Family and Child Connect

Service Model and Guidelines

This document is for funded FaCC providers and their workers as the key guide to inform work practices. It must be read in conjunction with the department's Families Investment Specifications and the Service Agreement between the department and each service provider which includes the Queensland Government Service Agreement – Standard Terms for Social Services

November 2023 (Version 6)

Queensland Government

Version History

Version	Date	Comments
Version 1.0	January 2016	• Following review of previous Program Description and Practice Guidelines
Version 1.1	February 2016	• Inclusion of attachment Principal Child Protection Practitioner guidelines • Amendments to information on Common Assessment Tools
Version 2.0	February 2018	• Refreshed content and format update • Definition at risk families/enquirers • Opening hours • Tertiary qualifications clarification • LLA requirements • TIS access
Version 3.0	April 2018	• Reformatting and removal of obsolete content
Version 4.0	October 2018	• Updated content to reflect the *Child Protection Reform Amendment Act 2017* • Updates Links to additional resources
Version 5.0	March 2020	• Added Local Level Alliance Best Practice Principles • Updated Engagement and Assessment, Closure and Referrals sections
Version 5.1	June 2023	• Remove reference to Family Risk Evaluation and including risk assessment practice guide (Appendix 4) • Inclusion of Appendix 5: Culturally Respectful, Safe and Responsive Service Delivery for Aboriginal and Torres Strait Islander Families • Update Christmas closure information • Additional requirements for feedback to referrers (Child Safety, Education and Health) • Update to translation services
Version 6	November 2023	• Clarification of brief intervention • Added Early exit definitions • Added Community engagement • Added Appendix:4 – closure/consent scenarios

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List of Acronyms

ARC	Advice, Referral and Case management
CALD	Cultural and Linguistically Diverse
CAP	Collaborative Assessment and Planning framework
CCR	Child Concern Report
CSSC	Child Safety Service Centre
DFV	Domestic and Family Violence
ECEC	Early Childhood Education and Care
FaCC	Family and Child Connect
FAST	Family Assessment Summary Tool
FGM	Family Group Meeting
FWS	Aboriginal and Torres Strait Islander Family Wellbeing Service
I&A	Investigation and Assessment
IFS	Intensive Family Support
IPA	Intervention with Parental Agreement
PCPP	Principal Child Protection Practitioner
P2i	Procure to Invest
RIS	Regional Intake Service
SDM	Structured Decision Making
Child Safety	Child Safety Services
The department	Department of Child Safety, Seniors and Disability Services

While a collective term of **Aboriginal and Torres Strait Islander** is used throughout this document, it must be noted these are two separate groups with unique cultures. It may not always be appropriate to consider from a collective position and it is important to respect individual needs, preferences and experiences.

For broad information about the Queensland Government's policy framework and requirements, see *https://www.qld.gov.au/firstnations*

While a collective term of **Cultural and Linguistically Diverse (CALD)** is used throughout this document, the CALD community is diverse and broad, from a range of unique cultures and can be described as 'communities with diverse languages, ethnic backgrounds, nationalities, traditions, societal structures and religions.' It may not always be appropriate to consider from a collective position and it is important to respect individual needs, preferences and experiences.

For broad information about the Queensland Government's policy framework and requirements, see *https://www.qld.gov.au/about/newsroom/making-a-multicultural-queensland*

While a collective term for **disability** is used throughout this document, it must be noted disability is diverse and broad in nature and may be visible or non-visible to others. It may not always be appropriate to consider from a collective position and it is important to respect individual needs and preferences.

For broad information about the Queensland Government's policy framework and requirements, see *https://www.qld.gov.au/disability*

1. Introduction

1.1 Purpose and Audience

This document (Version 6) replaces all previous versions of the Model and Guidelines

The Family and Child Connect (FaCC) model and guidelines outlines the model of service delivery expected by the Queensland Government from service providers and their staff funded by the department of to deliver FaCC services.

The document provides information on the service delivery context, reporting requirements and outcomes expected of funded FaCC service providers and must be read in conjunction with:

- the contractual obligations set out in the Service Agreement with each service provider; and
- the requirements set out in the Families Investment Specification[1] which describes the intent of funding, Service Users and identified issues, service types, and associated service delivery requirements for services under the Families funding area; and
- any additional legislative requirements and/or formal advice or instructions provided by the department which may not yet be compiled in the document.

All related program documentation, guidelines and supporting information is available on the secure sub-site for FaCC and IFS service providers and approved staff located at the public Family and Child Connect website at https://familychildconnect.org.au/secure/. Managers must ensure all relevant staff have access to the secure website and stay abreast of any updates. To request access to the secure sub-site, please email childandfamilycommissioning@cyjma.qld.gov.au

Further information is also available on the department's website:

Family and Child Connect | Community support | Queensland Government (www.qld.gov.au)

Funding, grants and investment – Department of Children, Youth Justice and Multicultural Affairs (cyjma.qld.gov.au)

1.2 Background

FaCC services were established across Queensland to support families who are at risk of entering or re-entering the child protection system.

FaCC services are uniquely positioned to provide a rapid assessment and referral options for enquirers and families to connect them to the right service at the right time. Eighteen services

[1] The Investment Specifications and other information about funding is available on the department's website at *https://www.cyjma.qld.gov.au/about-us/our-department/funding-grants-investment*

provide timely assistance to families and enquirers across the state. Departmental data indicates FaCC services manage around 30,000 enquiries per annum.

Available departmental data on the performance of all family support services (FaCC, IFS and Aboriginal and Torres Strait Islander Family Wellbeing Services can be found at https://performance.cyjma.qld.gov.au

1.3 Governing framework

Legislation

Two key pieces of legislation are central to the practice of providing protection to children in Queensland.

Child Protection Act 1999

The *Child Protection Act 1999* provides the overarching legislative framework for the protection of children in Queensland including the reporting of concerns. Of relevance to FaCC is the legislation's emphasis toward preventative measures to reduce the risk of entering the statutory protection system:

- Alternative referral pathways to services for families who need support
  - The preferred way of ensuring a child's safety and wellbeing is through supporting the child's family (s. 5B(c))
  - Allows prescribed entities[2] to refer a family to a service provider where it is considered a child is likely to become in need of protection without support being provided to their family (s. 13B(2))
- Clear information sharing provisions to remove barriers to collaboration and coordination of service delivery (Chapter 5A)
- The legal framework for reporting concerns about children to Child Safety including mandatory reporters (s.13E)
- Improving practice with Aboriginal and Torres Strait Islander children and families to reduce their disproportionate representation in the child protection system by acknowledging that stronger connections to kin, community, and culture result in better outcomes and the importance of family and community as the primary source of cultural knowledge.
- Additional principles for Aboriginal or Torres Strait Islander children including:

[2] Prescribed entity means each of the following entities— (a) the chief executive of a department that is mainly responsible for any of the following matters— (i) adult corrective services; (ii) community services; (iii) disability services; (iv) education; (v) housing services; (vi) public health; (b) the police commissioner; (c) the chief executive officer of Mater Misericordiae Ltd (d) a health service chief executive within the meaning of the Hospital and Health Boards Act 2011; (e) the principal of an accredited school under the Education (Accreditation of Non-State Schools) Act 2001; (f) a specialist service provider; (g) the chief executive of another entity that— (i) provides a service to children or families; and (ii) is prescribed by regulation.

- the right to self-determination (s.5c(1)(a))
- recognising the significant and long-term effect of decisions on identity and connection with, family and community (s.5c(1)(b))
- application of the five elements of the Aboriginal and Torres Strait Islander Child Placement Principle (Prevention, Partnership, Placement, Participation, and Connection (s. 5C (2)).

Appendix 3 provides details about the expectations for culturally respectful, safe and responsive service delivery for Aboriginal and Torres Strait Islander Families

Human Rights Act 2019[3]

The *Human Rights Act 2019* protects the rights of everyone in Queensland, regardless of residency, citizenship or visa status. The Act requires the Queensland public sector - Queensland Government departments and agencies, local councils, **and organisations providing services to the public on behalf of the state government** - to act and make decisions which are compatible with the rights it protects.

Of the 23 human rights protected in the Act, the following are directly relevant to the delivery of family support services:

- Protection of families and children (s. 26)
- Cultural rights for Aboriginal and Torres Strait Islander peoples (s.28)
- Cultural rights generally (s.27)
- Privacy and reputation (s. 25)

Resource: For more information see https://www.qhrc.qld.gov.au/your-rights/human-rights-law

1.4 Oversight and review mechanisms

Oversight and review are integral to delivering an effective child and family support system.

Systemic and external overview - Queensland Family and Child Commission

The independent Queensland Family and Child Commission (QFCC) is established under the *Family and Child Commission Act 2014* to review and improve the systems that protect and safeguard children. The QFCC promotes, empowers, and raises awareness with families and communities, drives system accountability and advocates for change. The QFCC is also supporting cultural change in the sector.

Resource: For more information about the QFCC see https://www.qfcc.qld.gov.au

[3] The Act applies from 1 January 2020 to acts and decisions made on or after that date (it is not retrospective).

Strategic oversight - FaCC and IFS Strategic Implementation Group

Established as a collaborative forum with the sector, the FaCC and IFS Strategic Implementation Group (SIG) provides strategic oversight and performance review of the FaCC and IFS programs.

Each service provider agency, along with relevant peak and government agencies are represented on the SIG. The forum is held bi-annually however ongoing dialogue can occur out-of-session as required.

Continuous improvement informed by practice, research, evidence, and policy developments is central to the SIG agenda.

Strategic Framework and Practice Tools

Two key strategic frameworks guide Queensland's child and family response and priorities[4]

- *Supporting Families Changing Futures 2019-2023*[5]
- *Our Way: a generational strategy for Aboriginal and Torres Strait Islander families* 2017-2037 (co-designed by the Queensland Government and Family Matters Queensland)

These strategic frameworks align with key national priorities to support children, young people and families, in particular (but not limited to):

- *Safe and Supported, The National Framework for Protecting Australia's Children 2021-2031*[6]
- *National Agreement on Closing the Gap*
- *National Plan to End Violence against Women and Children 2022-2032*

[4] See *www.cyjma.qld.gov.au/campaign/supporting-families* for detailed information about the child and family support system in Queensland.

[5] The Supporting Families Changing Futures framework is undergoing a review to outline the strategy post 2023.

[6] The National Framework at also outlines a range of additional national initiatives relevant to the objective of supporting children, young people and families. See *https://www.dss.gov.au/the-national-framework-for-protecting-australias-children-2021-2031*

2. The Model

2.1 Overview

Families, professionals and other members of the community who have concerns about a child's wellbeing are encouraged to contact FaCC for information and advice.

FaCC will assess the information provided by the enquirer and, considering the family's circumstances, provide resources, information and advice regarding appropriate support options. This will include, where appropriate, accepting a referral for the family for active engagement[7].

FaCC can also partner with enquirers to engage with and support the family. This has two key benefits, firstly, to assist the family to engage with services with the support of the enquirer who has an existing connection or relationship with the family and secondly, to increase the knowledge and skills of the enquirer in accessing support services for children and their families.

FaCC is an assessment/referral service and although it does not provide case management, in exceptional circumstances FaCC may provide brief interventions for families.

FaCC also support a Local Level Alliance (LLA) of government and non-government services within the community to ensure vulnerable families receive the right mix of services.

2.2 Service users

FaCC services provide support to two distinct user groups:

- **Referrers and Enquirers**
  - Referrers and enquirers are people who are concerned about the safety and/or wellbeing of a child or family and are seeking information, advice, or referral for support for the vulnerable family.
  - Referrers and enquirers can refer vulnerable and/or at risk families when they identify children or young people in need of support.
  - Referrers and enquirers include professionals (including those defined as mandatory reporters in the *Child Protection Act 1999*), prescribed entities[8], organisations, community members and/or families.
  - If a referrer or enquirer is a mandatory reporter, they must report a reasonable suspicion of harm that a child is a child in need of protection caused by physical or sexual abuse to Child Safety.

- **At Risk Families**
  - Families with children and young people under 18 years, including unborn children, who are at high risk of entering or re-entering the statutory child protection system.

[7] See page 16 – Response Type 4
[8] See page 12

- The family would benefit from access to family support interventions and/or referral to specialist support services.
- The child and family's circumstances or risk factors are likely to escalate if they do not receive support.
- The child is not currently in need of ongoing Child Safety intervention.
- Long term guardians may seek and access support through a FaCC where a child is not the subject of current case work being undertaken by the Department of Child Safety, Youth and Women.

2.3 Receiving enquiries and referrals

Contact can be made with a FaCC in person, over the telephone or by accessing the online referral form via the FaCC website.

13FAMILY telephone number

The 13FAMILY (13 32 64) telephone number is a unique statewide number to access FaCC services. Calls to 13FAMILY route the caller to the relevant FaCC service in their area. The exception is for 13FAMILY calls made in Cape York or Torres Strait which are routed to the Cairns FaCC to provide information and advice only for the Cape York/Torres Strait catchment.

Online Referral form

Referrals can be made to a FaCC at any time using the online referral form: Referral Form - Home - familyandchild connect (familysupportreferral.org.au)

When a referral is received through the online referral form, best practice requires that the FaCC worker **must** make all attempts to contact the referrer to gather or confirm all relevant and contextual information to assist in determining the most appropriate response for the family.

Referral pathways

Prescribed entities – referrals without consent

The *Child Protection Act 1999* enables prescribed entities (159M) to make referrals to FaCC without a family's consent to '*offer help and support to a child or child's family to stop the child becoming a child in need of protection*'.

Prescribed entities mean each of the following entities—

(a) the chief executive of a department that is mainly responsible for any of the following matters: adult corrective services; community services, disability services, education[9]; housing services; public health;
(b) the police commissioner;

[9] Although Early Childhood Education and Care (ECEC) services are mandatory reporters, they are not Prescribed Entities, therefore cannot make a referral to FaCC without consent of the family.

(c) the chief executive officer of Mater Misericordiae Ltd;
(d) a health service chief executive within the meaning of the *Hospital and Health Boards Act 2011*;
(e) the principal of an accredited school under the *Education (Accreditation of Non-State Schools) Act 2001*;
(f) a specialist service provider – a non-government entity other than a licensee or an independent Aboriginal or Torres Strait Islander entity for an Aboriginal or Torres Strait Islander child, funded by the State or the Commonwealth to provide a service to either a relevant child or the family of a relevant child[10]. Specialist service providers include both FaCC and IFS services.
(g) the chief executive of another entity that provides a service to children or families; and is prescribed by regulation.

Prescribed entities are responsible for managing delegation related to this role, including policy and procedural direction, guidance and support for their staff.

It should be noted some prescribed entities, particularly the Department of Education, have their own internal policy to gain consent from the parents before a referral is made regardless of their legislative ability to make a referral without consent.

Where a referral has been made without the family's consent by a prescribed entity under section 159M of the *Child Protection Act 1999*, both the referrer's details and the referred family's details need to be managed in accordance with both the *Information Privacy Act 2009* and under section 188 of the *Child Protection Act 1999*.

The *Information Privacy Act 2009* limits the right to share personal information other than where the person whose information is being shared has agreed to the information being shared with that other entity or individual. The only exceptions are:

- where there are reasonable grounds the disclosure is necessary to lessen or prevent a serious threat to the life, health, safety or welfare of an individual, or to public health, safety or welfare;
- where the disclosure is authorised or required under another law: or
- where the disclosure is directly related to obtaining information requested by the chief executive.

<u>Professionals and other organisations – referrals with consent</u>

Any other professionals and organisations, other than those listed as prescribed entities, that identify families experiencing vulnerability and meet the referral criteria may, with the family's consent, refer the family to FaCC.

[10] A relevant child is defined as a child in need of protection or a child who may become a child in need of protection if preventative support is not given to the child or the child's family

Community referrals

Community members seeking assistance for families experiencing vulnerabilities who need support may refer a family, with the family's consent, to FaCC service or encourage the family to self-refer.

Self-referrals

Families may self-refer to FaCC service for information, advice and support.

Receiving enquiries or referrals from outside your catchment

Response types 1 and 2

The receiving FaCC can and should provide response types 1 and 2 to any enquirer, regardless of the family's location.

Response types 3 and 4

The receiving FaCC will telephone the appropriate FaCC to advise that an out-of-area referral has been received. The receiving FaCC will then electronically transfer the referral to the appropriate FaCC service for their follow up.

Managing sensitive referrals

There may be occasions when FaCC receives a referral that is deemed sensitive, such as a referral from a family member or someone known to an employee.

In these cases, the service should be particularly mindful of the family's privacy when making contact to offer support. Consideration could be given to a more senior person in the organisation initiating first contact with the family to offer the option of working with FaCC. Best practice would be to provide the family the opportunity to choose whether they would like to receive support from the service.

Should the family choose not to work with the FaCC, efforts can be made, with the consent of the family, to link them with an alternative appropriate service. If the alternative service is a FaCC in an adjacent catchment, that service will need department approval through their contract manager to accept the case as it will be outside their catchment. Discussions with the FaCC and department need to occur prior to referring the family to the alternative service.

In extraordinary circumstances FaCC may need to advise the referrer they are unable to accept a referral that is deemed sensitive, again being mindful of the family's privacy, and recommend another service for that referral. Prior to taking this action, and without providing any personal details about the family, contact must be made with the alternative service to assess their capacity and willingness to accept the referral.

If the family lives outside the catchment of the alternative service (and it is funded by the department), that service will need to contact the department to ensure accepting the referral is not going to breach their service agreement. Once this has occurred, FaCC should assist the referrer to make the referral to the other service.

2.4 Response types

FaCC enquiry responses will fall into four categories. These responses are flexible and the focus is on providing the most effective response available to the enquirer and the family.

Response types are determined at the point of enquiry and reflect how the service has either responded to (response type 1 or 2) or intends to respond to (response types 3 or 4) the enquiry.

Response type definitions below use terms such as universal, secondary and tertiary service types to help clarify how each response differs. Secondary services include both intensive family support and targeted services.

Response type 1

Response type 1 is used in circumstances where the details of the enquiry indicate the issues raised concerning the child and their family do not require a secondary or tertiary service response. In these instances, the FaCC will provide advice to the enquirer on how they could respond to the situation and this might take the form of:

- information about local universal services to support and connect the family with their community;
- protective advice; or
- suggestions for the enquirer staying engaged with and supporting the family.

This advice may be provided via telephone, email, face to face and/or by providing brochures to the enquirer about local universal support services.

Response type 2

Response type 2 is used in circumstances where the initial assessment by FaCC indicates the concerns raised about a child are best met by the enquirer directly referring the family to a secondary or targeted service (including an Intensive Family Support service). FaCC is expected to encourage and support the enquirer to gain the consent of the family or individual family member for a referral to a service provider recommended by FaCC; and for the enquirer to then make a direct referral to this service.

To provide this response, FaCC will determine the enquirer is able and willing to make the referral on the family's behalf.

The FaCC should only provide an enquirer with details of an Intensive Family Support service when FaCC is satisfied the Intensive Family Support referral criteria are met and information indicates the family is willing to engage with this service.

FaCC can also provide additional information and advice as per response type one.

ARC tip: for Response Type 1 and 2, details of the response should be entered into the Enquiry tab.

Response type 3

Response Type 3 is used when FaCC make an initial assessment the concerns raised about a child would be best met by referring the family to a secondary or targeted service/s (including an Intensive Family Support) however additional support is required from FaCC to assist the enquirer in making the referral.

Response Type 3 acknowledges that the enquirer has an existing relationship with the family and is best placed to lead the family's engagement with services. However, unlike Response Type 2 where the enquirer makes the referral on the family's behalf without assistance, the purpose of Response Type 3 is to build enquirer confidence and change future referral behaviour by enhancing the enquirer's skills in talking with families about their worries and referral options.

FaCC is expected to support the enquirer to gain the family's consent and have contact with both the enquirer and the family to manage a smooth referral process. For example:

A teacher is new to a community and has developed a relationship with a family but is unsure about the local service system. The teacher seeks support about how to engage with the family in a way that enables them to maintain their relationship as well as link the family into relevant service supports. The teacher has the consent of the family to contact FaCC who then meet with the teacher and the family to support this discussion. This leads to the teacher making a referral with the family's consent to an appropriate family support service.

ARC tip: a case summary should be opened and once the enquirer completes the referral, the case is closed in ARC with the closure reason – *Referral to another service*.

Response type 4

Response type 4, also known as *active engagement*, is appropriate when FaCC make an initial assessment that the referral criteria (see below) are met and response type 3 is identified as not appropriate. A referral to FaCC for active engagement is most appropriate in circumstances where:

- the family's needs have not been able to be sufficiently ascertained, or
- further assessment is required to identify the most appropriate service/s to meet the family's needs, or
- the family may benefit from another secondary support service and referral can best be facilitated by the FaCC.

FaCC family support workers are expected to encourage referrers to use their connection with the family to gain consent for the referral.

Referral criteria for active engagement

- the referred family has a child unborn to 18 years of age, and
- the child is not currently in need of protection, and
- without support the child or young person are at risk of entering or re-entering the statutory child protection system, and

- the family would benefit from active engagement to assess their current needs; and
- the family has multiple and/or complex needs, that is, there is at least one family member presenting with behaviours or circumstances which are having negative consequences for the family, particularly children. Consider if there is:
  - more than one issue impacting on the child or family's wellbeing; or
  - there is a complex issue/s impacting on the child or family's wellbeing.

  Examples of issues include, but are not limited to: family violence, parenting challenges, mental health, substance misuse, learning difficulties, housing instability and financial stress.

In circumstances where FaCC makes an initial assessment that the referral criteria are met and an active engagement response is appropriate, FaCC will:

- advise the enquirer of the planned response
- seek engagement (i.e. direct contact) with the family
- undertake a detailed needs assessment with the family
- identify the range of services required by the family; and
- implement a plan to facilitate family's engagement with services.

2.5 Prioritisation of referrals

Services may choose to adopt a mechanism to assist prioritising referrals if a demand management strategy is required. Some of the factors to consider when prioritising referrals include –

- Referrals from Child Safety whereby the family is deemed to not currently be in need of protection, but the family is at high risk of entering the statutory child protection system without an intervention
- The child/ren is/are under 3 years old
- The degree of vulnerability of child/ren given consideration of factors such as developmental delay, physical/intellectual disability, health/medical needs and challenging behaviours etc.
- Complexity of need with multiple presenting factors (e.g. mental health, domestic and family violence, substance misuse, and disability issues, engagement in criminal activities)
- Social, environmental, cultural influences and networks (e.g. limited access to services, including housing)

2.6 Consent and Information Sharing

Consent based engagement

Informed consent is critical to engaging families. For active engagement cases, FaCC services require the family/family member's consent to engage with the service. The intent of gaining consent is to ensure the family is willing to engage with the service and take responsibility for achieving positive change for their family.

During an active engagement response, family members need to be aware what giving consent means and what information will be shared and why, including permission to share information about their family with other service providers who can assist them. There may be several points during the support process where a family's consent will be sought to share their personal information. A

family will have the option of limiting or not permitting the sharing of information with a particular service or organisation.

Where adults in the family have different views about providing consent, the service can work to ensure the adult willing to engage with the support service is safely able to provide consent and this will include permission to share information and access the services they need.

A parent can consent on behalf of their child. Young people can provide consent where developmentally appropriate and should be encouraged to consent on their own behalf where appropriate.

Informed consent will be sought where FaCC intends to undertake work with, or on behalf of a family and includes consent:

- from the family to work with FaCC
- to seek information about a family
- to seek to work collaboratively with another person or service
- to refer a family to another service

It is preferable **written consent** is obtained from the family to allow FaCC to refer a family to, or share information with, another service. The written consent is preserved as a record and can be referred to if there is any dispute. Each FaCC should have a consent form for use when obtaining a family's written consent to work with a FaCC and/or share their personal information with other service providers or organisations.

While a less preferable option, verbal consent can also be accepted. A file note recording the consent date should be created as soon as practicable after the consent was obtained.

Care needs to be taken to respond to any cultural and language barriers to the participation and understanding of families from Culturally and Linguistically Diverse (CALD) backgrounds and interpreters should be engaged as required.

It is imperative that all families are made aware of the duty of care service providers have to report significant harm or the risk of significant harm to a child to relevant authorities including Child Safety (note, consent is not required to report to Child Safety when a child may be in need of protection).

Under some circumstances, FaCC may be able to meet a family's needs without obtaining full consent from the family. For example, a short intervention through a one-off home visit or provision of information for the family to access another secondary or universal service may meet the family's needs without written consent or further assessment being required (or possible) by FaCC. In these circumstances, although the family has not consented to participating in an active engagement response, they have engaged in a discussion with FaCC to identify their needs and FaCC have provided a service to the family.

☐ **ARC tip**: in these circumstances, consent date should be entered and the closure reason recorded as: *Family's needs met by FaCC intervention*

Information sharing

The information sharing framework in the *Child Protection Act 1999* enables broad information sharing without consent for specific entities involved in the child protection and family support systems. Child Safety, prescribed entities and service providers may share information with each other to identify, assess and respond to child protection wellbeing concerns.

As specialist service providers, FaCC services may share information with each other (and other specialist service providers) to decrease the likelihood of a child becoming in need of protection. Some examples include:

- Transferring a referral that was submitted to a FaCC in the incorrect catchment so the service in the correct catchment can engage with the family;
- Sharing information with another FaCC if the family moves to another part of the state, ensuring the family continues to receive a service; or
- A FaCC that was previously working with a family can share information with another service, such as an IFS, when the new service begins working with the family.

Although the legislation allows referrals to FaCC and IFS services (and between these services) without consent, best practice is sharing information about a family should occur with consent unless it is not safe, possible or practical.

The management of the confidentiality and privacy of information is the responsibility of each FaCC service.

Sharing information with Child Safety

Child Safety may contact FaCC to seek information and FaCC can provide relevant information to Child Safety, for example:

- to assist in making plans or decisions regarding a child and their family
- when conducting a pre-notification check, to assist in determining if a notification response is required
- to assist in assessing or responding to the health, education and care needs of a child
- to assist in undertaking an investigation into an allegation of harm or risk of harm and assessment into a child's need for protection, or
- when developing a case plan during ongoing intervention.

If a FaCC is contacted and the family's records indicate they were the subject of a case consultation with the PCPP, FaCC should also advise the Child Safety intake officer a case consultation occurred. The intake officer can then also contact the PCPP for further information if required. Local protocols for managing requests for information from Child Safety may be beneficial.

2.7 Consulting the Principal Child Protection Practitioner

FaCC services can access the Principal Child Protection Practitioner (PCPP) to obtain expert generic child protection advice and guidance in accordance with Child Safety policies and procedures, statutory responsibilities, departmental objectives and current trends. The PCPP's role also includes providing a case consultation service to FaCC on complex cases and ensuring cases that may require statutory intervention are reported to Child Safety when necessary.

PCPPs can also be consulted about non-Child Safety referrals when, during active engagement, it becomes apparent the presenting issues for the family are concerning and a history check may confirm the family requires a greater level of intervention.

Further information on the PCPP role can be found on the FaCC secure website *http://www.familychildconnect.org.au/secure*.

2.8 Engagement and Assessment

Engagement

Effective engagement is crucial to working with families with multiple and complex needs, particularly as many referrals are made by Child Safety. Contact with formal services and supports in the past may influence a family's willingness to engage with FaCC.

Key practices principles for engaging effectively with families[11] include:

- Treating family members with respect and courtesy
- Focusing on building the family's strengths
- Promoting positive relationships among parents and children
- Developing trust through sensitive and inclusive inquiry about their circumstances
- Taking an active, caring, whole-of-family approach to their situation
- Focusing on the children's needs

Engagement begins from the first exchange with a family, therefore it is important to prepare well to increase the chances of successful engagement. Preparation may include: researching the referral; consulting with specialist workers (Aboriginal and Torres Strait Islander worker, DFV specialist, PCPP); considering the potential barriers to engagement (and how to mitigate these barriers); and preparing a script which is supportive and engaging. When making initial contact, ensure consideration is given to the safety of members of the family and provide alternative meetings places, such as cafes or parks, especially for families where domestic violence is a concern.

FaCC services may also consider non-stigmatising environments and soft-entry locations (such as child health, schools, legal aid) to enhance engagement. Additionally, holding community-based activities to engage with groups of families and raise awareness of the service may lead to increased engagement.

[11] Bromfield, L., Sutherland, K., & Parker, R (2012) Families with multiple and complex needs: Best interests case practice model. Department of Human Services, Victoria

FaCC will undertake work for a period up to **6 weeks** to engage with the family and obtain consent (extended to 8 weeks if a 3-hour return trip to visit the family is required). It is expected the following action will be undertaken during this timeframe:

- At least one attempt to contact the family by telephone (should contact number be available)
- At least one attempt to contact the family by unannounced home visit (cold call)
- Send initial letter seeking to engage family (letter templates can be found on the FaCC secure site *http://www.familychildconnect.org.au/secure*.)
- Send follow-up letter seeking to engage family

Analysis of engagement rates in FaCC indicated services with shorter average engagement periods generally have higher engagement rates, irrespective of funding levels. This suggests families seen shortly after referrals are initially received are more likely to engage. Research from Victoria also reinforces this view, indicating delays in commencement of services may lead to a loss of intervention momentum[12]. Best practice is a prompt cold call rather than sending letters as this appears to increase engagement.

ARC tip: If these activities have been undertaken and the family has declined support, case to be closed *Early exit – Refused support/did not consent*

Whilst gentle persistence when engaging hard-to-reach families is important, this must be balanced with the voluntary nature of FaCC services and the importance of respecting the family's wishes. Using a respectful approach with families, including accepting their decision not to accept support, can lead to future engagement even from families with a history of not consenting[13]. If families who are not ready for an intervention have a positive experience, they are more likely to return when they need it. In circumstances where family's decline support, FaCC should ensure families are well informed of what they can access when they are ready.

Practice note: If a family who identifies as Aboriginal and Torres Strait Islander declines support from FaCC, best practice is to offer a referral to their local FWS.

A tip sheet for Strengthening Engagement is attached as Appendix 1.

Assessment of the family's needs

Once consent is obtained from a family, FaCC will work with a family to undertake a needs assessment, determine appropriate referrals and facilitate a warm transfer of the family to the receiving service. FaCC can work with families for a maximum of 10 weeks (6 weeks to gain consent and 4 additional weeks). Extended timeframes for working with families (8 weeks to gain consent and 8 additional 16 weeks) are acceptable where return travel to a family takes three hours or longer.

[12] Commission for Child and Young People (2019) *Lost, not forgotten: inquiry into children who died by suicide and were known to Child Protection*. Melbourne, Victoria (page 71)
[13] FaCC review findings

The Collaborative Planning and Assessment (CAP) framework is an effective way to understand and articulate what is happening within a family and to work together to plan for the future. FaCC services may use the 'Skinny CAP' which is a streamlined version of the CAP framework which is organised around four key domains:

- What is not going so well?
- What is going well?
- Safety and wellbeing scale (how safe is it for the child using a scaling question)
- What needs to happen? (including worry statements, goal statements and actions steps)

Further information on the CAP framework and associated tools can be found on the FaCC secure site.

Brief intervention

If, based on the worker's assessment, a family would benefit from a short period of support to resolve issues (for example, family routines or parenting strategies) a brief intervention may be undertaken. This should not exceed the 10 week timeframe to work with the family (or 16 weeks where travel takes three hours or longer) and is **not** a case management response. This recognises that in some areas (particularly rural and remote) there may not be alternate services to refer to or there may be long waitlists.

The use of this intervention is at the discretion of the FaCC service and should **only** be used in exceptional circumstances due to risks associated with the family disengaging or not able to be successfully referred to support.

ARC tip: At the conclusion of this brief intervention where no referral has been made, and issues are resolved, the closure reason should be recorded as *Family's needs met by FaCC intervention.*

2.9 Practice Tools

Common Assessment Tools

Common assessment tools used by FaCC and IFS services support a shared understanding, language and consistent practice across all services. The common assessment tools used by FaCC include the Structured Decision Making (SDM®) Safety Assessment[14] and Collaborative Assessment and Planning (CAP) framework.

The SDM® Safety Assessment helps to identify children who are at imminent threat of serious harm. The Safety Assessment assesses the child's immediate danger and the interventions currently needed to protect the child and can be utilized to support decision-making:

- Are there indicators of immediate harm to a child, therefore requiring an immediate safety plan?

[14] FaCC services previously used the SDM Family Risk Evaluation (FRE) to determine future risk of maltreatment, however a decision was made by the department to cease using the tools by 1 July 2022.

- If there is an immediate harm indicator, what household strengths, protective actions and safety interventions can be implemented to create an immediate safety plan that addresses the harm and ensures a child's safety?
- Is there a reasonable suspicion that a child is in need of protection and a notification to Child Safety is required?

The goal of applying SDM® tools is to ensure critical case characteristics, immediate harm indicators are assessed for every family, every time, regardless of social or locational differences. Detailed definitions for assessment items increase the likelihood that workers assess families consistently using a similar framework.

FaCC also uses the Collaborative Assessment and Planning (CAP) Framework (SP Consultancy) and associated practice tools, such as Three Houses and Circle of Safety. The CAP framework supports a collaborative process of assessment (gathering, organising and analysing information) and collaborative planning for future safety and wellbeing.

Further information on these tools can be found on the FaCC secure site *http://familychildconnect.org.au/secure/*.

Risk assessment

The assessment of harm and risk of harm is a fundamental component of statutory child protection work. Risk assessment is 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. Given FaCC's position in the child protection continuum, workers should have a robust risk assessment framework to understand the risks to children and knowledge on how to reduce those risks to prevent escalation into the statutory child protection system. A practice guide, which is adapted from the department's practice guide, has been developed to provide guidance to FaCC services on understanding and assessing risk and ensures a shared understanding. The risk assessment guide is attached at Appendix 2.

2.10 Brokerage funding

FaCC can access brokerage funds to support a family. Brokerage funds can be accessed for the purchase of goods, services or activities that respond to an immediate identified need of a family.

The intended use of brokerage funds is to reduce risk or increase protective factors which impact on the safety and wellbeing of children and their family. Up to five per cent of the total available FaCC budget may be accessed for the use of brokerage.

Brokerage should only be used when publicly funded services are unavailable or the waitlist times for those services are prohibitive in responding to the immediate needs of a family.

2.11 Case closure – Early exit / Referrals / Family's needs met

Early exit

If a family does not complete an assessment or intervention with FaCC, this should be recorded as an early exit. Whether obtaining consent is recorded, will depend on when the work with the family ceases.

Closure reason	Description
Inappropriate referral	Referral does not meet the referral criteria for FaCC
Data entry error/duplicate referral	Errors in the referral – duplicate etc
Unable to contact or locate family	No contact is able to be made with the family
Moved out of area	FaCC commences work with a family and they subsequently relocate
Family declined service/ did not consent	Before consent is obtained, the family declines active engagement with FaCC
Secondary support service response not required	Referral does not meet the criteria for a FaCC service
Reported to Child Safety	FaCC suspects a child may be in need of protection and reports to Child Safety
Staffing or agency reason	FaCC are unable to on-refer the family to appropriate services following their assessment due to capacity issues with the other service/s.
Family disengaged with service/withdrew consent	The family initially consents to active engagement, however during intervention, withdraws their consent.
Other reason	Any other reason not captured
Already engaged	The family is already engaged with a service and does not require further assistance

Practice tip: Appendix 4 provides potential scenarios in relation to consent and closure reasons to promote consistency of practice across FaCC services.

Link with informal supports

FaCC workers may work with the family in identifying and strengthening their informal network who may be able to support the family and therefore potentially reduce the need for professionals' involvement.

The Circles of Safety and Support Tool (which can be found on the secure site) can be used to help parents identify people for their family's safety and support network. This tool can help workers have conversations with parents about why a safety and support network is important, the role the network can play and the process for determining who is most appropriate to participate in the family's informal network of support.

ARC tip: the closure reason should be recorded as *Family's needs met by FaCC intervention*.

Provision of Information and advice

Depending on the identified needs of the family, FaCC workers may provide information on appropriate resources and online supports the family can access.

ARC tip: the closure reason should be recorded as *Family's needs met by FaCC intervention*.

Referrals

Intensive Family Support services

Intensive Family Support (IFS) services deliver case management to families referred by FaCC in each child and family catchment. The expectation is referrals from FaCC to an IFS service will be for families with multiple and/or complex needs who would benefit from a case management response. FaCC will have actively engaged with the family, assessed their needs and gained consent for referral to the IFS service.

IFS services will accept a referral from FaCC where the referral criteria are met. IFS services will have developed internal strategies for active holding and demand management. Local agreements and procedures between FaCC and IFS services are to be developed regarding referral of families.

Practice tip: at a minimum, the referral information between FaCC and IFS should contain the most recent Safety Assessment and finalised CAP framework. This will ensure the work undertaken by the FaCC is known and the families are not having to retell their stories.

While every FaCC will have designated IFS service/s to undertake more intensive work with families, if the IFS service is at capacity and active holding is not an option for the IFS, the FaCC will actively support the family to engage with alternative family support options.

Other services

Depending on the needs identified in collaboration with the family, the FaCC worker will refer the family to appropriate secondary or universal services. Where possible, FaCC workers to undertake a warm transfer with the family and new service to ensure a smooth transition for the family.

There is considerable variation across catchments regarding the availability of support services to which FaCC can make referrals. It is acknowledged this may impact on timeframes and require FaCC to undertake active holding or close following a brief intervention.

Family's needs met

Where no on-referral is made but the family's needs are met during the intervention with FaCC, the outcome should be recorded as *Family needs met by FaCC intervention.*

ARC tip: Closure reason should be recorded as *Family's needs met by FaCC intervention*.

2.12 Active Holding

Following an assessment of the family's needs, if the immediate referral to another service is not possible, FaCC can initiate 'active holding' by keeping in touch with the family before handing the case over to an Intensive Family Support service or other lead agency as soon as there is capacity in that service. However, the timeframe for a family to be on 'active holding' with FaCC should be limited and appropriate to the family's circumstances and needs.

Ongoing issues have been identified from FaCC services regarding capacity issues in the sector causing a bottleneck in the throughput for FaCC services. An ARC change request has been logged to include *Referral to another service not accepted due to capacity issues* as a closure reason to better capture capacity issues. However until these changes are incorporated, FaCC should use *Early Exit – Staffing or agency reason* to enable the department to monitor capacity issues in the sector.

ARC tip: When FaCC services are unable to on-refer the family to appropriate services following their assessment due to significant capacity issues with the other service/s, closure reason should be recorded as *Early Exit – Staffing or agency reason*

2.13 Feedback to referrers

In order for a FaCC service to provide feedback to the referrer that includes the family's personal information, the family must provide their consent. For the family to provide informed consent for their information to be shared they need to know the identity of the referrer.

Without the consent FaCC can only advise the referrer:

- If contact with the family did not occur and the referral was closed.
- Whether the family did, or did not, engage with FaCC

With the family's consent, FaCC may advise the referrer on the outcome of the referral. The only exceptions to this are:

- FaCC can contact a referrer if they have referred a family to the incorrect FaCC to advise them of such; and
- Where Child Safety/Queensland Health/Department of Education is the referrer – see below.

A prepared letter/email for FaCC to send to referrers is located via the FaCC secure site – *http://familychildconnect.org.au/secure/*

Specific requirements for referrals from Child Safety, Queensland Health & Department of Education

In circumstances where Child Safety, Queensland Health or Department of Education refers a family to FaCC and the family cannot be contacted or chooses not to engage with the service, the FaCC must contact/email the referrer to advise of the outcome. The information provided should include the details of the FaCC's attempts at engagement, what strategies have been used and over what timeframe. This will assist the referrer when/if they have contact with the family again to help decide if a further referral is appropriate.

If it is a Child Safety referral, Child Safety Officer who receives this advice will make a record of the information and this information then becomes part of the client history for the family. If new or additional concerns are reported by the FaCC to Child Safety, this information will be assessed per the department's usual intake procedures.

Email templates for this purpose are securely located on the FaCC secure site- *http://familychildconnect.org.au/secure/*

2.14 Community engagement

Having a positive profile/presence in the community is vital to support FaCC workers' connections with families and may improve engagement and outcomes for children and families. In particular, for First Nations and Culturally and Linguistically Diverse communities, time is required to establish connections with communities and build credibility and trust in the service.

In recognition of the value of this work, community engagement can be considered as contributing towards FaCC services' contact hours. Whilst this functionality is built into ARC, it is recommended any hours related to community development be recorded in your service's quarterly P2i report under the GM01 performance measure "*Number of occasions information, advice and referral services were provided (not provided elsewhere) to Service Users during the reporting period*."

Practice tip: Until functionality is built into ARC, community engagement should be captured in P2i under GM01. Achieved value should record the hours spent undertaking the community development activity. Comments should include an overview of the activity undertaken.

Measure Code	Description	Achieved Value	Target Value	UOM	Comments
GM01	Number of occasions that information, advice and referral services were provided (not provided elsewhere) to Service Users during the reporting period	0	0	Service Users	

3. FaCC service delivery

3.1 Hours of Operation

To ensure families access the information, resources and support they need, the FaCC service will be open 52 weeks per year, excluding public holidays. To increase accessibility to FaCC for families, including working parents, telephones will be staffed from 8.30am to 5.30pm on normal business days.

FaCC will meet the needs of the community by providing flexible appointment times for families who cannot be contacted or access the service during normal business hours.

FaCC will have a telephone system that can receive voicemail messages for calls received outside the hours of operation outlined above. It is expected these messages will be responded to on the next working day. The FaCC voicemail message will also direct callers to the FaCC website which provides access to self-help resources.

If services choose to close during the Christmas/New Year period, services must have an on-call arrangement in place which includes:

- Staff are rostered on for on-call support (with face-to-face contact if necessary)
- A voicemail option is available for callers to leave messages, and which directs callers to suitable resources e.g. websites and other appropriate helplines
- Information is provided to existing clients of these arrangements prior to the Christmas break

3.2 Staffing

FaCC staffing levels will vary in size and roles from service to service state-wide. A majority of staff will hold university qualifications (undergraduate qualifications or above) in human services or a relevant related field. This applies to roles that work directly with families or have clinical roles, but not to clerical or administrative roles.

There may be circumstances, such as in remote parts of Queensland, where the recruitment of staff with appropriate skills and expertise can be difficult, particularly to find the right mix of qualifications, cultural connections and knowledge of the local area, skills and life experience required in the team. If FaCC services are unable to recruit staff with university qualifications, flexibility in the recruitment of staff is permitted. FaCC services should document the rationale for deeming the candidate the best person for the position, including their experience, knowledge and skills. FaCC services should also support all staff to successfully meet the requirements of their role through internal and external training and encouragement to attain appropriate professional qualifications where required.

FaCC staff will be required to demonstrate skills in engaging hard-to-reach families. Each FaCC service will have a multidisciplinary team of professionals, including specialist family support workers, specialist domestic and family violence worker/s and may recruit workers with other relevant qualifications, skills and experience, such as youth workers and early childhood health or education professionals.

All specialist positions outlined below will have varying responsibilities based on the needs of their local FaCC. This variation is important in ensuring the needs of the service and region in which they operate are met.

3.3 Principal Child Protection Practitioner

The role of the PCPP is to provide specialist child protection expertise to FaCC services and work collaboratively with government and non-government organisations within the catchment to support earlier and more effective intervention for children and families. Each FaCC will have a PCPP who is physically located for part of each week with the service.

The position will provide consultancy and advice on child protection matters to FaCC, IFS and Aboriginal and Torres Strait Islander Family Wellbeing Service staff, as well as community education to government (excluding Child Safety) and non-government organisations on statutory child protection processes and responsibilities.

In summary the PCPP will undertake the following:

- Provide expert generic child protection advice and guidance to FaCC, IFS and FWS in accordance with departmental policies and procedures, statutory responsibilities, departmental objectives and current practice.
- Commitment to working with the Aboriginal and Torres Strait Islander Child Protection Principle and community controlled organisations.
- Provide a case consultation service to FaCC, IFS and FWS on multiple and/or complex cases and ensure cases that may require statutory intervention are reported to Child Safety. The PCPP role includes oversight of the reporting quality. This may include a child protection history check (where appropriate).
- Assist in safety planning and identification/prioritisation of needs.
- Build the child protection expertise of FaCC, IFS and FWS, and broader intensive secondary service providers through training and professional development initiatives.
- Provide training and education (and/or training and education resources) to schools, early childhood education providers, police and health professionals, on reporting/referral behaviour to support adherence to the Child Protection Guide (CPG).
- Perform a cross sector co-ordination role, establishing and maintaining effective working relationships with FaCC, IFS and FWS, broader intensive secondary services, and other government and non-government agencies to promote better collaboration between services and with Child Safety.
- Actively participate in meetings with FaCC, IFS and FWS, broader intensive secondary services, and other government and non-government organisations including the LLA, as a representative of Child Safety.

More information on the roles and responsibilities of the PCPP are located on the FaCC secure site- *http://familychildconnect.org.au/secure/*

3.4 Specialist Domestic and Family Violence worker

Each FaCC will have one full-time experienced professional with specific and well-developed experience and exposure to working directly with domestic and family violence, or extensive studies in domestic and family violence. The requirement of this role recognises the high proportion of vulnerable families who are affected by domestic and family violence.

The key benefit of the specialist domestic and family violence worker is the support and advice provided for the timely and effective identification and response to domestic and family violence issues to FaCC staff working with families experiencing domestic and family violence. The specialist domestic and family violence worker will have skills to identify the high level of risk domestic and family violence poses within a family to the safety and wellbeing of children, young people and family members and possess the specialist skills required to assess risk, safely engage with affected families, and develop appropriate service responses that prioritise safety.

This specialist role ensures each FaCC service is highly cognisant of the nature and impact of domestic and family violence and that this awareness informs all points of engagement with referrers, family members and other services. The role works as part of the FaCC team to provide specialist advice and assistance to other FaCC staff members and those contacting the service. Examples include:

- Raise awareness of nature and impact of domestic and family violence
- Domestic and family violence screening and risk assessment using the DFV Common Risk and Safety Framework (DFV common risk and safety framework | Department of Justice and Attorney-General)
- Specialist advice and assistance to team and inquirers
- Advice on safe engagement strategies
- Assist with assessment of client needs
- Assist with support and referral planning and decisions.

The role also provides a conduit between the FaCC, the domestic and family violence professional within Intensive Family Support services and specialist, community based domestic and family violence services to ensure client pathways between services are seamless and relevant information around risk and safety is being shared appropriately (with consent).

The role will ensure the FaCC is effectively linked to local domestic and family violence prevention and support services; including participation in any existing local domestic and family violence integrated responses and sector networks. This includes:

- Working in partnership with the Local Level Alliance (LLA) worker to assist domestic and family violence services to participate in LLAs
- Support domestic and family violence services to be part of earlier interventions that support families to provide a safe home for their children
- Assist in resolving any identified service issues related to domestic and family violence intervention.

Through maintaining close links with community based domestic and family violence services, the domestic and family violence professional will draw upon the resources and expertise of the specialist services to meet client needs and use these linkages as a peer support and professional development mechanism.

The specialist domestic and family violence professional is not expected to:

- be the only staff member with domestic and family violence skills and expertise
- respond to every query about domestic and family violence issues, or
- be the only FaCC staff member to engage with domestic and family violence services.

Specialist domestic and family violence professionals within FaCC are also encouraged, along with their Intensive Family Support colleagues, to engage with each other across the State to create a peer network for support and practice development. The department supports a Community of Practice (CoP) specifically for this purpose. The CoP meets on a quarterly basis and is led by the Queensland Centre for Domestic and Family Violence Research (QCDFVR) at the University of Central Queensland. QCDFVR also hosts a monthly peer support group in response to the expressed need of the more 'isolated' services. Requests to join the CoP can be made by emailing the Child and Family Team at childandfamilycommissioning@cyjma.qld.gov.au

General information about domestic and family violence, research, fact sheets and other resources are available through:

- *www.ourwatch.org.au*
- *www.anrows.org.au*

3.5 Local Level Alliance worker

Each FaCC has a Local Level Alliance worker (LLA worker). This role takes the lead in identifying key agencies and services that contribute to the service system for vulnerable children and their families and establishing a forum for collaboration.

The LLA works together to strengthen the local service system response to families. The LLA worker acts as the driver and coordinator for the actions undertaken by the LLA to establish and/or strengthen connections between local services that are involved with working with vulnerable families to ensure families receive the right service at the right time.

While there may be existing local networks of services within the local catchment, the role of the LLA is not intended to duplicate or replace these forums. The specific focus of the LLA is vulnerable families with children. Ongoing communication and connections with other networks within the catchment are important to the effectiveness of the LLA.

Refer to section 4 - 'Local Level Alliance' for further information.

3.6 Specified Aboriginal and Torres Strait Islander staff

One of the key strategies identified in FaCC as supporting the achievement of high-quality outcomes for Aboriginal and Torres Strait Islander families, is through directly employing Aboriginal and Torres Strait Islander staff who can:

- provide culturally appropriate advice to other staff within FaCC regarding their engagement with Aboriginal and Torres Strait Islander families and services
- liaise with and maintain relationships with Aboriginal and Torres Strait Islander service partners and the community
- engage directly with Aboriginal and Torres Strait Islander families to support their engagement with both FaCC and the services the family is being referred to.

It is also recognised it is not possible for all First Nations staff to service all Aboriginal and Torres Strait Islander clients that prefer a First Nations worker due to the workload. However, they play a critical role in providing support and advice to non-indigenous staff.

Having a positive profile/presence in the community is vital to support FaCC's connections with First Nations families and to improve engagement and child and family outcomes.

3.7 Interface with Child Safety

Threshold for making a report to Child Safety

Where a reasonable suspicion is identified that a child or young person is in need of protection, FaCC have a responsibility to report the matter to Child Safety through the appropriate Regional Intake Service. FaCC does not need the family's consent to report to Child Safety.

Under section 13A of the *Child Protection Act 1999*, any person may make a report to Child Safety if they form a reasonable suspicion that:

- a child may be in need of protection; or
- an unborn child may be in need of protection after he or she is born.

If you believe a child is in immediate danger or in a life-threatening situation, contact Emergency Services immediately by dialing 000.

If urgent contact is required with Child Safety during normal business hours, contact the local Regional Intake Service Regional Intake Services - Department of Child Safety, Seniors and Disability Services (cyjma.qld.gov.au). If immediate contact is required after hours, contact the Child Safety After-Hours Service Centre on **1800 177 135**.

In all other circumstances when making a report to Child Safety, FaCC should use the on-line report form and download a copy of the report to retain for records. The online report of suspected child in need of protection can be accessed via the following link: Child Safety Reports - (communities.qld.gov.au)

Queensland Child Protection Guide

The Queensland Child Protection Guide is an online decision support tool that assists those who have concerns about a child or young person to make a decision about whether to make a report to Child Safety or refer to another service best placed to meet the family's needs. The guide is available statewide and supports professionals to report their concerns to Child Safety or refer the family to a support service.

If the outcome is a report to Child Safety or a referral to a FaCC or an Intensive Family Support service is recommended, the CPG will link the user to the appropriate online form for the user to complete and submit electronically.

RESOURCE: the CPG and supporting instructions is accessible at QLD Child Protection Guide (communities.qld.gov.au)

Reporting to Child Safety based on information provided at referral

When a FaCC receives a referral where the concerns are assessed as reaching the threshold for a report to Child Safety, FaCC will contact the referrer and encourage them to report directly to the appropriate RIS. This not only ensures all relevant information is provided directly to Child Safety but by making a direct report to Child Safety, the referrer receives protection as a notifier under the *Child Protection Act 1999*.

The only exception to re-contacting the referrer to make a report direct to Child Safety would be under circumstances where doing so could adversely affect the safety of a child or another member of the family.

When a professional referrer agrees to make a report to Child Safety, FaCC will request an email from the referrer to confirm this has occurred, allowing the FaCC referral record to be closed. If this advice/email is not received within a 48-hour period, FaCC should report the matter directly to the RIS, including details of the concerns and the identity of the original referrer. Under these circumstances the FaCC worker is recorded and protected as a notifier.

If the referrer is not a professional and FaCC assesses the concerns detailed in the referral reach the threshold for a report to Child Safety, FaCC should report the matter directly to the RIS.

Practice tip: if uncertain, FaCC may contact their PCPP to discuss any concerns to determine if a report to Child Safety is required.

Reporting to Child Safety based on information gathered during an intervention

If, during the course of their engagement with a family, FaCC suspects a child may be in need of protection, FaCC is responsible for reporting the matter to Child Safety through the RIS.

FaCC may use the CPG to support their decision making as to whether their concerns should be reported to Child Safety and a case consultation with the PCPP may also assist.

Where the concerns clearly reach the threshold for a report to Child Safety or an urgent response is considered necessary, the FaCC can report to Child Safety without prior consultation with either the

CPG or the PCPP (*Note: the service will report information about immediate danger to the relevant Emergency Service/s*).

Where active engagement has commenced with the family, regardless of FaCC reporting the matter to Child Safety, engagement will continue with the family unless exceptional circumstances exist (e.g. concerns regarding the safety of staff or under direction from Child Safety).

FaCC will only cease involvement with a family if they are advised the family is subject to ongoing departmental intervention (i.e. Intervention with Parental Agreement (IPA) or Child Protection Order). This also applies if while working with a family, FaCC become aware Child Safety is currently undertaking an Investigation and Assessment.

However, if the FaCC receives a referral and prior to commencing engagement with the family the FaCC is made aware an Investigation & Assessment (I&A) is pending from Child Safety, the FaCC will not commence any engagement until after the I&A is completed and the outcome known.

Where FaCC suspect or are informed Child Safety are currently involved with a family, FaCC should contact Child Safety to inform them of current FaCC involvement and where safe to do so, help coordinate the best options for the family. The PCPP may assist by coordinating this liaison.

Local protocols for managing these scenarios are encouraged.

3.8 Working with Aboriginal and Torres Strait Islander families

Aboriginal and Torres Strait Islander families continue to be disproportionately impacted by and within the child protection system and FaCC services have an opportunity to make a significant difference for First Nations families. While Aboriginal and Torres Strait Islander Family Wellbeing Services are the specialist option for service delivery, there may be times when a First Nation family chooses to access FaCC. Mainstream FaCCs' service response must be culturally safe and ideally delivered by a First Nations staff member. Active application of the Aboriginal and Torres Strait Islander Child Placement Principle is not only applicable to statutory child protection and must be part of practice by FaCC workers.

Appendix 4 outlines the practice principles for responding effectively to Aboriginal and Torres Strait Islander children, young people and their families. A mandatory consideration is the Aboriginal and Torres Strait Islander Child Placement Principle and its active application. At the core is acknowledgement of the negative legacy of colonialism in Australia and the historical and continuing intergenerational trauma on Aboriginal and Torres Strait Islander families. The right to self-determination must be respected and a commitment made to prevent re-traumatisation. This is achieved by fostering genuine partnerships with cultural allies to maintain cultural integrity in service provision and by facilitating meaningful participation by First Nations families in decisions which impact their lives.

3.9 Working with Culturally and Linguistically Diverse Families

FaCC staff are required to be capable of responding in a culturally sensitive way to families from culturally and linguistically diverse (CALD) backgrounds.

Families from CALD backgrounds require services to be responsive to their specific needs. Services need to demonstrate their willingness and capacity to work with people from diverse backgrounds by developing specific strategies including linking with local multicultural organisations and engaging interpreter services where required.

The department supports fee-free access to interpreters for funded service providers and clients from non-English speaking backgrounds who have difficulties communicating in English.

Accessing Translating and Interpreting (TIS) services

As of 30 June 2023, the current arrangements with TIS National will come to an end, meaning the current client codes will no longer be in effect from 1 July 2023. From this date, the department will be providing access to all eligible NGOs with the new panel of providers:

- 2M Communications Pty Ltd
- Translationz Pty Ltd
- TIS National

To access this arrangement, eligible service providers must obtain a unique account access from the department. Eligible service providers use their unique account access when accessing interpreter services through the providers' booking portals. The providers then invoice the department directly for charges incurred for services provided to departmentally funded NGOs.

To request a unique account access under the program, please email the following information to interpreting.services@cyjma.qld.gov.au:

- Service Name
- Service Contact Person
- Service Contact Email
- Service Address
- Service Postal Address
- Contact Phone
- Program/Initiative
- Service Outlet Number/s

For further information about accessing the Department of Child Safety, Seniors, and Disability Services funded interpreter services please contact: interpreting.services@cyjma.qld.gov.au or via phone on 07 3097 5903

4. Local Level Alliance

4.1 Purpose

The purpose of the Local Level Alliance (LLA) is to establish or strengthen connections and networks between local services that are involved with working with vulnerable families to ensure they receive the right service/s at the right time.

The LLA is supported in each FaCC by a funded position for a designated LLA worker. This role will take the lead in identifying key agencies and services that contribute to the service system for vulnerable children and their families and establishing a forum for collaboration and to assist in identifying service system gaps.

It is acknowledged every service system has a number of networks. The LLA is not intended to duplicate or replace these forums, though in some locations the existing family support networks or Supporting Families Alliances are transitioning to the new LLA framework. The specific focus of the LLA is vulnerable families with children.

Each FaCC catchment area will have at least one LLA and in some instances, usually in large catchment areas, multiple LLAs.

4.2 Outcomes

It is expected that the LLA will work towards achieving the following outcomes:

- building community capacity to provide more efficient service provision for families and a thriving local community
- improved, and more direct, referral pathways for families to access appropriate services
- FaCC embedded as an alternate pathway for families to be connected to the right support at the right time
- improved information sharing between providers to enable more coordinated and effective responses to families
- responses aligned to better support vulnerable families and strengthen service integration, such as a shared practice framework and resources
- contribute to service system integration through identification of available services and service gaps, improvement in the alignment between the configuration of the service system and the needs of local families
- contribute to place-based planning for the development of an integrated suite of local services that provide families with responsive, accessible and effective support.

4.3 Benefits

Through strengthening the service system LLA will contribute to:

- improved outcomes for at risk families and children through increased referrals to family support services and/or family needs met by FaCC
- a reduction in unnecessary reports to Child Safety as a result of more efficient and effective pathways for children and families to access child and family support services

- a reduction of in the number of children at risk and in out-of-home care through increased use of family support services and improved matching of services to high risk families.

4.4 Membership

The LLA will include government and non-government agencies, including Local Councils and Australian Government service providers.

Members will be drawn from agencies providing services in the local area who work with vulnerable families or family members and will include the FaCC, IFS, ATSIFWS and departmentally funded DFV services. Departmentally funded secondary and targeted services are also encouraged to participate in the LLA.

Each LLA will include Aboriginal and/or a Torres Strait Islander representation to reflect the views, needs and aspirations of Aboriginal and Torres Strait Islander people.

The underlying principle is for the LLA to include members who are best placed to meet the goal of strengthening the local service system to effectively respond to vulnerable families. It is important decision making representatives from agencies attend the LLA meetings.

While leadership arrangements will vary across LLAs, it is intended that these arrangements will reflect a sharing of leadership responsibilities between the non-government sector and the government sector.

4.5 Co-ordination and Reporting

The FaCC service will resource and support the LLA and report quarterly to the department in keeping with their funding and service contract. Each report will detail LLA activities undertaken, effectiveness and/or issues relating to local agreements and protocols, and gaps in referral options and services.

Each FaCC is funded to provide an LLA Coordinator (or Alliance worker). This role plays a significant part in identifying key agencies and services which contribute to the service system for vulnerable families and inviting them to participate.

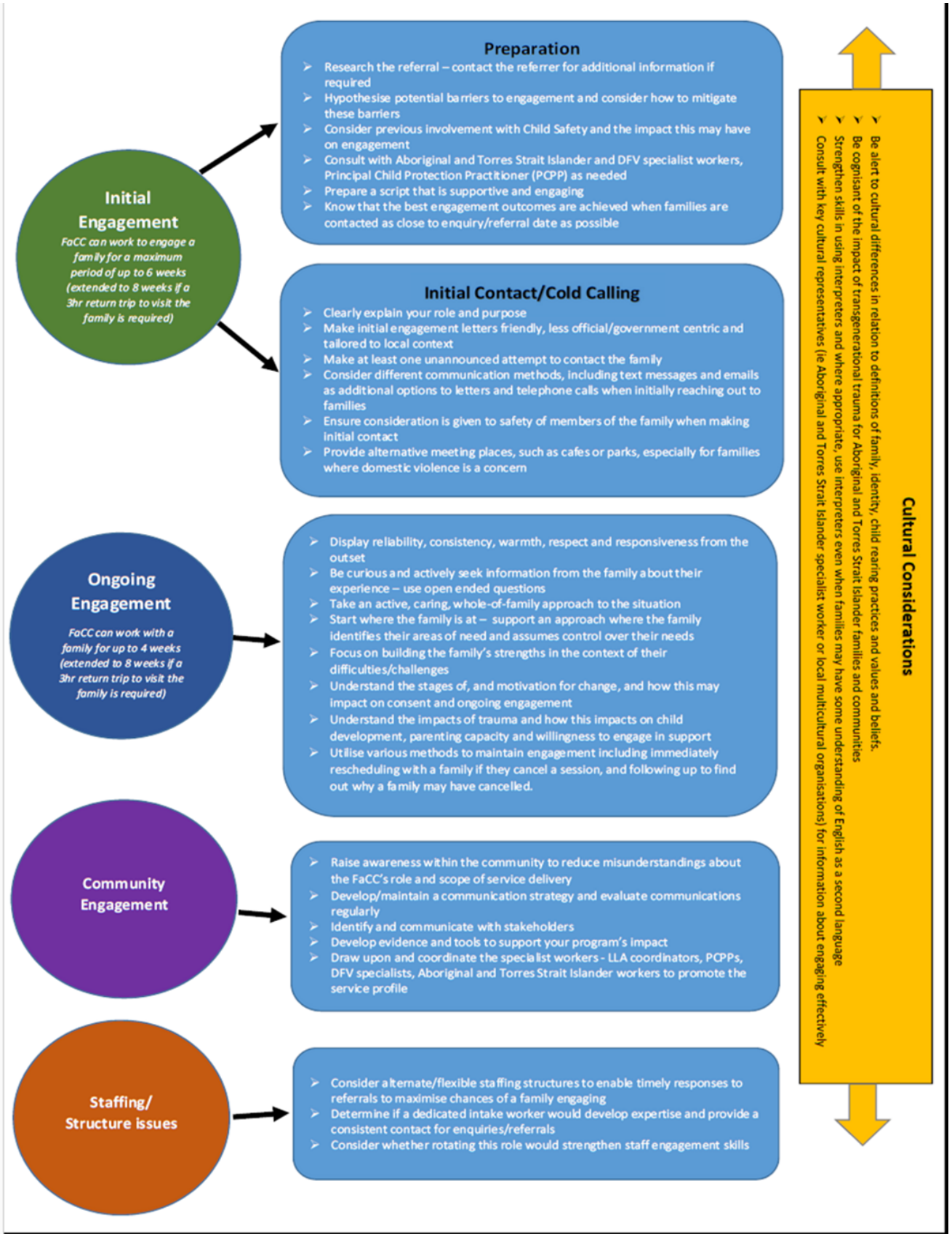
4.6 Best Practice Principles

A Review of Local Level Alliance Functioning and Best Practice was undertaken in 2018. Fourteen practice principles were identified during this review. These 14 principles have been refined and condensed into seven Best Practice Principles -

1. Undertake well-structured meetings
2. Ensure Aboriginal and Torres Strait Islander representation at LLA meetings
3. Utilise evidence based and data-driven strategies
4. Value what already exists
5. Establish working groups to address priority issues
6. Ensure consistent communication with members
7. Develop clear governance structure and linkages with Regional Child Youth and Family Committee (RCYFC)

Appendix 5 – Local Level Alliance – Best Practice Principles provides further details on these principles.

Appendix 1 – Strengthening Engagement



Appendix 2 – Assessment of Harm and Risk of Harm

Introduction

The assessment of harm and risk of harm is a fundamental component of child protection work. Risk assessment is 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. Given FaCC and IFS's position in the child protection continuum, workers in these services must have a robust risk assessment framework to understand the risks to children, knowledge on how to reduce those risks to prevent issues from escalating and requiring statutory intervention. and understanding of when escalation into the child protection system is required.

This practice guide is adapted from the Department of Child Safety, Seniors and Disability Service's "*Practice guide: Assess harm and risk of harm*" thus ensuring a shared understanding between the department and the secondary family support system.

Key concepts

The concepts outlined below are used within child protection practice and provide a common language for use between the sectors. It also supports consistent practice so the same indicators of harm and risk of future harm are considered for each family regardless of where they present.

The relationship between abuse and harm

Understanding the relationship between abuse and harm is crucial to assessing harm and risk of harm to a child. Abuse (an act of commission) can be physical, emotional or sexual. Neglect, which refers to acts of omission, is also referred to as a form of abuse. Abuse is what happens to a child. Harm to a child is the result of the abuse they experience. The *Child Protection Act 1999*, section 9, defines harm to a child as any detrimental effect of a significant nature on a child's physical, psychological or emotional wellbeing. The relationship between abuse and harm is illustrated by examples in Table 1.

Table 1: Relationship between abuse and harm

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

Resulting harm *(impact experienced by the child)*	**Physical *(refers to the body)***	**Emotional *(refers to the ability to express emotions)***	**Psychological *(refers to the mind and cognitive processes)***
	Bruising Fractures Internal injuries Burns	Depression Hypervigilance Poor self esteem Self-harm	Learning and developmental delays Disorganised attachment Impaired self-image

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.

Risk assessment and immediate safety

Risk assessment is a process that is focused on forming a professional judgement about the likelihood or probability 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 which 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. Research has identified risk factors are found more often in families where harm has occurred than in the general population.

Risk factors 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 which 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 the presence of these factors necessarily leads to child abuse or neglect
- an awareness of factors which 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 caregiver/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 caregiver/parent accesses support and this results in meaningful, sustained change. It is important to be aware of disguised compliance when considering whether a caregiver/parent's behaviour is a strength or a protective factor. Disguised compliance is where a caregiver/parent gives the appearance of cooperation to avoid raising suspicion and to allay concern.

Refer to **Table of risk and protective factors** for further information.

Process for risk assessment

Undertaking risk assessment in FaCC and IFS is not an additional task and should form part of our work with families. The purpose of a risk assessment is to begin to explore and understand the risk factors and safety needs of the child to help inform an effective response, that is, we need to understand the risks to know how to reduce them. Risk assessment informs how worried we should be about a family and helps to inform the harm/worry statements in the Collaborative Assessment and Planning (CAP) framework.

Every assessment is unique to a child and family and no checklist can be applied to all situations. The process involves workers remaining open-minded, while applying their professional, evidence-based knowledge and critical thinking to the child and family's particular situation and circumstances - *what is the likelihood of future significant harm for this child in this family*? It is not about what action is needed or what impact intervention may have – it is about the level and likelihood of future harm.

The four-stage process of risk assessment includes:

1. What is the purpose of the assessment?
2. Gather all relevant information
3. Analyse the information
4. Form a professional assessment

1. What is the purpose of the assessment?

Every assessment helps to inform a decision and if we are unclear about the decision we need to make, the assessment process will be impacted from the start. Therefore, to begin the process, workers should clarify the purpose of the assessment. Being clear about the purpose of the assessment is important because it helps the worker to reflect on what information might be needed and from what sources and decide the relevant issues to focus on.

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 support and guidance to help clarify the matters relevant to the assessment and assist with facilitating the child and family's participation in the process.

The purpose of the assessment will impact on the extent of assessment undertaken. A comprehensive analysis of risk would likely occur for FaCC in Active Engagement (Response type 4) cases and a majority of IFS cases.

For example, for FaCC:

- *At referral*: brief assessment is made on receipt of a FaCC referral to determine if it meets referral criteria, look for any immediate risks (and whether these risks can be safely managed by FaCC) and determine response priority)
- *During engagement*: Does new information gathered during work with the family indicate the child may need protection and require reporting to Child Safety?
- *During FaCC assessment (for Response type 4 – Active engagement):* Can the risks identified be managed by a referral to a less intensive support service or is a referral to IFS required to address the multiple and complex needs of the family?

For IFS:

- *At referral* - brief assessment is made on receipt of a referral to determine if it meets referral criteria, look for any immediate risks (and whether these risks can be safely managed by IFS) and determine response priority
- *During collaborative case planning*: Are there risks that must be included in the case plan to reduce the risk of future harm to the child/ren?
- *At case plan review*: Have some of the identified risks been addressed and are no longer impacting on the safety of the child/ren?
- *At closure*: Has the risk of future harm reduced where Intensive Family Support can cease involvement with the family?

2. Gather all the relevant information

Once we are clear about the purpose of the assessment, the relevant information should be gathered in relation to the child; the caregiver/parents; the environment; the harm and abuse; the family and cultural context. This will enable the worker to identify the presence of factors that increase risk to the child/ren (what we are worried about) and the acts of protection/strengths and resources that mitigate against risk (what is going well).

The information to be gathered is unique to each assessment and specific to the decision that needs to be made. Depending on the purpose of the assessment the information may be gathered by:

- hearing the voice of and having purposeful interactions with the child, parents and family
- speaking with others who know about the child's situation
- requesting and sharing information with government and non-government agencies who are providing services or support to the child or caregiver/parents.
- directly observing and assessing of the quality of interactions between the child, caregiver/parents and others within the environment.

FaCC and IFS services operate on a voluntary engagement basis and therefore client consent is required before information can be shared or sought from other agencies or service providers. Further information regarding consent-based engagement and information sharing can be found in the FaCC and IFS Model and Guidelines.

On a case-by-case basis, consider what additional knowledge may be needed to help inform the assessment and who might be an appropriate source of professional knowledge. This may include professional knowledge or cultural knowledge. For example, seeking further information about the family's child protection history from the department through your Principal Child Protection Practitioner (PCPP) or seeking to understand cultural factors through Aboriginal and/or Torres Strait Islander practitioners in services and including the voices of those with cultural authority for an Aboriginal or Torres Strait Islander child. Cultural factors may include, for example, traditional child rearing practices or kinship structures for an Aboriginal or Torres Strait Islander child.

3. Analyse the information

This stage of the process requires the identification of risk and protective factors from the information that has been gathered, which are then analysed in the context of the child's situation to establish the interaction between them (refer to *Table of risk and protective factors below*).

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 the young 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 the application of critical thinking and exploring, and professional knowledge. It is not just about stating the information or considering risk and protective factors in isolation of one and other. Instead, it is about considering what the information means collectively for the particular child, in their particular situation. Consider:

- What is more likely to occur in the future, rather than less likely?
- What are adults/caregivers more likely to do/not do? When, where, and why?
- What is the child likely to experience? When, where, and why?
- What do you think will activate or trigger this future harm playing out? Think about people, place, time, certain events/situations/circumstances
- What do you think will prevent/inhibit this risk of future harm playing out? Think about people, place, time, certain events/situations/circumstances.

When analysing the information to understand and determine the risk and impact on the child:

- consider whether information 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 certain types of harm may not be observable until a later stage in the child's development
- distinguish a caregiver/parent's intention or motivation to safely care for and protect a child from demonstrated behaviour. Seek and verify examples of acts of protection.
- look for patterns of behaviour, including abuse and neglect, or protection. This helps to understand likelihood of future harm, i.e., is it possible or probable?
- recognise risk and protective factors, vulnerabilities and strengths, can be static or fixed – it's the dynamic variables (the ones that can change) that need to be tracked
- ensure each individual child's voice has been heard and they are visible
- consider information in the context of cultural knowledge and relevant cultural factors[15]

To assist to organise and analyse the information you have gathered, a Risk Assessment Analysis template is available to download from the FaCC and IFS secure sub-site which groups information into four quadrants: a child's vulnerability; the impact on the child; safety and probability.

4. Form a professional assessment

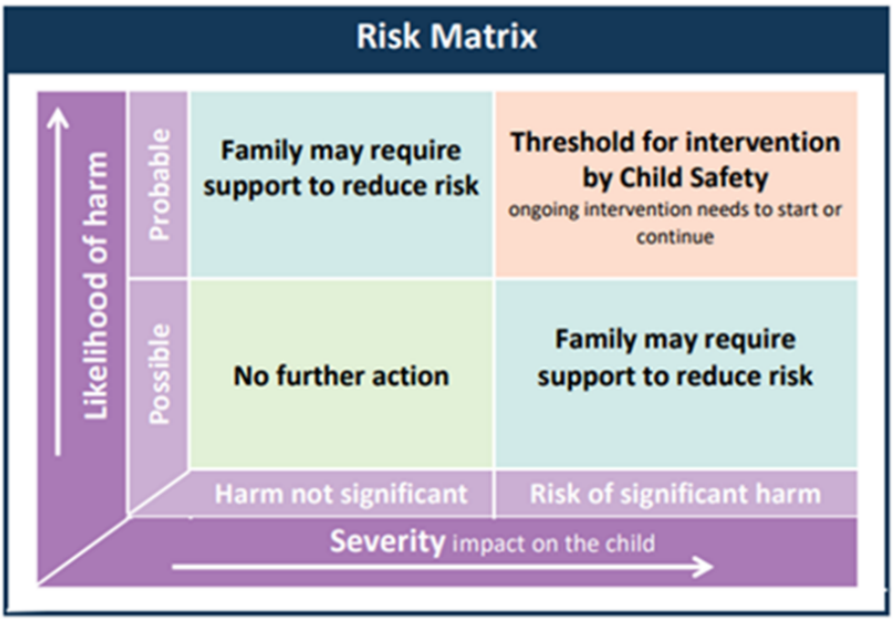
A professional assessment is formed by synthesising (bringing together) the analysis to determine the overall assessment of harm and risk of harm to a child. Although FaCC and IFS workers are not responsible for assessing outcomes in relation to whether a child is in need of protection (i.e. *the child has been harmed/at risk of harm AND does not have a parent able and willing*) it is important workers are clear about the risk factors for the child so that these factors can be articulated and addressed as appropriate.

It is also important FaCC and IFS workers understand departmental thresholds around risk of harm. Assessment about risk of harm is formed by bringing together the analysis of the information, with a particular focus on determining the *severity* and *likelihood* of future harm. The risk matrix (Figure 2

[15] Refer to snaicc_stronger_safer_together_report.pdf (dss.gov.au) for information about understanding strengths of Aboriginal and Torres Strait Islander child rearing practices, p29.

below) is used by the department and may be useful for FaCC/IFS services to understand thresholds and when it is considered appropriate for referrals to be made to the secondary service sector.

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 the child wouldn't be impacted, or they would be impacted, but the impact would not have a detrimental effect of a significant nature OR significant, meaning the statutory threshold for harm would be reached.
- Identify the assessment of likelihood on the vertical axis. This will have been either: possible, meaning harm may occur, but it is not likely OR probable, meaning 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 options:

1. **Threshold for intervention by Child Safety** – this quadrant reflects outcomes which suggest the child is in need of protection. Where the severity is assessed as significant, and the likelihood assessed as probable, ongoing intervention by Child Safety needs to occur. *Note: If during your assessment you conclude the risk to the children falls within this quadrant, if possible, consult with your PCPP and decide if a report to Child Safety is required.*
2. **Family may require support to reduce risk** – this quadrant reflects the risk is appropriately managed within the secondary family support sector, particularly Intensive Family Support. *Note: if your assessment of the family's circumstances falls within this quadrant, continue to work with the family to reduce the identified risks to a child and reduce the likelihood of escalation to the child protection system.*
3. **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. *Note: If your assessment of the family's circumstances falls within this quadrant, an intensive service like IFS may not be required and consideration should be given to a referral to less intensive family support services.*

Document

The full Collaborative Assessment and Planning framework or the ‘Skinny CAP” can be used to document harm and risk of harm as well as the acts of protection/strengths and resources. If you have used the risk assessment analysis template, this should be attached to ARC. Your assessment can also be documented in your case plan, a case note, or referral documents.

Revise the assessment

An assessment of harm and risk of harm is a point-in-time assessment. Therefore, when a child or family’s circumstances change or new information becomes available, then your assessment may change, and an updated assessment will be required to ascertain if or how the new information alters the risk and/or safety concerns. Begin the assessment process again, incorporating new information, analysing the child’s situation in the context of their changed circumstances and document your new assessment.

Table of Risk and Protective Factors

HARM/ABUSE FACTORS
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 caregiver/parent • When a caregiver/parent minimises current harm, justifies the abuse, cannot recognize or denies responsibility for the harm, this may lead to increased risk of harm. It may also suggest a non-accidental injury. • If the caregiver/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. • If a caregiver/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 substantiated. In addition to any substantiated harm, all previous history including child concern reports, and unsubstantiated investigation and assessments 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 caregiver/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 caregiver/parent and any other children in the family, the caregiver/parent's behaviour or caregiver/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 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 substantiation 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 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 caregiver/parent has made a threat to cause serious harm to the child

- A caregiver/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.

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 caregiver/parent's 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 caregiver/parents' capacity and household resources
    - the age of the children, with younger children (for example) requiring more of the caregiver/parents' time and attention for their care and supervision
    - the needs of the children where complex or challenging needs place increased demand on the caregiver/parents' capacity, time and resources,
- the caregiver/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.

CHILD FACTORS	
Risk factors	**Protective factors**
Infant aged under 12 months • Infants are more vulnerable due to their dependency on their caregiver/parent for all their needs. • 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; or ➢ has an illness or disability. • Rough or unsafe handling, slapping, kicking, pinching, or shaking can all result in significant physical harm 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. Poor attachment and lack of bonding may result in neglect of the child, rejection, scapegoating, or harsh discipline, resulting in physical or emotional harm.	**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 action is taken before a child is harmed. Seeking help during or after an incident which may have caused or contributed to further harm to a child is not a protective factor.
Unsafe sleeping practices • Unsafe sleeping practices are linked to infant deaths. Unsafe practices include: ➢ co-sleeping with a caregiver/parent affected by drugs (including some prescribed drugs) or alcohol ➢ ill-fitting mattress and bedding. ➢ cluttered cots - soft toys and pillows that can cover an infant's face. • For further information, refer to the Queensland Government website Safe sleeping (health.qld.gov.au)	**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 caregiver/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 aged under 5 years increases vulnerability • Children aged under 5 years are more vulnerable to harm as they are: ➢ reliant on their caregiver/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. ➢ may display behaviour that challenges a caregiver/parent, causing the caregiver/parent to feel stressed and frustrated.	**Child with a strong sense of personal control** • A child may demonstrate a belief 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.
The child has diagnosed or apparent needs which increases their vulnerability such as developmental delays, physical or intellectual disability, medical concerns • Stresses and higher demands of managing daily care needs can affect the caregiver/parent's ability to meet the needs of the child, impacting on caregiver/parent-child attachment; communication; mobility and ability to access basic needs or supports both inside and outside the home.	**Connection to culture** • Strong connection to culture can promote a child's resilience. • There may be cultural factors that promote a child's health, safety and wellbeing, for example the presence of safe and effective kinship networks, an ability to engage in traditional food sourcing practices or customs that increase a child's sense of worth and place within their family.

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. • 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.	• 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.
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 (ACEs) toolkit - Emerging Minds	
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 and sexually reactive or sexually abusive behaviours • 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. • High risk behaviours can be the result of harm and can contribute to increased risk of harm. This may be due to increased caregiver/parental stressors in responding to these behaviours and/or conflict with the child and disruption of the caregiver/parent-child relationship. For children engage in high-risk behaviours, the caregiver/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.	
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 caregiver/parent.	

CAREGIVER/PARENT FACTORS	
Risk Factors	Protective factors
A caregiver/parent is refusing access to the child or the family is likely to flee • If a caregiver/parent is refusing access to a child, it may be to avoid further assessment of notified harms	**The caregiver/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 caregiver/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 caregiver/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 caregiver/parent's views on the harm needs to be considered as part of the broader risk assessment. In assessing their actual capacity to prevent future harm, their ability to protect must be assessed with particular emphasis on any impediments to that ability (for example, substance misuse, domestic and family violence, Family Court residency and contact orders). • If a caregiver/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.
Issues in the caregiver/parent-child relationship and connection • Where the relationship between the child and the caregiver/parent is absent, disrupted, disordered or under stress, the risk of harm is increased.	**Secure attachment between the caregiver/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.

• 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 caregiver/parent is unable or does not respond to the child's needs, insecure attachment results, with a child showing avoidance or ambivalence to the caregiver/parent and others. • Disorganised attachment is evident in some children who have suffered harm through impacts of chronic family violence, or whose caregiver misuses substances. Disorganised attachment in infancy has been linked to complex trauma and a higher risk of behaviour problems in later childhood, adolescence and adulthood.	
Caregiver/parental expectations of the child are unrealistic • A caregiver/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 caregiver/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 caregiver/parent's expectations do not align with the child's actual or expected milestones, this may cause or contribute to caregiver stress. A child may have delayed access to early intervention to assist them in meeting development milestones if a caregiver/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	**A caregiver/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.

participating in age appropriate activities due to the caregiver's 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 for 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 by 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 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 caregiving responsibilities.	
A caregiver/parent is impulsive • Research indicates a caregiver/parent who has poor impulse control may be more likely to engage in inappropriate caregiving 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 caregiving 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 caregiver/parent's ability to tend to the needs of a child over their own needs and wishes. • Substance abuse may impact on the caregiver/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 they are prioritizing the relationship with the perpetrator over the needs and wellbeing 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 caregiver/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 caregiver/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 caregiver/parent being physical or verbally abused, the child may become wary of adults; overly compliant; experience mental health conditions, resulting in emotional harm.	

The caregiver/parent has experienced childhood abuse • Caregiver/parenting skills are believed to largely be learned/modelled from childhood experiences. The intergenerational transmission of abuse occurs when caregiver/parents who have been physically, emotionally or psychologically harmed as children use harmful caregiver/parenting behaviours on their own children. Childhood abuse may skew or diminish their perspectives of their own caregiver/parenting and impacts on their child. In their own caregiving, they may repeat the patterns of behaviour they experienced. • Caregiver/parents may also engage in other harmful caregiving strategies in an attempt to prevent or avoid repeating the patterns of their own childhood. For example, a caregiver/parent may isolate the child for fear they will be sexually abused, preventing the child from accessing medical treatment or education.	
FAMILY	
Risk factors	**Protective Factors**
There is domestic and family violence • Any child with a caregiver/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 caregiver/parent being physically abused, caregiver injuries, property damage, threats and manipulation, and/or intervening or experiencing harm from physical assaults and property damage. • A non-offending caregiver/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 caregiver/parent may be or appear to be unable to act protectively due to the coercive control and violence,	**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 caregiver/parent

for example the perpetrator has made threats of murder or suicide if the non-offending caregiver/parent attempts to leave with the children. • The non-offending caregiver/parent may over-discipline a child in an attempt to control the child's behaviour and protect them from the perpetrator's violent and controlling behaviour.	➢ will be able to effectively protect the child from the identified harm or risk of harm by their presence.
The family is experiencing a high degree of stress • Research indicates increased stress for a family (and caregiver/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.	**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 caregiver/parental and household stress
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 caregiver/parent family • Being a sole or single caregiver/parent is not in itself a risk factor but may be when other factors are present in the family. Research has identified single caregiver/parents face increased financial pressures, higher stress levels and isolation, often with less access to emotional and social supports. • When there is only one caregiver/parent, the care responsibilities fall to one person which can be associated with increased risk. Caregiver/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 caregiver/parent may become a sole caregiver/parent because of separation, divorce or death of a partner, placing further stresses on the family through loss and grief.	
ENVIRONMENTAL	
Risk factors	**Protective factors**
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 caregiver/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 caregiver/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 caregiver/parental provision of basic care, consider a referral to other relevant council or government services.*	**The family is supported by a safety and support network** • Contact with another professional or community agency may reduce caregiver/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, wellbeing 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.
Poor social networks and isolation from services • A lack of services; inability to access infrastructure such as parks, transport, shops, schools and childcare; 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,	**Adequate income and housing** • Fewer stresses by having basic housing and income can decrease anxiety, increase self-worth, support caregiver/parent-child relationships and buffer emotional harm and neglect.

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 childcare 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 caregiver/parent leaving a violent partner or household member - an action taken to protect the child.	Connection to culture or religion • Children, parents and families who experience a meaningful connect to their culture or religion can mitigate against harm through increased sense of worth and belonging, access to community/neighbourhood 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.
Cultural context • Cultural or religious beliefs or practices may be associated with behaviour which 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 caregiver/parents' core values and beliefs, it is less likely they will recognise the behaviour as harmful, more likely they will justify or excuse the harm for cultural or religious grounds, and more likely the behaviour will continue.	

Non-biological parent • The presence of a step-parent or a person undertaking a caregiving 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 a non-relative. Causal factors may relate to bonding and attachment issues, less sensitive care giving, poorer quality of interactions, and viewing caregiving as burdensome or not their role. • While a female partner may also cause harm to their partner's child, research indicates male partners are more likely to be responsible for harm.	

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Appendix 3 – Culturally Respectful, Safe and Responsive Service Delivery for Aboriginal and Torres Strait Islander Families

Priority response to reduce disproportionate representation of Aboriginal and Torres Strait Islander children in statutory care

The steadfast commitment by the Queensland Government (and also at the national level) to take action to improves outcomes for Aboriginal and Torres Strait Islander families means a transformation in service delivery responses is a non-negotiable priority.

Our Way, a generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037

- *Our Way, a generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037* sets Queensland's strategic framework to achieve generational change over the 20 years of the strategy.
- The Our Way strategy is co-developed with Family Matters Queensland and guided by Aboriginal and Torres Strait Islander perspectives.
- The Queensland Government is a signatory to the Family Matters[16] national campaign's Statement of Commitment to ensure Queensland Aboriginal and Torres Strait Islander children and young people grow up safe and cared for in family, community and culture.

The Our Way Strategy [17] represents a whole-of-government and whole-of-community long-term commitment to work together to:

- ensure all Aboriginal and Torres Strait Islander children grow up safe and cared for in family, community and culture
- eliminate the disproportionate representation of Aboriginal and Torres Strait Islander children in the child protection system
- close the gap in life outcomes for Aboriginal and Torres Strait Islander children and families.

Four building blocks underpin the Our Way strategy:

- All families enjoy **access to quality, culturally safe universal and targeted services** necessary for Aboriginal and Torres Strait Islander children to thrive
- Aboriginal and Torres Strait Islander peoples and organisations **participate in and have control over decisions** that affect their children
- Law, policy and practice in child and family welfare are **culturally safe and responsive**

[16] Family Matters is a national campaign led by more than 150 Aboriginal, Torres Strait Islander and non-Indigenous organisations across Australia committed to eliminating the disproportionate representation of Aboriginal and Torres Strait Islander children in statutory out-of-home care, within a generation. Annual reports are published on jurisdictional progress towards reducing over-representation of Aboriginal and Torres Strait children in statutory child protection. See *www.familymatters.org.au* for more details.
[17] Implementation of the Our Way Strategy is supported by three-year action plans addressing priority areas across over three cycles of change. More information at https://www.cyjma.qld.gov.au/campaign/supporting-families/implementing-reforms/strategy-action-plan-aboriginal-torres-strait-islander-children-families.

- **Governments and community services are accountable** to Aboriginal and Torres Strait Islander peoples

The ENABLERS for the Our Way Strategy outline key focus areas which IFS services can consider as part of their strategies and practice	
❖ Focus on the child	❖ Empower parents, families and communities
❖ Enable self-determination	❖ Set high expectations and positive norms
❖ Take a holistic and life-course approach	❖ Recognise culture as a protective factor
❖ Address trauma and enable healing	❖ Share power, responsibility and accountability
❖ Shift and balance investment	❖ Provide accessible and coordinated services
❖ Create partnerships	❖ Innovate, build evidence and adjust

The Aboriginal and Torres Strait Islander Child Placement Principle

The Aboriginal and Torres Strait Islander Child Placement Principle is enshrined in Queensland's child protection legislation. All services must **actively** apply the relevant element/s of the Aboriginal and Torres Strait Islander Child Placement Principle in their work, practice and interactions with Aboriginal and Torres Strait Islander families.

Active efforts mean ensuring affirmative, active, thorough and timely interactions which align with the relevant element/s and the intent of the Principle.

Five elements of the Aboriginal and Torres Strait Islander Child Placement Principle
❖ Element 1: Prevention – protecting children's rights to grow up in family, community and culture by redressing the causes of child protection intervention
❖ Element 2: Connection – maintaining and supporting connections to family, community, culture traditions and language
❖ Element 3: Partnership – ensuring the participation of community representatives in service design, delivery and individual case decisions
❖ Element 4: Participation – ensuring the participation of children, parents and family in decisions regarding the care and protection of their children
❖ Element 5: Placement – placing children in out of home care in accordance with established placement hierarchy

In order to actively apply the Principle, it is important to understand its **aims**:

- embed an understanding that culture is integral to safety and wellbeing for Aboriginal and Torres Strait Islander children and young people and is embedded in policy and practice
- recognise and protect the rights of Aboriginal and Torres Strait Islander children, family members and communities in child safety matters
- support self-determination of Aboriginal and Torres Strait Islander people in child safety matters
- reduce the over-representation of Aboriginal and Torres Strait Islander children in child protection and out-of-home care systems.

RESOURCES: SNAICC has comprehensive research and resources on understanding and applying the Aboriginal and Torres Strait Islander Child Placement Principle. SNAICC also undertakes an annual review on implementation across each jurisdiction. To access these resources, see *https://www.snaicc.org.au/reviewing-implementation-of-the-aboriginal-and-torres-strait-islander-child-placement-principle-2020*

FaCC role and responsibilities

FaCC has a significant role and responsibility as a mainstream secondary service to reduce the disproportionate representation of Aboriginal and Torres Strait Islander children in the statutory child protection system.

Aboriginal and Torres Strait Islander families are more likely to engage and feel safe and respected with organisations that are recognised for being actively engaged in the life of their community.

FaCC services contribute to these commitments by ensuring their services and support for Aboriginal and Torres Strait Islander families is managed and delivered in culturally respectful, safe and responsive ways. This requires strong cultural capability across the key elements of service delivery, evidenced by:

Agency/service level

The agency places importance on recognising the historical facts of Australian history, the ongoing legacy of colonialisation and the impacts of intergenerational trauma for Aboriginal and Torres Strait Islander peoples.

The agency is clear in its policies and procedures that the services and support delivered are based on a healing framework and every care is taken to prevent the re-traumatisation of Aboriginal and Torres Strait Islander families.

The agency is clear in its policies and procedures that racism is not tolerated in any form. The service develops effective links with local Aboriginal and Torres Strait Islander organisations and community representatives to help build a culturally safe profile. To aid the cultural safety of the service, it is strongly recommended that:

- a **Cultural Practice Framework** is developed, implemented, and regularly monitored

- the **Family Matters Cultural Reflective Practice Tool**[18] is actively used to deliver culturally capable service and to identify areas and plan for improvement

RESOURCE: The **Family Matters Cultural Reflective Practice Tool** is currently the only tool that ensures a cultural lens is applied to reflecting on application of the five elements of the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP) while also aligning with both the Family Matters and the Our Way Strategy's building blocks and principles.

It invites signatories to challenge systemic racism, uphold children's rights, and transfer capacity to enable community controlled organisations to provide services based on community needs.

Details and supporting information on the Family Matters Reflective Practice Toolkit and template (including Queensland trial findings) is available at *https://www.familymatters.org.au/publications*

- The service provides practitioners with ongoing cultural supervision and accessible options to cultural advice.
- The physical features of the service outlet are characterised in a manner which is welcoming and without stigma for Aboriginal and Torres Strait Islander families and partners (for example featuring Aboriginal and Torres Strait Islander artefacts and symbols).

Staffing level

- All staff, with an increased expectation on practitioners, demonstrate strong understanding of the histories, cultures, traditions and customs of Aboriginal and Torres Strait Islander peoples, including common and relevant terminology.
- Practitioners demonstrate a strong understanding of the legislative requirements in providing services for Aboriginal and Torres Strait Islander families *(Child Protection Act 1999; Human Rights Act 2019)*.
- Practitioners acknowledge the strong protective factors of connections to kin, community, and culture.
- Practitioners work with a trauma-informed lens, practice deep listening, and take into consideration the impacts of accumulative harms and the need for healing responses.

[18] The National Family Matters Reflective Practice Tool was developed in 2019 to assist campaign signatories to assess their commitment to uphold the campaign principles and building blocks and to identify actions to take in accordance with each principle.

Practitioners demonstrate strong understanding and capability regarding cultural differences in:

- communication styles
- engagement practices
- yarning
- child development
- concept, language and potential concerns relating to disability[19]
- child rearing and parenting styles
- family structures

- Practitioners actively apply the elements of the Aboriginal and Torres Strait Islander Placement Principle in their interactions and decisions (in particular, the elements of prevention, partnership, participation and connection are relevant to IFS service delivery).[20]

- Practitioners are provided with sufficient support to work with Aboriginal and Torres Strait families recognising the building of trusting respectful relationships requires time and flexibility.

- Practitioners understand that for Aboriginal and Torres Strait Islander families, the importance of kin, extended family and the community in the raising of safe and happy children is paramount, and where appropriate, the significant extended family members should be encouraged and welcomed to participate in decision making processes.

- Practitioners should consult with cultural experts and services and be aware of and plan around any significant cultural events or occasions which may impact on a family. Of great importance is respecting the cultural practices, customs and protocols associated with the death of Aboriginal and/or Torres Strait Islander peoples in community (Sorry Business). This may require both staff and clients of the service to attend funerals and participate in Sorry Business or bereavement protocols. This is not considered a disruption of service delivery, but an important component of community and cultural life and supportive responses to people and communities grieving the loss of members of the community. Sorry Business is not a disruption to service delivery but an essential sign of respect.

- Practitioners recognise that longer periods of engagement may be required when working with Aboriginal and Torres Strait Islander families and to appreciate the importance of taking the time to build trusting respectful relationships and rapport.

[19] 'Disability' is a socially constructed concept from western culture and society. People from Aboriginal and Torres Strait Islander backgrounds may have a very different understanding of the concept and the use of the word may not exist. There are additional challenges such as fear of discrimination and of having a child with disability removed from a family's care (see Child Safety Practice Manual Practice Kit for more information).

[20] Only the element of 'placement' is not relevant as it is concerns children in the statutory arm of the children protection system.

Practice note: Identification

Family Matters Report 2021:

The *Family Matters Report 2021* recommended that children and families be asked at their earliest engagement with the service system about their Aboriginal and Torres Strait Islander identity; this question is revisited regularly; and that their identity is recorded as early as possible.

Implementation measures must include training to practitioners on culturally safe ways to discuss and explore cultural identity with children and families.

There must also be protections against the de-identification of children without consultation with Aboriginal and Torres Strait Islander communities.

Families Investment Specification (Department of Children, Youth Justice and Multicultural Affairs):

A family is considered to be Aboriginal and/or Torres Strait Islander if a member of the family identifies as Aboriginal and/or Torres Strait Islander.

Child Protection Act 1999:

s.11 (3) A parent of an Aboriginal child includes a person who, under Aboriginal tradition, is regarded as a parent of the child.

s.11 (4) A parent of a Torres Strait Islander child includes a person who, under Island custom, is regarded as a parent of the child.

A **culturally safe place** for Aboriginal and Torres Strait Islander staff and families is characterised by the following factors (Queensland Child Safety Practice Manual).

- welcomes Aboriginal and Torres Strait Islander families and partners in the physical environment
- acknowledges the richness of Aboriginal and Torres Strait Islander cultures
- acknowledges the differences between Aboriginal and Torres Strait Islander cultures
- encourages ally behaviours
- does not stay silent in the face of inappropriate behaviour (even minor). Staying silent can be seen as condoning.
- recruits Aboriginal and Torres Strait Islander staff
- models an expectation of behaviour—we talk about children, families, partners and others as though they were sitting in the room with us
- expects growth to be uncomfortable
- has Aboriginal and Torres Strait Islander people on recruitment panels
- considers using storytelling questions in interviews

- understands the concept of cultural humility. Aboriginal and Torres Strait Islander people will often sell themselves short rather than talk themselves up. We need to be curious and ask them more
- knows that maintaining 'cultural capital' is essential. Aboriginal and Torres Strait Islander staff need contact with their mob and other Aboriginal and Torres Strait Islander staff to build capital and maintain a sense of self
- encourages collectivist responsibility
- ensures staff have genuine engagement in cultural learning
- has staff who accept their responsibility to educate themselves about Aboriginal and Torres Strait Islander history
- understands that Aboriginal and Torres Strait Islander history is Australia's shared history.

Cultural services / resources

- National crisis support line for Aboriginal and Torres Strait Islander peoples

13YARN [Thirteen YARN / 139276] is the national crisis support line for mob who are feeling overwhelmed or having difficulty coping. They offer a confidential one-on-one yarning opportunity with a Lifeline-trained Aboriginal and Torres Strait Islander Crisis Supporter who can provide crisis support 24 hours a day, 7 days a week.

13YARN empowers mob with the opportunity to yarn without judgement and provide a culturally safe space to speak about their needs, worries or concerns.

- Indigenous Triple P

Indigenous Triple P allows providers accredited in Primary Care, Group and/or Standard Triple P programs to tailor their delivery of the programs to suit Aboriginal and Torres Strait Islander families. Materials and content for Indigenous Triple P were created in consultation with elders from a variety of Aboriginal and Torres Strait Islander communities in Australia. Indigenous Triple P has been used with both Indigenous Australian families and aboriginal Canadian families. (Specialist programs - Triple P)

SOURCES OF TRUSTED EXPERT INFORMATION

There are many resources available to inform and support the understanding, development and delivery of culturally capable services. Recommended sources include:

- **Queensland Aboriginal and Torres Strait Islander Child Protection Peak Limited (QATSICPP)** *[https://www.qatsicpp.com.au]*

QATSICPP's mission is to develop policies and strategies to lead, resource and build the capacity of Aboriginal and Torres Strait Islander agencies who work alongside parents, families and communities to ensure the safety and wellbeing of children and young people. There is a wide range of expert resources available on their website to guide mainstream service practice when working with Aboriginal and Torres Strait Islander families. This support will continue to grow, with the establishment of a QATSICPP Centre of Excellence in 2022 to share collective knowledge and experience, and practice wisdom based on the evidence.

An example of a useful resource is *QATSICPP Practice Standards (2017)* – see https://www.qatsicpp.com.au/our-work/practice-resources/

- **Secretariat of National Aboriginal and Islander Child Care (SNAICC) – National Voice for our Children** *[https://www.snaicc.org.au]*

SNAICC is the national non-governmental peak body for Aboriginal and Torres Strait Islander children, working for the fulfilment of the rights of children, to ensure their safety, development and well-being with connection to family and culture at the forefront.
There is a wide range of expert resources available on their website relating to Child Safety and Wellbeing; Early Childhood; and Child Rights. Also of relevance for IFS are the resources on Genuine Partnerships to support Aboriginal and Torres Strait Islander and non-Indigenous organisations on building partnerships for child and family service delivery.
See https://www.snaicc.org.au/policy-and-research/

A recommended resource is *Moving to Prevention research report: Intensive family support services for Aboriginal and Torres Strait Islander children (2015)* which provides a detailed account of the best practice elements to support services and practitioners in developing their practice to better support Aboriginal and Torres Strait Islander children and families – see https://www.snaicc.org.au/moving-to-prevention-intensive-and-targeted-family-support/

- **Family Matters: Strong Communities. Strong Culture, Stronger Children – Australia's national campaign to ensure Aboriginal and Torres Strait Islander children and young people grow up safe and cared for in family, community and culture** *[https://www.familymatters.org.au]*

Family Matters is led by SNAICC and aims to eliminate the over-representation of Aboriginal and Torres Strait Islander children in out-of-home care by 2040. Hundreds of supporters have officially made a commitment to the vision, including community organisations, community services, governments, parliamentarians, research institutions, universities, charities and peak bodies.

The Family Matters Report is an essential resource for IFS. The report is produced annually and examines what each Australian jurisdiction is doing to turn the tide on over-representation and the

outcomes for children. It also highlights solutions and strengths-based actions to invest in. In Queensland, the Our Way Strategy is co-designed by Family Matters Queensland and the Queensland Government (see details above).

❖ **The Healing Foundation** *[https://healingfoundation.org.au]*

The Healing Foundation is a national Aboriginal and Torres Strait Islander organisation that partners with communities to address the ongoing trauma caused by actions such as the forced removal of children from their families: *For Aboriginal and Torres Strait Islander people, healing is a holistic process, which addresses mental, physical, emotional and spiritual needs and involves connections to culture, family and land. Healing works best when solutions are culturally strong, developed and driven at the local level, and led by Aboriginal and Torres Strait Islander peoples*.

There is a wide range of expert information and resources on trauma and healing available on the Foundation's website.

❖ **Australian Institute of Family Studies (AIFS)** *[https://aifs.gov.au]*

AIFS conducts high-quality, impartial research into the wellbeing of Australian families, to inform government policy and promote evidence-based practice in the family services sector. The topic area 'Aboriginal and Torres Strait Islander families' provides a wide range of information. Examples of useful research and practice information include: *Working with Indigenous children, families and communities: Lessons from practice (2011*); *Enhancing the implementation of the Aboriginal and Torres Strait Islander Child Placement Principle (2015)* and *Child protection and Aboriginal and Torres Strait Slander children (2020)*.

Queensland Government resources:

❖ **Queensland Child Safety Practice Manual (CSPM)** *[https://cspm.csyw.qld.gov.au]*

The CSPM also has useful information which can be applied to family support practice.

- The Practice Kit on *Safe care and connection* to inform culturally capable practice with Aboriginal and Torres Islander children and families.
- The Practice Kit on *Disability in Aboriginal and Torres Strait Islander cultures* to inform understanding of disability and impacts from the perspective of people from Aboriginal and/or Torres Strait Islander backgrounds.

❖ **Aboriginal and Torres Strait Islander Family Wellbeing Services (FWS) Program Guidelines**

[accessible on the ARC landing page]

Aboriginal and Torres Strait Islander FWS are a critical component of implementing the Our Way Strategy. The service makes it easier for Aboriginal and Torres Strait Islander families in communities across Queensland to access culturally responsive support to improve their social, emotional, physical and spiritual wellbeing, and build their capacity to safely care for and protect their children. The Program Guidelines may be useful for IFS services. Information about the program is also available at *https://www.familywellbeingqld.org.au*

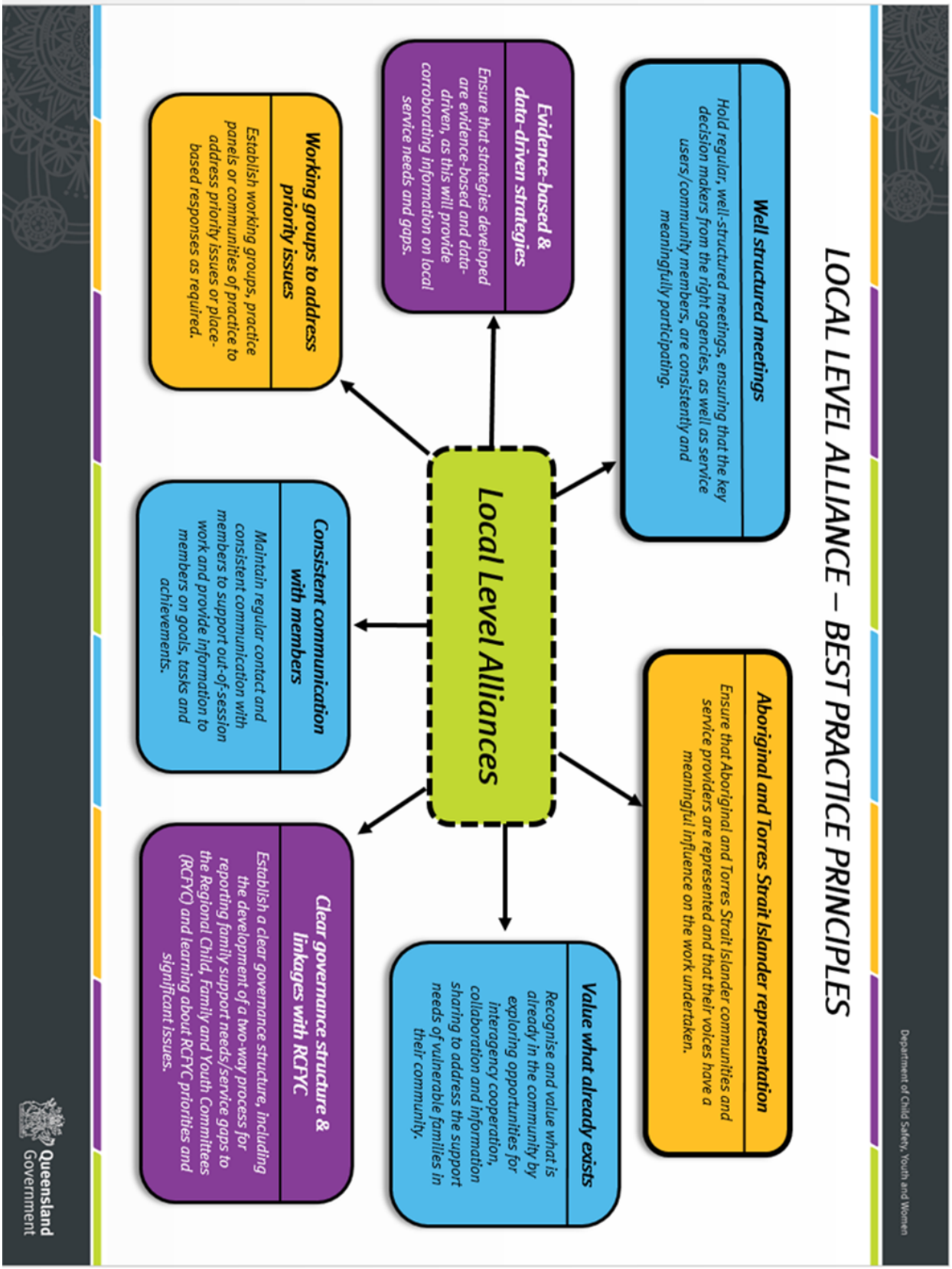
❖ **Aboriginal and Torres Strait Islander Respectful Language Guide** *[https://www.cyjma.qld.gov.au/resources/dcsyw/about-us/research/respectful-language-guide.pdf]*

The Respectful Language Guide was designed for government staff to make respectful, conscious and insightful choices of words, terms and language and is relevant for IFS services.

Appendix 4: Consent and Closure Reason Scenarios

Scenario	Record consent?	Closure reasons
A family opens to door to an unannounced visit by a FaCC worker. The family invites the worker in for a chat about the referral.	No. Consent cannot be assumed by being invited into the family home or a family agreeing to meet during a phone call. If during the home visit the family subsequently consent, this date can be included in ARC.	Not applicable
During a home visit the family reports they do not require any referrals but are interested in the phone number of a DFV service. FaCC worker provide DFV details and closes case.	Yes. Although they have not consented to active engagement, they have engaged in a conversation with workers and have identified a service which will meet their family's needs.	Family's needs met by FaCC intervention: information and advice ***Note**: until these changes are made in ARC, please choose Family's needs met by FaCC intervention*
After a cold call, a letter and a couple of missed phone call, the family calls FaCC back. The family is happy to chat about concerns over the phone however they report they do not need support at this time and accept general community brochures. The case is closed.	Yes. Although they have not consented to active engagement, they have engaged in a conversation with workers and have identified a service which will meet their family's needs.	Family's needs met by FaCC intervention: information and advice ***Note**: until these changes are made in ARC, please choose Family's needs met by FaCC intervention*
After a cold call, a letter and a couple of missed phone call, the family calls FaCC back. The family is happy to chat about concerns over the phone however report they do not need support at this time but accept a list of phone numbers and brochures specific to the issues identified in the referral. The case is closed.	Yes. Although they have not consented to active engagement, they have engaged in a conversation with workers and have identified a service which will meet their family's needs.	Family's needs met by FaCC intervention: information and advice ***Note**: until these changes are made in ARC, please choose Family's needs met by FaCC intervention*

Scenario	Record consent?	Closure reasons
During a home visit, the family declines service as they have existing services in place and do not wish for any further referrals. Case is closed.	No. Family not wanting to engage as there are already services involved.	Early exit: already engaged
FaCC worker has met with the family a number of times to discuss the referral and their family's needs. Worker offers advice relating to parenting which the family reports as useful, however decline any further referrals. Case is closed.	Yes.	Family's needs met by FaCC intervention: information and advice OR Family's needs met by FaCC intervention: brief intervention ***Note**: until these changes are made in ARC, please choose Family's needs met by FaCC intervention*
A parent self-refers to FaCC and agrees for FaCC to visit. FaCC arrives at family home and parent then indicates they have changed their mind and does not wish to proceed.	If informed consent was received over the phone initially then the date of this phone call would be consent obtained, but outcome would be early exit.	Early exit: family disengaged from service/withdrew consent
The family meets with the FaCC worker several times and sign a consent form. The worker provides details of a specific service they believe would benefit the family, however the family is going to self-refer. The case is closed	Yes	Family's needs met by FaCC intervention: information and advice ***Note**: until these changes are made in ARC, please choose Family's needs met by FaCC intervention*

Scenario	Record consent?	Closure reasons
An active engagement response has been completed and an appropriate referral service has been identified. Family is unable to be referred to this service in a timely way due to capacity issues.	Yes	Referral to another service: Referred service unavailable due to capacity issues ***Note**: until these changes are made in ARC, please choose Early Exit: Staffing or agency reason*

Appendix 5 - LLA Best Practice Principles