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| Demand management of child wellbeing and safety concerns Child FIRST and Family Services demand management framework |
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Department of Health

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| To receive this publication in an accessible format email ChildrenYouthFamilies@dhhs.vic.gov.auAuthorised and published by the Victorian Government, 1 Treasury Place, Melbourne.© State of Victoria, Department of Health and Human Services August, 2019.Where the term ‘Aboriginal’ is used it refers to both Aboriginal and Torres Strait Islander people. Indigenous is retained when it is part of the title of a report, program or quotation.Available on the [Family Services page](https://providers.dhhs.vic.gov.au/family-services) of the Providers website.<https://providers.dhhs.vic.gov.au/family-services> |
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# Introduction

Child and Family Services Alliances are responsible for the effective prioritisation of Child Wellbeing referrals received by Child FIRST, The Orange Door or Family Services directly to manage demand at a catchment level.

The process of monitoring and managing demand is complex and involves understanding demand and capacity factors, prioritising resources and making difficult decisions to achieve an optimal balance between providing service responses to the most vulnerable, and providing early intervention to prevent an individual or family’s situation from escalating.

While prioritisation shifts to the most vulnerable families during times of very high demand, equally, there should be a continued attempt to intervene earlier to address the safety, stability and development of less vulnerable families, to prevent them having to get to ‘breaking point’ before receiving a response.

This document outlines practice approaches to manage demand for services, while also ensuring that quality services that respond to the best interests of children are provided. While Alliances already have Demand management strategies in place, the intention of this document is to support consistent practices across Victoria in measuring, managing and influencing demand for Family Services. Alliances will be asked to review their existing demand management strategies, tools and templates in line with the advice in this document.

This document is targeted primarily to Child FIRST catchments that have yet to transition to The Orange Door, but will be integrated into broader demand management work being undertaken by Family Safety Victoria as part of the implementation of The Orange Doors. It applies to both the Child FIRST intake point and also the Family Services response.

Family Safety Victoria is developing a Demand management framework that will apply across core family violence, family services and perpetrator services. It will provide the necessary policies, strategies, tools and templates for Hubs and connected core services to effectively monitor and manage demand including demand tools.

This *Demand Management Framework for Child wellbeing concerns* will help to inform this broader Hubs and Core services Demand Management Framework, and remain in place until this larger Framework is released.

## Demand interface between the Orange Door and Family Services in Orange Door sites.

As Family Services in Orange Door areas receive the majority of their referrals through the Orange Door, increase in demand in the Orange Door for child wellbeing referrals is likely to put pressure on the whole Child and Family Service system. Section 61 of the Children Youth and Families Act (2005) - Responsibilities of registered community services states that ‘prioritisation of provision of services will occur based on need’.

Whilst the role of The Orange Door is to monitor core agency capacity and allocate accordingly with respect to threshold, it is important that collaboration remains a central feature between the Orange Door and Family Services to ensure that the Best Interests of Children remain paramount.

The Orange Door and Family Services should utilise existing Child and Family Alliance (Alliance) mechanisms to ensure there is a shared understanding of the demand on the Orange Door for child wellbeing referrals and on the capacity of Family Services to accept referrals and provide an appropriate response to families.  Within each local area, including in Orange Door areas, the Child and Family Services Alliances are non-incorporated groups of family service providers and key partner services in a specific geographic area that work under a Memorandum of Understanding to deliver coordinated responses to vulnerable children, young people and their families.

There is an Orange Door interim demand management plan that is intended to provide strategies to manage demand within the Orange Door, however, Family Services ability to receive allocations is reliant on Family Services also having capacity to accept referrals.

Family Services can refer to this document *Demand management of child wellbeing and safety concerns* for an overview of demand principles and practice approaches and also some strategies for managing demand that Family Services could consider in their practice, for example; conducting a review of cases that have been open more than six months and reviewing cases that have a low number of hours in relation to length of time they have been open.

In Orange Door areas, restriction of intake will not occur within the Orange Door. In order to manage the consistent demand on The Orange Door and Family Services, demand management should continue as a standing agenda item at Alliance meetings and strategies should be put in place so that it is proactively managed, including through open and ongoing conversations between the Orange Door representative/s and family services.

## Children and families reform

The intent of Children and Families Reform outlined in Roadmap for Reform is for vulnerable children and families to get the right help, at the right time to keep them:

* • safe and secure
* • healthy and well
* • connected to culture and community
* • capable of taking part in learning, education and employment**.**

through a child and family system that:

* • is person-centred, outcomes focussed and evidence-informed
* • prioritises self-determination and self-management for Aboriginal Victorians
* • offers integrated, tailored and flexible support
* • has capacity to provide earlier intervention - building parental capability and helping prevent family problems getting worse.

# Requirements

## Legislative requirements

The *Children Youth and Families Act 2005* (the Act) provides the legislative basis for an integrated system of services for vulnerable children, young people and their families.

The legislative context promotes the safety, stability and healthy development of children. It also places a strong emphasis on the need to consider the impacts of cumulative harm[[1]](#footnote-1) and to preserve cultural identity.

In accordance with the Act (section 61), family and early parenting services are required to provide their services in relation to a child in a manner that is in the best interests of the child and to work collaboratively with local service networks to promote the best interests of the child. Family and early parenting services are also required to ensure that services are accessible to and made widely known to the public, recognising that prioritisation of services will occur based on need.

The decision-making principles of the Act highlight the importance of involving children and families in decision-making processes, and of providing them with assistance and support to do so in a meaningful way.

Additional principles provide a framework for decision making in relation to Aboriginal children and families. These provide a stronger basis for ensuring that Aboriginal children remain within, or connected to, their community and culture.

## Agency Performance and System Support

Agency Performance and System Support teams hold portfolio responsibility for Child and Family Services Alliances, and are active members of the Alliance.

Agency Performance and System Support are the conduit between Alliances and the central Family Services team. In order for the central Family Services team to have an accurate understanding of the function of Alliances, in particular demand issues, it is vital that there is strong information exchange between local areas and the central Family Services team. Accurate data collection and reporting is also vital to understand demand pressures and support state budget proposals.

## Governance

Child and Family Services Alliances are responsible for operational management of services responding to vulnerable children, including allocations to family services, high level strategic decisions, developing and maintaining strategic partnerships, development and endorsement of the Alliance plan and demand management strategy.

Alliances have representation from Child FIRST and Family Services providers including Cradle to Kinder, Agency Performance and System Support, Child Protection, and broader representation where possible from Local Government, Department of Education and Training, Alcohol and other Drug services, Mental Health and Family Violence services.

The Alliance is responsible for holding regular governance meetings, including Alliance Executive, Operations group, allocations meetings and bi-annual meetings.

Demand management should be a regular agenda item at these meetings. Demand for services should be monitored and regularly reported on to the Alliance Executive. If demand escalates to unsustainable levels, the Child and Family Services Alliance Executive, including the Department of Health and Human Services Area Director, should discuss the implementation of appropriate actions. In the event of restricted intake Agency Performance and System Support must facilitate formal sign off by the Area Director and notify the Children, Youth and Families Unit (**Attachment 2** –*Reporting advice of restricted intake in Child FIRST or Restricted allocation to Integrated Family Services template*).

## Policy requirements

Each Child and Family Services Alliance is required to have a demand management strategy (outlined in the *Strategic framework for Family Services, January 2007*).

Local Demand Management Strategies should align with the guidance in this paper to support state-wide consistency.

Alliances are required to review their strategies on an annual basis. The Department of Health and Human Services (Local Area) is required to maintain local oversight and recommend revision of strategies if required.

Strategies should focus on proactively managing increasing demand for services through:

* + tracking of demand from, and maintaining proactive relationships with, major referral sources
	+ deployment of child and family alliance resources to most effective use

*The Program requirements for family and early parenting services in Victoria* (Program requirements) outline the expectations and requirements to guide, support and inform quality service delivery. Service providers must adhere to these requirements when delivering funded activities, in order to meet obligations under the service agreement. The Program requirements outline the key practice requirements for Child FIRST and Family Services as well as providing specific system and organisational requirements that may assist in managing demand for services such as service planning and collaboration and partnerships.

# Principles of demand management

* Responsive - the service is responsive and has the capacity and flexibility to attend promptly to children and young people whose family is in crisis.
* Therapeutic relationship begins at first point of contact - children and young people receive appropriate support and intervention from their first point of contact with the service.
* Short waiting times – active holding will be minimised as much as possible within resource limitations with recognition that long waiting times have a negative impact on outcomes for children and young people.
* Proactive approach - proactive rather than reactive approaches will be taken to demand management so as to avoid a build-up of waiting times.
* Quality - strategies for managing demand will not compromise quality of service for any children or young people. All children and young people will have access to the type of service that bests suits their needs.
* Safety - strategies for managing demand will not compromise the safety of children and young people.
* Protection of staff - strategies for managing demand will not create excess burden on staff.
* Equity – Aboriginal and Torres Strait Islander families, children and young people from culturally and linguistically diverse backgrounds, children and young people with a disability or members of other marginalised or vulnerable groups will be prioritised for allocation.

## Practice approaches

Practice approaches should be supported by:

* consistent practices in measuring, managing and influencing demand for family services referrals across the state.
* an understanding of client pathways, sources of demand and system blockages to support policy, design and operations decision making.
* the collection, analysis and distribution of data for demand forecasting, service planning and resource allocation at both the state-wide and local levels.

This data should include: number of new cases, referral sources, allocation rates.

# Prioritisation and allocations

A significant factor impacting on the ability to manage demand for Child FIRST and Family Services is the appropriateness of referrals. Please refer to Table 1 Risk factors and priority access to support decision making around prioritisation of allocations. Section 61 of the Children, Youth and Families Act 2005 requires Family Services to prioritise services based on need.

* Service providers will target and prioritise their services to vulnerable children and families most in need, including families where children have been exposed to multiple and co-occurring risk factors, and those who without appropriate support are likely to progress further into the statutory system.
* Service providers will determine the priority of response for children, young people and families based on needs and the best interests of children and young people, and in accordance with specific practice instructions.
* Service providers will have processes/protocols in place to monitor and improve the timeliness of responses to children, youth and families and actively respond to changes that may impact on demand for services and their capacity to respond. Alliances will maintain proactive relationships with major referral sources including Child Protection, hospitals, kindergartens and schools, and Maternal and Child Health services to support appropriateness of referrals, and joint response to children and families.
* Self-referrals should be prioritised alongside referrals from other service providers
* Referrals made directly to Family Services agencies must be prioritised alongside referrals coming to Child FIRST or the Orange Door.

## Risk factors and priority access

The below table provides information on factors for consideration in assessing the level of priority as assessed by Child FIRST for access to family services. It will also assist Child FIRST in prioritising their initial intake and access response to referrals that are received.

Aboriginal and Torres Strait Islander families, children and young people from culturally and linguistically diverse backgrounds, children and young people with a disability or members of other marginalised or vulnerable groups will be prioritised for allocation.

Table 1. Assessing priority for response from Child FIRST and for allocation to a family service

| Priority Level | Factors for consideration |
| --- | --- |
| Very high | * Infants 0 – 2 years old
* High risk pregnancies
* Child with a disability who is solely dependent on their carer for their basic needs to be met
* Children/young people at risk of Statutory involvement/OoHC placement.

and* Additional risk factors as outlined in High category below

and* Without intensive or timely response, the child’s wellbeing is likely to deteriorate and they are likely to progress further into the statutory system.

Where there are reasonable grounds for believing a child has suffered or is suffering significant harm, a consultation should occur between Child FIRST or Family Services and Senior Child Protection Practitioner Community Based (SCPPCB). If it is agreed that a report to Child Protection is warranted, this will be facilitated by the SCPPCB. |
| High | * Parents have minimal capacity to provide for safety, stability and development needs of children due to risk factors such as mental health concerns, developmental delays, isolation
* Significant concern for the wellbeing of a child/ren, including the impact of cumulative harm, where the immediate safety of the child is not compromised.
* There is a history or pattern of significant concerns with this child, or other children in the family
* The youngest child is less than three years old (including unborn children)
* Presence of family violence[[2]](#footnote-2)
* Parental substance abuse/other illegal behaviour that impacts on the parent/s ability to care appropriately for their child/ren

and/or * Family has multiple or complex support needs requiring intensive assistance

and/or* Without intensive or timely response, the child’s wellbeing is likely to deteriorate, and they are likely to progress further into the statutory system.

Where there are reasonable grounds for believing a child has suffered or is suffering significant harm, a consultation should occur between Child FIRST or Family Services and Senior Child Protection Practitioner Community Based (SCPPCB). If it is agreed that a report to Child Protection is warranted, this will be facilitated by the SCPPCB. |
| Medium | * Parents have reduced capacity to provide for safety, stability and development needs of children.
* Moderate concern for the wellbeing of a child/ren, including the impact of cumulative harm

and* Family has one or more significant support needs.

and/or* Family has no or few personal/professional supports.

and/or* Early intervention is required to prevent the development of more serious parental difficulties.
 |
| Low | * Mild parental difficulties
* Low level concern for the wellbeing of a child/ren, including the impact of cumulative harm

and/or * Family has minor support needs
* Some vulnerabilities at moderate to low levels
* A one-off period of crisis

and* Families have considerable strength and competency.
* Families with protective factors in place, such as existing natural or other professional supports in place.
 |

## Families with risk factors above the threshold for family services

Where risk factors are above the threshold for Family Services, that is, where there are reasonable grounds for believing a child has suffered or is suffering significant harm, a Section 38 consultation should occur between Child FIRST or Family Services and Senior Child Protection Practitioner Community Based (SCPPCB). If it is agreed that a report to Child Protection is warranted, this will be facilitated by the SCPPCB.

Please refer to the *Procedural requirements for referral and consultation: Child Protection and Child FIRST/Integrated Family Services* for more information regarding the referral/report pathways between Child FIRST and Family Services and Child Protection.

## Interface with Child Protection

Child FIRST and Family Services providers and Child Protection are expected to work together on demand management in the local area. Demand management is most likely to be effective when all phases of Child Protection are involved in the Child and Family Alliance.

Child Protection Referral pathways include;

* Child Protection Intake should refer to Child FIRST where there is significant concern for child wellbeing, but concerns do not meet threshold for Child Protection, that is, there are reasonable grounds for believing a child has suffered or is suffering significant harm.
* Child Protection (all other phases) should target families assessed as suitable and likely to engage and benefit from Family Services. Child Protection referrals should include a clear role for Family Services intervention. Families may be supported by joint case work if necessary to ensure engagement is established and maintained.
* Child Protection should refer to universal and other services (such as mental health, alcohol and other drugs services) where this is the primary issue and it is not necessarily related to parenting capacity.

## Relationship management

In a highly integrated system comprising both statutory and non-statutory services, robust advocacy and dialogue about a child’s best interests are necessary and encouraged. This can at times lead to differing views in regards to the assessment of risks to a child or young person and thresholds for Family Services or Child Protection involvement.

The key to building trust and relationships is a commitment to managing differences and resolving any conflict that arises through client focus, cooperation, collaboration, mutual respect, transparency, accountability, effective communication and timely responses.

Please refer to the Procedural requirements for more information on relationship management and dispute resolution processes.

## Interface with universal and other services

Families with risk factors that do not include a significant concern for a child or family wellbeing, parenting capacity issues or cumulative harm of a child or children, should be referred to the appropriate alternate services (universal services, mental health, alcohol and other drugs services) if required.

Alliances should maintain relationships that support effective referral pathways and roles and clear roles and responsibilities with universal and other services.

## Assessing capacity to meet demand

***Attachment 1*** **–** This tool asks Alliances to measure their usual capacity against current demand pressures.

This tool is designed to be used by Alliances to identify, communicate and mobilise resources or strategies to resolve pressure points, particularly during periods of high demand. The tool works through potential pressure points such as:

* + demand reflected in referral numbers from different sources
	+ reduced capacity due to unfilled EFT

throughputs in Family Services.It can be used as a business as usual communication tool, or it can be used during periods of very high demand or reduced capacity. This or a similar alliance data tool which includes similar factors should be provided as an attachment to Area Directors when seeking their endorsement of restrictions of service, Area Directors should then provide a copy to the Family Services Policy team.

This tool asks Alliances to establish ‘usual’ levels of demand at various points for an Area as a baseline. The tool acknowledges that ‘normal’ thresholds and demand pressures are already high. Suggested measures are included in the tools, but the Alliance may have and can use their preferred measures.

The tool may be useful in helping to determine appropriate demand management strategies, either from the list below or other local strategies that are effective in managing demand.

## Managing demand

Table 2 outlines potential strategies and actions that may be implemented to manage demand. Any actions that are taken should be first agreed by the Alliance before implementing. Roles, responsibilities and timeframes should be outlined prior to the actions being undertaken and an assessment of the effectiveness of the strategies should be monitored.

Alliances are also encouraged to consult with each other across alliances and share knowledge of successful strategies in managing demand.

Table 2. Possible actions/strategies to assist in managing demand

| **Action/Strategy**  | **Responsibility** |
| --- | --- |
| Conduct a review of cases in Child FIRST or Family Services and assess if referral to universal service could meet the family’s needs in accordance with risk assessment.  | Team leader |
| Consideration of effective brief intervention strategies by Child FIRST or currently engaged stakeholder to provide a more timely response to families who are not assessed as needing a longer term intervention.  | Team leader |
| Conduct a review of open family services cases that:have been open for more than six months. have a low number of hours in relation to the amount of time it has been open.  | Team leader |
| Identify referrals where a professional has referred the family (i.e. GP, school, Maternal and Child Health) for that professional to continue to work with the family until demand for Family Services decreases and referrals can be accepted for case work. | Worker/ Team leader |
| Family Services agencies in the Alliance with capacity to assist in undertaking Child FIRST assessments.  | Alliance governance, operations and executive. Operations managers at each agency |
| Child FIRST and Family Services to purchase in locum staff for short term work, if program budgets permit. | Program managers in line with Agency policy and procedure. |
| Family Services agencies with capacity could temporarily transfer workers to other agencies/ co-locate/ hot desk/ to assist with case load of agencies unable to respond to meet their demand. Standard practices, case plans etc. would increase the ease of this interchangeability between agencies. | Operations managers at each agency to approve |
| Alliances could discuss the possibility of implementing a ‘cap’ on the number of referrals Child FIRST will accept from Child Protection in each calendar month, if the alliance has determined that Child FIRST do not have capacity to accept all Child Protection referrals. This would also involve work with Child Protection to assist them to identify alternate referral sources for families.  | Alliance Executive to agree (note Alliance includes representation from Child Protection) |
| Review referral trends from major referral sources, in particular the proportion of cases that are not allocated through to Family Services (the proportion that do not proceed) – Referrals should not be discouraged but the alliance should continuously consider processes to improve the appropriateness of referrals or otherwise meet the needs of referring organisations. | Alliance governance, operations and executive  |
| Alliances could consider the possibility of co-location arrangements such as having a Child FIRST worker co-located in a local primary school or community service to support in capacity building of school or community service to provide effective responses to families who may not require a family services or Child Protection response. | Alliance governance, operations and executive |
| Processes are in place around ‘own cases’ or direct referrals to family services, to ensure they are prioritised alongside Child FIRST referrals to the same threshold decisions. | Alliance governance, operations and executive |

## Restriction of service

Restricted intake in Child FIRST and Family Services is *strongly discouraged* and should only be implemented if there is no other option and all resources are used. Department representatives should understand how long restriction is expected, which referrals will be accepted during restriction and what referrers will be advised. A clear communications strategy to relevant stakeholders must support any restricted intake.

In the event of any restricted intake decision made by the Alliance, Agency Performance and System Support must facilitate sign off by the Area Director, and notify the Family Services Policy unit as soon as possible. See **Attachment 2** –*Reporting advice of restricted intake in Child FIRST or Restricted allocation to Integrated Family Services.*

The purpose of the Area Director sign off is to create a consistent and high level endorsement and description of ‘restricted intakes’ that can be referred to when the department describes demand and restricted intake at a state-wide level. Its purpose is not to provide additional oversight; DHHS Local Area will already have been involved in the decision to implement restricted intake through their role in the Alliance.

In the event of a restriction of service, the Alliance chair should ensure:

* all agencies in the Alliance are aware of the restrictions
* Child Protection is aware of the restrictions and which referrals will and will not be accepted
* neighbouring Alliances are aware of the restrictions
* relevant community based organisations are aware (i.e. local schools, Local Council/Maternal and Child Health, hospitals etc.).

Agency Performance and System Support, Area Director, Children, Youth and Families unit, Child Protection and the above organisations should be advised when services return to normal practice.

## Definitions

| Term | Definition |
| --- | --- |
| **Active holding** | Active holding includes a range of activities that can be employed as a defined and specific holding response for families awaiting either an intake outcome in Child FIRST or an allocation to Family Services. The active holding response should include phone contact with the client and where possible an initial home visit, it may also include case conferencing, provision of brokerage funding, participation in a group, volunteer support, negotiation with other service providers and/or client advocacy.  |
| **Allocations process**  | A weekly meeting involving representatives from Child FIRST and each of the funded Family Services agencies to review cases referred from Child FIRST for allocation to Family Services.  |
| **Brief interventions** | Brief intervention strategies could be considered in relation to families where a short, goal focused intervention could be put in place to support a family with lower-level needs or facing a single issue, or where there are more complex needs but a supported referral to another service could provide the required support to a family at the time. This is different to the Brief target type. |
| **Complex Issues** | Alcohol and other drugs, Child Protection, disability – intellectual, disability - physical, family violence, mental health, sexual assault and legal issues. |
| **Natural supports** | Family including extended family and family-like relationships, neighbours, community groups, who are active and able to support families. |
| **Other issues** | Service access, behaviour, disasters, education, financial, gambling, health, household management, housing, isolation, legal, migrant/ refugee, parenting skills, relationships, separation, grief and loss. |
| **Professional supports** | General Practitioners, other services (Mental Health, Allied Health, Schools, Maternal and Child Health and Alcohol and Other Drug services) who are engaged with the family. |
| **Restriction of service** | A reduced level of service response in Child FIRST or Family Services during a period of very high demand – where all attempts to alleviate demand pressure through actions listed in this document - have been implemented and the situation has not been resolved. |
| **Significant wellbeing concerns** | Significant concerns (of the referrer) about the wellbeing of vulnerable children and families. Significant is defined as ‘more than minor’. |
| **Standard capacity**  | Standard capacity is the standard level of staffing required to respond to the funded number of targets. Staffing capacity takes into account recreational and reasonably anticipated levels of sick leave, professional development and public holidays.  |
| **Standard demand levels** | The anticipated standard level of demand based on funding and targets.  |
| **The Orange Door** | The Orange Door is the new access point for women, children and young people who are experiencing family violence or families who need assistance with the care and wellbeing of children to access the services they need to be safe and supported.Child FIRST, as the access point for family services, is progressively transitioning to The Orange Door. |
| **Vulnerable families** | Vulnerable families include:those who have a limited network of family and community support and find it difficult to access additional services.those that have been impacted by social disadvantage and have family members who may have physical or mental health problems, disability, substance abuse or have experienced family violence. single parent families, parents who have experienced abuse and neglect and poor parenting themselves and those who have not had models of effective parenting may struggle to parent their children and raise them in the way they intended.  |

1. Cumulative harm refers to the effects of multiple adverse or harmful circumstances or events in an individual’s life that diminish and harm an individual’s sense of safety, stability and wellbeing. It may be caused by an accumulation of a single recurring adverse circumstance or event, or by multiple circumstances or events, such as exposure to family violence. [↑](#footnote-ref-1)
2. The Family Violence Multi-Agency Risk Assessment and Management Framework provides guidance to organisations prescribed under regulations that have responsibilities in assessing and managing family violence risk. The MARAM can be used to identify signs of trauma that may indicate family violence is occurring, and the approach to screening by asking questions about a short set of risk factors to assist professionals to decide if further action and/or assessment is required.  [↑](#footnote-ref-2)