PRACTICE GUIDE

Assess harm and risk of harm

The assessment of harm and risk of harm is a fundamental component of statutory child protection work. It refers to an ongoing process of purposeful gathering and analysis of information, to form a professional judgement about the severity and likelihood of future harm to a child. Professional judgements are used to inform decisions about a course of action to ensure a child's safety.

This practice guide sets out the key concepts relevant to risk assessment, as well as a four-stage process for undertaking an assessment of harm and risk of harm.

Key concepts

Abuse

Abuse (an act of commission) can be physical, emotional, sexual (including exploitation) or exposure to domestic and family violence. Neglect, which refers to an act of omission, is also referred to as a form of abuse. Abuse is what happens to a child. Definitions of each abuse type are provided in Attachment 1 of this practice guide.

Harm

Harm to a child is the result of the abuse they experience. The *Child Protection Act 1999*, section 9, defines harm as any detrimental effect of a significant nature on a child's physical, psychological or emotional wellbeing. To assist with identifying harm to a child, consider:

- the physical and behavioural indicators of each abuse type (as listed in Attachment 1)
- whether the child's behaviour and functioning is consistent with their age and stage of development (refer to the practice guide Physical and cognitive developmental milestones)
- that some types of harm (namely emotional and psychological) may not be demonstrable at the time of assessment and may manifest at a later stage in the child's development
- the Queensland Health resource Red Flags Early Identification Guide (birth to 5 years), to help identify developmental concerns.

Cumulative harm

Harm can be the result of a single act, omission or circumstance, or a series of acts, omissions or circumstances. The latter is referred to as 'cumulative harm', which occurs when a child has been harmed (or is at risk of harm) because of:

- an ongoing, adverse event or circumstance in their life (for example, ongoing neglect)
- an accumulation of adverse circumstances (for example, experiences of neglect, inconsistent and harsh discipline, exposure to harm).

Assessing cumulative harm requires a focus on the cumulative impact of recurring conditions, circumstances or incidents, which may not have met the threshold for tertiary child protection involvement previously. These conditions, circumstances or incidents may be the same in nature, such as ongoing neglect, or may be comprised of different abuse types.

For further information about cumulative harm, refer to the practice guide Cumulative harm.

The relationship between abuse and harm

The relationship between abuse and harm is illustrated by examples in Table 1.

Types of abuse (actions/behaviours by parent/carer)	Physical	Emotional	Sexual	Neglect	Exposure to domestic and family violence
	Hitting Punching Scalding	Scapegoating Rejection Persistent hostility	Penetration Sexual exploitation Exposure to pornography	Failure to attend to medical needs Poor hygiene/nutrition Inadequate supervision	Hearing, seeing or otherwise impacted by domestic and family violence

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	Learning and developmental delays Disorganised attachment Impaired self-image

Table 1: Relationship between abuse and harm

Risk assessment and immediate safety

Risk assessment is a process that is focused on forming a professional judgement about the likelihood or probability that a child will suffer significant physical, psychological or emotional harm in the future, if nothing changes. Risk assessments are particular to a child, with a specific focus on identifying the likelihood and severity of future harm.

Assessing a child's immediate safety has a focus on identifying factors that place a child in immediate danger. These are referred to as 'immediate harm indicators' and are identified through the completion of the SDM safety assessment.

Risk and protective factors

Factors that increase risk to a child are referred to as risk factors. They may be static or dynamic. A static risk factor is a one that doesn't change. For example, a person having a criminal history or child protection history is a static risk factor. Dynamic risk factors are risk factors that change over time. For example, low birth weight ceases to be a risk factor for abuse and neglect after a child attains one year of age.

Protective factors are attributes or conditions that may mitigate the risk of harm to the child. A protective factor can influence the extent to which one or multiple risk factors can be mitigated. Where a protective factor is identified within a family, it must be verified before it can be assessed as mitigating or reducing identified risk.

For an Aboriginal or Torres Strait Islander child, worker bias can be reduced by understanding the lens through which the assessment is made and should be done through a full and proper assessment of strengths, needs and risks. Open and honest discussion about these factors with persons recognised as having cultural authority can promote collaborative practice and better decision-making based on actual, rather than perceived risk.

When identifying and considering risk and protective factors, it is important to be aware that:

- risk factors may exist among families where child abuse and neglect occur, this does not mean that the presence of these factors necessarily leads to child abuse or neglect
- an awareness of factors that contribute to risk or protection alone does not enable us to predict outcomes for a child (i.e. there is always uncertainty in child protection). Therefore, risk and protective factors need to be analysed to understand what they mean for the particular child, in their particular circumstances
- a strength is not the same as a protective factor. A strength can be harnessed to support future positive change but does not provide safety. A protective factor mitigates the risk of harm to a child. For example, a parent asking for help or expressing a desire to want to change harmful behaviour is a strength, but it does not offer the child safety or mitigate the risk of harm unless the parent accesses support and this results in meaningful, sustained change. (It is important to be aware of disguised compliance when considering whether a parent's behaviour is a strength or a protective factor. Disguised compliance is where a parent gives the appearance of cooperation to avoid raising suspicion and allaying concern. For further information, refer to the Safeguarding network.)

Refer to the Table of risk and protective factors provided in Attachment 2 of this practice guide.

Process for the assessment of harm and risk of harm

Every assessment is unique to a child and family, and therefore no checklist or formula for assessment can be applied to all situations. The four-stage process set out below provides a foundation for the assessment of harm and risk of harm, to guide practitioners in forming a professional judgement about the severity and likelihood of future harm to a child. The process involves practitioners remaining open-minded, while applying their professional, evidence-based knowledge and critical thinking to the child's particular situation and circumstances.

The four-stage process of risk assessment is shown at Figure 1, with the central question to risk assessment appearing in the middle.

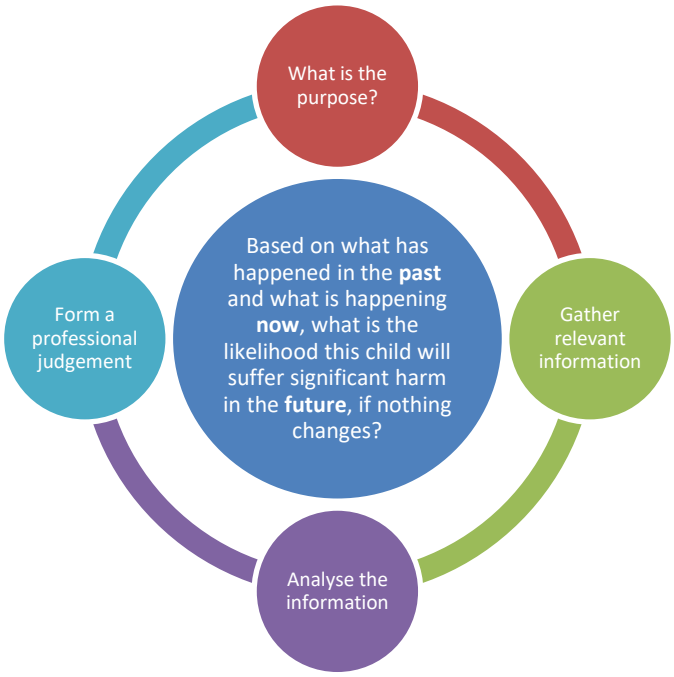

Figure 1: Process for assessing harm and risk of harm

1. What is the purpose of the assessment?

To begin the process, clarify the purpose of the assessment. Every assessment helps to inform a decision. If we are unclear about the decision we need to make, the assessment process will be impacted from the start.

For example, at intake, the purpose of the risk assessment may be to inform a decision about whether there is a reasonable suspicion a child may be in need of protection or during ongoing intervention, the decision may be about whether risk has been adequately addressed for a child to be reunified.

Being clear about the purpose of the assessment is important because it helps the practitioner to:

- formulate initial ideas about what the key issues may be
- reflect on what information might be needed and from what sources
- decide the relevant issues to focus on
- consider their existing knowledge (and gaps in knowledge) on particular issues.

If the assessment relates to an Aboriginal or Torres Strait Islander child, actively seek to involve an Aboriginal or Torres Strait Islander person with cultural authority who can provide cultural knowledge and guidance to help clarify the matters relevant to the assessment and assist with facilitating the child and family's participation in the process.

2. Gather all the relevant information

Once the practitioner is clear about the purpose of the assessment, the relevant information needs to be gathered relating to the child; the parents; the environment; the harm and abuse; the family

and cultural context, to identify harm, the presence of factors that increase risk to a child and factors that offer a child protection.

Consider using the Information gathering template provided in Attachment 3 of this practice guide, to assist with identifying, gathering and documenting the relevant information. The Information gathering template includes prompts that help to elicit information about the presence of risk and protective factors for the child to inform a rigorous and balanced assessment. It is important to note that the prompts within the Information gathering template are to be used as a guide only and are not exhaustive. The information that needs to be gathered is unique to each assessment and specific to the decision that needs to be made.

Sources of information

Depending on the purpose of the assessment and the phase of the child protection continuum the assessment is being completed, the information may be gathered by:

- engaging the notifier to gather information about how the parental behaviour or actions are impacting on the child
- engaging in meaningful discussions and having purposeful interactions with the child, parents and family
- speaking with others who know about the child's situation such as foster carers, household members and other significant people in the child's life (being mindful of client privacy and confidentiality)
- requesting and sharing information with government and non-government agencies who are providing services or support to the child or parents.

- for Aboriginal and Torres Strait Islander families, seeking to understand cultural practices and protocols by involving an Aboriginal or Torres Strait Islander practitioner or person with cultural authority.
- directly observing and assessing the quality of interactions between the child, parents, foster carers and others within their environment.

Voice of the child

Ensuring the voice of the child is present is central is to a child-focused risk assessment. Engaging with a child in a way that is appropriate for their age, stage of development, level of functioning and cultural identity enables us to 'hear' from them about their experience. This may include:

- speaking directly with the child
- observing the child
- interacting with the child.

Even in circumstances where a child cannot communicate verbally, sighting and engaging with them is critical. It ensures that we gather relevant information about the impact of abuse on the child to inform the assessment and maintains our focus on the child (who must remain at the centre of our assessment).

Under the *Child Protection Act 1999*, section 5B(n), children have a right to express their views about what is and what is not in their best interests. The *Child Protection Act 1999*, section 5E sets out principles for children's participation in decisions that Child Safety make that affect them.

Child protection history

All child protection history recorded about a child and each family member, including siblings and the parents' history as children, needs to be collated and considered to form an assessment of harm and risk of harm. Any records of the person alleged responsible for harm to the child, if not a parent, must also be reviewed.

Past concerns may have been about similar or different harms and may not have met the threshold for a notification or ongoing intervention, however previous decision-making should not influence the current assessment. Consider any past decisions recorded in the child protection history in the context of the new information to help inform the current assessment. Prior

Review and analysis of the child protection history will assist in identifying risk and protective factors, as well as patterns that inform the current assessment, including patterns indicative of cumulative harm.

Professional knowledge

An assessment of harm and risk of harm is informed by professional knowledge. Depending on the issues or factors being assessed, consider what professional knowledge you hold, and what professional knowledge needs to be sought to inform the assessment.

For example, a risk assessment relating to sexual abuse may require input from an expert in sexually reactive behaviours, or an assessment relating to neglect of an infant may require professional knowledge relating to early childhood development or infant mental health.

On a case-by-case basis, consider what professional knowledge may be needed to help inform the assessment of harm and risk of harm to a child, and who might be an appropriate source of professional knowledge. This may include professionals, information contained within practice kits (in the Child Safety Practice Manual) or iLearn courses.

Cultural knowledge

Seek to understand cultural factors and include the voices of those with cultural authority for an Aboriginal or Torres Strait Islander child. Cultural factors may include traditional child rearing practices or kinship structures for an Aboriginal or Torres Strait Islander child. A lack of appropriate participation and cultural knowledge can result in information being inappropriately interpreted, generalisation and ill-informed assessments.

Analyse the information

Analyse the identified risk protective factors in the context of the child's situation to establish the interaction between them (refer to the Table of risk and protective factors provided in Attachment 2 of this practice guide). Multiple risk factors may increase the likelihood of harm occurring, while the presence of protective factors may decrease the likelihood of harm occurring.

For example, a parent's young age is considered a risk factor, however if that parent resides with supportive and safe adults who are assisting with the infant's care, the infant may not be at increased risk. However, an infant is at increased risk if they have a young parent who is also experiencing housing instability and abusing substances.

Analysis requires an awareness of bias and the application of critical thinking and professional knowledge. It is not just about stating the information or considering risk and protective factors in isolation. Instead, it is about determining what the information means collectively for the child, in their particular situation.

When analysing the information:

- consider whether the information that has been provided has been verified and if not, make all attempts to check the information for validity
- consider the information about the child, their family and situation with what is known from research and practice experience
- recognise indicators of harm, which may be physical, psychological or emotional.
- consider that certain types of harm may not be directly observable until a later stage in the child's development
- distinguish a parent's intention or motivation to safely care for and protect a child from harm and seek to verify examples of acts of protection
- look for patterns of behaviour, including abuse and neglect, or protection
- ensure the child has been given meaningful and ongoing opportunities to participate and are visible in the assessment
- apply cultural knowledge (refer to Stronger Safer Together, page 29, for information about understanding the strengths of Aboriginal and Torres Strait Islander child rearing practices).

To assist with the analysis stage, it can be helpful to group, organise and analyse the information in the context of:

- a child's vulnerability
- the impact on the child
- safety
- probability.

This can be done using the Template for analysing the information gathered provided in Attachment 4 of this practice guide).

3. Form a professional judgement

Your professional judgement is your answer to the central question of risk assessment: Based on what has happened in the **past** and what is happening **now**, what is the likelihood this child will suffer significant harm in the **future**, if nothing changes?

A professional judgement is formed by synthesising (bringing together) the analysis to determine the overall assessment of harm and risk of harm to a child.

Professional judgement about harm

A professional judgement about whether a child has suffered significant harm can be formed from the analysis and in particular, information about how seriously the child has been impacted by abuse they have experienced.

Remember that harm may be experienced by one act, omission or circumstance, or ongoing acts, omissions or circumstances (cumulative harm). Consider the cumulative effect of multiple or recurring adverse events over time on the child's physical, psychological or emotional wellbeing, rather than the effect of individual events in isolation.

It is important to clearly identify:

- who is responsible for harming the child
- how the child has been harmed (the abuse)
- the impact on the child (the harm).

While the impact of some types of harm may be visible at the time the assessment is being made (for example, a child who has suffered physical abuse may have physical injuries), this may not always be the case. In some instances where the harm relates to emotional or psychological harm:

- the impact of the abuse or neglect may not be observable at the time of the assessment
- the harm may not manifest or be visible until a later stage in the child's development.

Using your research-based knowledge, including childhood development and the impact of trauma, consider whether on the balance of probabilities, the child has experienced significant harm.

Professional judgement about risk of harm

A professional judgement about risk of harm is formed by bringing together (synthesising) the analysis of the information, with a particular focus on determining the severity and likelihood of future harm to the child.

Focusing on severity and likelihood helps us to establish:

- the extent to which the child would be impacted in the future. The severity may be "not significant" or 'significant'.
- how likely the child is to suffer harm in the future. The likelihood may be 'possible' or 'probable'.

Where the severity is assessed as 'significant' (that is, the child is likely to suffer a detrimental effect of significant nature on their physical, psychological or emotional wellbeing), and the likelihood is 'probable', the child is in need of protection. (The *Child Protection Act 1999*, section 10 defines a child in need of protection as a child who has suffered significant harm, is suffering significant harm, or is at unacceptable risk of suffering significant harm, and does not have a parent able and willing to protect the child from the harm.)

When synthesising the information to form an assessment, keep in mind:

- There is always uncertainty in risk assessment. Consider whether it is more likely than not that the child will suffer harm in the foreseeable future (balance of probabilities).
- Future harm may be caused by a single act, omission or circumstance, or a series of acts, omissions or circumstances (cumulative harm). Consider the likely effect of multiple or recurring adverse events over time, and the cumulative impact these experiences will have on the child, if nothing changes.
- Past behaviour is one of the most accurate predictors of future behaviour.
- Where past behaviour has resulted in harm to a child, the probability of future harm is increased if sustained change is not evident.
- The presence of risk factors in a family does not necessarily mean that the child will suffer abuse or neglect.
- The likelihood of harm is increased if the pattern of abuse is increasing in frequency, severity or chronicity.
- Protective factors must be able to be described as behaviours that directly mitigate the risk of harm to the child.

Use the professional judgement to inform a decision

After completing the four stages of the process for assessing harm and risk of harm, use professional judgement (along with legislation, policies, procedures, and practice and guidance to inform a decision about a course of action relating to a child's safety and protection. This comes back to the purpose of the assessment (the first stage of the process) and may include decisions about:

- whether a child is in need of protection
- whether to offer family support, for a child not in need of protection
- whether to close an ongoing intervention case for a child subject to an intervention with parental agreement
- whether to reunify a child.

Where the decision is a significant decision for an Aboriginal or Torres Strait Islander child, if not already engaged and with the agreement of the child and family, involve the Family Participation Program to convene a family-led decision-making process. This is in addition to the participation of the independent person (if the family have agreed to their involvement). The family-led decision making process supports an Aboriginal or Torres Strait Islander family's right to self-determination and offers a culturally safe space to work together to solve problems and lead decision-making.

Apply the professional judgement to the decision

This risk matrix may be used to help apply the professional judgement to the decision.

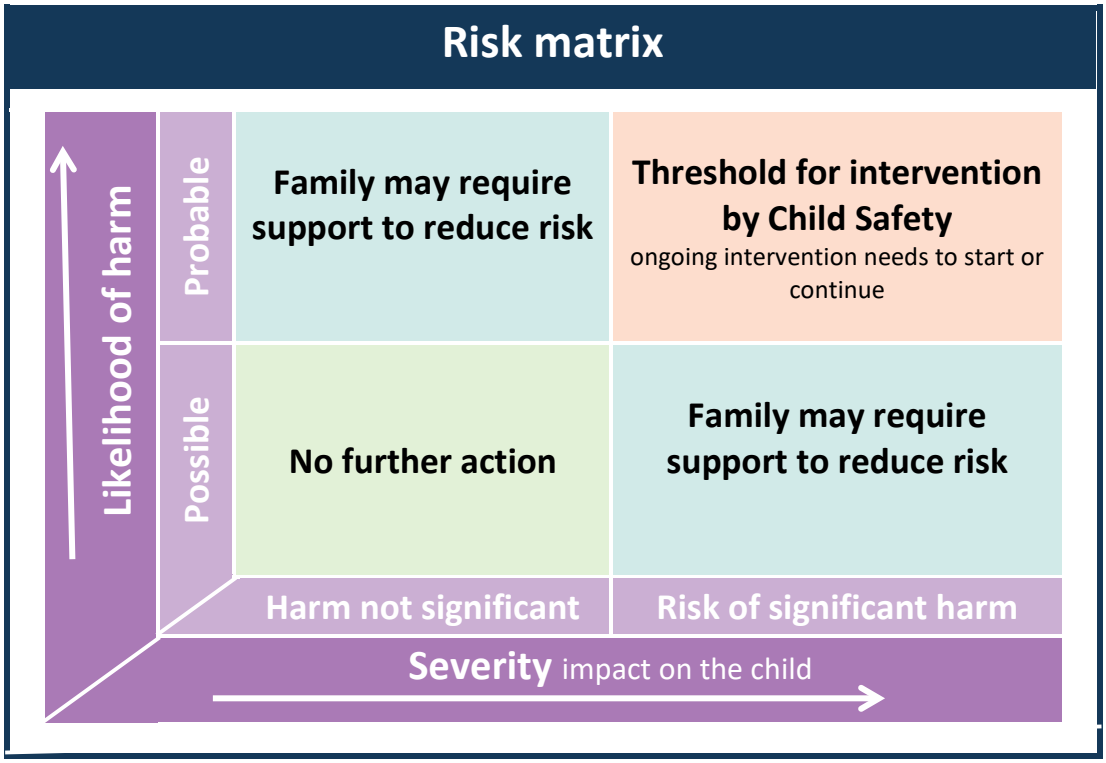

Figure 2: Risk matrix

To use the Risk matrix:

- Identify the assessment of severity on the horizontal axis. This will be either
  - not significant, meaning that the child wouldn't be impacted, or they would be impacted, but the impact would not have a detrimental effect of a significant nature
  - significant, meaning that the statutory threshold for harm would be reached.
- Identify the assessment of likelihood on the vertical axis. This will have been either
  - 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.
- Identify the quadrant that corresponds with the assessment of severity and likelihood.

The Risk matrix provides three outcomes:

- Threshold for intervention by Child Safety – this quadrant reflects outcomes where the overall assessment suggests the child is in need of protection. Where the severity is assessed as significant, and the likelihood assessed as probable, ongoing intervention needs to start or continue.
- Family may require support to reduce risk – practitioners should consider offering a family support by way of a referral to an appropriate service, to reduce ongoing risk to a child.
- No further action – there is minimal to no likelihood of future significant harm to a child, and therefore no further action needs to be taken.

Record the assessment and decision

Practitioners must record their assessment and decision, including the information they used to inform their assessment. It is critical for the assessment to be able to be read and understood by others and should therefore be:

- well written, succinct, with text accurately reflecting meaning
- accurate, relevant, sufficient, and unbiased
- client-centred, with the child's voice present, written respectfully, as if it is going to be shared with the family
- clear about how a practitioner arrived at their assessment of harm or risk of harm, making clear links between the information gathered, analysis of that information (including the factors that were considered), and the professional judgement.

Revise the assessment

A professional judgement of harm and risk of harm is formed through a point-in-time assessment of a child's experience of harm and the likelihood they will experience harm in the future, if nothing changes.

As such, when a child's circumstances change or new information becomes available, the professional judgement formed about harm and risk of harm may change, which may then require a new or updated decision.

If an updated assessment of harm or risk of harm is required, begin the four-stage assessment process again, incorporating new information and analysing the child's situation in the context of their changed circumstances.

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Attachment 1: 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 information about 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.
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.

This table 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.

Type of neglect	Explanation
	• 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. See the section below on 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 • fear • non-suicidal self-injury • frequent illness or presence of stress-related conditions.	• 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 • 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.

Physical indicators of exposure to domestic and family violence	Behavioural indicators of exposure to domestic and family violence
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 High risk of lethality factors. • 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)?

Attachment 2: Table of risk and protective factors

Risk factors (Child)
Infant aged under 12 months Infants are more vulnerable due to their dependency on their parent for all their needs. For further information, refer to the practice guide Infants at high risk. Risk of harm also increases if the infant: • has been the subject child in a notification, including unborn. • is the result of an unplanned pregnancy • is born prematurely/drug dependent/subject to birth complications • is of low birth weight • has poor sleeping and/or feeding patterns • has been exposed to domestic and family violence in utero; or • has a complex medical issue, illness or disability. Rough or unsafe handling, slapping, kicking, pinching or shaking can all result in significant physical harm with possible lifelong implications or death. Shaking may result in physical harm causing brain damage, even without any external signs of injury. If an infant is showing signs of or is diagnosed as 'failing to thrive' (resulting from neglect or other causes), a delayed response can result in significant illness, physical harm or death. Failure to obtain medical attention may result in physical harm. If an infant has injuries, it is important to seek appropriate medical assessments. Consider the developmental milestones relevant to the age of the child to understand the nature of injuries, including corrected age for premature infants. Poor attachment and lack of bonding may result in neglect of the child, rejection, scapegoating, or harsh discipline, resulting in physical or emotional harm.
Unsafe sleeping practices Unsafe sleeping practices are linked to infant deaths. Unsafe practices include: • co-sleeping with a parent affected by drugs (including some prescribed drugs) or alcohol or other environmental factors that impact the responsiveness of the caregiver when co-sleeping • ill-fitting mattress and bedding • smoking in the environment • cluttered cots - soft toys and pillows that can cover an infant's face. For further information, refer to the Queensland Government website, Safe sleeping.
Child aged under 5 years increases vulnerability Children aged under 5 years are more vulnerable to harm as they are: • reliant on their parent to attend to their needs • less verbal and are often less able to communicate their needs. Younger children will have limited expressive language and limited ability to communicate with adults and others outside the home or family (both in their independent access to other adults and in their communication ability) • less able to seek assistance independently and/or may be isolated from others who may act protectively or could assist in meeting their needs or intervening for their safety and wellbeing.

Risk factors (Child)
• may display behaviour that challenges a parent, causing the parent to feel stressed and frustrated. Children under 5 can also be less visible in the community if they are not attending day care or kindergarten programs.
The child has diagnosed or apparent needs which increases their vulnerability such as developmental delays, physical or intellectual disability and medical concerns Stresses and higher demands of 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. A child with more than one disability is at greater risk of harm, and the level of harm is also likely to be more severe and chronic. Any NDIS package/support needs to be understood carefully if it is considered a protective factor. A child with a disability or increased vulnerability may be: • unable to communicate their concerns or disclose harm • unable to protect themselves • isolated and unable to access safe adults • dependent on other people including people responsible for harm • less likely to receive education on sex and personal boundaries, therefore less likely to understand or recognise this type of abuse.
Adverse childhood experiences and past trauma Any child who has experienced trauma, resulting in traumatic stress, is more vulnerable to harm (regardless of how the trauma was caused) and has decreased ability to protect themselves. They may be more likely to be significantly affected by any abuse or neglect they experience. Adverse childhood experiences contribute to disrupted neurodevelopment and can lead to social, emotional and cognitive impairment. This can manifest later in development in the adoption of health-risk behaviours, contributing to disease, disability and social problems and associated with early death or shortened lifespan. For further information about Adverse Childhood Experiences (ACEs), refer to the Emerging Minds website, Adverse Childhood Experiences toolkit.
High risk behaviours High risk behaviours can be related to any harm type and the behaviour may be an attempt to cope with the impacts of harm (including cumulative harm) or a way of expressing distress or unmet needs. High risk behaviours may include (but are not limited to): • self-harming (for example cutting or burning) • suicidal threats or behaviours • substance misuse • harmful sexual behaviours • crime. The vulnerability of a young person who is engaging in high risk behaviour is heightened. Their capacity to protect themselves should not be over-estimated or assessed on their age or stage of development alone, but in the context of their mental and emotional functioning, in addition to the environment that they find themselves in. High risk behaviours can be the result of harm and can contribute to an increased risk of harm as a result of increased parental stressors in responding to these behaviours and/or conflict with the child and disruption of the parent-child relationship.

Risk factors (Child)
For children who engage in high-risk behaviours, the parent may be willing to protect the child or young person but not be able to, for example when the behaviours occur outside the home, due to the young person's physical strength and use of threat and/or violence.
Mental health Mental health can affect anyone, however a child who has experienced trauma or loss may be at a greater risk and more vulnerable to being diagnosed with a mental health illness. Children and young people who are at a greater risk of mental health issues can include (however not limited to): • children who identify as lesbian, gay, bisexual, transgender/trans, intersex and queer (LGBTIQ+) • have experienced abuse • children who use alcohol and drugs • reside in care • homelessness or risk of homelessness • identify as Aboriginal and Torres Strait Islander. Particular attention and support should be given to children and young people who identify as trans and they are at a greater risk of suicidal attempts (11 times more likely than children who do not identify as gender diverse). (National LGBQIA+ Health Education).
Youth Justice involvement or offending behaviour Young people who have experienced abuse or neglect are at increased risk of offending, particularly when the abuse or neglect begins or continues into adolescence. Other factors that may lead to offending behaviour include homelessness, anti-social or violent tendencies, developmental delays, reduced resilience or poor impulse control. Children may engage in offending behaviour as a result of peer or social influences, developmentally related to changing influence of social and peers or to feel a sense of belonging and acceptance within a peer group. Children engaging in offending behaviour, in particular children aged 12 and under, may have needs that are neglected or not adequately met by their parent that could otherwise deter or redirect them from the offending.
Gender and sexual orientation diversity The Australian Childhood Maltreatment Study (Haslam et al, 2023) found that people who identify in gender diverse ways are three times more likely to experience all types of child maltreatment. Ninety per cent of diverse gender respondents reported experiencing childhood abuse. Studies also reveal that transgender adolescents exhibit disproportionate levels of mental health problems compared with cisgender adolescents, additionally they had elevated rates of psychological, physical, and sexual abuse compared with heterosexual cisgender adolescents. Risk for psychological abuse was highest among transgender adolescents assigned female at birth. Disparities in Childhood Abuse Between Transgender and Cisgender Adolescents - PMC (nih.gov) Recognition, including the correct recording of the child's gender can support with engagement and ensure accessibility to important information about the child or young person's identity and experience.

Protective factors (Child)
The child has skills and abilities that may provide a degree of self-protection To assess a child's capacity to protect themselves from harm, the type of harm and overall impact on the child needs to be considered. While children aged around 10 years and over are more likely to have problem solving and social skills and abilities, the impact of any previous trauma, special needs such as developmental delays, or learning/intellectual/physical disability must be considered. The child's ability to remove themselves or seek assistance may be considered a protective factor in relation to physical harm, however, even though this may mean they can avoid physical injury, it is not the child's responsibility to protect themselves from harm. Where a child holds responsibility beyond their capacity or beyond what could be considered appropriate or reasonable, they may be at risk of emotional harm due to undue stress and responsibility. Some measure of safety may be possible where the child has capacity to participate in and action a safety plan, with a safety and support network. This means that action is taken before a child is harmed. Seeking help during or after an incident that may have caused or contributed to further harm to a child is not a protective factor.
The child has an effective safety and support network, is monitored through these supports and has positive relationships with significant others The child has a safety and support network of significant people and professionals (such as school, day care, health staff), who know everything about the situation and are able to provide effective support to a parent to safely care for an protect the child through actioning an agreed safety plan. Open, clear communication about expectations, roles and responsibilities is necessary if the safety and support network is to undertake an effective role in keeping the child safe. A child may only seek protection from harm if there is a positive relationship within the safety and support network and the child has a sense of belonging to that environment. Encouraging positive relationships and supporting this contact may counteract risk of harm as it assists the child in accessing already available supports.
Child with a strong sense of personal control A child may demonstrate a belief that they can control the impact of harm that has occurred, rather than the harm controlling them. 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. Characteristics of resiliency within a child may act to prevent the internalisation of the impacts of harm such as depression and anxiety. As indicated above, however, this should be considered careful as the impacts of having a high sense of responsibility on a child may also be harmful.
Connection to culture Strong connection to culture can promote a child's resilience and their sense of self, identity and belonging. 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, in addition to opportunities to connect with their community and land that increase a child's sense of worth and place within their family. 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.

Risk factors (Parent)
Alcohol and other drug use A parent using alcohol and/or other drugs to the extent that their ability to meet their child's care and protective needs is impaired increases the risk of harm to their children. For example, a parent who is frequently intoxicated is more likely to be unable to appropriately supervise their child/ren or respond to their child/ren's physical and emotional care needs. Consideration needs to be given not just to the parental behaviour but also to the impact that behaviour (or inaction) has on the child. Child/ren are also at increased risk of harm if they have access to substances or implements used by their parents. Also consider how much of the household income the parent is using to supply the drugs and/or alcohol and the impact that this has on their ability to meet the child's daily basic care needs.
Mental illness On many occasions a parent's experience of mental illness may not disrupt their parenting. However, consideration needs to be given to any impact that the parent's mental illness may be having on their ability to care for their child particularly if the nature of their illness is severe or chronic over time. Parents suffering from mental illness may have reduced emotional availability, a changed view of their child, reduced ability to support child development or maladaptive coping strategies.
A parent is refusing access to the child or the family is likely to flee If a parent is refusing access to a child, it may be to avoid further assessment of notified harms.
Issues in the parent-child relationship and connection Where the relationship between the child and the parent is absent, disrupted, disordered or under stress, the risk of harm is increased. Secure attachment occurs when a primary carer provides consistent care and is responsive to the needs of the child - with a critical time for the development of secure attachment being from around six to eighteen months of age. If a parent is unable or does not respond to the child's needs, insecure attachment results, with a child showing avoidance or ambivalence to the parent and others. Disorganised attachment is evident in some children who have suffered harm through impacts of chronic family violence, or whose parents misuse substances. Disorganised attachment in infancy has been linked to complex trauma and a higher risk of behaviour problems in later childhood, adolescence and adulthood.
Parental expectations of the child are unrealistic A parent may not recognise or be aware of developmental milestones and appropriate behaviour and disciplining techniques consistent with the age and developmental phase of their child. The parent may place unrealistic expectations on the child physically, emotionally or psychologically or may find it difficult to recognise and respond to needs or challenges for the child's healthy development. Where a parents' expectations do not align with the child's actual or expected milestones, this may cause or contribute to parental stress. A child may have delayed access to early intervention to assist them in meeting development milestones if a parent is unwilling or unaware of the child's support and intervention needs. A child may be given responsibility to care for themselves and/or younger siblings beyond their capacity and maturity. Conversely, a child may be restricted from participating in age appropriate activities due to the parents' underestimation of what could be reasonable for a child of that age and development. *Note: Aboriginal and Torres Strait Islander child rearing practices and kinship systems can mean the roles and responsibilities children differ from non-Indigenous definitions of family. Children and young people may take on responsibility in their family and community at a young age; such as caring for siblings or extended family members. This responsibility is determined the family based on the need and the child's ability, and less likely to be related to the child's age.*
Young parental age or immaturity Risk of harm generally increases for parents who lack maturity and emotional intelligence, acquired parenting knowledge and/or are less able to tolerate stress. These factors are not unique to young

Risk factors (Parent)
parents, however, given their less mature developmental phase these factors are often present for young parents, particularly those who have their first child when they are a teenager. Young parental age may also correlate with other risk factors such as lower educational achievement, lower self-esteem, substance misuse and housing and financial pressures. Young parents social support systems are less likely to include peers and social interactions that are focused on or compatible with parenting responsibilities. If these multiple factors exist together the risk of harm is increased.
A parent is impulsive 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. There are numerous causes and contributing factors to impulsivity and this may also link to gambling, drug and alcohol use, or anger management which also impact on parenting capacity.
Lack of ability and willingness to prioritise the child's needs over their own Immaturity and psychological or cognitive issues can impact on a parent's ability to tend to the needs of a child over their own needs and wishes. Substance abuse may impact on the parents' ability to provide basic care to a child as their addiction makes it more difficult to attend to and respond to the needs of the child as a priority. Coercive control may make it more difficult to recognize acts of protection by the survivor of domestic and family violence. It may appear that they are prioritizing the relationship with the perpetrator over the needs and well being of the children, therefore a full understanding of the perpetrator pattern and the full range of the survivor's protection is necessary to understand the potential harm and future risk of harm.
A parent's behaviour is violent and/or controlling A person who uses violence (physical force) in any context is more likely to cause physical harm a child. Use of violence contributes to the perpetrators ability to exert ongoing power and control over family members. Threats of violence may also indicate a likelihood of actual violence in the future. Threat of violence may be a 'once off' however the resulting harm from ongoing fear can be cumulative. Coercive control, even in the absence of physical violence or threats, increases the risk of harm to the child. Domestic and family violence can limit a parent's ability to meet a child's needs; or exacerbate existing concerns (such as substance use or mental health concerns). If a child lives in a fearful environment and experiences their parent being physical or verbally abused, the child may become wary of adults; overly compliant; experience mental health conditions, resulting in emotional harm.
The parent has experienced childhood abuse 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 harmful parenting behaviours on their own children. Childhood abuse may skew or diminish the parents' perspectives of their own parenting and impacts on their child. In their own parenting, they may repeat the patterns of behaviour they experienced. Parents may also engage in other harmful parenting strategies in an attempt to prevent or avoid repeating the patterns of their own childhood. For example, a parent may isolate the child for fear that they will be sexually abused, preventing the child from accessing medical treatment or education.

Protective factors (Parent)

The parent acknowledges harm to the child, takes responsibility for change, seeks appropriate treatment and assistance and/or has the capacity to prevent future harm

A parent who acknowledges their role in a harmful incident or 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. Conversely, admission alone is not a protective factor.

A parent's views on the harm needs to be considered as part of the broader risk assessment. 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 Law Court orders).

If a 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 awareness and a degree of acknowledgement of the significance of the harm and risk of future harm.

Where appropriate and timely treatment or assistance is sought, the circumstances are more likely to change and reduce the likelihood of future harm.

Secure attachment between the parent and child

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.

A parent has an effective and responsive safety and support network

Secure and supportive relationships with other significant people may buffer against the effects of stress and facilitate positive coping strategies.

For example, 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.

Harm and abuse factors

The current injury/physical harm or condition is severe

The more severe an injury or condition, the more significant the impact is on child and the greater likelihood of future harm.

Multiple and/or recurring injuries are more likely to cause significant harm and indicate increased future risk of harm.

For infants, any incidents or evidence of shaking or other signs of injury or failure to thrive is significant.

For a child of any age, the location of injuries can increase the severity of the physical harm. For example injuries to the head or face are more serious due to the potential for permanent brain, eye and ear damage.

Internal physical injuries may not be obvious. Behaviours such as flinching or a young child who is unable to be consoled/settled may indicate any underlying injury, however, there may also be no obvious or observable signs.

Inconsistent explanations, denial or minimisation of harm by a parent

When a parent minimises current harm, justifies the abuse, cannot recognise or denies responsibility for the harm, this may lead to increased risk of harm. It may also suggest a non-accidental injury.

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.

Harm and abuse factors
If a parent is unable to accept or acknowledge how their actions have caused harm, the abuse is more likely to continue and have a cumulative effect, resulting in emotional or physical harm.
There is previous departmental history Risk of harm increases if harm has previously been found. In addition to any harm, all previous history including child concern reports, and assessments of all types should also be considered and critically reviewed; any record of concern may indicate cumulative harm. 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. If a parent has been identified as a 'person responsible' for harm to a child in the past, it is more likely that harm will reoccur; either to that child, another child and/or the harm may become cumulative, unless significant positive and sustained changes have occurred in the relationship between the child and parent and any other children in the family, the parent's behaviour or parenting skills or the family environment.
The pattern of harm is escalating The harm is escalating over time, increasing in severity and/or frequency. Previous concerns may relate to a different harm type to the current concerns and *all* past harm should be considered. Consider all child protection history and information from other sources (for example family and network members, police, medical practitioners, school) so the pattern of harm can be better understood.
The pattern of harm is continuing but not escalating The more often harm has occurred in the past, the more likely it is to occur again in the future. Pattern of harm may be well established and have been occurring in the same way for a long period of time. Where harm has been occurring for longer periods of time, the behaviour is more likely to continue and the resultant (possibly cumulative) impacts are more significant. Behavioural patterns that have been in place for some time are more difficult to change and therefore, more likely continue (without intervention). Consider all past reports of harm, including those that did not meet the threshold for a notification or found harm to determine future risk of harm and identify cumulative harm.
Perpetrator's access to the child The risk of harm occurring is increased if the alleged person responsible has access to the child. Research suggests that sexual abuse can be compulsive or addictive - people with a history of sexual offences against children have a high rate of recidivism. A child is more likely to be harmed if a person who is alleged to have sexually abused a child, is reasonably suspected of having sexually abused a child or has been convicted of perpetrating sexual offences against children has unlimited or unfettered access to a child.
The parent has made a threat to cause serious harm to the child A parent may make threats to harm the child, another family member or a pet. Threats involving weapons or implements increases the likelihood of emotional harm and where weapons or implements are accessible for the threat to be carried out, there is increased risk of physical harm, including death. Where the pattern of coercive control by a perpetrator of domestic violence includes threats, there is an increased risk of lethality, and well as physical and emotional harm. A child living in a fearful state due to threatening behaviour may exhibit withdrawal, regression, bedwetting and soiling, sleep disturbances, nightmares fearful responses, anxiety/agitation/hypervigilance or externalised emotional distress such as aggression. These may be indicators of emotional harm which may be cumulative in nature.

Harm and abuse factors

Chronic neglect is identified

Chronic neglect has a cumulative impact on a child's functioning and their future emotional, behavioural, cognitive, social and physical development and well-being. The likelihood of neglect having an acute or cumulative impact on the child is increased by anything that stretches or places pressure on household resources or the parents capacity (including their ability, availability and responsiveness); making it more difficult for the needs of child/ren to be met, contributing to or leading to neglect. This may include:

- the number of children in the home with more children potentially placing increased demand on the parents' capacity and household resources
- the age of the children, with younger children (for example) requiring more of the parents' time and attention for their care and supervision
- the needs of the children where complex or challenging needs place increased demand on the parents' capacity, time and resources,
- the parents' capacity and availability may be limited or depleted by the impacts of coercive control in domestic and family violence situations, substance abuse or mental health concerns, poverty.

Multi-type abuse

Multi-type abuse (also known as multi-type maltreatment) is when a child experiences more than one of the abuse types (physical abuse, emotional abuse, sexual abuse, neglect or exposure to DFV). An understanding of multi-type abuse highlights patterns of risk and vulnerability for children (Haslam et al, 2023). Family related adversity factors such as parental separation, family mental illness, substance misuse and economic hardship are significant risk factors for multi-type abuse. That means, the more risk factors that are identified for a family, the higher the likelihood that children will experience multiple types of abuse. For instance, the Australian Childhood Maltreatment Study (Haslam et al, 2023) found that Exposure to DFV was the most common form of child maltreatment present in multi-type combinations, noting that it rarely occurs in isolation. In practice, this means staying alert to other types of abuse when DFV is present.

Risk factors (Family)

There is domestic and family violence

Any child with a parent who has experienced domestic and family violence will be impacted in some way, considering the multiple pathways to harm caused by domestic and family violence. 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.

A non-offending parent's ability to protect and to meet a child's needs can be impacted by violence and coercion perpetrated by a partner or other family members.

The non-offending parent may be or appear to be unable to act protectively due to the coercive control and violence, for example the person using violence has made threats of murder or suicide if the non-offending parent attempts to leave with the children.

The non-offending parent may over-discipline a child in an attempt to control the child's behaviour and protect them from the violent and controlling behavior of the person using violence.

Consider the presence of high risk of lethality factors and the risks these pose to the mother and her children.

The family is experiencing a high degree of stress

Research indicates that increased stress for a family (and parent) increases the likelihood of future harm for a child.

Family 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.

Risk factors (Family)

The family is highly mobile

A highly mobile family decreases the opportunity for effective interventions to be established, increasing the likelihood of future harm to the child. It may be difficult to access historical or current information that helps inform the assessment as information may be lost or difficult to locate or access.

Impacts for the child of high mobility may include disrupted education resulting in cumulative harm, isolation and disruption to peer and family relationships and basic materials need not being met.

Single parent family

Being a sole or single parent is not in itself a risk factor but may be when other factors are present in the family. Research has identified single parents face increased financial pressures, higher stress levels and isolation, often with less access to emotional and social supports.

When there is only one parent, the care responsibilities fall to one person which can be associated with increased risk. 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.

The parent may become a sole parent because of separation, divorce or death of a partner, placing further stresses on the family through loss and grief.

Protective factors (Family)

There is another safe adult actively involved, present and accessible who is able and willing to protect the child

Consider the frequency and regularity of the child's contact with the protective person when assessing whether their involvement may reduce the future risk of harm. Another safe adults' involvement and presence may decrease the risk of physical harm and provide a positive role model for the person responsible for harm.

A protective person is someone who:

- is aware of the harm and wants to protect the child
- understands how harm occurred and acknowledges any likelihood of future harm
- does not pose a risk to the child themselves
- possesses significant influence with the child and their parent
- will be able to effectively protect the child from the identified harm or risk of harm by their presence.

There are clear household boundaries, routines and structure

Predictable routines can mitigate against chaotic stress and provide a sense of security to the child, promoting connection and well-being and supporting behaviour and household management, reducing parental and household stress

Risk factors (Environment)

The physical and social environment is chaotic, hazardous and unsafe

A chaotic, unhygienic, unsafe environment can pose a risk to a child's health or safety. Exposure to bacteria or disease or hazards and heights may result in illness or injury causing physical harm. A child's social environment may hazardous due to the parent's functioning and behaviour which directly contributes to the environment being unsafe, unhygienic or chaotic and risk of harm is increased.

Risk of harm will also depend on what safety strategies have been put in place by the parent to protect the child in this environment.

Note: *In some areas, housing may be limited and yet adequate by community standards. If community living conditions are not related to inadequate parental provision of basic care, consider a referral to other relevant council or government services.*

Poor social networks and isolation from services

A lack of services; inability to access infrastructure such as parks, transport, shops, schools and child care; and low levels of social support can heighten the probability of harm as the child may not engaging in the community and intervention is not available. A child who is isolated may experience any type of harm, which may continue due to the absence of intervention and support resulting in cumulative harm.

Social isolation may be more prevalent in rural and remote areas, and for families of minority or marginalized groups. For example, 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.

Poverty impacting on food insecurity, employment opportunities and/or housing stability and homelessness

Poverty and unemployment may be linked to residing in a disadvantaged community, with associated inability to access services and locate and afford adequate housing.

Linked to low family income and other stressors, housing instability can impact on the child's learning, social and developmental needs. Housing instability and food insecurity may be the result of a parent leaving a violent partner or household member - an action taken to protect the child.

Cultural context

Cultural or religious beliefs or practices may be associated with behaviour that results in significant harm to the child. When assessing harm and risk of harm, information about the culture, beliefs, values and practices for the child and family should be obtained from the family and/or community with cultural knowledge and authority.

Where the harm is related to cultural or religious beliefs or practice and the behaviour is linked to the parents' core values and beliefs, it is less likely they will recognize the behaviour as harmful, more likely they will justify or excuse the harm for cultural or religious grounds, and more likely that the behaviour will continue.

Non-biological parent

The presence of a step-parent or a person undertaking a parenting role as the partner of the parent can be a risk factor across all harm types. There is an increased risk of emotional abuse due to behaviours such as scapegoating or rejection, increased risk of sexual abuse and physical and emotional harm caused by a step-parent and increased risk of physical harm due to assault by an non-relative. Causal 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.

While a female partner may also cause harm to their partners child, research indicates that male partners are more likely to be responsible for harm.

Protective factors (Environment)
The family is supported by a safety and support network Contact with another professional or community agency may reduce parental stress and increase their ability to cope. 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. Where non-professionals, family and community members are actively supporting a family, this can also ameliorate stress, improve support, well being and family functioning to reduce the likelihood of future harm. To be able to take protective action to mitigate risk, members of the network must be aware, available and able to take action and intervene in relation to the risk of harm.
Adequate income and housing Fewer stresses by way of basic housing and income can decrease anxiety, increase self-worth, support parent-child relationships and buffer emotional harm and neglect.
Connection to culture or religion Children, parents and families who experience a meaningful connection to their culture or religion can mitigate against harm through increased sense of worth and belonging, access to community/neighborhood supports and access to people and opportunities for cultural practices that support emotional wellbeing. For example, an Aboriginal mother residing in community may connect 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.

Attachment 3: Information gathering template

Category	Prompts for information gathering	Information gathered
The child	Factors relating to a child's vulnerability, such as age, stage of development, high-risk behaviour (for a young person), behaviour that challenges the parent (for a child under 5), medical/health or disability needs. Previous harm or exposure to traumatic experiences (Refer to What are adverse childhood experiences (ACEs)?) Information about and observations of the child's behaviour and their relationship or attachment with their parents. Information about and observations of the child's functioning and/or developmental ability. For an infant, information about their pre-natal experiences, birth, sleeping arrangements/practices and circumstances of the pregnancy. (Refer to the practice guide Infants at high risk.) For a young person, information about substance use, intellectual ability, acceptance within a peer group/sense of belonging, behavioural control, learning disorders, involvement with Youth Justice.	
The parents	The age or level of maturity of the parent/s Information about the parents' childhood experiences, including whether they had adverse experiences or suffered harm. The parents' relationship with the child, expectations and perception of the child. The parent's level of care, supervision and discipline of the child. Information about whether a parents' ability to protect a child is impacted by an intellectual or physical disability, a health issue, or coercive control (where a parent is the victim of domestic and family violence). Information about whether a parent's ability to safely parent a child is affected by their use of alcohol or other drugs, perpetrating domestic and family violence or a mental health issue. Information about the parents' willingness to protect a child. Whether the parent have a criminal history that is relevant to the assessment of harm or risk of harm to the child. The parents' explanation of the harm (is the explanation consistent, or does the parent deny, minimise or blame?). Information about strengths, resources and acts of protection.	

Category	Prompts for information gathering	Information gathered
The harm/abuse	Based on the child protection history: • information about whether this type of abuse has occurred before, whether the child has suffered harm previously as a result, and who was responsible • information about whether the child has suffered harm in the past, as a result of other types of abuse (and who was responsible) • information about who has been responsible for protecting the child in the past, including how • information about whether the person alleged responsible for harm now, has caused harm to any other child in the past • what patterns of behaviour can be identified, including information about frequency and severity? Consider all child protection history, not just information that has 'screened-in' or been 'substantiated'. What has happened/is happening for the child now (ie who is perpetrating abuse, how and in what circumstances)? Does the alleged person response/person responsible have access to the child or have a parenting role? What has been the cumulative impact of the child's experiences on their physical, psychological or emotional wellbeing?	
Family and cultural context	Information about an Aboriginal or Torres Strait Islander child and their parents' connection to their culture, and how this connection contributes to protection for the child. This information may relate to kinship structures and the role of extended family and community in raising the child, traditional child rearing practices, including autonomy, independence and responsibility and the role of elders and spirituality. (Refer to Strengths of Australian Aboriginal cultural practices in family life and child rearing) for further information). Information relevant to Culturally and Linguistically Diverse (CALD) culture and their parenting and child rearing practices. Information about positive supports parents have to help them to safely parent a child, including extended family members. Gather information about exactly how this support looks and what the support persons do to help.	

Category	Prompts for information gathering	Information gathered
The environment	Information about the household composition (such as single parent household, or non-biological parent) and size of the household. Information about stressors in the household. Does the family have adequate resources such as income and stable housing? Is the family mobile or does the child have unstable or unsafe living arrangements? Is the physical environment safe and does the child have adequate supervision? Does the family have access to services, including education, child care, transport and health services?	

Attachment 4: Template for analysing the information gathered

What does the information that has been gathered mean for this child?	
Vulnerability – analyse information about: • the child's vulnerability • whether the person alleged responsible for harm to the child has access to them or takes on a parenting role.	**Safety** – analyse information about: • protective factors that mitigate against risk • acts of protection by a parent to stop harm or exposure to harm • a parent's ability and willingness to protect the child from the harm.
Impact – analyse information about: • the harm the child has suffered in the past, is suffering now or may suffer in the future, if nothing changes • the abuse (including type, patterns, severity, frequency, and chronicity of the behaviour towards the child).	**Probability** – analyse information about: • the risk factors, and how these interact with one and other • the attitudes and beliefs of the parent • the parents' capacity, not just intention or willingness, to protect the child.