

# PRACTICE GUIDE

## Assessing harm and risk of harm

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### **Purpose:**

This practice guide outlines the factors to be considered when assessing harm and risk of harm as part of a rigorous and balanced child protection assessment. The process of assessing harm and risk is a key element of every Child Safety Officer's (CSO) role, beginning at intake and continuing until intervention is finalised. It is undertaken in partnership with the child, family, their safety and support network, in line with the Framework for Practice and the Child Placement Principle.

The Framework for Practice provides a common set of values, principles, knowledge and skills to guide our work. The Collaborative Assessment and Planning (CAP) tool is used to engage families and networks through the assessment process and to assist staff to develop a safety oriented, strengths based and solution focused assessment with families. The CAP includes harm statement/s, complicating factors, strengths and resources, acts of protection and belonging and SDM Safety and risk assessments. Harm and worry statements are formulated to inform the development of goals and action plans.

This guide provides professional knowledge about harm and risk and supports the use of professional judgement, collaboration with families, and Structured Decision Making (SDM) tools in the development of a rigorous and balanced assessment. For Aboriginal and Torres Strait Islander children the five elements of the Child Placement Principle: prevention, partnership, participation, connection and placement must be applied.

### **The relationship between abuse and harm**

Where abuse is an action against a child, harm refers to the detrimental effect or impact of that action on the child. To assess harm, a CSO must identify parental actions, behaviour, motivation, and intent to determine the impact on the child, which may be cumulative in nature.

For statutory intervention to occur, there must be information to suggest that the child has suffered, is suffering or is at an unacceptable risk of suffering significant harm and may not have a parent able and willing to protect them from the harm. The level of harm must be identifiable or observable through physical, emotional and / or psychological impacts. It may be assessed that there is an unacceptable risk of harm to the child in the future, due to insufficient protective factors existing to ensure the child's safety and well-being. When identifying protective factors these must be demonstrated acts of protection by the parent and/or support from the family's Safety and Support network.

Examples of the relationship between parental actions, behaviours or intent, and the resulting harms for the child are provided in the table:

**Table 1: Relationship between abuse and harm**

Type of abuse Actions/behaviours by parent/carer	Physical	Emotional	Sexual	Neglect
	Hitting Punching Scalding Choking	Scapegoating Rejection Persistent hostility Threats to harm parent or child Coercive and controlling behaviours	Penetration Sexual exploitation Exposure to pornography	Failure to attend to medical needs Poor hygiene / nutrition Inadequate supervision

Resulting Harm Impact experienced by the child	Physical – Refers to the body	Emotional – Refers to the ability to express emotions	Psychological – Refers to the mind and cognitive processes
	Bruising Fractures Internal injuries Burns	Depression Hypervigilance Poor self esteem Self-harm Fear/anxiety	Learning and developmental delays Disorganised attachment Impaired self-image In infants, neurological changes in the developing brain

Note: Domestic and family violence can include any of the above actions and behaviours that are physically, emotionally and/or sexually abusive, or behaviours that cause neglect. These behaviours may be perpetrated towards a child's non-offending caregiver, or a child. Children residing in a household with domestic and family violence are not simply 'exposed' to domestic and family violence, they experience it.

**Cumulative harm**

Cumulative harm is experienced by a child as a result of a series or pattern of harmful events and experiences that may be historical or ongoing, with the strong possibility of the risk factors being multiple (i.e. from physical, emotional and/or sexual abuse or neglect) and co-existing over critical developmental periods.

**The inappropriate adult behaviour may be any of the following:**

- Of a sustained and repetitive nature
- Sporadic events that have a significant impact on the child
- An isolated event that has a significant impact on the child

The impacts of cumulative harm can be profound and have been widely associated with children experiencing complex trauma. The following developmental effects and behaviours can be indicators of cumulative harm:

- disruptions to early brain development, with permanent impacts on behavioural and emotional responses
- post-traumatic stress disorder or other mental health disorders
- disturbed patterns of attachment
- behavioural regression

- aggressive behaviour against self and others
- lack of awareness of danger or self-endangering behaviours
- self-hatred and self-blame
- chronic feelings of ineffectiveness.

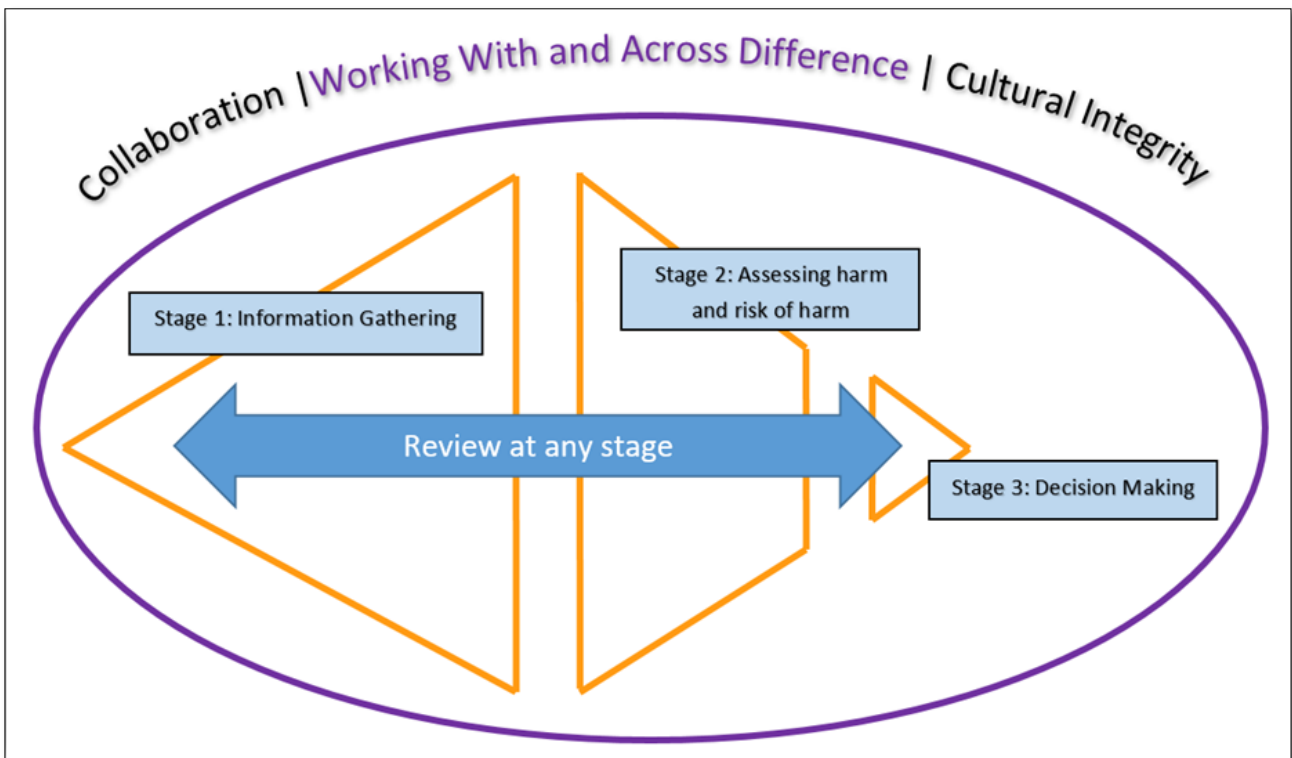
Further information on cumulative harm is found below in *Stage 2. Assessing harm, immediate safety and risk of harm* section.

### Model for decision making when assessing harm and risk of harm

Assessing harm and risk of harm is a critical process within itself and is also part of a broader model of decision making. Once an assessment has been completed, a decision must be made as to what action, if any, will be taken. The below model shows how the combined process of information gathering **and** the holistic assessment of harm and risk of harm informs decision making. The information gathering stage is open and broad, indicating the need to engage with and seek information from a range of sources. The assessment stage begins to narrow where information is analysed and synthesised to make an assessment of harm and risk of harm. The process then closes with the decision-making stage where a determination is made as to whether a departmental response is required; whether ongoing intervention is necessary; and, if so, at what level to ensure the child’s ongoing safety and well-being. At any time a review can occur through analysis of new information as well as analysis of changes that have occurred for the child and family through any intervention.

The model has overarching values, principles and skills that are critical to have at the forefront throughout the process including collaboration, working with and across difference, and cultural integrity.

**Figure 1: Model for decision making when assessing harm and risk of harm**



## Working with and across difference

When gathering information, assessing harm and risk of harm and during decision making processes, keep in mind engagement will occur with families, children, young people and communities whose ethnicity, religion, spirituality, economic status, age, gender, culture, sexual orientation, and upbringing may differ greatly from your own. Intrinsically, people are influenced by personal experiences and therefore can be biased when assessing others who differ from themselves. When undertaking risk assessments, remain aware of your potential for bias, and gather information from the family, network and specific cultural elders or advisors to ensure that their assessment considers the family's individual histories and characteristics.

### Stage 1. Information Gathering

To continually assess harm and risk of harm along the child protection continuum, clear and factual information needs to be gathered about:

- the alleged harm / risk of harm
- the child
- the parents
- the family context
- cultural details and considerations that influence child and family functioning
- social and environmental factors.

At most points in the continuum, a strong collaborative approach with the child, family, safety and support network members and other professionals should be taken to assist you to identify and obtain relevant information. The exception is intake where information is obtained from the notifier, child protection history and where appropriate, pre-notification checks.

Information can be gathered by:

- engaging with the notifier to gather information about their concerns for the child – the who / what / where / when – *intake phase*
- critically reviewing relevant file material - both electronic and paper based departmental records - *all phases*
- purposeful interactions with the child, siblings, parents, foster carers, relevant family and household members, significant people in the child's life and community, relevant professionals, community elders or culturally relevant organisations where the child is Aboriginal or Torres Strait Islander, and service providers in contact with the family - *investigation and assessment; and ongoing intervention, including during family group meetings, and case plan reviews*
- direct observations and assessment of the quality of interactions between the child, parents, foster and kinship carers, and others within the environment - *investigation and assessment; and ongoing intervention, including home visits and family contact visits.*

Information gathering is a continual process, and the receipt of new information may require a review of decision-making and a re-assessment of harm and risk of harm.

### Collate and consider all child protection history

Undertaking a holistic assessment of harm and risk of harm requires the collation and consideration of all child protection history recorded on each family member, including any siblings of the subject child, and the parents when they were children.

When receiving new concerns about a child, current information needs to be carefully integrated with the history contained in previous child concern reports, notifications, investigation and assessments and other file material available. Past concerns may have been about similar or different harms and may not have met the threshold for a notification. This previous decision-making should not influence the assessment of the current harms and will assist in identifying risk and protective factors and indicators of cumulative harm.

### **Identify risk and protective factors**

Research evidence indicates harm to a child may be due to the interplay of multiple factors both within and outside the family. To understand this interplay, an assessment of risk and protective factors that may exist is required.

### **Risk factors**

Significant research has identified certain risk factors that are found more often in families where harm has occurred than in the general population. These risk factors may indicate a heightened likelihood that a child may be harmed in the future or be a 'predictor of harm'. Descriptions of risk factors and examples of harm that may occur are provided in [Appendix 1: Risk and protective factors relating to harm; the child; the parent; the family context; and the environment.](#)

Risk factors may be recognised within information obtained on:

- the identified harm/risk of harm
- the child
- the parent
- the family context/interactions
- the environment, including the cultural context

When considering risk factors in the context of the Collaborative Assessment and Planning Framework (CAP) tool, many risk factors are 'complicating factors' in the tool and also form the basis for worry statements, if not sufficiently mitigated by acts of protection by a parent and actions of the safety and support network.

As part of an Investigation and Assessment, the SDM Family Risk Evaluation tool is completed. This tool helps to identify families that have high, moderate, or low probabilities of abusing or neglecting their children in the future and provides an objective appraisal of the likelihood that a family will abuse their children and cause them harm in the next 12-24 months. High risk families have significantly higher rates than low risk families of subsequent notification and substantiation and are more often involved in serious abuse or neglect incidents.

As predictors of harm, risk factors should be considered cautiously on their own. Critical analysis of all information needs to occur to determine each factor's significance for the ongoing safety of the child. While acknowledging it is not possible to predict the future behaviour of a person with any certainty, risk factors can be viewed as markers which require further consideration using professional knowledge and judgement. It is the interaction between risk factors that may increase the probability of harm occurring. Likewise, the presence of protective factors may also decrease the probability of harm occurring. Risk factors may carry different weight within an assessment due to the interplay between factors - for example, being a young parent is not a risk

factor in itself, but combined with substance misuse and housing instability, the risk of harm to the child increases.

When making an assessment of risk in relation to an Aboriginal or Torres Strait Islander child, the identified risk factors should be considered within the child's community and cultural context. The family should be the primary source of information regarding cultural and community information, and child rearing practices, however additional information can be sought from Cultural Practice Advisors, community organisations or elders who are significant to the child and family.

### **Protective factors**

To complete a rigorous and balanced assessment, risk factors cannot be considered in isolation - they must be assessed in conjunction with identifiable protective factors. These protective factors can influence the extent to which one or multiple risk factors can be mitigated to inform the appropriate response or outcome. Through engagement with families and safety and support networks, it is essential to explore 'What is working well?' This information can be categorised in the CAP tool under 'protection and belonging' or 'strengths and resources', and identified protective factors established. If families or networks are initially unable to identify what is working well for them or times when they have taken action to promote the child's safety, belonging and/or wellbeing, using an appreciative inquiry approach or solution focused questions can assist families in identifying positive behaviours, attributes or resources which can be built upon.

*Appendix 1: Risk and protective factors relating to harm; the child; the parent; the family context; and the environment* provides descriptions of protective factors identified in research with examples of their application. Where protective factors are identified within a family, they must be verified or checked before they can be assessed as mitigating or reducing the identified risks. Accepting what a parent or relative describes as a protective action without verification may result in a child being placed at further risk. Seek examples of demonstrated acts of protection by the parent.

Certain protective factors may influence the timing and priority for a departmental response, and may identify safety and support networks to be strengthened when undertaking case planning with a family. For Aboriginal and Torres Strait Islander children, information regarding the child and family's culture including relevant protective factors and strengths within the child's family, community and clan or language group must be obtained and considered.

### **In assessing protective factors there is a need to differentiate between:**

1. factors which may provide immediate safety for the child, but do not decrease the overall and ongoing risk of harm (for example, the child staying elsewhere temporarily)
2. factors which reduce the overall risk of harm for the child and therefore influence the decision about intervention (for example, the continued and verified presence of a protective adult in the household).
3. To make an assessment for any child, comprehensive knowledge and understanding of both risk and protective factors is required so analysis of their interplay can occur during the assessment stage.

### **Stage 2. Assessing harm, immediate safety and risk of harm**

The second stage in the decision making model is to make an assessment regarding harm and risk of harm. During this stage, your focus becomes narrower as you take the information you have gathered and engage in the dynamic process of analysis and synthesis to assess:

- whether the child has been harmed and/or is likely to be harmed in the future
- the level or degree of harm experienced previously, currently, and likely to be experienced by the child in the future, giving consideration to the child's vulnerability
- whether there has been a detrimental effect of a significant nature on the child's well-being, or there is an unacceptable risk of this occurring in the future
- existing protective factors and how these mitigate harm or future harm
- whether there is a parent both able and willing to protect the child from harm.

Engaging the family in a collaborative assessment and planning process using the CAP tool during the assessment phase will enable the family to have an understanding of how the harm and level of risk to the child has been assessed, and to identify what further supports and protective factors are present or could be implemented to mitigate the risk to the child. Fundamental to the assessment process is the need to have a clear purpose for undertaking the assessment and asking questions to gather the information required. Using the CAP tool as a working document can support you to develop clarity in the risk assessment while you move through the assessment process to determine the following:

- **past harm** - *harm previously experienced by a child*. Times in the past when the child has been harmed is in the 'harm statement' section of the CAP tool. Past harm is an important consideration for assessing cumulative harm, and may also help you understand the duration of the current harm the child may be experiencing. If there are worries from past harms that are no longer harming a child but still make it difficult for a family to protect and care for the child, these are 'complicating factors' in the CAP tool.
- **current harm** – *actual harm that exists for a child in the present*. If an immediate harm indicator is selected on the SDM Safety Assessment tool and that particular harm has already occurred, this is reflected in the 'harm statement' section in the CAP tool.
- **risk of harm** - *the likelihood and level of harm that may occur to the child in the future*. If an immediate harm indicator is selected on the SDM Safety Assessment tool that refers to a *risk of harm* that may occur in the immediate future, this is reflected as a 'complicating factor' in the CAP tool and a worry statement is then developed. Individual items on the FRE assessment and other risk factors established with the family may also be complicating factors.
- **existing protective factors** - *factors that may mitigate against risk of harm*. Verified protective factors are reflected in the 'protection and belonging' section in the CAP tool.

### Assess immediate safety

The purpose of an immediate safety assessment is to:

- assess whether any children in a household are currently in immediate danger of serious harm; and, if needed,
- determine what interventions should be initiated or maintained to ensure the child's safety.

Where a risk assessment focuses on the likelihood of *future* harm occurring, an immediate safety assessment focuses on *current* harm. A safety assessment is done in addition to a risk assessment. In completing a safety assessment, information is gathered and analysed about immediate harm indicators within the household, as indicated by the actions or inactions of any adult in the home. This information is used, together with professional judgement, to complete the safety assessment.

A safety assessment is completed during an investigation and assessment at the initial contact with the family. Additional safety assessments are also completed at critical times during the investigation and assessment and / or ongoing intervention, for example if household circumstances change, prior to reunification or prior to closing an ongoing intervention case.

## Incorporate knowledge of cumulative harm

When assessing harm and risk of harm, the focus should not just be on the specific incident that may have been notified, as this may lead to non-identification of cumulative harm. Cumulative harm may not be evident at the initial stages of an investigation or following a single event, therefore consideration should be given to multiple or reoccurring adverse circumstances or events that a child has experienced, and the impact this may have had or is currently having on them.

While it is useful to consider 'past harm' for assessing a child's current experience of cumulative harm, past harm does not need to have been substantiated in order to consider whether a child is experiencing cumulative harm at the current point in time. Cumulative harm can occur due to a child's prolonged experience to low level adverse circumstances, even if such circumstances have never previously reached the threshold for notification or harm substantiation.

## Professional analysis

The analysis of harm and risk of harm is the examination and evaluation process undertaken prior to identifying an appropriate response or intervention. As part of undertaking an analysis to make a determination about the likelihood of future harm to a child, the degree of that harm, and the probability of cumulative harm occurring, seven key factors need to be considered. Some of these key factors are static, in that they remain unchangeable even if current circumstances change. Some of these are dynamic, which means they do not remain the same and can change over time.

- **frequency of harm** - the number of incidents that have occurred over time; any knowledge of prior unreported incidents; and whether there have been previous concerns for similar issues
- **type of harm** – the number of harm categories notified and whether there are indicators of other harm types in addition to those notified. For example, neglect may be the notified concern however further information gathered indicates regular incidents of domestic and family violence, resulting in physical and emotional harm to a child
- **severity** - whether the alleged harm is significant, or is likely to cause significant harm if it were repeated over a prolonged period; and whether the impact of the harm on the child's development and well-being is, or will be, significantly detrimental
- **source of harm** - the number of people responsible for the harm; the significance of the relationship between the child and person/s responsible (consider both intra and extra- familial); and whether the child's current situation makes them more vulnerable to other perpetrators
- **duration** - the period of time over which harm has occurred, including prior history that did not reach the threshold for a notification but where the impacts of harm may have accumulated over time
- **probability** - estimating the likelihood or probability that future harm will occur
- **vulnerability** - assessing the vulnerability of a child to future harm, taking into account their age, developmental stage, any disabilities, medical conditions and social isolation.

In addition to considering these seven key factors, other critical elements of analysis include:

- gathering all available information, including cultural information from the family and / or other relevant people about an Aboriginal and/or Torres Strait Islander child
- integrating the harm characteristics known (frequency, type, severity, source and duration of harm) with all previous child protection history
- considering risk factors, protective factors, family strengths, safety and support network and the family's access to services and resources
- critiquing previous responses / assessments in light of this information - this may mean challenging previous decisions made about the family to identify any cumulative impact on the

child (where a number of child concern reports and identified risk factors demonstrate significant cumulative harm), or to reconsider the appropriateness of the current intervention

- reflecting on and assessing the experiences of any siblings.

**Research has identified a higher likelihood of harm, including cumulative harm, occurring if:**

- there have been multiple concerns reported over time
- there is history of multiple sources of notifiers alleging similar problems
- concerns relate to multiple harm types and / or multiple persons responsible for harm over time
- concerns have been received from service providers / professionals
- reports include incidents of inappropriate parenting in public
- there is evidence of children not reaching developmental milestones.

Risk assessment is a dynamic process - it is a 'point in time' snapshot that will change in the future, therefore ongoing analysis of information obtained during all contact with a child, their family and others is required. Risk assessment is to be undertaken in the best interests of the child, with emphasis on the child's safety and well-being, to ensure intervention, decision-making and service provision meets the changing needs of the child.

**Assess the parent's ability and willingness to protect the child**

To ascertain the ongoing safety of the child, an assessment needs to include whether one or both parents are able and willing to protect the child from any harm in the future. Previously identified risk and protective factors need to be integrated with an assessment of harm characteristics, and parental attitudes and characteristics that may impinge on a parent's ability and willingness to act protectively. This assessment may be informed by the following factors outlined below.

**Harm characteristics** - a parent may not be able or willing to protect if:

- the child has experienced more than one type of harm - there is a greater likelihood the family will have difficulty in resolving causative factors relating to the harm, and the probability of cumulative harm occurring is increased
- a parent has harmed the child and the behaviour causing the harm is not recognised as inappropriate by the parent
- the harm is recent or is escalating in frequency and/or severity
- the harm is severe, deliberate or intentional - indicating the parent may have a lack of insight or a tendency to use excessive discipline.

**Parental attitudes and characteristics** - the parent's attitude to the harm that has occurred links to the probability of harm occurring in the future and their ability and willingness to protect the child. Consider:

- identification of the harm/risk of harm and its significance - a parent may minimize or conceal the impacts of their behaviour and not identify the significance of the harm, leading to an increased likelihood of harm reoccurring
- acknowledgment of the parent's role in the harm/risk of harm - a parent may be unwilling to change their behaviour or circumstances to protect the child from harm
- parent's perception of the child - if the child is viewed as the 'problem' or perceived negatively, future harm may be probable
- young age / immaturity / lack of parenting knowledge and skills - these factors can impact on understanding the significance of harm

- behaviour - poor impulse control and / or intimidating or violent behaviour will significantly impact on a parent's ability to act protectively
- environmental stressors may be present that can impact on a parent's ability to protect - for example financial stress, social isolation and lack of supports, grief and loss issues, divorce / family court proceedings
- substance misuse; mental illness; history of childhood abuse; mobility; homelessness; physical / intellectual disability; ongoing health issues - are all complicating factors that need to be carefully assessed, particularly if several factors exist in combination, as they can impact on a parent's insight and understanding as to the impacts of harm on a child
- parental / household relationships - domestic and family violence (whether the perpetrator is a member of the household or otherwise) can impact on a non-offending parent's ability to protect a child due to their fear of the perpetrator, and / or the perpetrator's power and control over family members. A non-offending parent may be willing to protect a child but be unable to do so.

A parent's ability and willingness to act protectively is enhanced if the parent is acknowledging the harm, is capable and willing to engage with services and is focused on addressing the circumstances leading to the harm. A parent may still be able to act protectively and address the circumstances leading to harm without a statement of guilt being made. An admission from a parent can be part of your assessment, however the absence of a parent accepting responsibility for harm does not preclude them from addressing the worries and should be considered holistically with all other available information to determine the risk of future harm.

Near the completion of your assessment and prior to deciding the response during investigation and assessment or during ongoing intervention, collaboration with the family and their safety and support network to share details of your assessment is critical. This provides an opportunity for the family to understand their risk level and what the worries are and ensure that all efforts to explore protective factors that mitigate the identified risks have been exhausted. For Aboriginal and Torres Strait Islander children subject to an investigation and assessment which is likely to be substantiated, this is also an opportunity for the family to participate in a Family Led Decision Making process to explore possibilities for mitigating the identified risks in a way that is culturally responsive and directed by the family. In any family where domestic and family violence is present or suspected, the safety of the child and non-offending caregiver is paramount with the principles of Safe and Together being implemented throughout the collaborative assessment process and ongoing case work.

### **Stage 3. Decision Making**

After comprehensive information gathering and analysis to form a clear, rigorous and balanced assessment, the final stage of the model is the decision making process including whether a departmental response is required; whether ongoing intervention is necessary; and, if so, at what level to ensure the child's ongoing safety and well-being. The decision as to the appropriate response once harm or risk of harm has been identified is dependent on what phase of statutory child protection intervention the risk assessment has been completed in – at intake, investigation and assessment, or during ongoing intervention.

To make a decision to investigate or take other action in relation to concerns received about harm or risk of harm, it must be reasonably suspected that the child is in need of protection, that is:

- the child has suffered significant harm, is suffering significant harm or is at unacceptable risk of significant harm, and

- does not have a parent able and willing to protect the child from the harm (*Child Protection Act 1999*, s.10, s.14)

### **Determine the response**

Once the level of harm, risk level and the ability and willingness of the parent to act protectively has been determined, the departmental responses include:

- at intake - the recording of a child concern report, including referrals to support services, or a notification
- following completion of an investigation and assessment – the outcome of the investigation and assessment (Substantiated or Unsubstantiated) and whether ongoing intervention may be required to meet the child's protective needs; if so, what level of intervention is required, and whether an out-of-home care placement is required
- during ongoing intervention - following review, consideration may need to be given to reunification decisions, contact decisions, or whether the case can be closed as the child's safety, belonging and well-being needs are now able to be met by the parents.

### **Determine the level of intervention necessary**

If it has been assessed that the child is in need of protection and ongoing intervention is required to ensure that the child's protection and care needs are met, the type of intervention needs to be determined. This decision incorporates the assessment of the parent's ability and willingness to protect - will the child be safe and protected within the household while intervention occurs to address the concerns with the parents' agreement, or is a child protection order with / without a placement required to ensure the child's safety, protective and care needs are met?

In determining the level of intervention necessary, the following factors should be considered:

- the harm type – significance, frequency, severity, chronicity, cumulative impact, future risk of harm
- the number and significance of risk factors identified, and the interplay with all verified protective factors
- the characteristics of the child - age, vulnerability, special needs, behavioural indicators, disclosures by the child and their perceptions of their parent and of the harm that has occurred
- the parents' ability and willingness to protect the child from any harm
- the parents' consent to intervention
- the parents' attitude to, and compliance with, engaging with services / supports, including maintaining contact with service providers if requested
- the ability of safety and support network members to provide support identified - including understanding their role if undertaking a monitoring role with the family
- for an Aboriginal and or Torres Strait Islander child, information in relation to the core elements of the Aboriginal and Torres Strait Islander Child Placement Principle.

### **Identify child and parent strengths and needs to help develop effective case plans**

In deciding the level of ongoing intervention, an assessment of the strengths and needs of both the child and parent is required, completed through the use of SDM tools. These assessment outcomes will direct and guide case planning decisions targeted at improving the child's physical, psychological and emotional well-being through direct services and support to the child and / or their parents.

## Strengths

Research has identified certain characteristics within children and parents that interact together to assist the development of positive coping mechanisms and relationships. These characteristics, or strengths, can then be supported through effective case planning strategies. Strengths are not considered protective factors as they do not mitigate against risk of harm, but they can be supported and built on during ongoing intervention to achieve positive outcomes in the family. The strengths identified in the child and parental strengths and needs assessment are documented in the 'Strengths and resources' section of the CAP tool.

In addition to the child and parental strengths and needs assessment domains, a key individual characteristic to be supported is resilience. Resilience is the capacity of a person to overcome stress or adversity and do well despite difficult, traumatic or unfavourable circumstances.

### **Strength and resilience characteristics in children are identified by their ability to:**

- develop and maintain positive nurturing relationships with others, including peers - requiring secure attachment, social competence, flexibility, caring and empathy towards others and the ability to communicate well
- have effective problem-solving skills - being able to work out what the problem is, thinking of different ways to solve the problem and being able to plan ahead
- be autonomous - requiring high self-esteem, self-discipline, life skills and independence within a context of belonging
- have a sense of control, purpose and future - having goals, being motivated, wanting to be educated, being persistent and hopeful
- have a strong link to culture, and knowledge and understanding of their place within their culture.

### **Strength and resilience characteristics in parents are identified by their ability to:**

- have knowledge of, and a sense of competence in parenting - requiring knowledge of developmental phases in childhood, and associated needs of the child and incorporating this knowledge into skills to respond effectively to a child
- have secure supportive relationships with significant others - characterised by affection, warmth, support for autonomy, sharing of responsibilities and an identified support network
- have well developed positive coping strategies and problem solving skills - requiring emotional stability, and an ability to reflect on past traumatic experiences and incorporate new strategies to counteract any prior harm
- have effective conflict management skills - communicating openly, with mutual respect
- lead a healthy lifestyle - actively making and promoting healthy choices, having a positive attitude and setting goals.

## Needs

The parental strengths and needs assessment may identify areas of need in parent's functioning that will be prioritised and addressed in the case plan for the child. Some parental needs are risk factors which are then picked up in the worries section of the CAP tool and form the basis of 'worry statements'. Every worry statement will have a correlating 'goal statement' with the most significant needs taking priority as case planning goals which include targeted actions to be undertaken to achieve positive outcomes for the child. By addressing needs and supporting and building on protective factors and strengths, a parents' ability to respond and interact with their child more effectively will be enhanced, building resilience in the future. This will assist in decreasing the likelihood of future harm and its long-term effects.

## Reviewing risk assessments

At any stage along the child protection continuum, the risk to a child can increase or decrease. By revisiting the stages of the decision-making process and incorporating new information, any changes can be analysed. Changes that heighten or lower the level of risk may require a change in the type of intervention required to meet the child's needs.

Throughout ongoing intervention, holistic reviewing of previous assessments of the child and family are required as part of the case management cycle of assessment, planning, implementation and review of a child's safety belonging and well-being needs. Every risk assessment must be analysed and integrated with the family's previous history and current functioning to determine service delivery responses. Correlating SDM tools are also **completed to further guide risk** assessment analysis during ongoing intervention including the Family Risk Re-Evaluation, Family Reunification Assessment and Safety Assessment.

During ongoing intervention, a review of previous risk assessments is integral to a broader assessment, and is particularly important when:

- the child remains at home during intervention with parental agreement
- when working with a pregnant woman during a support service case
- there are plans to work towards reunification
- significant changes occur within the family and/or household
- undertaking planning prior to case reviews
- considering closing a case.

<b>1.1 Risk Factors – Harm and future risk of harm</b>	
<b>Explanation / practice prompt regarding risk factor</b>	<b>Example of risk factor and resulting harm</b>
<p><b>The current injury / harm / condition is severe</b></p> <ul style="list-style-type: none"> <li>• The more severe an injury, the greater the harm to the child and the greater likelihood of re-occurrence.</li> <li>• Multiple injuries indicate significant harm and future risk of harm.</li> <li>• The age of the child needs to be considered, with increased vulnerability of significant harm occurring to infants.</li> <li>• For infants, any evidence of shaking / other signs of injury / failure to thrive is significant.</li> <li>• The location of certain injuries can increase the severity of the physical harm, for example head/face injuries are more serious due to the potential for permanent brain, eye and ear damage.</li> <li>• Physical injuries may be internal and not visible. They may present through behaviours such as flinching, a young child is unable to console/settle.</li> </ul>	<ul style="list-style-type: none"> <li>• An infant may be physically assaulted by their parent in the torso area causing internal bleeding and a broken rib (physical harm).</li> </ul>
<p><b>The pattern of harm is escalating</b></p> <ul style="list-style-type: none"> <li>• The harm is escalating over time, increasing in severity and/or frequency</li> <li>• All child protection history and information from other sources (for example police, medical practitioners, school) is to be considered so the pattern of harm can be better understood.</li> <li>• Previous concerns may have related to a different harm type.</li> </ul>	<ul style="list-style-type: none"> <li>• A parent's criticism of a child escalates to scapegoating and rejection of the child, resulting in emotional harm.</li> <li>• There is an increase in the severity of inappropriate disciplinary techniques used toward a child causing significant bruising (physical harm), and the child is constantly distressed and anxious (emotional harm).</li> </ul>
<p><b>The pattern of harm is continuing but not escalating</b></p> <ul style="list-style-type: none"> <li>• The more often harm has occurred in the past, the more likely it is to occur in the future.</li> <li>• Reports of harm should not be viewed as unconnected events. Past reports of harm that did not meet the threshold for a notification or substantiation are still relevant when considering cumulative harm. Cumulative harm is identified if the pattern of harm over time is considered.</li> </ul>	<ul style="list-style-type: none"> <li>• There have been seven CCRs recorded for a child and their parents regarding domestic and family violence over two years. The child has developmental delays, low self-esteem, and self-harming behaviours which are likely to be the result of the cumulative effects of continuing domestic and family violence.</li> </ul>
<p><b>A parent has made a threat to cause serious harm to the child</b></p> <ul style="list-style-type: none"> <li>• A parent may make threats following actual physical harm. The threat may be to harm the child, another family member or a pet.</li> <li>• Threats involving the use of weapons or implements, where those weapons / implements are accessible, increases the likelihood of emotional and physical harm occurring, including death.</li> <li>• A parent threatening harm to a child may be in the context of domestic and family violence, which increases the risk of harm to a child.</li> </ul>	<ul style="list-style-type: none"> <li>• A child living in a fearful state due to threatening behaviour may exhibit bedwetting and soiling; sleep disturbances; nightmares; fear response to person responsible; anxiety/agitation/hypervigilance; or externalised emotional distress such as aggression. These may be indicators of emotional harm which may be cumulative in nature.</li> </ul>

<p><b>Accessibility of the perpetrator to the child</b></p> <ul style="list-style-type: none"> <li>• Probability of further harm occurring increases if the alleged person responsible has unlimited access to the child.</li> <li>• Research suggests that sexually abusive behaviours are compulsive or addictive - people with a history of sexual offences against children have a high rate of recidivism.</li> </ul>	<ul style="list-style-type: none"> <li>• Incidents of harm (for example, sexual abuse) may continue until the child is able to disclose to a protective person, or until the incidents meet the threshold for intervention, which may result in cumulative harm, in addition to any physical or emotional harm caused by any isolated incidences of harm.</li> </ul>
<p><b>Chronic neglect is identified</b></p> <ul style="list-style-type: none"> <li>• The chronic nature of neglect has a cumulative impact on a child’s functioning and their future emotional, behavioural, cognitive, social and physical development and well-being.</li> <li>• The chronicity of the neglect can be impacted on by factors such as the number of children in the home, the age of children in the home (younger children increases the risk), any developmental / physical disability, and / or parental substance use or mental health concerns.</li> </ul>	<p>Neglect may occur due to:</p> <ul style="list-style-type: none"> <li>• inadequate supervision, causing death or physical injury, resulting in physical harm.</li> <li>• failure to meet medical needs, causing lifelong physical health problems, resulting in physical harm or cumulative harm.</li> <li>• failure to protect, leading to physical, emotional or psychological harm.</li> </ul>
<p><b>There is previous departmental history</b></p> <ul style="list-style-type: none"> <li>• All previous history including child concern reports, and unsubstantiated and substantiated investigation and assessments should be considered and critically reviewed - any reports may indicate cumulative harm.</li> <li>• Risk of further harm increases if harm has previously been substantiated.</li> </ul>	<ul style="list-style-type: none"> <li>• A child may exhibit a variety of behaviours to indicate they have been significantly impacted by any previous concerns, such as being shy, withdrawn, exhibiting uncommunicative behaviours; hyperactivity, aggression, regressive behaviours; developmental delays; behaviours associated with anxiety or depression. These may be indicators of emotional harm.</li> </ul>
<p><b>1.2 Risk Factors – Child</b></p>	
<p><b>Child risk factors and practice prompt / explanation</b></p>	<p><b>Example of risk factor and resulting harm</b></p>
<p><b>Infant aged under 12 months</b></p> <p>An infant is more vulnerable due to their age and dependency on their carer. Risk of harm increases if the infant:</p> <ul style="list-style-type: none"> <li>• has been the subject child in a notification</li> <li>• is the result of an unwanted pregnancy</li> <li>• is born prematurely/drug dependent/subject to birth complications</li> <li>• is of low birth weight</li> <li>• has poor sleeping and / or feeding patterns; and/or</li> <li>• has an illness or disability.</li> </ul>	<ul style="list-style-type: none"> <li>• Slapping, kicking, pinching or shaking can result in physical harm. Any physical harm to an infant is significant.</li> <li>• Any shaking of an infant may cause brain damage without any external signs of injury, resulting in physical harm.</li> <li>• Failure to thrive or failure to obtain medical attention due to neglect may result in physical harm.</li> <li>• Poor attachment and lack of bonding may result in neglect of the child, rejection, scapegoating, or harsh discipline, resulting in physical or emotional harm.</li> </ul>

<p><b>Unsafe sleeping practices</b></p> <p>Unsafe sleeping practices have been linked to infant deaths. Unsafe practices include:</p> <ul style="list-style-type: none"> <li>• co-sleeping with a parent on medication/under the influence of drugs or alcohol</li> <li>• ill-fitting mattress and bedding</li> <li>• cluttered cots - soft toys and pillows that can cover an infant's face.</li> </ul>	<ul style="list-style-type: none"> <li>• A parent may use drugs, alcohol or other medication which impacts on their awareness and ability to meet an infant's needs, causing injury to limbs or suffocation of the infant if a parent's body or arms cover an infant's face / nose, resulting in physical harm or death.</li> </ul>
<p><b>Child aged under 5 years increases vulnerability</b></p> <p>Children aged under 5 years are more vulnerable to harm as they are:</p> <ul style="list-style-type: none"> <li>• unable to protect themselves and reliant on their parent to attend to their needs</li> <li>• are less verbal</li> <li>• are less able to communicate their needs</li> <li>• are less able to seek assistance</li> <li>• may display challenging toddler behaviours</li> <li>• may be isolated from others who may act protectively</li> </ul>	<ul style="list-style-type: none"> <li>• Shaking, hitting, dropping, or parental actions causing failure to thrive can result in physical harm.</li> <li>• Due to physical or emotional abuse or neglect, the child may experience developmental delays; attachment disorders; neurological changes to the developing brain (psychological harm).</li> <li>• A child under 5 years residing in a household where there is domestic and family violence is unable to protect themselves, which may result in physical harm from property damage; or emotional harm from ongoing anxiety or fearfulness.</li> </ul>
<p><b>A child has experienced past trauma</b></p> <ul style="list-style-type: none"> <li>• Any child who has experienced trauma (regardless of how the trauma was caused) resulting in traumatic stress makes them more vulnerable to harm and decreases the child's ability to protect themselves. They may be more likely to be significantly affected by any abuse or neglect they experience.</li> </ul>	<ul style="list-style-type: none"> <li>• A thirteen year old child who is a refugee who has experienced traumatic stress from war in her homeland goes into 'freeze' mode when domestic and family violence occurs in her household. She is unable to call the police or remove herself from the home when the violence is happening even though a child of her age may usually have some capacity to engage in these self-protective measures.</li> </ul>
<p><b>The child has significant diagnosed or apparent special needs which increases their vulnerability such as developmental delays, physical / intellectual disability, medical concerns</b></p> <ul style="list-style-type: none"> <li>• Stresses from managing daily care needs can affect the parent's ability to meet the needs of the child, impacting on parent - child attachment; communication; mobility and ability to access basic needs or supports both inside and outside the home.</li> <li>• A child with more than one disability is at greater risk of harm, with the level of harm likely to be more severe and chronic.</li> <li>• A child with a disability or diminished physical capacity may be:             <ul style="list-style-type: none"> <li>○ Unable to communicate their concerns or disclose harm</li> <li>○ Unable to protect themselves</li> <li>○ Isolated and unable to access safe adults</li> <li>○ Dependent on other people including people responsible for harm</li> <li>○ Less likely to receive education on sex and personal boundaries, therefore less likely</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• A parent neglecting to meet a child's medical needs, or excessively harsh discipline/ use of excessive physical force may result in physical harm.</li> <li>• Due to a child's developmental delays, a child may experience rejection, scapegoating, isolation from lack of social interaction, or abandonment resulting in emotional harm.</li> <li>• A child with a physical disability and complex communication needs relies on her father to communicate on her behalf. She is unable to disclose his abusive behaviour towards her as she is never given an opportunity to communicate with others alone.</li> </ul>

<p>to understand or recognise abusive behaviour.</p>	
<p><b>At risk / challenging behaviours</b></p> <ul style="list-style-type: none"> <li>• At-risk behaviours may be indicators of all harm types, with the behaviour being an attempt to cope with the impacts of the harm (including cumulative harm). At risk behaviours include:             <ul style="list-style-type: none"> <li>○ self-harming (for example cutting or burning)</li> <li>○ suicidal threats or behaviours</li> <li>○ substance misuse</li> <li>○ sexually reactive or sexually abusive behaviours</li> </ul> </li> <li>• A child of any age with challenging behaviours may have a higher likelihood of being harmed due to the greater potential for disruption to the parent – child attachment, increased parental stressors from managing difficult behaviours and resulting conflict with the child.</li> <li>• For children who have at risk / challenging behaviours, the parent may be willing to protect the child / young person but not be able to as the behaviours may occur outside the home, or the young person’s physical strength, or violent or threatening behaviours may preclude the parent from being able to protect the child.</li> </ul>	<ul style="list-style-type: none"> <li>• Self-harm; suicide attempts or suicide completion; overdosing; sexually transmitted infections; infectious diseases from shared syringes; or the use of physical force to intervene or attempt to manage a child’s behaviour may result in physical harm or death.</li> <li>• Low self-esteem; withdrawal and isolation from social networks; depression and anxiety or other mental health disorders may be indicative of emotional harm and can be cumulative in nature.</li> </ul>
<p><b>Youth Justice involvement / Offending behaviour</b></p> <ul style="list-style-type: none"> <li>• There are correlations between children and young people involved in the youth justice system and children and young people who experience abuse and neglect.</li> <li>• Children who experience or continue to experience trauma or maltreatment may exhibit anti-social behaviours; violent tendencies; developmental delays; reduced resilience; poor-impulse control; or remove themselves from the source of harm in the home, all of which can lead to offending behaviours and involvement in the youth justice system.</li> <li>• Children engaging in offending behaviour, in particular children age 12 and under, may not be receiving adequate parental supervision.</li> </ul>	<ul style="list-style-type: none"> <li>• A young person is continually coming into contact with the youth justice system due to their violent behaviours towards peers. It becomes apparent that the young person runs away from home, has poor impulse control and violent tendencies due to the physical and emotional harm they have experienced in their home environment.</li> </ul>

<b>1.3 Risk factors - Parent / primary caregiver</b>	
<b>Parent / primary caregiver risk factors and practice prompt / explanation</b>	<b>Example of risk factor and resulting harm</b>
<p><b>A parent has been responsible for harm to a child in the past</b></p> <p>If a parent has previously been identified as a 'person responsible' for harm to a child in the past, there is an increased likelihood that harm to that child will reoccur or another child will be harmed by the parent, unless significant positive changes have occurred regarding:</p> <ul style="list-style-type: none"> <li>the relationship between the child and parent</li> <li>the relationship between the parent and any other children in the family</li> <li>the parent's behaviour / parenting skills</li> <li>their environment.</li> </ul> <p>Harm may be cumulative in nature - the history and pattern of harm should be considered to assess impacts of cumulative harm.</p>	<ul style="list-style-type: none"> <li>Established parenting patterns failing to meet the child's needs such as poor impulse control; low tolerance thresholds; poor anger management; or reactive parenting practices such as excessive discipline may all result in physical harm.</li> <li>Chronic scapegoating and rejection may result in emotional harm.</li> <li>The parents' ongoing failure to meet daily care needs may result in physical or emotional harm due to chronic neglect.</li> </ul>
<p><b>Inconsistent explanations, denial and / or minimisation of harm by a parent</b></p> <ul style="list-style-type: none"> <li>May suggest a non-accidental injury.</li> <li>A parent minimising current harm, justifying the behaviour that led to harm or not recognising / denying responsibility for the harm may lead to higher risk in the future.</li> </ul>	<ul style="list-style-type: none"> <li>If the parent minimises a child's physical injuries or illness and fails to seek medical attention, a child's condition can worsen causing further physical harm or death.</li> <li>If a parent continues to deny their actions have caused harm or does not recognize the concern regarding their actions, parental behavior may continue to result in emotional / physical harm, and may result in cumulative harm.</li> </ul>
<p><b>A parent is refusing access to the child, the family is likely to flee or the family is highly mobile</b></p> <ul style="list-style-type: none"> <li>If parents are refusing access to a child, it may be to avoid further assessment of notified harms.</li> <li>A highly mobile family decreases the opportunity for effective interventions to be established, increasing the likelihood of future harm to the child.</li> <li>Tracking of families can be difficult if highly mobile, with previous child protection history not being identified or readily accessible.</li> </ul>	<p>Harms from high mobility may include:</p> <ul style="list-style-type: none"> <li>Disrupted education resulting in cumulative harm such as developmental delays.</li> <li>Isolation and disruption to peer and family relationships resulting in emotional harm.</li> <li>Basic shelter and material needs not being met resulting in physical / emotional harm.</li> </ul>
<p><b>Lack of willingness or ability to prioritise the child's needs over their own</b></p> <ul style="list-style-type: none"> <li>Immaturity and psychological and cognitive issues can impact on a parent's ability to tend to the needs of a child over their own needs for security, affection and attention.</li> <li>Substance dependency may impact on the ability to provide basic care to a child as the</li> </ul>	<ul style="list-style-type: none"> <li>Neglect can occur due to unmet basic needs, for example malnourishment due to not being fed; injury due to lack of supervision; sickness due to lack of appropriate clothing or access to medical care, resulting in physical or emotional harm.</li> </ul>

<p>parent's need to use a substance is a higher priority.</p> <ul style="list-style-type: none"> <li>Domestic and Family Violence can be a contributing factor to a parent's ability to prioritise a child's needs over their own.</li> </ul>	
<p><b>Parental expectations of the child are unrealistic</b></p> <ul style="list-style-type: none"> <li>A parent may be unaware of childhood developmental milestones and appropriate behaviour and disciplining techniques consistent with the age and developmental phase of the child.</li> <li>A child may be given responsibility to care for themselves and younger siblings at an inappropriate age; or is restricted from participating in age appropriate activities.</li> </ul> <p><i>Note: Practitioners must consider that Aboriginal and Torres Strait Islander families have a community focus on child rearing practices and this kinship system can define the roles and responsibilities children have which can differ from existing non-Indigenous definitions of family. Children may be given more responsibility at a younger age within their home and community in regard to the care of siblings and extended family members. The child's capacity to manage this responsibility may not be deemed by age but rather when the family decide on the need and the child's ability.</i></p>	<ul style="list-style-type: none"> <li>Harsh physical discipline or inattention to physical and hygiene needs of a young child may result in physical harm.</li> <li>A 7 year old child placed in the role of surrogate parent to their younger siblings may affect their ability to develop healthy sibling and peer relationships, resulting in emotional harm.</li> </ul>
<p><b>Insecure or disorganised attachment between the parent and child</b></p> <ul style="list-style-type: none"> <li>Secure attachment occurs when a parent provides consistent care and is responsive to the needs of the child - with the significant time for the development of primary attachment being from around six to eighteen months of age.</li> <li>If a parent is unable to or does not respond to the child's needs, insecure attachment results, with a child showing avoidant or ambivalent behaviour towards the parent and others.</li> <li>Disorganised attachment is evident in some children who have suffered harm through impacts of chronic family violence, or whose parents misuse substances.</li> <li>Disorganised attachment in infancy has been linked to complex trauma and a higher risk of behaviour problems in later childhood, adolescence and adulthood.</li> </ul>	<ul style="list-style-type: none"> <li>A child may exhibit indiscriminate friendliness with adults, misinterpreting boundaries and placing them in high risk situations, resulting in physical or emotional harm due to sexual or physical abuse.</li> <li>Rejection and scapegoating due to a poor attachment may result in emotional harm.</li> <li>By adolescence, truancy; self-harm; chronic attention seeking behaviours; or substance abuse may be indicators of a disorganised attachment resulting in emotional harm.</li> </ul>
<p><b>Young parental age – under 20 years at birth of first child; or immaturity</b></p> <ul style="list-style-type: none"> <li>Risk of harm generally increases for parents of a younger age as it may indicate immaturity, a lack of acquired parenting knowledge, and an inability to tolerate stress given a less mature developmental phase.</li> <li>Young parental age may also link to lower educational achievement, lower self-esteem, substance misuse and housing and financial pressures. If these multiple factors exist together the risk of harm is increased.</li> </ul>	<ul style="list-style-type: none"> <li>If the parent has insufficient knowledge and ability to meet a child's dietary, hygiene or physical care needs this may result in physical harm.</li> <li>If the parent has insufficient knowledge and ability to meet the child's attachment needs for warmth, care and emotional nurturing, this may result in emotional harm.</li> </ul>
<p><b>A parent's behaviour is violent</b></p> <ul style="list-style-type: none"> <li>A person who uses violence (physical force) in any context is more likely to use violence with</li> </ul>	<ul style="list-style-type: none"> <li>A child may be deliberately pushed, hit or shaken, causing death or injury.</li> </ul>

*Appendix 1: Risk and protective factors relating to harm; the child; the parent; the family context; and the environment.*

<p>a child.</p> <ul style="list-style-type: none"> <li>• Use of violence links to the ability to exert ongoing power and control over family members.</li> <li>• Threats of violence towards a child or another person in the household may also indicate a likelihood of actual violence in the future.</li> <li>• Threat of further violence may be based on one incident of actual violence that occurred in the past; however the resulting harm from ongoing fear can be cumulative.</li> <li>• Domestic and family violence can limit a non-offending caregiver's ability to meet a child's needs; or exacerbate existing concerns (such as substance use or mental health concerns).</li> </ul>	<ul style="list-style-type: none"> <li>• A child may be punched or kicked accidentally, or have objects thrown at them if domestic and family violence is occurring in the home, resulting in physical harm.</li> <li>• If a child lives in a fearful environment and experiences their non-offending caregiver being physical or verbally abused, the child may become wary of adults; overly compliant; experience mental health conditions, resulting in emotional harm.</li> </ul>
<p><b>A parent is impulsive</b></p> <ul style="list-style-type: none"> <li>• Research indicates that parent who has poor impulse control may be more likely to engage in inappropriate parenting practices such as negative comments, physical threats or physical behaviour management practices.</li> <li>• Parental impulsivity may link to gambling, drug and alcohol use, or anger management which may impact on parenting capacity.</li> </ul>	<ul style="list-style-type: none"> <li>• A parent may physically lash out at their child on an ongoing basis, resulting in physical and cumulative emotional harm.</li> </ul>
<p><b>A parent has an intellectual or physical disability, previous or current mental health concerns, a substance misuse problem and / or past or current criminal history (including as a juvenile)</b></p> <ul style="list-style-type: none"> <li>• These factors may impact on a parent's ability to provide care to their child and respond to their child's emotional and physical needs.</li> <li>• Parental behaviours may include disinhibition, mood swings and poor impulse control - leading to low tolerance, agitation, frustration, or an inability to control emotional outbursts.</li> <li>• If treatment for a mental health condition or addiction is ceased without medical supervision any risks to the child are significantly increased.</li> <li>• If another household member has a diagnosed disorder or known history this should also be taken into account when assessing immediate safety and risk of further harm.</li> <li>• Criminal history may relate to violence, intimidation, substance misuse, theft, or prostitution and indicate a parent with intergenerational abuse issues, low self-esteem, poor impulse control, aggression, or addictions (gambling, substances).</li> </ul>	<ul style="list-style-type: none"> <li>• A parent may leave the child with an inappropriate carer or unsupervised, resulting in physical harm.</li> <li>• A child may sustain needle stick injuries or ingest drugs, resulting in physical harm.</li> <li>• A parent's inability or unwillingness to manage their mental health symptoms may result in emotional or physical harm, and be cumulative in nature.</li> <li>• In unborn children, physical harm relating to foetal alcohol syndrome disorder and chemical dependency at birth needs to be considered.</li> </ul>
<p><b>Single parent status</b></p> <ul style="list-style-type: none"> <li>• Research has identified single parents face increased financial pressures, higher stress levels and isolation, with less access to emotional and social supports.</li> <li>• The status of single parent may have arisen from separation, divorce or death of a partner, placing further stresses on the family through loss and grief.</li> <li>• Single parent status is not in itself a risk factor but may be when other factors are present in the family.</li> </ul>	<ul style="list-style-type: none"> <li>• Parental stressors may lead to anxiety, depression and emotional issues, impacting on their ability to appropriately care and meet the needs of a child which may result in physical or emotional harm, including as a result of neglect.</li> <li>• If sole parents of infants are sleep deprived or experience undiagnosed post-natal depression, they may shake / hit the child, resulting in physical harm.</li> </ul>

<p><b>Male in household as partner of parent</b></p> <ul style="list-style-type: none"> <li>• Presence of a step-parent or person undertaking a parenting role with a non-biological child has been identified as a risk factor.</li> <li>• Causative factors may relate to bonding and attachment issues, less sensitive care giving, poorer quality of interactions, and viewing parenting as burdensome or not their role of choice in a relationship.</li> </ul>	<p>All harm types can be exacerbated by this factor, with strong links to:</p> <ul style="list-style-type: none"> <li>• Physical harm due to physical assaults by a male towards an unrelated infant/child</li> <li>• Physical / emotional harm, due to sexual abuse by a step-parent</li> <li>• Emotional abuse due to scapegoating and rejection.</li> </ul>
<p><b>1.4 Risk factors - Family context and interactions</b></p>	
<p><b>Family context risk factors and practice prompt / explanation</b></p>	<p><b>Example of risk factor and resulting harm</b></p>
<p><b>The parent has experienced childhood abuse</b></p> <ul style="list-style-type: none"> <li>• Parenting skills are believed to largely be learned/modelled from childhood experiences. The intergenerational transmission of abuse occurs when parents who have been physically, emotionally or psychologically harmed as children use the same harmful parenting behaviours on their own children.</li> <li>• Research indicates there is a risk that a person may become a perpetrator of sexual abuse if they experienced sexual abuse as a child and have normalised this experience over time.</li> </ul>	<ul style="list-style-type: none"> <li>• Excessive or inappropriate discipline learned from prior family interactions may result in physical harm</li> <li>• Disorganised attachment and enmeshment issues perpetuated by poor family relationships may result in emotional and psychological harm.</li> <li>• Sexual abuse from parent or others as parent minimises or fails to recognise harm from sexually abusive incidents; inappropriate touching; and/or lack of appropriate boundaries may result in physical or emotional harm.</li> </ul>
<p><b>There is domestic and family violence occurring</b></p> <ul style="list-style-type: none"> <li>• Whenever a parent is using violence or coercion towards another parent or partner, this is always experienced by a child. They may experience their parent being physically abused, parental injuries, property damage, threats and manipulation, and / or intervening or experiencing harm from physical assaults and property damage.</li> <li>• A non-offending parent's ability to protect and to meet a child's needs may be impacted by violence and coercion perpetrated by a partner or other family members even if they do not reside with the child fulltime.</li> <li>• The non-offending parent may be or appear to be unable to act protectively due to fearing for their own safety or the safety of their child, for example the perpetrator has made threats of murder / suicide if the non-offending parent attempts to leave with the children.</li> <li>• The non-offending parent may over-discipline a child in an attempt to control the child's behaviour and protect them from the perpetrator's violent and controlling behavior.</li> </ul>	<ul style="list-style-type: none"> <li>• Physical harm may result due to a child being hit by an object during property damage, or by physically intervening if a perpetrator is harming the non-offending parent.</li> <li>• A child living in a threatening and controlling environment may develop anxiety or PTSD symptoms; exhibit regressive or aggressive behaviours; or have toileting issues, which may be indicative of emotional and / or cumulative harm.</li> </ul>
<p><b>The family is experiencing a high degree of stress</b></p> <ul style="list-style-type: none"> <li>• Research indicates that the greater the stress for a parent the greater the likelihood of future harm for a child.</li> </ul>	<ul style="list-style-type: none"> <li>• Due to poor impulse control when stressed, physical abuse resulting in physical harm may occur.</li> <li>• Emotional harm may occur as a parent takes out frustrations</li> </ul>

*Appendix 1: Risk and protective factors relating to harm; the child; the parent; the family context; and the environment.*

- Stressors may include separation/divorce; financial issues; physical or emotional isolation; health issues; and grief and loss.
- Larger numbers of children in a family or multiple births may also lead to increased stresses.

verbally on a child, or distances themselves from the child as a coping mechanism or as a consequence of depression.

<b>1.5 Risk Factors – Environmental Context</b>	
<b>Environmental risk factors and practice prompt / explanation</b>	<b>Example of risk factor and resulting harm</b>
<p><b>The physical and social environment is chaotic, hazardous and unsafe</b></p> <ul style="list-style-type: none"> <li>• A chaotic, unhygienic, unsafe physical environment can pose a risk to a child's health or safety.</li> <li>• The behaviour and ability of the parent to protect the child within the environment should be assessed to ascertain whether: the parent's functioning contributes to the environment being unsafe, unhygienic or chaotic; any safety strategies have been provided to protect the child in this environment.</li> <li>• A family's social environment may be considered chaotic or hazardous due to lifestyle choices made by the parent, for example, being a member of a peer group that uses illegal substances or is involved in criminal or violent behaviours.</li> </ul> <p><i>Cultural consideration note: In some areas, the choice of housing may be limited and yet adequate by community standards. The consideration is whether the current housing conditions pose a threat to the child's safety as a result of inadequate parental provision of basic care. If community living conditions are not related to inadequate parental provision of basic care, consider a referral to other relevant council or government services.</i></p>	<ul style="list-style-type: none"> <li>• Exposure to bacteria / disease; or exposure to hazards such as hot water, stairs, swimming pools and heights (for example, windows and balconies in disrepair) may result in physical harm.</li> <li>• A chaotic environment may result in emotional harm and sexual abuse through exposure to multiple unknown adults if there is inadequate parental supervision.</li> </ul>
<p><b>Poor social networks and isolation from services</b></p> <ul style="list-style-type: none"> <li>• A lack of support services; inability to access infrastructure such as parks, transport, shops, schools and child care; and low levels of family and social support can heighten the probability of harm occurring as the child may not be visible and engaging in the community and supportive intervention is not available.</li> <li>• Social isolation may be more prevalent in rural and remote areas, and for families of minority cultural groups.</li> </ul>	<ul style="list-style-type: none"> <li>• Post-natal care, and educational and child care facilities cannot be accessed, resulting in neglect of the child and subsequent developmental delays and associated harms.</li> <li>• A child who is isolated and not visible to protective support agencies may experience any type of harm, which may continue due to the absence of intervention and support resulting in cumulative harm.</li> </ul>
<p><b>Poverty impacting on employment opportunities and / or housing stability and homelessness</b></p> <ul style="list-style-type: none"> <li>• Poverty and unemployment may be linked to residing in a disadvantaged community, with associated inability to access services and locate and afford adequate housing.</li> <li>• Linked to low family income and other stressors, housing instability can impact on the child's learning, social and developmental needs.</li> <li>• Housing instability may be the result of a parent leaving a violent partner or household member - an action taken to protect the child.</li> </ul>	<p>Disadvantage may lead to neglect resulting in physical and emotional harm through:</p> <ul style="list-style-type: none"> <li>• poor medical, nutritional and dental care</li> <li>• unsafe housing standards for children's needs</li> <li>• disrupted education - impacting on cognitive and social development</li> <li>• increased mobility.</li> </ul>

<p><b>Cultural context</b></p> <ul style="list-style-type: none"> <li>• Cultural significance can be placed on families with regard to gender of children, family values about supervision, the provision of types of medical care, and the role of children within the family. These cultural values and rituals may conflict with the predominant culture and statutory child protection thresholds.</li> <li>• When assessing cultural considerations, information about the culture, beliefs, values and practices should be obtained from the family and verified by a service provider or similar representing that culture.</li> </ul>	<ul style="list-style-type: none"> <li>• If the child is of unwanted gender, this may leading to rejection by parents / extended family resulting in emotional harm.</li> <li>• Physical harm may occur through rituals that are not accepted in wider society e.g. female genital mutilation.</li> </ul>
<p><b>2.1 Protective factors - Child based</b></p>	
<p><b>Child based protective factor practice prompt / explanation</b></p>	<p><b>Example of protective factor</b></p>
<p><b>The child has skills and abilities that may provide a degree of self-protection</b></p> <ul style="list-style-type: none"> <li>• The child’s ability to remove themselves / seek assistance may be considered a protective factor in relation to physical harm. While this may help protect them from immediate physical injury, it is not the child’s responsibility to protect themselves from harm.</li> <li>• It is a misconception that young people can protect themselves from all forms of harm as it is difficult for any person to predict the behaviour of others. To assess skills and abilities as a protective factor, the impact of the overall harm on the child needs to be considered.</li> <li>• While children aged 10 years and over are more likely to have problem solving and social skills and abilities, the impact of any special needs such as developmental delays, or learning / intellectual / physical disability must be considered.</li> </ul>	<p>Some measure of safety may be provided if the child:</p> <ul style="list-style-type: none"> <li>• Is able to use the telephone</li> <li>• Can leave a dangerous or volatile situation</li> <li>• Can request police or other assistance regarding domestic and family violence or other dangerous circumstances</li> <li>• Can go to the home of supportive others</li> <li>• Has the verbal ability and opportunity to disclose factors that may contribute to harm.</li> </ul>
<p><b>The child has access to an effective safety and support network, is monitored through these supports and has positive relationships with significant others.</b></p> <ul style="list-style-type: none"> <li>• Where the child is seen on a regular basis by a school, day care centre, health centre and/or knows that they can talk about their current circumstances, a measure of safety may be provided for the child.</li> <li>• The protective factor is the presence of an effective safety and support network who know about the harm and worries and are able to adequately respond to the child’s needs.</li> <li>• Open, clear communication about expectations, roles and responsibilities is necessary if the safety and support network is to undertake an active role in keeping the child safe.</li> </ul>	<ul style="list-style-type: none"> <li>• A child may only seek support if there is a positive relationship within the safety and support network and the child has a sense of belonging to that environment.</li> <li>• Encouraging positive relationships and supporting this contact may counteract risk of harm as it assists the child in accessing already available supports.</li> </ul>
<p><b>Child with a strong sense of personal control</b></p> <ul style="list-style-type: none"> <li>• A child may demonstrate a belief that they can control the impact of harm that has occurred, rather than the harm controlling them.</li> <li>• Characteristics of resiliency within a child may act to prevent the internalisation of the impacts</li> </ul>	<ul style="list-style-type: none"> <li>• Risk of harm may be mitigated if the child presents as resilient, autonomous, mature, can plan ahead, and is not dependent on others to find solutions to problems.</li> </ul>

<p>of harm such as depression and anxiety.</p>	
<p><b>Connection to culture</b></p> <ul style="list-style-type: none"> <li>• Strong connections to culture and a sense of cultural pride can promote a child’s resilience.</li> <li>• There may be cultural factors that promote a child’s health, safety and wellbeing, for example the presence of safe and effective kinship networks, an ability to engage in traditional food sourcing practices or customs that increase a child’s sense of worth and place within their family.</li> </ul>	<ul style="list-style-type: none"> <li>• Risk of harm to a child with strong cultural connections may be mitigated due to the child having developed strong resilience and having trusted community members to provide safety, guide and support them.</li> </ul>
<p><b>2.2 Protective factors - Parent based</b></p>	
<p><b>Primary parent / caregiver based protective factor prompts / explanation</b></p>	<p><b>Example of protective factor</b></p>
<p><b>Appropriate treatment or assistance for the child has been sought</b></p> <ul style="list-style-type: none"> <li>• If the parent is providing an accurate account of how the injury or condition occurred and is seeking treatment and support for the child, this may indicate parental awareness of the significance of the harm and risk of harm.</li> </ul>	<ul style="list-style-type: none"> <li>• A parent may act against the wishes of the other parent / person responsible and access medical attention for a child who has been physically harmed or sexually abused.</li> </ul>
<p><b>The parent acknowledges harm to the child, takes responsibility for change and / or has the capacity to prevent future harm</b></p> <ul style="list-style-type: none"> <li>• A parent who acknowledges their role in a harmful incident / condition and takes responsibility for their actions, may be more willing to engage with appropriate supports and work to change the harmful circumstances to ensure the future safety of the child. However, a parent does not need to make an admission regarding harm to a child in order for them to act protectively and address the child protection concerns. A parent’s views on the harm needs to be considered as part of the broader risk assessment.</li> <li>• In assessing a parent’s actual capacity to prevent future harm, their ability to protect must be assessed with particular emphasis on any impediments to that ability (for example, substance misuse, domestic and family violence, Family Court residency and contact orders).</li> </ul>	<ul style="list-style-type: none"> <li>• A parent may engage in legal action to apply for a domestic and family violence protection order or change current Family Court orders to prevent access to the child by the person responsible for the harm.</li> <li>• Court orders do not guarantee the child’s safety but a level of protection may be provided.</li> <li>• A parent with limited parenting skills engages in a parenting program resulting in a behavioral change of increased parenting capacity.</li> </ul>
<p><b>A parent who has secure relationships with others</b></p> <ul style="list-style-type: none"> <li>• Secure and supportive relationships with other significant people may buffer against the effects of stress and facilitate positive coping strategies.</li> </ul>	<ul style="list-style-type: none"> <li>• Where parent - adolescent conflict exists, a parent who has a positive relationship with extended family members may be able to access support and assistance prior to conflict occurring, including arranging family supports for the young person.</li> </ul>
<p><b>Secure attachment between the parent and child</b></p> <ul style="list-style-type: none"> <li>• Secure attachment occurs when a parent provides consistent care and is responsive to the needs of the child - with the significant time for the development of primary attachment being from around six months to eighteen months of age.</li> </ul>	<ul style="list-style-type: none"> <li>• If a parent and child share a secure attachment, this may increase the parent’s willingness to protect the child from harm and reduces the risk of emotional abuse occurring such as rejection or scapegoating.</li> </ul>

<ul style="list-style-type: none"> <li>• A secure attachment supports a child’s healthy brain development, and social and emotional development, and helps a child to learn to regulate their emotions</li> </ul>	
<b>2.3 Protective factors - Family based</b>	
<b>Family based protective factor practice prompts / explanation</b>	<b>Example</b>
<p><b>There is a person present who is able and willing to protect the child, including extended family members</b></p> <p>A protective person is someone who:</p> <ul style="list-style-type: none"> <li>• is aware of the harm and wants to protect the child</li> <li>• understands how harm occurred and acknowledges any likelihood of future harm</li> <li>• does not pose a risk to the child themselves</li> <li>• possesses significant influence with the child and their parent</li> <li>• will be able to effectively protect the child from the identified harm or risk of harm by their presence.</li> </ul> <p>In assessing if risk of harm may be reduced, the frequency and regularity of contact with the protective person should be considered.</p>	<ul style="list-style-type: none"> <li>• A person’s immediate presence may decrease the risk of physical harm and provide a positive role model for the person responsible for harm.</li> <li>• The crucial question to ask is, "Is the presence of this person going to reduce the risk of harm, and will they be present / accessible to reduce the risk of harm?"</li> <li>• Extended family members may be able to immediately intervene and provide food, shelter, and/or child care when the parent cannot.</li> <li>• Respite arrangements may also be arranged through protective extended family.</li> </ul>
<p><b>There are clear household boundaries, routines and structure</b></p> <ul style="list-style-type: none"> <li>• Predictable routines can mitigate against chaotic stress and provide a sense of security to the child.</li> </ul>	<ul style="list-style-type: none"> <li>• Family boundaries where parent and child relationships are delineated may decrease the likelihood of sexual abuse occurring.</li> <li>• Clear boundaries may counteract the influences that place a child in a parental role.</li> </ul>
<b>2.4 Protective factors - Environmental based</b>	
<b>Environmental based protective factor practice prompts / explanation</b>	<b>Example</b>
<p><b>The family is supported by a professional network</b></p> <ul style="list-style-type: none"> <li>• Contact with another professional or community agency may reduce parental stress and increase their ability to cope.</li> <li>• A professional support network may act to improve the family's functioning and reduce the likelihood and severity of future harm by enabling access to housing, income and support services.</li> </ul>	<ul style="list-style-type: none"> <li>• A domestic and family violence service may offer a variety of programs for the family - a perpetrator program; housing assistance for the mother; counselling and support group for the child.</li> </ul>
<p><b>Adequate income and housing</b></p> <ul style="list-style-type: none"> <li>• By having basic income and housing needs met, stresses may be mitigated.</li> </ul>	<ul style="list-style-type: none"> <li>• Fewer stresses can decrease anxiety, increase self-worth and promote healthier parent - child relationships, buffering emotional harm and neglect.</li> </ul>

**Connection to culture / religion**

- Children, parents and families who reside in or near communities or neighborhoods where their culture / religion is recognised and able to be practiced can mitigate against harm through:
  - Increased sense of worth and belonging
  - Access to community / neighborhood supports
  - Access to people and opportunities for cultural practices that support emotional wellbeing.
- An Aboriginal mother residing in community could work with a trusted elder and use traditional bush medicine to support her healing. These practices increase her feelings of wellness and ability to meet the needs of her child.

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# Version history

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