PRACTICE GUIDE
Decision making at intake

At intake, practitioners need to establish:

- Whether the information received from a notifier, and any other professional contacted, indicates a reasonable suspicion that a child has been harmed and/or is at risk of harm if nothing changes for them in the future.
- Whether a child has a parent who is able and willing to protect them from that harm.

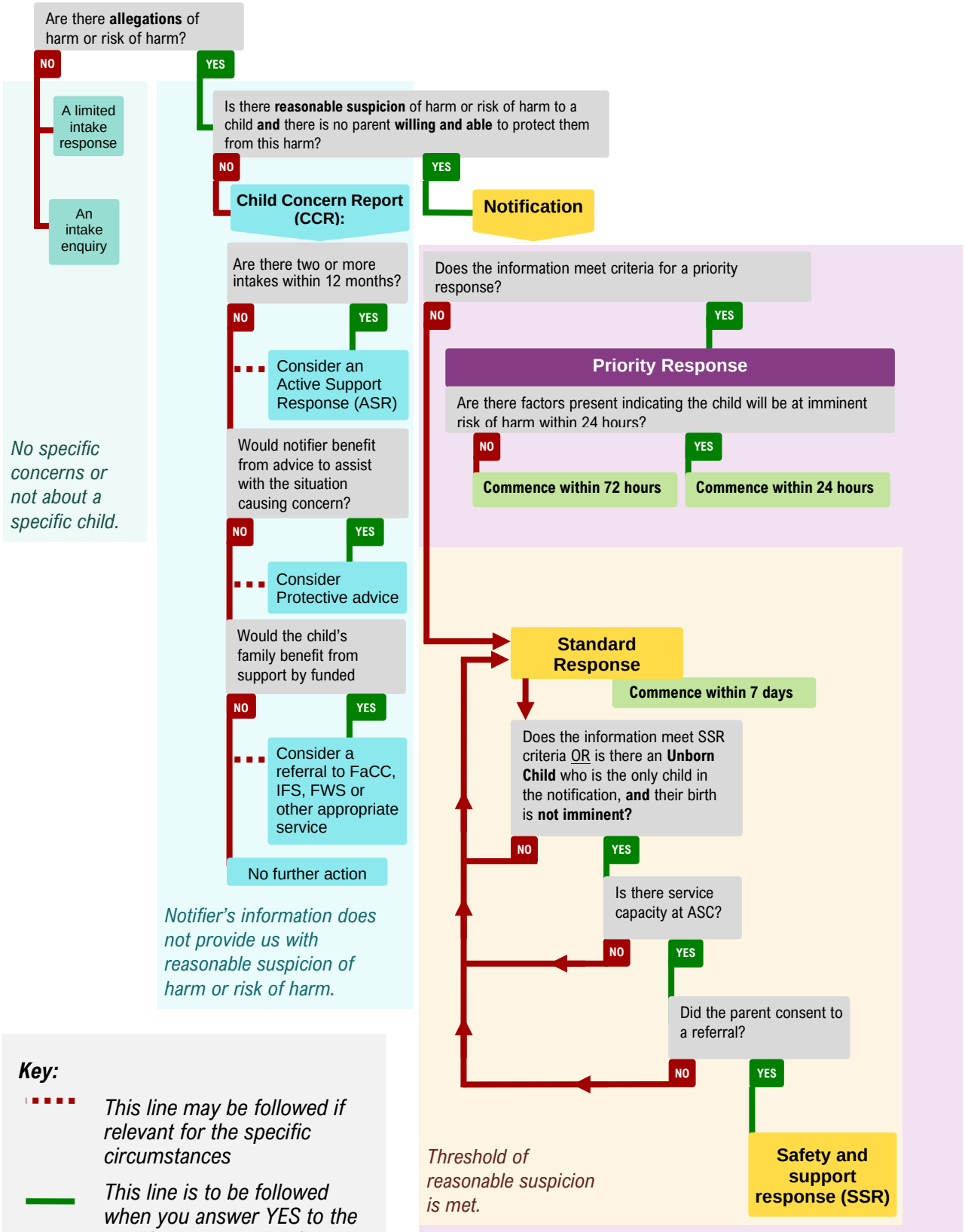
Intake matters will be finalised as either:

- an intake – limited intake response or intake enquiry
- a child concern report with an active support response, referral for family support, protective advice or no further action
- a notification with a priority response, standard response or safety and support response.

This guide assists practitioners to understand and undertake the intake process:

- receive and gather information
- analyse that information
- form a judgement and
- make a decision about the response needed.

Intake: Decide the response



Key:

- *This line may be followed if relevant for the specific circumstances*
- *This line is to be followed when you answer YES to the practice prompt question.*
- *This line is to be followed when you answer NO to the practice prompt question.*

Queensland Government

Important definitions

Child's home

A child's home is where the child lives, with a parent or parental figure (including a person recognised under Aboriginal tradition or Island custom who is regarded as the child's parent).

It is recognised that some children may have more than one place they call home, and some children may have many members of their home who provide care to them. A child's home extends beyond their physical environment/house where they reside or spend their time and may include parents and caregivers who do not live with them. The focus on a child's home:

- helps to ensure that assessments are on the child and their experience, rather than the person who is alleged responsible for the harm or risk of harm and their behaviour
- provides clarity about who the relevant people are for the purposes of assessing the child's safety and wellbeing.

It is important to think about the safety of the child, regardless of where they live and maintain a focus on whether a child has a parent able and willing to protect them.

The meaning of a child's home also requires additional consideration for Aboriginal and Torres Strait Islander families, where cultural norms can differ from non-indigenous cultures.

Definitions of abuse

Physical abuse

Physical abuse involves the deliberate or reckless use of physical force against a child that causes injury, harm, pain, or trauma, or has a high likelihood of resulting in injury, harm, pain, or trauma, where it is clearly not reasonable corporal punishment.

This type of abuse may involve hitting, kicking, shaking, pushing, biting, burning and choking. It may also involve restraint, prevention of free movement or the use of implements or weapons against a child or young person. To note, any object can be used as a weapon. The focus is about the impact on the child and the potential for future danger.

Physical abuse can also include 'factitious disorder imposed on another' (previously known as Munchausen syndrome by proxy). This is where a parent or carer makes up the symptoms of an illness or causes the child in their care to become unwell.

Physical indicators of physical abuse	Behavioural indicators of physical abuse
• Broken or fractured bones, dislocations, or unexplained, suspicious or excessive bruises or injuries • bruising or marks showing the shape of an object • exposure to domestic and family violence resulting in or likely to result in the child experiencing physical injury – this can include direct and indirect harm • female genital mutilation • multiple scars of different sizes or ages • drowsiness, vomiting, abdominal pain, fits or dehydration • brain damage, skull or bone fracture, or subdural haemorrhage or haematoma • internal injury or poisoning • burns or scalds • bite marks or choke marks. To note strangulation marks may not always be physically observable and may include burst blood vessels in the face or eyes (not just marks on the neck).	• Child seeming to be accident prone • attempts to conceal an injury – for example wearing clothing to cover marks/bruises/injuries • the explanation for an injury seems unlikely or is inconsistent with the injury type • injuries that are inconsistent with the developmental stage of a child • injuries located in unusual areas of the body or there are multiple marks in the same area of the body • several different explanations provided for an injury • family use of different doctors and hospital emergency departments • unexplained delay in seeking treatment • failure to attend appointments • when the child presents for treatment, parents/carers absent without good reason, or uninterested in the injury • reluctance by child, parents/carers to give information or mention previous injuries • child uses unusual amounts of physical aggression in their play with peers or is engaging in bullying behaviour • children provided with alcohol or non-prescribed drugs.

Physical abuse considerations

- Is there an infant or young child who has been shaken or sustained suspicious injuries? For example, bruising on or to a non-mobile infant.
- Has the child required medical attention or intervention to address an injury?
- Are there any concerns about the child's physical appearance (including any injuries such as location, size, colour and probable cause)?
- Describe the injury and location of the injury (i.e. what part of the child or young person's body?).
- What is the physical condition of the child's home? Are there hazards that may contribute to or cause harm?

If the alleged harm to a child may involve the commission of a criminal offence, then there is a requirement under the *Child Protection Act 1999*, section 14(2) to report the information to the Queensland Police Service.

Sexual abuse

Child sexual abuse is any act that exposes a child or young person to, or involves a child or young person in, sexual activities that:

- they do not understand
- they do not or cannot consent to
- are not accepted by the community
- are unlawful.

Sexual abuse can cause emotional, psychological and physical harm and have a range of adverse impacts across the life course.

Child sexual exploitation is a form of sexual abuse where an individual or group targets child/ren under 18, who are manipulated, coerced or deceived into sexual acts. This can be in exchange for something (such as food, accommodation, affection, money or gifts) or for financial advantage, increased status or other reward for the person exploiting the child. Sometimes there is no reward, such as sharing of images. A child over the legal age of consent may have been sexually exploited even if the sexual act appears consensual. The exploitation can take place in person or via technology, or a combination of both.

Child sexual abuse can be physical, verbal or emotional in nature and includes contact and non-contact activities. Sexual abuse and child sexual exploitation may include (but is not limited to):

- sexual touching of any part of the body, either clothed or unclothed
- preparing or encouraging a child to engage in sexual activity
- sex or sexual acts of any kind with a child, both penetrative or non-penetrative (penetration is using fingers, penis or any other object and inserting them into a mouth, anus or vagina)
- persuading or forcing a child to engage in sexual activity, including forcing a child to masturbate, encouraging a child to perform sexual acts in front of a webcam, recording device or other technology
- young people receiving something (for example: food, accommodation, drugs, alcohol, cigarettes, affection, gifts or money) in return for participating in sexual activities
- engaging in any kind of sexual activity in front of a child, including watching pornography or sexually assaulting another family member in their presence
- taking, downloading, viewing, producing or distributing sexual images of children
- possessing images of child sexual abuse
- communicating in a sexual manner by phone or online (including “sexting”)
- grooming a child (or their parent or carer for the purposes of gaining access to the child).

Grooming refers to the manipulation and conditioning tactics used by some child sexual offenders to facilitate, initiate and continue sexual abuse of a child. Grooming most commonly includes behaviours targeted both towards the child themselves, and adults in their community who may act to protect them.

Grooming tactics act to increase the vulnerability of the child to being sexually abused and to the capacity of non-offending adults to protect the child.

It can be difficult to identify because the behaviour itself may not appear abusive or sexual to others and can, at times, appear to others to be loving or ordinary care. Grooming can often occur online and can occur for days, weeks or years before contact sexual abuse takes place.

Sexting is the act of sending intimate images or sexually explicit text messages or emails, usually via mobile telephones and other communication technologies. Its creation may be the result of image-based abuse and coercion and may have criminal implications. For more information refer to Respond to sexting.

Information that could potentially constitute a criminal offence requires referral to the Queensland Police Service in accordance with the *Child Protection Act 1999,* section 14(2).

Physical indicators of sexual abuse	Behavioural indicators of sexual abuse
• Bruising or bleeding in the genital area • sexually transmitted infections • pregnancy or pregnancy scares • bruising to breasts, buttocks, lower abdomen or thighs • headaches • stomach aches • bed-wetting • change in appetite or weight loss • nightmares or sleep disturbances • pain or burning when going to the toilet (Raising Children 2023).	• Mental health issues (depression, anxiety, post-traumatic stress disorder • suicidal thoughts or suicide attempt • non-suicidal self-injury • alcohol and other drugs misuse • poor physical self-care, a lack of grooming or attention to hygiene • body dysmorphia, including disordered eating or eating disorders • difficulties learning or concentrating or maintaining supportive relationships • engaging in risky sexual behaviour. For example, sexual intercourse at a young age, multiple sexual partners, unprotected sex. Each increases the risk of sexually transmitted diseases and infections including HIV, and sex work or exploitation • engaging in sexually aggressive, or unusual behaviour (for example, trying to 'tongue kiss' carers or family members, removing clothes in view of others and viewing sex as transactional)

Sexual abuse considerations

Sexual abuse rarely occurs in isolation, often occurring alongside other abuse and family dysfunction.

Gather comprehensive information from the notifier about the family's situation and context. This will contribute to the assessment which informs the intake decision.

Identify any power imbalances, as these are integral to the function of sexual abuse. The person engaging in sexually abusive behaviour most commonly holds power, responsibility or authority over the child they are abusing. Power differentials may include greater social status, wealth or access to resources, physical size, age, or level of ability. This increases the risk for children, who by nature of their age and development are additionally vulnerable.

Due to the shame and stigma associated with being sexually abused, the victim may not want to talk or disclose the abuse to others, both during childhood and as adults.

Experiences of domestic and family violence increase the vulnerability of children to:

- all potential sexual abuse perpetrators
- develop harmful sexual behaviour
- being subjected to harmful sexual behaviour by other children, including their siblings.

Harmful sibling sexual behaviour is one of the most common types of sexual abuse experienced by children (Yates & Allardyce, 2021).

Non-suicidal self-injury and suicidal thoughts are often indicators of underlying emotional distress, which may be associated with multiple abuse types including sexual abuse.

It is important to understand the range of appropriate sexual behaviours for children across the developmental stages. (Refer to Developmental and Harmful Sexual Behaviour Continuum at a Glance for detailed developmentally appropriate behaviour.)

Emotional abuse

Emotional abuse involves non-physical interactions with the child, which convey to a child they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs.

These interactions are typically persistent but may occur in isolation. From these interactions, the child's emotional, social or cognitive development has, or is likely to be, significantly impaired.

Emotional and psychological abuse is generally ongoing in nature and does not leave physical injuries. Often there is no specific 'crisis or incident' to identify this abuse. Emotional and psychological abuse frequently co-occur with other types of abuse.

Emotional or psychological abuse can have serious short and long-term effects on a child's health, emotional wellbeing and development. It can impact a child's:

- cognitive and emotional development
- executive functioning skills (how they manage emotions and prioritise tasks)
- stress responses
- ability to form relationships and express emotions.

Physical indicators of emotional abuse	Behavioural indicators of emotional abuse
• speech disorders • delayed physical development • substance abuse • ulcers, asthma, severe allergies • non-suicidal self-injury.	• constant feelings of worthlessness about life and themselves • overly self-reliant • difficulty in seeking emotional support from others • deliberately holding back or suppressing emotions • unable to value others • lack of trust in people • lack of people skills necessary for daily functioning • extreme attention-seeking behaviour • obsessively eager to please or obey adults • takes extreme risks, is markedly disruptive, bullying or aggressive • highly self-critical, depressed or anxious • persistent running away from home • suicidal thoughts or suicide attempt • non-suicidal self-injury • child may idolise or appear to idolise their abuser excessively • decline in mental health or social and emotional well-being • child may monitor the abuser and their reactions, as a way to increase safety.

Emotional abuse considerations
Emotional abuse can present as a sudden change in the child's demeanour, or a steady decline in the child's emotional presentation over time. Explore any concerns surrounding delayed development or a decline in schoolwork. The child may present as anxious, distressed or afraid and may present differently across environments (school, at home, or with friends and family). The child may appear withdrawn, or with a low self-image, self-esteem or confidence. Explore the child's feelings about their parents and what others have observed or reported about the child's attachment system.

The table below explains different types of emotionally abusive behaviours.

Type of emotionally abusive behaviour	Explanation
Bullying	This may include verbal humiliation, name-calling and undermining or mocking a child.
Emotional neglect	This includes a parent being psychologically unavailable, scapegoating, ignoring or depriving the child of stimulation, not showing affection, or not responding appropriately to a child's emotional needs.
Isolating the child	A parent puts unreasonable limitations on a child's freedom or restricts or prevents normal opportunities for social interaction.
Manipulation	This may include coercing or persuading a child to take part in activities that: • they are not comfortable with • are not appropriate for their age or stage of development • are unsafe • encourage the development of false social values, reinforcing antisocial or deviant behavioural patterns. For example, aggression, criminal acts or substance abuse. A parent may 'gaslight' to emotionally manipulate the child to doubt their own perception, judgment or memory.
Rejection	A parent may tell the child they are not good enough, exclude them from activities, not listen to the child's views or belittle the child. This may include a parent threatening to relinquish care of their child. A child may also experience rejection if their parent actively rejects their sexuality or gender identity.
Terrorising the child	This may include threatening violence or severe punishment, developing a climate of fear or threat, deliberately frightening or putting the child into a dangerous situation.

Type of emotionally abusive behaviour	Explanation
Parentification	Parentification describes a set of behaviours that occur in children when there is a distortion or lack of boundaries between children and family subsystems, such that children take on roles and responsibilities usually reserved for adults (Hooper, 2008). Research commonly separates parentification into emotional parentification and instrumental parentification: Emotional parentification is when the child participates in the 'socioemotional needs of family members and the family as a whole' (Jurkovic, Morrell & Thirkield 1999). The child may be described as a confidant, companion or mate-like figure for their parent. Instrumental parentification is when the child participates in the 'physical maintenance and sustenance of a family' (Jurkovic et al, 1999). The child may do the chores such as grocery shopping, cooking, house cleaning or caring for parents and siblings to a level not expected for their cultural background, age or stage of development. Indicators of parentification can be signs of emotional abuse or neglect.

Neglect

Neglect involves the failure by a parent or caregiver to provide the child with the basic necessities of life, as suited to the child's developmental stage, and as recognised by the child's cultural context. Neglect normally involves a pattern of repeated conduct but may be a single omission in severe circumstances.

A child is experiencing neglect if their basic needs (for food, clothing, shelter, medical and dental care, parental supervision, parenting, care and protection) are not being met to the extent that it is negatively impacting the child's growth and development.

Physical indicators of neglect	Behavioural indicators of neglect
• low weight for age • failure to thrive and develop • untreated physical problems such as sores, serious nappy rash, scabies, head lice and urine scalds, dental decay • poor standards of hygiene, for example a child or young person consistently unwashed • untreated health and medical issues that can lead to infections and/or long term health issues • child abandoned or relinquished with no arrangements for care.	• child not adequately supervised for their age • scavenging or stealing food and focus on basic survival • extended stays at school or public places • longs for or indiscriminately seeks adult affection • rocking, sucking, head-banging • poor school attendance.

Considerations for neglect

Be alert to cumulative harm in cases of chronic neglect, characterised by an unremitting low level of care. It is critical to consider the harm neglect causes (it is no 'lesser problem' than other forms of maltreatment) as evidence clearly demonstrates the consequences can be damaging.

When domestic and family violence is also identified, neglect (including medical neglect), may occur as an outcome of economic abuse or control the person using violence exerts over the family.

In the context of parents misusing substances, neglect may occur where parents are unable to respond to the needs of the child's due to the impairment the drugs or alcohol creates.

The child's basic needs (shelter, food, medical) may not be provided as the parents' prioritise their drug use or addiction.

Although poverty and child neglect are linked, not all children experiencing poverty are neglected.

When limited household resources are identified, consider if distribution of those resources is meeting the needs of the child.

Neglect occurs due to the action or inaction of a parent, which must be differentiated from poverty which is a state that a family experience as opposed to inflict.

Unsafe or unhygienic households can cause harm and need to be considered for the specific child's vulnerability (including their age, stage of development including any disability).

Neglect is often portrayed as the 'fault' of mothers, while failing to take into account the role of neglectful fathers (Scott, 2014). Both parents should be held to the same parenting standard.

The table below explains different types of neglect.

Type of neglect	Explanation
Lack of supervision	Caused by parental absence or inattention and can lead to physical harm (for example injury or sexual abuse). The inattention may be the direct result of: • drug or alcohol use • any related 'crash cycle' as the parent withdraws from the substance • the pattern of drug or alcohol misuse For example, allowing children to play on a busy road, not arranging for an appropriate person to supervise the children, or leaving an infant in the care of an adult who is affected by alcohol or other drugs. Each of these, place the child at risk of harm. By law in Queensland, children under 12 years should not be left for an unreasonable amount of time without supervision and care.
Physical neglect	Failing to provide a child with age-appropriate physical necessities including food, clothing, suitable shelter. For example, unstable living arrangements, or unsafe living space (access to needles, broken glass, faeces, weapons or chemicals) that pose specific risks to the child.
Medical neglect	Failing to provide required medical care for a child or acknowledge the seriousness of a child's illness, disability or condition. This can include deliberately withholding appropriate care. This includes circumstances where the parent's religious beliefs inhibiting required medical interventions, for example, withholding blood transfusions. Seek medical advice to determine the impact of medical mismanagement or neglect on the child at Intake, to inform the risk assessment.
Educational neglect	Failing to support a child to receive and participate in the education system. This includes enabling or allowing a child to miss school or preventing their attendance without an appropriate reason.
Abandonment	When a child is left alone for a significant period and the parent has not put any alternative arrangements in place for the child's care.
Emotional neglect	Failing to provide the child with adequate nurturing, affection, encouragement and support. If a parent calls the child names, or actively isolates and demeans the child, this can also be regarded as emotional abuse.

Failure to protect	When a parent is unable or unwilling to protect a child who has been harmed, or is at risk of further harm, by allowing access to a child by someone else. This is only applicable where a parent knows of the risk of abuse posed by the other person and have the power or responsibility to reduce or remove the risk, but negligently fails to do so. Failure to protect includes: • allowing access to a known sex offender • not providing care to a child • not making safe and appropriate arrangements for a child's care. Please note: this category should not be applied in isolation to a person experiencing domestic and family violence regarding harm or alleged harm caused by the person using violence. In such a circumstance, alternative abuse types which hold the person using violence to account for the impact their behaviour is causing the child. Refer to Exposure to domestic and family violence for more information.
Prevented from protecting	When domestic and family violence is also identified, a person using violence may prevent the other parent from protecting the child. Over time the person experiencing violence cannot protect the child from the person using violence.
Unable to protect	When a parent is unable to protect the child from the presenting harm, despite their best efforts. For example, unable to protect the child from their own self-injury, suicidal distress or high risk behaviours. Or the parent is unable to prevent another parent (or partner) from threatening harm to the child, or harming the child, despite any attempts to protect the child.

Exposure to domestic and family violence

Exposure to domestic and family violence occurs when a child sees, hears or is impacted by acts of violence towards other family members in the child's home. The acts are typically done by a parent but may also be done by other members of the child's family. Acts of violence are not limited to physical violence and can include emotionally or coercively controlling behaviours.

Exposure to domestic and family violence can affect children's behaviour, schooling, cognitive development, mental and physical wellbeing and is the leading cause of homelessness for children. It is a pattern of abusive behaviour, designed to control the other person/people through fear and intimidation. (Refer to the practice kit Domestic and family violence.)

Domestic and family violence includes:

- physical violence
- sexual abuse or coercion (including reproductive control)
- social and geographical isolation
- verbal abuse
- economic abuse
- emotional or psychological abuse (e.g. gaslighting)
- stalking and surveillance (often via technology)
- identity-based abuse (focused on someone's culture, religion, sexual orientation or gender identity, level of ability)
- threats to harm or kill (the person, a pet or someone they care about)
- property damage.

This abuse type rarely occurs in isolation from other forms of maltreatment, and often creates conditions which enable other types of abuse.

Gather comprehensive information from the notifier about the family's situation and context. Apply strategies for identifying and mitigating bias, consider the roles and responsibilities for each parent and consider that the child may be experiencing multiple forms of abuse concurrently to the impact of exposure to domestic and family violence. This will contribute to the assessment which informs the intake decision

Research suggests the co-occurrence of domestic and family violence alongside other abuse types is so prevalent, practitioners should seek to 'rule out' domestic and family violence (rather than ruling it in) at intake to ensure accurate assessments.

Domestic and family violence is a gendered issue. The majority of people who experience domestic and family violence are women and their children. That is not to say that women don't use violence against men or that men can't be victimised. However, most people who use coercive control or abuse in interpersonal relationships are men.

Terminology – throughout this resource the terms 'person using violence' and 'person experiencing violence' are used. Victim-survivor language is also used across the sector and refers to the person experiencing violence.

Physical indicators of exposure to domestic and family violence	Behavioural indicators of exposure to domestic and family violence
• Headaches • stomach aches • bed-wetting • change in appetite and/or weight loss • nightmares and sleep disturbances	• Impaired cognitive functioning • hypervigilance to perpetrator's mood and behaviour • parentification • social isolation, and difficulty forming healthy peer relationships • violent behaviour from children in the family home, including increased violence by adolescent children towards the non-offending parent

Physical indicators of exposure to domestic and family violence	Behavioural indicators of exposure to domestic and family violence
• fear • non-suicidal self-injury • frequent illness or presence of stress-related conditions.	• poorer academic outcomes including learning difficulties • challenges in responding to authority • depression, anxiety and poor mental wellbeing • low self-esteem • low school attendance • bullying (both as victim and perpetrator) • Post Traumatic Stress Disorder (PTSD) • poor coping mechanisms • eating disorders • suicidal thoughts or suicide attempt • non-suicidal self-injury • substance abuse.
Exposure to domestic and family violence considerations	
The characteristics of the relationship between the person experiencing violence and the person using violence:	• What patterns of behaviour exist? • What is the intent of their behaviour? • Who holds and wields the power in the relationship? • Who makes decisions about how resources are used, where people go, who they see, where they live? What happens if someone disagrees with a decision? • Is coercive control guiding their behaviour? • Have they prevented the person experiencing violence from protecting the child?
The behaviour and situational factors of the person using violence:	Refer to the practice kit Domestic and family violence Risk factors and identification tools. • The person using violence may blame substance use for their behaviour to avoid accountability. • The person using violence may weaponise substance use by the victim-survivor.
The personality characteristics of the person using violence:	• Are they highly controlling or manipulative? • Are they erratic, obsessive or fixated on the victim? • Do they believe that their behaviour is justified? • Is there a sudden or recent change in personality or behaviour?
The experience for the person experiencing violence:	• Their level of fear of the person using violence. • Their additional vulnerabilities (such as geographical or social isolation, mental health issues, drug or alcohol misuse or dependency, financial or physical dependence on the person using violence) • Poor mental health specifically depression, anxiety and post-traumatic stress disorder are common responses to the trauma • How have they promoted safety, nurturance or stability for the child and are these mitigating the risks?

	• Where women are reported as violent towards their male partner, is it possible this is retaliatory or defensive violence?
The child's experience:	• What is the impact on child's behaviours, emotions and thoughts? • What is the impact on the child's learning? • What is the impact on the child's physical health (developmental milestones? • Is the exposure causing an indirect impact? For example, compromised housing (instability, transience, physical damage to the home), medical educational or social needs unmet due to financial abuse by the person using violence. • What additional vulnerabilities exist for the child (such as under school age, disability, or diagnosis, subject to threats or actual physical harm from the person using violence, non-biological child of the person using violence, subject to parenting orders or shared care arrangements). • Is the domestic violence a distraction from other types of abuse (sexual or physical abuse)? • Are there indicators of or risk of cumulative harm?
The child's environment:	• Are there economic impacts such as an overall lack of access to resources. For example, appropriate clothing, transport, extra-curricular activities). • Is the person using violence controlling or withholding available resources from the victims or child? • Has the person experiencing violence been coerced into criminal activity (including theft, sex work or fraud)?
Has anyone sought help previously?	• What was the outcome? • Was the person using violence held to account by anyone (have there been any domestic violence orders, breeches, or arrests)?

Process of decision making at intake

At intake, staff are required to:

- Receive and gather information
- Analyse that information
- Form a judgement and,
- Make a decision about the response needed.

Paying particular attention to each of these elements separately and making efforts to 'delay intuition' (Kahneman, 2011) helps to reduce noise and bias in decision making and increase the accuracy of decisions. (Refer to the practice guide Bias in child protection decision making)

Receive and gather information

The ability to make robust decisions at intake largely depends on the quality of information gathering. The scope of information gathering at intake can include but is not limited to:

- notifier information – recontact to clarify/gain further information
- child protection history
    - when there are previous intakes for a family that have either not been assessed or if so, have determined that the child is not in need of protection, do not assume that this case is not one of significant risk as there maybe errors in previous assessments.
    - It is critical that all of the information in the history is thoroughly analysed, and practitioners refrain from solely relying on the outcome.
- information about
    - the **child** and their vulnerability
    - the **harm**- type, severity, pattern and likelihood including child protection history.
    - **parent** or caregiver – actions and inactions, repeating or current pattern of concerning behaviours, capacity to meet needs and address harm
    - family, community and **environment -**including the child's culture and connections
    - **strengths and protective** factors.

Note: In Queensland, professionals such as doctors, nurses, teachers, early childhood educators, certain police officers and child advocates are mandated to report physical and sexual abuse to Child Safety. Many of these professionals have significant expertise and knowledge which should be recognised when determining reasonable suspicion. For example, a specialist paediatrician or other medical or allied health practitioner expressing concerns regarding injuries to a child or impacts of missed health appointments will meet a reasonable suspicion threshold.

Refer to the handout Information gathering prompts.

Analyse the information

Once information is received and gathered it must be analysed to determine:

- Whether the information received from a notifier, and any other professional contacted, indicates a reasonable suspicion that a child has been harmed and/or is at risk of harm if nothing changes for them in the future.
- Whether a child has a parent able and willing to protect them from that harm.

To ensure appropriate consideration of cumulative harm, critically reflect on the child protection history, focusing on the cumulative impact of multiple adverse (abusive or neglectful) experiences on the child over a prolonged period.

If there have been previous intakes for the child that did not meet the threshold for a notification, or previous assessments that did not result in ongoing intervention, challenge these outcomes based on the new information.

Be aware that in the previous intakes and assessments:

- previous adverse experiences and events, when considered in isolation, may not meet the statutory threshold
- episodic assessments may have failed to consider the child's cumulative experience
- there may have been insufficient information gathering and analysis
- the available information may not have been adequate to substantiate harm.

Refer to the practice guide Cumulative harm for further information about recognising and responding to cumulative harm.

Step 1 - Receive and gather information	Step 2 - Analysis	Step 3 - Judgement
Ensure information is gathered for each of the following: • child • harm • parent • environment • strengths • acts of protection.	Consider what is known about the reported abuse and harm: • type of harm • severity of harm • location of harm • frequency of harm • pattern-increasing, escalating or chronic • cumulative harm • history of abuse and harm • individual child experience and impact of harm. Consider factors that increase the child's vulnerability including: • young age and infancy • prematurity • developmental delay, disability or medical needs • death of a sibling • child risk taking behaviours • child non-suicidal self-injury or suicidal intent • opportunity for harm • unsafe sleeping arrangements • isolated from family or community • limited parental capacity to meet needs and address harm • parents refusing access or likely to flee.	**Impact** Vulnerability of the child and severity of harm come together to make a judgement about impact on the child. The impact of the harm is either: • significant, or • non-significant. Significant harm is more than minor, that is severe and demonstrable in the child's body or functioning and would have ongoing substantial negative consequence for the child if no one intervened to prevent harm. Non-significant impact means that the consequence for the child is minor and overcome without intervention. Consider if: • There is a reasonable suspicion that a child's physical, psychological or emotional wellbeing has been or is likely to be significantly impacted.

<table>
<tr><th>Step 1 - Receive and gather information</th><th>Step 2 - Analysis</th><th>Step 3 - Judgement</th></tr>
<tr><td rowspan="2"></td><td>Consider factors that increase the likelihood harm has occurred or is likely to occur again:
prior pattern and behaviour towards the child / child protection history
attitudes and beliefs of the parents
behaviours of the parent
contributing factors
mental health issues impacting parental functioning
domestic and family violence
alcohol and other drug misuse impacting parental functioning
young parental age/parents with low maturity/limited parenting skills.</td><td rowspan="2">Probability
The task here is to determine whether future harm is possible or probable:
possible, meaning that harm may occur, but it is not likely
probable, meaning that on the balance of probability, it is more likely than not that the child will experience harm.
Past harm is the best predictor of future harm.
Consider if:
There is a reasonable suspicion that the child does not have at least one parent able and willing to protect them.</td></tr>
<tr><td>Strengths and protective factors
Factors that decrease the likelihood that harm has occurred or is likely to occur again:
acts of protection by a parent – does the child have at least one parent who is able and willing to protect them?
consider child, parental and community strengths.</td></tr>
<tr><td>Step 4
Make a decision</td><td colspan="2">Does the information reach the threshold for a notification to be recorded?
What is the appropriate response?</td></tr>
</table>

The below provides more comprehensive information to assist analysis.

1. The child

Age, development and functioning are key factors that may increase the vulnerability of a child. Practitioners must incorporate professional knowledge and research regarding ages and stages of development.

The below lists include factors to consider when analysing the child and their vulnerability.

All ages

- What has been the impact on the child to date?
- Are there any signs of trauma?
- Developmental stage – consider developmental milestones and specific developmental needs. It can be helpful when analysing developmental stage to visually imagine the child in your mind's eye. Imagine them and their characteristics.
- What are the likely impacts on the child's development should their circumstances remain unchanged?
- Reliance on caregivers – how does the child's age and stage of development impact their reliance on a caregiver? Does the child have a disability which increases their reliance on caregivers?
- What is the quality of the parent-child relationship?

Refer to the practice guide Physical and Cognitive Development Milestones.

Children

- How is the child functioning at day care, school and other environments? What does this tell you about their development?
- Consider information regarding the child's relationship with siblings, peers, parents, family and others.
- Consider any indications that the child may be developing or have developed behavioural issues.

Infants

- Generally, the younger the child is the more vulnerable they are to harm.
- Infants are fully dependent on adults to have their daily care needs met.
- Infancy is a critical period for development.
- Premature babies are particularly vulnerable to harm.

Young people

- Consider that the cumulative effect of neglect can present as increased risk-taking behaviour.
- Young people may be at increased vulnerability due to factors such as suicide or non-suicidal self-injury and mental health.
- Often in this stage of development, young people have increased impulsivity and lowered ability to assess risk to themselves which can result in behaviours that put them at high risk of harm.

2. Harm

This section involves considering the type and severity of the harm. Harm to a child is the result of the abuse or neglect they experience. It is important here to focus on what the child's experience has been, is, or would be based on the available information.

Key considerations:

- Remember that one or more types of harm may be present for a child at any one time.
- Keep in mind the vulnerability of the child – different types of harm may have a different impact for the child based on their specific vulnerabilities.
- Cumulative harm is usually not visible.
- What is the pattern or history of harm – is the harm escalating (getting worse), chronic (ongoing) or episodic (once off)?
- Patterns of harm are indicators of future harm – if it's happened once then it is more likely to happen again.

Refer to the practice guide Infants at high risk for risk factors associated with abuse and harm to infants that may result in serious physical injury or death.

3. Parents and caregivers

This section examines the parents' characteristics to identify any risks and their capacity to meet the child's needs. Factors that may increase likelihood of harm:

- parents have caused serious harm to any child in the past
- parent's explanation for the current injury is inconsistent or it is minimised
- parents deny the abuse or do not allow access to the child
- parents have a history of using violence in or out of the home
- parent has limited parenting skills
- parent is immature or impulsive- consider disrupted attachment and step parenting relationships
- parent has poor attachment to the child
- parental functioning is impaired by alcohol and other drug use, mental health issues, high degrees of stress, acquired brain injury or other circumstances and no supports are in place
- parent has unrealistic expectation of the child or does not understand developmental milestones.

4. Family, community and environment

Factors that may increase likelihood of harm:

- the physical and social environment is chaotic, hazardous and unsafe
- poor social networks and isolation from services
- limited food security and employment options
- housing instability and homelessness
- high levels of family stress.

5. Strengths and protective factors

This section examines the way strengths and acts of protection can contribute to a decrease in the likelihood of harm occurring or reoccurring.

All families have strengths. However, those strengths are not always enough to provide protection and mitigate the identified harm. It is important to still identify these strengths so they can be built on and potentially help create future protection and safety.

Protective factors are actions or direct behaviours undertaken by a parent or caregiver which directly address the risk of harm to a child. Practitioners cannot assume that strengths will provide protection for a child. The correct identification of strengths and protective factors can help reduce thinking errors in risk assessment at intake.

Some examples of behaviours that would be considered strengths that do not automatically provide protection for a child include:

- a child attending school or day care
- a person using violence attending a behaviour change program
- a parent obtaining a domestic violence order
- a parent stating they will cease using drugs.

Some examples of protective factors include:

- a parent proactively makes appropriate alternative care arrangements for the child to ensure they are not exposed to parental substance misuse
- parent and family have an effective and responsive safety and support network of informal and formal supports
- adequate income and housing
- connection to culture and community- access to trusted family and community members who offer safe childcare and practical supports such as food and money.

The unique challenge at intake is that if acts of protection are identified, practitioners must ensure there is sufficient information to suggest they can be sustained over time to prevent harm or risk of harm to the child. A stated commitment or intention from the parent to act protectively is not enough. There must be verified or validated information that protective factors have been demonstrated.

Known risk factors

Domestic and family violence

When a person using violence commits domestic and family violence in a family with a child, that child is exposed to the violence. This exposure may be direct or indirect with both having the potential to cause significant harm to a child's development, mental, emotional and physical health, and general wellbeing.

The higher frequency or severity of the violence, both now in past relationships, the higher risk of harm to a child living with a person using violence or victim-survivor.

A victim-survivor may be willing to protect the child from the violence but prevented from doing so because of being a victim. That is, it may be unsafe for both the victim-survivor and the child if the victim-survivor were to act to protect the child from being exposed to the violence.

At intake, focus to:

- the child's experience of the violence
- the perpetrator's patterns of behaviour, both now and in the past
- the victim's ability to protect the child from the violence.

Pay particular attention to the presence of factors that are commonly associated with a high likelihood of domestic and family violence re-occurring with serious injury or death as a result.

For further considerations at intake refer to:

- Exposure to domestic and family violence (above)
- The practice kit Domestic and family violence, High risk of lethality factors.

Parental mental health

It is not uncommon for a parent to experience mental health concerns or receive a mental health diagnosis. Each family's situation is different, and a diagnosis of a mental illness may be short or long term and needs to be reviewed by a professional when changes occur. While on many occasions a parent's mental health concerns do not disrupt their parenting, the following may indicate when a parent's mental health concerns are impacting on their ability to parent, including:

- reduced emotional availability
- changed view of their child
- reduced ability to support child development
- the pattern of parental mental health concerns
- the impact of mental health concerns on parenting
- the family's home environment
- parent's medication use
- parent's ability to understand the concerns about their mental health and social and emotional wellbeing
- child and family's safety and support network
- immediate harm versus risk.

Consideration also needs to be given to protective factors for parents when they are experiencing mental health concerns, including:

- parent accessing effective treatment for their mental health concerns
- Aboriginal and Torres Strait Islander parents accessing cultural healing and supports for social and emotional wellbeing concerns
- access to family support
- supportive safety and support network for the child and family
- other adult caregivers in the home providing care for the children.

Social and emotional wellbeing is a holistic concept of mental health for Aboriginal and Torres Strait Islander people. Further information is available in the following resources:

- Social and Emotional Wellbeing – Emerging Minds
- Evolve Therapeutic Services – Aboriginal and Torres Strait Islander People's Social and Emotional Wellbeing: Domains, Contributing/Risk factors and Protective Factors

Alcohol and other drug use

Consideration must be given to how the parent's behaviour impacts on the child. Factors that are useful to consider include:

- The effects of alcohol and other drug use on behaviour, parenting and relationships.
- The role alcohol and other drug use has in the parent's life (does this issue co-exist alongside other factors for the parent such as past trauma, domestic and family violence or mental health issues?).
- Episodes of alcohol and other drug use – what information is present or can be reasonably inferred about how long the parent's alcohol and other drug use could impair their ability to care for their child?

When considering the impact of parental alcohol and other drug use on a child, consider:

- the people and places that the child is around
- what the child sees and has access to
- what the child sees, thinks and feels during their parent's 'episode'
- how the parent responds, or does not respond, to the child's needs
- what the parent's alcohol and other drug use looks like.

Refer to the Alcohol and other drugs practice kit for further information.

Co-existing risk factors

Domestic and family violence, alcohol and other drug concerns and mental health concerns can often co-exist and will interact with each other in complex ways. Consider the patterns that may be occurring including frequency of substance use or domestic and family violence, and the impact this may be having on a parent's mental health and wellbeing (Wright et al, 2021). Seek opportunities to reduce parental risk factors and increase protective factors, alongside referrals for support services for parents.

Form a judgement

After analysing the concerns presented, practitioners must form a judgement about the severity of harm and the likelihood of it occurring.

Is the harm significant or non-significant?

The consequence of the harm for the child is known as "severity". That is, if nothing changes –what will be the impact on the child. Practitioners must consider whether the impact is "significant" or "non-significant".

Is the likelihood probable or possible?

Practitioners can never predict with certainty how likely it is that harm will occur for a child in the future. However, practitioners must form a judgement about whether future harm is probable or possible.

If harm is probable, then it is more likely than not to occur.

If harm is possible, then it may occur, but is not likely.

When considering whether a child is at risk of cumulative harm consider:

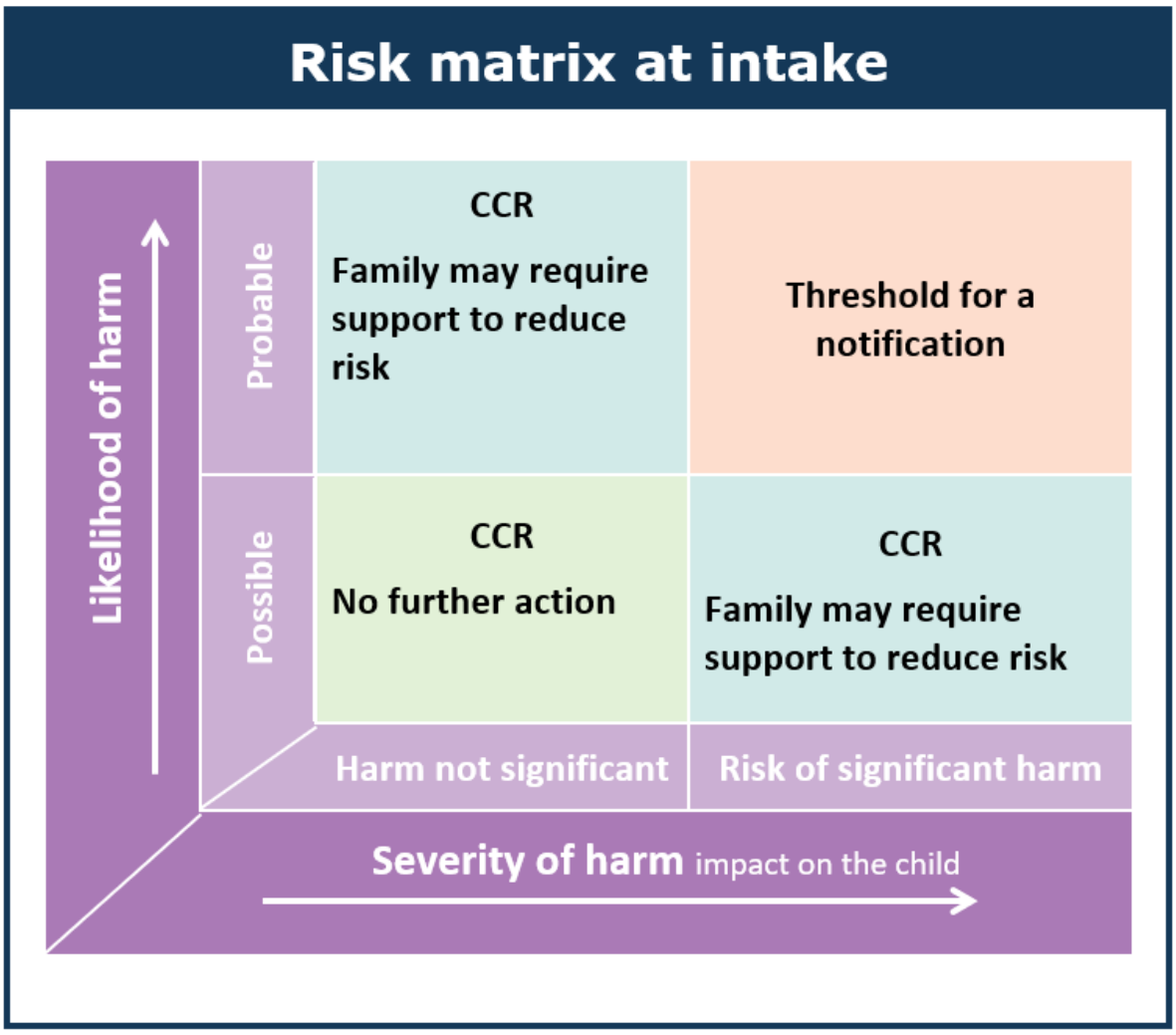
- how often (the frequency) the child has experienced harm and from your analysis of the history, whether there a pattern of this repeating
- the duration of time the child has experienced these adverse circumstances and events, taking into account their age and developmental stage.

Does the child have at least one parent able and willing to protect them?

A parent must be assessed as both **able and willing** to protect their child. A common definition applies, that is, 'able' refers to capacity and 'willing' refers to readiness or motivation.

Consider whether a parent may be willing to protect a child, but not have the means or capacity to do so. Conversely a parent may be able to protect their child but not willing to do so because of the child's behaviours or because of personal benefits to themselves.

If a child lives across multiple homes, then in order for a parent to be **able and willing** to protect their child they must be able to do so across environments.



Make a decision

Does the information reach the threshold for a notification to be recorded?

In circumstances where the severity of harm is significant, and the likelihood of harm is probable, then a notification must be recorded.

If there is no reasonable suspicion of significant harm, a child concern report is recorded.

If no allegations or risk of harm are identified, a limited intake response or intake enquiry is recorded.

Responses to notifications

Child Safety has an obligation to take appropriate action when it is reasonably suspected that a child may be in need of protection (*Child Protection Act 1999*, section 14(1)). This will be either:

- a priority response, which involves the assessment of the child's need for protection by an authorised officer or
- a standard response, which involves the assessment of the child's immediate safety and the family's support needs by an authorised officer, as well as support coordination, if necessary, or
- a safety and support response, which involves an assessment of the family's needs by an Assessment and Service Connect provider, and support coordination, if necessary.

These options allow for flexible and proportionate responses to a family's needs, with the ability to escalate to another response, if necessary.

The paramount consideration when deciding the response to a notification is the safety, wellbeing and best interests of the child. Always focus on the most vulnerable child when deciding the response to the notification.

Priority response

Notifications that require a priority response are generally higher-risk, and will result in ongoing intervention, if the outcome of the assessment is 'child in need of protection'. However, there may be other circumstances when a priority response is required.

To determine whether a notification requires a priority response, apply the criteria to the information that has been gathered and analysed. If one or more of the criteria are met, a priority response is the appropriate response to the notification.

The priority response criteria are:

- The concerns relate to
    - sexual abuse
    - significant physical abuse, including unexplained injuries
    - severe neglect
    - severe emotional abuse with indicators of significant impact
- The concerns relate to domestic and family violence and one or more of the following apply
    - the victim-survivor's perception of the risk is high
    - the violence is escalating in frequency or severity
    - the person using violence has threatened to kill the victim-survivor or the subject child (including an unborn child)

    - the person using violence has tried to choke or strangle (including attempts to smother or drown) the victim-survivor
    - the person using violence threatened to use or used a weapon against the victim-survivor.
- An assessment of the child's need for protection is required.
- A parent or alleged person responsible has previously been responsible for causing the death of or a serious injury to a child.
- A child has died in suspicious or unexplained circumstances, and a response is required for other children in the home.
- A child is subject to
    - an intervention with parental agreement case
    - a directive order
    - a supervision order
    - a child protection order granting custody or guardianship to the chief executive
- An unborn child has been assessed as being in need of protection after their birth.
- There is credible information that indicates that a parent or pregnant person would relocate to avoid contact, placing the child or unborn child at increased risk of significant harm.
- There are concerns relating to cumulative harm with indicators of significant impact on the child.

If a child is subject to an order granting long-term guardianship to a suitable person or a permanent care order, decide the response to the notification based on the criteria. If the criteria for a priority response is not met, complete a standard response or a safety and support response – whichever is appropriate in the circumstances.

A priority response for an unborn child is the appropriate response when:

- the criteria for a priority response is met
  or
- the birth of the unborn child is imminent, and the concerns and timeframes do not allow for the pregnant person to be referred for help and support.

Standard response criteria

A standard response involves:

- an assessment of the child's immediate safety
- an assessment of the family's support needs
- support coordination, if necessary.

The intent of a standard response is to offer help and support to a family, to decrease the likelihood of the child becoming a child in need of protection.

The family needs assessment is a proportionate assessment, that focuses on needs that, if not address, increase risk to a child.

A standard response is the appropriate response to a notification when the criteria for a priority response are not met.

Safety and support response criteria

A safety and support response is a sub-set of a standard response, and therefore similarly the intent is to offer targeted support to a family, to decrease the likelihood of the child becoming a child in need of protection, or an unborn child requiring protection following their birth.

Other than seeking consent to participate in a safety and support response, Child Safety do not engage with the child or parents, and a safety assessment is not completed.

A safety and support response is the appropriate response to a notification when:

- There are identified strengths within the family that could be built on with the help of an early intervention service, to provide for the child's safety or unborn child's safety after their birth.
- The child is visible within their family and community, such as at school.
- It is appropriate for the service to engage with the family without Child Safety assessing the child's immediate safety.

Deciding the commencement timeframe for a priority response

If it has been determined that a matter meets criteria for a priority response, a decision needs to be made about how quickly the priority response must be commenced (i.e., the urgency).

The timeframes for commencement of a priority response are:

- within 24-hours
- within 72-hours.

When determining the appropriate commencement timeframe, consider whether there is concern for the child's immediate safety. When there are multiple subject children in a notification, base the decision on the most vulnerable child.

To decide whether a matter needs to be commenced with 24-hours, review the relevant factors in the table below to decide whether one or more of the urgency prompts in Unify apply. Priority responses that do not require a 24-hour commencement timeframe will be assigned a 72-hour commencement timeframe.

Relevant Factors	Urgency prompt (in Unify)
• There is a credible threat to the child's life, life threatening injuries to the child, or a child with suicidal thoughts and an imminent plan (without a safety plan or a response by a mental health professional). • There is a pattern of abuse or neglect that is increasing in frequency or severity and is likely to result in harm in the next 24 hours. • The alleged person responsible has easy access to the child within the next 24 hours and the child is at immediate risk of further harm (for example, the alleged person responsible lives in the house, has a care role or contact is scheduled to occur). • The living situations is dangerous/unhealthy/seriously chaotic and likely to cause harm within the next 24 hours.	Is the child likely to experience harm in the next 24 hours? Consider: • the child's vulnerability • access of the person alleged responsible for the harm to the child • the severity of the harm the child may experience.

Relevant Factors	Urgency prompt (in Unify)
• The child has been abandoned or relinquished and has no care arrangements. • The information indicates that the child is significantly fearful or is experiencing severe emotional distress that needs a response within the next 24 hours.	
• The child requires immediate medical attention in the next 24 hours.	Does the child require urgent medical attention?
• An ICARE interview is required and cannot be delayed for more than 24 hours without increasing risk to the child's safety and wellbeing. • The child is alleged to have visible injuries, including alleged non-accidental or inflicted injuries, that must be sighted to inform the assessment. • The child is aged less than five years, or their capacity is limited by physical or cognitive disability, and they are alleged to have observable injuries	Is immediate contact with the child necessary to gather information about alleged harm, including observable injuries?
• There is credible information which suggests a high probability of the family relocating/going missing/fleeing in the next 24 hours to prevent the assessment from commencing.	Is the family likely to flee to avoid contact with Child Safety, placing the child at increased risk of harm?

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