.

7. Date Client first seen.

Definition: Where the service is provided, the date that the client is seen for the first time since the planning meeting / process occurs.

8. Service provided to.

Definition: Where the service is provided, the nature of the relationship of the client to the identified child(ren) at risk of harm.

List of Items:

1. Child at risk of harm
2. Young person at risk of harm
3. Sibling of Child / young person at risk of harm
4. Parent / Carer
5. Other Family member

Source of Information: This decision is made at the time that the Health Service Manager and worker confer.

9. Time between Request Received at Health Service and Client first seen.

Definition: Where the service is provided, the time period that has elapsed between the date that the Health Service receiving the request to the date that the client was first seen.

List of Items:

1. Immediately (within 2 days)
2. Between 3 and 7 days
3. Between 1 and 2 weeks
4. Between 2 and 4 weeks
5. Between 4 and 6 weeks
6. Between 6 and 8 weeks

Source of Information: Case notes.

10. Time between Planning Meeting / Process and Client First Seen.

Definition: Where the service is provided, the time period that has elapsed between the date of the occurrence of a planning meeting / process and the date that the client was first seen.

List of Items:

1. Immediately (within 2 days)
2. Between 3 and 7 days
3. Between 1 and 2 weeks
4. Between 2 and 4 weeks
5. Between 4 and 6 weeks

Source of Information: Case notes.

11. Reason for Service not provided.

Definition: Where the service is not provided, the reason for non provision.

Guide for Use:

1. One of the listed items needs to be checked.
2. Specify reasons where prompted.

List of Items:

1. DoCs did not proceed with referral
2. Planning meeting / process still pending
3. Appointment made but client not yet attended
4. Client still on waiting list
5. Service not proceeded with due to unresolved safety concerns.
Note: specify date this has been discussed with a DoCS Officer.
6. Attempts to contact the client unsuccessful.
Note: specify date(s) of attempted contact.
7. Service not proceeded with for other reason.
Note: specify details.

Source of Information: Case notes.

Response Form for Best Endeavours Requests for Service from the Department of Community Services

This form must be provided to the Central Register and to the DoCS Centre from where the request originated.

1. Today's Date: __/__/____

Details:

2. Health Service Name: _____

3. Health Service Type Requested: _____

(Community Health Code List)

4. DoCS Reference Number: _____

5. CIS No(s) of Child(ren) concerned:

6. Client Date of Birth: __/__/____

7. Date of Request: __/__/____

8. Date and time received at Health Service:
__/__/____ __ (24hr) __ (min)

9. Date and time considered by Health Service:
__/__/____ __ (24hr) __ (min)

10. Source of Request:

Request received from CSC / JIT.

Name: _____

OR

Request received from DoCS Helpline.

Signed: _____

Name: _____

Service Manager

Outcome of Request

Contact with DoCS must be made within 2 working days of receiving the request.

Request Accepted.

11. Estimated time of service provision:

Service provided before written request
Immediately (within 2 days)
Between 3 – 7 days
Between 1 and 2 weeks
Between 2 and 4 weeks
Between 4 and 6 weeks
Between 6 and 8 weeks

OR If waiting time is outside this timeframe:

Request has been prioritised on the waiting list for the next vacancy. OR
Request has been placed on the waiting list to be assessed according to priority against other demands.

12. Reason why Request Not Accepted.

Service requested is not currently provided due to staff vacancy. OR
Service requested is not consistent with the service responsibilities.

Specify _____ OR

Providing the service would prejudice the discharge of the service functions.

Specify: _____ OR

Service requested is not currently provided due to other reason.

Specify: _____ OR

Request has been transferred to an alternate Health Service which has agreed to accept the request. Details are shown below.

Date Transferred: __/__/____

Service Contact Details:

Service Name _____

Contact Name _____

Phone _____

Fax _____

email _____

Response Form for Best Endeavours Requests for Service from the Department of Community Services

This form must be provided to the Central Register and to the DoCS Centre from where the request originated.

Health Service Type

- 01 Mental Health Assessment
- 02 Forensic Medical Examination
- 03 Emergency Medical treatment
- 04 Other Crisis / trauma response
- 21 Acute / Post Acute Care Services
- 22 Aged Care Service
- 23 Ambulance Service
- 24 Child Health Service
- 25 Child Protection Service (PANOC)
- 26 Counselling Service
- 27 Disability Service
- 28 Drug & Alcohol Service
- 29 Ethnic / Migrant Health Service
- 30 Home Based Care Service
- 31 Indigenous Health Service
- 32 Men's Health Service
- 33 Mental Health Service
- 34 Oral Health Service
- 35 Palliative Care / Hospice Care Services
- 36 Primary Care Health Service
- 37 Public Health Service
- 38 Rehabilitation Service
- 39 Respite Care Service
- 40 Sexual Assault Service
- 41 Sexual Health Service
- 42 Women's Health Service
- 43 Youth Health Service
- 44 Other Health Service.....Specify

Update to Best Endeavours Requests for Service

This information must be provided to the Central Register six weeks after accepting a the Request for Service.

1. Today's Date: __/__/____

Details:

2. Health Service Name _____

3. DoCS Reference Number _____

4. Client Date of Birth: __/__/____

5. Date of Request: __/__/____

6. Date of Planning Meeting / Process: __/__/____

Outcome of Contact with Client:

A: Where Service is Provided:

7. Date client first seen: __/__/____

8. Service provided to:

Child at risk of harm

Young person at risk of harm

Sibling of child / young person at risk of harm

Parent / carer

Other Family Member

9. Time between Request Received at Health Service and Client first seen.

Immediately (within 2 days)

Between 3-7 days

Between 1 to 2 weeks

Between 2 to 4 weeks

Between 4 to 6 weeks

Between 6 to 8 weeks

10. Time between Planning Meeting / Process and Client first seen.

Immediately (within 2 days)

Between 3 to 7 days

Between 1 to 2 weeks

Between 2 to 4 weeks

Between 4 to 6 weeks

B: Where Service is Not Provided:

11. Reason for Service Not Provided:

DoCS did not proceed with referral. OR

Planning meeting / process still pending. OR

Appointment made but client not yet attended. OR

Client still on waiting list. OR

Service not proceeded with due to unresolved safety concerns.

Date discussed with DoCS: __/__/____ OR

Attempts to contact client unsuccessful.

Date(s) of attempted contact:

__/__/____

__/__/____

__/__/____

__/__/____

Service not proceeded with for other reason.

Specify _____

Signed: _____

Name: _____

Service Manager

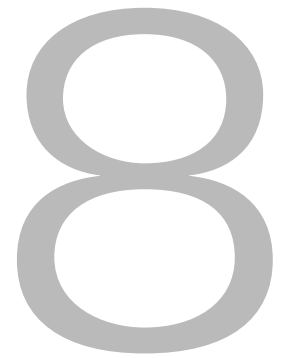
Response Form for Best Endeavours Requests for Service from the Department of Community Services

This form must be provided to the Central Register and to the DoCS Centre from where the request originated.

Health Service Type

- 01 Mental Health Assessment
- 02 Forensic Medical Examination
- 03 Emergency Medical treatment
- 04 Other Crisis / trauma response
- 21 Acute / Post Acute Care Services
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- 24 Child Health Service
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- 32 Men's Health Service
- 33 Mental Health Service
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- 36 Primary Care Health Service
- 37 Public Health Service
- 38 Rehabilitation Service
- 39 Respite Care Service
- 40 Sexual Assault Service
- 41 Sexual Health Service
- 42 Women's Health Service
- 43 Youth Health Service
- 44 Other Health Service.....Specify

Appendix



Information Request Form

(to be used by agencies seeking information from DoCS) (Current at December 2000)

Section 248 of the Children and Young Persons (Care and Protection) Act 1998 provides for the exchange of information regarding the safety, welfare and well being of a particular child or young person or class of children or young persons.

The Act authorises DoCS to use discretion in the decision to provide information in response to this request. DoCS will provide the requested information only if it is determined by DoCS that the provision of information is in the best interests of the child or young person, or the class of children or young persons.

To _____
(name of DoCs position) _____

At _____
(office / CSC) _____

From _____
(name of person requesting information) _____

At _____
(Government department or agency) _____

This request is made in regard to:

name of child/ren or young person/s

Date of Birth: _____
Gender: M F

Information is sought regarding the following persons:

Name	Relationship to child/young person	DOB

Comment

(include any relevant information which may assist the agency in identifying the subject of the information required)

Specific information is requested in regard to:

- current and/or past history of involvement with the child, young person and/or their family
- family/ relationship dynamics (if known)
- attitude of the child, young person and/ or family to agency/service involvement
- other details required

Please provide the requested information

- by phone
- by fax*
- in the form of a written report.

* Care should be taken in providing sensitive information via fax. This procedure must be negotiated with and agreed to by the agency providing the information.

The information is required by _____ date _____

This information is sought in relation to the following issues of concern held for the above mentioned child/young person or class of children or young persons:

Client consent should be sought in regard to the exchange of information. However, the Act authorises the exchange of information under section 248 without consent. Consent requires that the person has been given adequate information in a manner and language that they understand.

The child/ young person/ parent/carer has given consent for the release of information requested in this form. or

The child/ young person/ parent/carer has not given consent for the release of information requested in this form. The reason for this is:OR

The principle of participation requires that clients be adequately informed about decisions and processes that affect their lives. All information must be imparted in a manner and language that is understood by the persons involved.

The child or young person's parent/carer has been informed of this request for information? or

The child or young person's parent/carer has not been informed of this request for information? The reason for this is:

Delegated Officer of the Department of Community Services

Name: _____

Signature: _____

Date: _____

Contact details of the person making the request.

Phone: _____ Fax: _____

Address: _____ Email: _____

9

Appendix

The Impact and Dynamics of Child Abuse and Neglect

The developmental years of childhood and adolescence play a critical role in establishing the foundations, skills and abilities needed for optimal health throughout life. The experience of abuse and neglect can have a devastating impact on the health and well-being of children and young people. This may result in a legacy of physical and psychological disabilities that are carried on into adult life:

"Adult problems in self-perception and self-acceptance, relationship to others, and world view can often be understood as the logical consequences of childhood maltreatment." (Finkelhor, 1992, ix)

Whatever form it takes, abuse or neglect experienced in childhood can have severe impacts because of the vulnerability and dependency of children. While the family is for most children a place of nurture and security, the abused or neglected child or young person is trapped in an impossible position:

"Like other victims, abused children experience significant psychological distress and dysfunction. Unlike adults, however, they are traumatized during the most critical period of their lives: when assumptions about self, others, and the world are being formed; when their relations to their own internal states are being established; and when coping and affiliative skills are first acquired. Such post traumatic reactions can also have an impact on subsequent psychological and social maturation." (Briere, 1992, 17)

Many of the difficulties reported by adult survivors of childhood abuse or neglect can be understood as the outcome of a child or young person's attempts to cope in a situation of helplessness and fear. However these coping mechanisms, so essential to survival in childhood, become problems in themselves in adult life.

In addition to the suffering caused to those affected, there is a developing view that child abuse is inextricably linked with many major social problems currently confronting the community.

"If the nation is serious about the prevention of mental health problems, substance abuse, and crime, it must learn about child abuse and neglect" (Melton and Flood, 1994, 2).

At the same time there is emerging evidence that not all those abused in childhood go on to suffer the type of ill effects identified. Identifying the factors that mediate the impact of abuse is of crucial importance to both the prevention and treatment of child abuse (Werner, 1989; Wolff, 1995).

Awareness of the potential long-term impact of all forms of child abuse and neglect adds urgency to our efforts to both prevent abuse and neglect and, if this is not possible, to recognise abuse where it is occurring and intervene effectively to prevent the development of long term problems and suffering.

While all forms of abuse have similarities, particularly in their long term impact on victims and in the core dynamic of the entrapment caused by the child's dependence, immaturity and vulnerability, it is suggested by some experts that identifying the differences between the dynamics of the various forms of abuse is also important if prevention and intervention are to be accurately targeted and effective (Scott, 1995). However, it is also important to recognise that some children are subjected to multiple forms of abuse and children and young people who are experiencing abuse are often also witnessing domestic violence (Tomison, 2000). Recognition of one type of child abuse or domestic violence should therefore alert Health workers to the possibility that other forms of abuse may be occurring. Australian and overseas research has established that in up to 66% of families where child abuse risk indicators are present, domestic violence in the household was also identified. (Farmer and Owen, 1995; Stanley and Goddard, 1993).

In addition, children who are exposed to domestic violence have been found to experience a similar trauma response as other abused or neglected children (Stephens, 1999; Edleson, 1999).

Child sexual abuse differs in some significant ways from other forms of child abuse and neglect. For example while the ability to predict any form of abuse is far from perfect, it is even more difficult in the case of child sexual abuse. Neither potential victims nor potential perpetrators are able to be reliably identified (Daro, 1994). In addition, while perpetrators of child sexual abuse are more likely to be known to the child than to be strangers, they are not limited to parents or caregivers as is most often the case with other forms of abuse. Sexual offenders against children and young people represent the broad spectrum of adults and adolescents who have contact with children. They include siblings, extended family members, neighbours, family friends, clergy and teachers. These features of child sexual abuse shape the types of prevention activities which are possible.

Child sexual assault is a crime. Intervention by the criminal justice system is more common with child sexual assault than with other forms of child abuse or neglect. The involvement of child victims and non-offending family with the criminal justice system requires a specialist response by Health workers who understand the legal system and its impact on children and non-offending family members and can provide appropriate preparation and support.

Because of the intractable nature of sexual offending, separating offenders from victims and potential child victims is essential to ensure safety. In contrast, the approach to intervention with physical abuse less frequently involves criminal prosecution except if the abuse includes serious physical assault or is sadistic. If the child's safety can be assured, it is more common in cases of physical abuse for the child to remain in the care of parents and caregivers. They are then offered a range of services, such as counselling, parenting education and home visiting programs, to help them to care for the child.

Current approaches to physical abuse and neglect emphasise the development of partnerships with parents to empower them to function as nurturing, confident parents. This approach is possible because many parents and caregivers actively seek help with parenting, sometimes because of fears of harming a child.

An important area of difference in types of abuse and neglect is gender. For example, for states where Australian data is available, women were more likely to neglect their children (NSW Child Protection Council, 1994). This reflects the over-representation of female single parent families in the substantiated cases of neglect, relative to their proportion in the population, and highlights the pressure on single parents in child rearing.

In addition, women subjected to violence from their male partners are more likely to abuse their children (James, 1994).

In contrast, the overwhelming majority of child sexual assault offenders are male and gender has been identified as important in understanding and responding to child sexual abuse (Marshall, Laws & Barbaree, 1990). Theory development has addressed aspects of male socialisation, such as a lesser degree of empathy for children, which may contribute to child sexual abuse and may suggest directions for prevention (Finkelhor and Lewis, 1988). There is some evidence to suggest that women do feature as both offenders of child sexual assault and domestic violence, however the vast majority of offenders are male (Finkelhor, Hotaling, Lewis & Smith, 1990; NSW Health, 1997).

Until recently, theory, research and practice have understated gender differences in the occurrence of physical abuse, despite evidence that men are responsible for at least half of all physical abuse and for the majority of the most serious physical abuse (Tomison, 1996; Leventhal, 1996). Much of the work to date has concentrated on working with mothers of abused children:

"The failure of workers and researchers to engage father figures in casework or research has been attributed to sexist, cultural and legal assumptions whereby mothers having any role in the care of their children are automatically assumed to be accountable." (Tomison, 1996, 8)

The issue of gender is only one example of the different dynamics in the various forms of child abuse and neglect. NSW Health recognises that effective prevention and intervention in child abuse must be based on a sound understanding of the similarities and differences between the various forms of abuse and neglect.

10

Appendix

NSW Health Mental Health Tribunal

PO Box 2019
BORONIA PARK NSW 2111
Tel (02) 9816 5955
Fax (02) 9817 4543

NSW Pre-Trial Diversion of Offenders Program

Cedar Cottage
PO Box 45
WESTMEAD NSW 2145
Tel (02) 9891 6199
Fax (02) 9891 1080

Pharmaceutical Services Branch – NSW Health

Building 29
Gladesville Hospital Campus
Cnr Victoria and Punt Roads
GLADESVILLE NSW 1675
Tel (02) 9879 3214
Fax (02) 9859 5165

Department of Community Services

164-174 Liverpool Road
ASHFIELD NSW 2131
Tel (02) 9716 2222
Fax (02) 9789 5486
DX21212 Ashfield
www.community.nsw.gov.au

Education Centre Against Violence

Locked Bag 7118
PARRAMATTA BC NSW 2150
Tel (02) 9840 3737
Fax (02) 9840 3754
Email: ecav@wsahs.nsw.gov.au

Guardianship Tribunal

Locked Bag 9
BALMAIN NSW 2041
Tel (02) 9555 8500
Fax (02) 9555 9049

NSW Health Department

Staff Records Management Unit
PO Box 961
North Sydney NSW 2059
Tel (02) 9219 7494
Fax (02) 9211 8861

NSW Commission for Children and Young People

Level 2
407 Elizabeth Street
SURRY HILLS NSW 2010
Tel (02) 9286 7276
Fax (02) 9286 7267
www.kids.nsw.gov.au

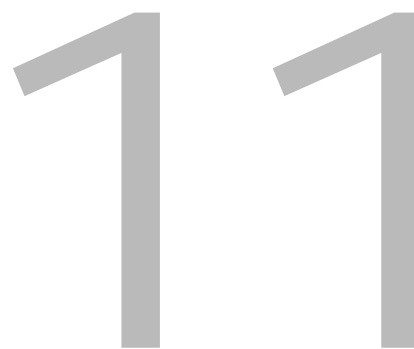
Victims of Crime Bureau

Locked Bag A5010
SYDNEY SOUTH NSW 1235
Tel (02) 9374 3005 or 1800 633 063
Fax (02) 9374 3020
www.lawlink.nsw.gov.au/vcb

NSW Department of Health Web Site

www.health.nsw.gov.au

Appendix



Glossary

(Adapted from the Interagency Guidelines for Child Protection Intervention 2000)

adolescent: A person at the stage of human development between puberty and adulthood.

assault: is any act done intentionally or recklessly which causes another person to fear immediate and unlawful violence. The term assault usually includes battery but assault may occur without battery. The act must be a hostile one. An assault can be reckless with foresight of the likelihood of inflicting injury. Battery is the intentional or reckless application of force.

developmental assessment: An assessment by a health or education professional of the child's physical, social or cognitive development and functioning.

child and family assessment: An assessment of the functioning of a particular family in relation to meeting the needs of a child or young person. The assessment may include an assessment of the child or young person's relationship with family members.

psychological assessment: An assessment by a psychologist, child psychiatrist, social worker, guidance or education worker of a child's neurological, intellectual, social, emotional, developmental or scholastic functioning.

risk assessment: An assessment of the likelihood of further risk of harm to a child or young person from abuse or neglect, based on the seriousness and circumstances of past and current risk of harm, the capacity of adults to protect the child or young person and the age and vulnerability of the child or young person.

caregiver: A person who, while not a parent of the child, has actual custody of the child. Caregivers may provide the care with or without fee or reward and can include relatives, friends or acquaintances of a parent, residential care workers, child care workers, youth workers, nursing staff and foster parents.

child: Any person under 16 years of age, except where otherwise stated.

class of children or young people: More than one child or young person who may be at risk of harm because of association with a person or a situation causing risk of harm from abuse and neglect.

female genital mutilation: According to the World Health Organisation, female genital mutilation includes all procedures that involve partial or total removal of the female external genitalia, and/or injury to female genital organs for cultural or other non-therapeutic reasons.

Health service manager: The manager, director or team leader of any unit or facility operated by an Area Health Service, Corrections Health Service, Ambulance Service or the Children's Hospital at Westmead.

Health worker/employee: In this manual, the term Health worker or Health employee covers employees both paid and unpaid within the Public Health System according to the purposes of the Health Services Act 1997, 154 section 6, Chapter 2 Part 6.

interpreter: Accredited language or sign interpreters and people experienced in the use of facilitated communication techniques for people with disabilities.

investigation: has different meanings depending on the context.

In matters where there is risk of harm or a criminal offence, it is a process for gathering information in response to a report about risk of harm by officers of the Department of Community Services or by police officers in response to an allegation of risk of harm or a suspected criminal offence against a child. An investigation may include interviews and other enquiries into all of the child's circumstances and any risk to their future safety and welfare.

In matters involving an allegation of child abuse against an employee, the term 'agency investigation' is used. This is a broad fact finding process where a designated agency carries out some form of inquiry and assessment and possible adjudication of the allegation.

mandatory reporting: is the act of a person mandated under s27 of the Children and Young Persons (Care and Protection) Act reporting that they suspect a child is at risk of harm.

out-of-home care: means residential care and control of a child or young person at a place other than their usual home and by a person who is not the child or young person's parent or relative. It can include staying with friends and acquaintances, foster care, residential care, shared family care and other forms of substitute care.

parent: Any person having parental responsibility for a child or young person.

parental responsibility: All the duties, powers, responsibility and authority which parents have by law in relation to their children.

practitioner: A person who works with or without fee or reward in any government or non-government setting for the benefit of children. It includes police officers, teachers, psychologists, welfare workers, health workers and counsellors.

protective intervention: The action taken by agencies to protect a child or young person from abuse and neglect by providing care, services and support or apprehending and prosecuting those responsible for their abuse.

reasonable grounds: are grounds which would cause a reasonable person to form a judgement of risk of harm having regard to the circumstances of the individual case. These include the nature and seriousness of the allegations made, the age and physical condition of the child, any corroborative evidence which exists, and other relevant information.

report: Information provided, in accordance with sections 23, 25 or 27 of the Child and Young Persons (Care and Protection) Act 1998, by a person who forms the belief on reasonable grounds that there are current concerns for a child, young person or a class of children due to risk of harm from abuse or neglect.

reporting: The act of making a report to the Department of Community Services.

risk of harm: Agencies and practitioners are required to make judgements about risk of harm to a child or young person from child abuse or neglect. The assessment requires an evaluation of both the degree of harm and its probability and must take into account the age and vulnerability of the child or young person.

young person: Any person who is aged 16 years or above but who is under 18 years.

Appendix

12

Reference List

- Bayatpour, M., Wells, R. and Holford, S. (1992), 'Physical and Sexual Abuse as predictors of substance abuse and suicide among pregnant teenagers, *Journal of Adolescent Health*, vol. 12, pp.128-132.
- Briere, J. N. (1992), *Child Abuse Trauma: Theory and Treatment of the Lasting Effects*, Sage, Newbury Park.
- Chandy, J., Blum, R. and Resnick, M. (1996), Gender specific outcomes and sexually abused adolescents, *Child Abuse and Neglect*, vol. 20, no. 12, pp.1219-1231.
- Children, Australia: A *Social Report* (1999), Australian Bureau of Statistics, Canberra (Catalogue No. 4119.0).
- Daro, D.A. (1994), 'Prevention of child sexual abuse', *The Future of Children*, vol. 4, pp. 198-223.
- Edleson, J. L. (1999), 'Children's witnessing of adult domestic violence', *Journal of Interpersonal Violence*, vol. 14, no. 4, pp. 839-870.
- Farmer, E. and Owen, M. (1995), 'Child protection practice: Private risks and public remedies', *Studies in Child Protection*, HMSO, London.
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P. and Marks, J. S. (1998), 'Relationships of childhood abuse and household dysfunction to many of the leading causes of death in adults', *American Journal of Preventive Medicine*, vol. 14, no. 4, pp. 245-258.
- Finkelhor, D. and Lewis, I. A. (1988), 'An epidemiologic approach to the study of child molestation', in R. A. Prentky and V. L. Quinsey (Eds), *Human Sexual Aggression: Current Perspectives*, The New York Academy of Sciences, New York.
- Finkelhor, D., Hotaling, D., Lewis, I. A., & Smith, C. (1990), 'Sexual abuse in a national survey of adult men and women: prevalence, characteristics, and risk factors', *Child Abuse and Neglect*, vol. 14, pp. 19-28.
- Finkelhor, D. (1992), 'Preface', in J. N. Briere, *Child Abuse Trauma: Theory and Treatment of the Lasting Effects*, Sage, Newbury Park.
- Graziano, A, and Mills, J. (1992), 'Treatment for abused children: When is a partial solution acceptable, *Child Abuse and Neglect* , vol. 16
- Glod, C, and Teicher, M. (1996), 'Relationship between early abuse, post traumatic stress disorder and activity levels in pre-pubertal children, *Journal of Academy of Child and Adolescent psychiatry*, vol. 34, no. 10.
- James, M. (1994), Domestic violence as a form of child abuse: Identification and Prevention, *National Child Protection Clearing House Newsletter*, No. 2.
- John, V., Messer L. B., Arora, R., Fung, S., Hatzis, E., Nguyen, T., San, A. and Thomas, K. (1999), 'Child abuse and dentistry: A study of knowledge and attitudes among dentists in Victoria, Australia. *Australian Dental Journal*, vol. 44, pp. 259-267.
- Kaplan, S., Pelcovitz, D., Salzinger, S., Mandel, F. and Weiner, M. (1997), Adolescent physical abuse and suicide attempts, *Journal of the American Academy of Child and Adolescent Psychiatry*, vol. 36, no. 6, pp. 799-808.
- Leventhal, J.M. (1996), 'Twenty years later: We do know how to prevent child abuse and neglect', *Child Abuse and Neglect*, vol. 20, pp. 647-653.
- Marshall, W., Laws, D. and Barbaree, H. (1990), 'Issues in sexual assault', in W. Marshall, D. Laws and H. Barbaree (Eds), *Handbook of Sexual assault: Issues, Theories and Treatment of the Offender*, Plenum Press, New York.
- Martin, G (1996), 'Reported family dynamics, sexual abuse and suicidal behaviours in community adolescents, *Archives of Suicidal Research*, vol. 2, pp.183-195.

- Mazza, D., Dennerstein, L. and Ryan, V. (1996), 'Physical, sexual and emotional violence against women: A general practice-based prevalence study'. *Medical Journal of Australia*, vol. 164, pp. 14-17.
- Melton, G. B. and Flood, M. F. (1994), 'Research policy and child maltreatment: Developing the scientific foundation for effective protection of children', *Child Abuse and Neglect*, vol. 18, sup. 1, pp. 1-28.
- NSW Child Protection Council (1994), Neglect of Neglect: Research and Practice, *Report on a Seminar* by Dr Kari Killen, Sydney.
- NSW Department of Community Services (1999), Annual Report 1998-1999. *NSW Department of Community Services*, NSW Government, Sydney.
- NSW Health (1999). *Review of NSW Health Domestic Violence Policy Discussion Paper*, NSW Health Department, Sydney.
- Raphael S. (1999), 'Bottle caries and dental neglect', *NSW Public Health Bulletin*, vol. 10, pp. 31-32.
- Scott, D. (1995), 'Issues in primary and secondary prevention, Keynote Paper,' *NSW Child Protection Council State Conference*, Goulburn.
- Smith, J., O'Connor, I., and Berthelson, D. (1996), 'The effects of witnessing domestic violence on young children's psycho-social adjustment, *Australian Social Work*, vol. 49.
- Stanley, J. R. and Goddard, C. R. (1993), 'The association between child abuse and other family violence', *Australian Social Work*, vol. 46, no. 2, pp. 3-8.
- Stephens, D. L. (1999), 'Battered women's views of their children', *Journal of Interpersonal Violence*, vol. 14, no. 7, pp. 731-746.
- Tomison, A. (1996), 'Intergenerational transmission of maltreatment', *Issues in Child Abuse Prevention, National Child Protection Clearing House Issues Paper*, Australian Institute of Family Studies, No. 6, Winter.
- Tomison, A. (2000), 'Exploring family violence: Linked between child maltreatment and domestic violence', *Issues in Child Abuse Prevention, National Child Protection Clearing House Issues*, Australian Institute of Family Studies, No 13, Winter.
- Werner, E. E. (1989), 'The Children of Garden Island', *Scientific American*, April, pp. 76-81.
- Wolff, S. (1995), 'The Concept of Resilience', *Australian and New Zealand Journal of Psychology*, vol. 9, pp. 565-571.