the family law DOORS

J. E. McIntosh and C. Ralfs






handbook

Detection of Overall Risk Screen (DOORS)

Australian INSTITUTE of SOCIAL RELATIONS™

Family Transitions

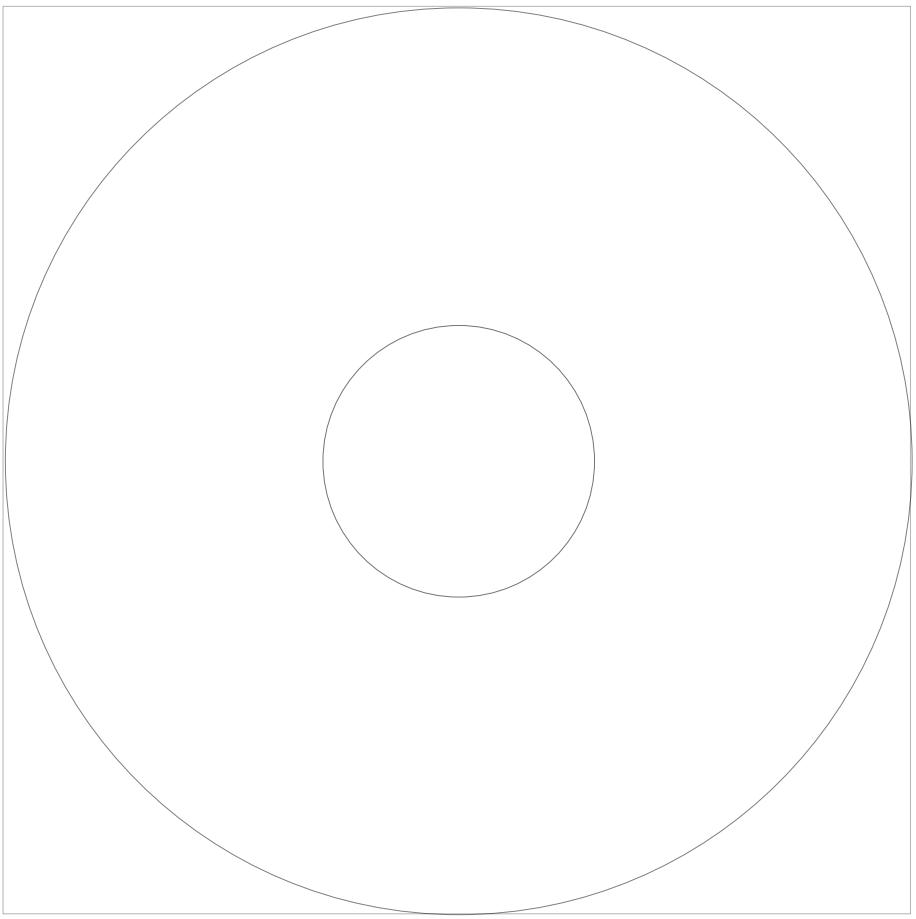
Australian Government
Attorney-General's Department

The Family Law DOORS DVD and DVD-ROM

The DVD-ROM contains the DOORS software package, practitioner forms and learning guide-related materials.

The DVD contains videos for the DOORS learning guide.

For detailed information on the contents of these discs please see pp.175-178



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1.DOORS Framework

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3.DOOR 1 & DOOR 2 Tools

a) Jennifer E. McIntosh (2011). DOOR 1: Parent Self-Report Form. In: The Family Law DOORS Handbook. Jennifer E. McIntosh and Claire Ralfs (2012). Australian Government Attorney-General's Department, Canberra.
b) Jennifer E. McIntosh (2011). DOOR 2: Practitioner Aide Memoire. In: The Family Law DOORS Handbook. Jennifer E. McIntosh and Claire Ralfs (2012). Australian Government Attorney-General's Department, Canberra.

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Contents

Disclaimer: All web links are current at time of going to press. However, please note that websites frequently change and we cannot guarantee any link.

Glossary

CHILD ABUSE (working definition): Any non-accidental behaviour that constitutes a risk to the child of emotional or physical harm. There are five main areas of abusive behaviours recognised within Australia. These include sexual, emotional and physical abuse, neglect, and the witnessing of family violence. The aetiology and recognition of child abuse are complex matters, which are well covered by the National Child Protection Clearinghouse.

See http://www.aifs.gov.au/nch/pubs/sheets/rs6/rs6.html for a comprehensive explanation.

CHILD ABUSE (legal definition): Abuse, in relation to a child, means:

(a) an assault, including a sexual assault, of the child; or

(b) a person (the first person) involving the child in a sexual activity with the first person or another person in which the child is used, directly or indirectly, as a sexual object by the first person or the other person, and where there is unequal power in the relationship between the child and the first person; or

(c) causing the child to suffer serious psychological harm, including (but not limited to) when that harm is caused by the child being subjected to, or exposed to, family violence; or

(d) serious neglect of the child.

A COMMON SCREENING OF RISK FRAMEWORK: As used within DOORS, this term refers to a practical, empirically-grounded set of resources to support a universal early risk appraisal process.

The framework functions to 1) provide a rationale for screening to both practitioners and clients; 2) offer a standardised method for screening; 3) guide further enquiry and response when significant markers of risk are evident from the initial screen, or otherwise identified by the practitioner. Supporting materials include literature summaries, tools for follow-up, and suggested referral options and strategies. The framework supports decision making about appropriate responses to the risks detected, and provides links to comprehensive assessment and referral options.

As such, the framework can be applied by all practitioners in the family law system to assist them with early detection and evaluation of safety and wellbeing concerns and other matters of urgency. Through its generic language, the DOORS framework seeks to open communication channels and support coordinated action across the family law system.

FAMILY VIOLENCE (working definition): Family violence in divorced/separated families is a complex phenomenon with no single agreed definition (Australian Bureau of Statistics, 2009, p. 1). Different definitions reflect various understandings of types of relationships, living arrangements and the nature of offences. Consequently, interpretations of family violence events can vary according to the jurisdictional (legal, policy, service, research) context.

The *Family Law Act* 1975 (Section 4) defines family violence as:

> *…threatening or other behaviour by a person that coerces or controls a member of the person's family (the family member), or causes the family member to be fearful.*

The DOORS adopts this working definition of violent acts or threatening experiences that occur between immediate family (former partners and children) and extended family

members (families of origin, new partners). These include physically, sexually, emotionally abusive and neglectful behaviours, as well as threatening behaviours. Other definitions relevant to this framework include those for domestic violence and intimate partner violence.

FAMILY VIOLENCE (legal definition):
Family Law Act 1975 4AB

(1) For the purposes of this Act, family violence means violent, threatening or other behaviour by a person that coerces or controls a member of the person's family (the family member), or causes the family member to be fearful.

(2) Examples of behaviour that may constitute family violence include (but are not limited to):

(a) an assault; or

(b) a sexual assault or other sexually abusive behaviour; or

(c) stalking; or

(d) repeated derogatory taunts; or

(e) intentionally damaging or destroying property; or

(f) intentionally causing death or injury to an animal; or

(g) unreasonably denying the family member the financial autonomy that he or she would otherwise have had; or

(h) unreasonably withholding financial support needed to meet the reasonable living expenses of the family member, or his or her child, at a time when the family member is entirely or predominantly dependent on the person for financial support; or

(i) preventing the family member from making or keeping connections with his or her family, friends or culture; or

(j) unlawfully depriving the family member, or any member of the family member's family, of his or her liberty.

(3) For the purposes of this Act, a child is exposed to family violence if the child sees or hears family violence or otherwise experiences the effects of family violence.

(4) Examples of situations that may constitute a child being exposed to family violence include (but are not limited to) the child:

(a) overhearing threats of death or personal injury by a member of the child's family towards another member of the child's family; or

(b) seeing or hearing an assault of a member of the child's family by another member of the child's family; or

(c) comforting or providing assistance to a member of the child's family who has been assaulted by another member of the child's family; or

(d) cleaning up a site after a member of the child's family has intentionally damaged property of another member of the child's family; or

(e) being present when police or ambulance officers attend an incident involving the assault of a member of the child's family by another member of the child's family.

LEARNING GUIDE: This provides materials that support practitioners to develop a thorough understanding of the evidence that grounds the Family Law DOORS and to enable proficiency in the use of the associated tools and procedures. These resources take the form of a structured learning guide which provides guidance in the effective implementation of The Family Law DOORS.

PRACTITIONER: This refers to all practitioners working within the family law system. Practitioners include: court staff, family law lawyers, legal services staff, family dispute resolution practitioners, family relationships centre staff, child contact service staff, parenting orders program staff and private practitioners.

RISK: This includes risks to the immediate physical safety, psychological wellbeing, or developmental wellbeing of the children or adults involved in a family law dispute. It includes imminent risks to the safety of others associated with the family (e.g. new partners, friends, extended family). Risk is built through overlapping and mutually reinforcing factors, including individual characteristics, situational variables, and historic factors that combine to increase the likelihood of adverse safety and wellbeing outcomes. As used in the DOORS, risk is an outcome of a constellation of long-term and short-term factors that act together, can change over time, and vary from family to family. In the context of point-of-entry screening, the DOORS will assist practitioners to identify and evaluate risk factors.

RISK ASSESSMENT: This involves professional judgement about the form, potency and likelihood that the risks identified may translate into further harm. Risk assessment is the basis for planning treatment pathways and responses. DOOR 3 provides specialist resources and references that will support practitioners to assess and respond to identified risks.

RISK IDENTIFICATION: Within this framework risk identification refers to a coordinated, semi-structured and evidence-based approach to early assessment of client safety and wellbeing, including standardised tools and supporting materials
for primary and secondary enquiry and response planning.

SAFETY SCREENING: This is the first level of risk assessment. Safety, in the context of universal early detection screening, refers to the physical safety of adults and children, as well as significant risks to their psychological wellbeing. Screening is usually brief and conducted through standardised questions, usually beginning with client self-report, either self-completed or administered by the practitioner.

SAFETY SCREENING TOOL: This refers to a systematic set of questions for clients, surveying major risk factors leading to safety and wellbeing problems across multiple domains of family life, post-separation. In the DOORS framework, this is represented by DOOR 1 and functions to alert practitioners to potential risk areas. DOOR 2 then follows, supporting professional follow-up and decision making processes.

SOFTWARE PROGRAM: In the DOORS framework, software program refers to the tailored DOORS software package that analyses input from the standardised screening process (DOOR 1) and provides a PDF report (DOOR 2) which flags the evident risks, provides prompts to guide follow-up and decision making about appropriate risk response. This report can be saved by the practitioner or organisation on their secure database system.

The Family Law DOORS: Introduction

What is the DOORS?

The Family Law '**D**etection **O**f **O**verall **R**isk **S**creen' (known as the **DOORS**[1]) is a three-part framework that assists separating parents and family law professionals to detect and respond to wellbeing and safety risks that family members may be experiencing after separation (see Using the DOORS: Practitioner forms, pp. 23-46).

DOORS was designed for families in which former intimate partners have or seek an ongoing parenting role with their children. A separate version also exists for clients of the family law system who are not parents (see Using the DOORS: Practitioner forms, pp. 23-46).

The DOORS philosophy is based on the following axioms:

- Risk is not a static factor; it is multi-determined and changes over time.
- Risk assessment therefore needs to occur across many areas and over time.
- Best practice in risk identification involves three steps, with emphasis on each step varying according to the needs of the case:
  1) Universal self-report screening
  2) Tailored professional follow-up, evaluation and response planning
  3) Implementation and monitoring
- These are universal elements of risk screening, regardless of the setting.

There are three DOORS within this framework, each outlined below. Each DOOR within the framework enables a different level of exploration of individual and family functioning after separation, with a focus on identifying risks to safety, parents' wellbeing and children's wellbeing and development.

DOOR 1 Parent Self-Report Form Entry into the framework is through DOOR 1, a standardised parent self-report questionnaire, covering ten domains of risk. Depending on the needs of the case, the practitioner can choose to screen for all domains of risk, or only some. The domains are:

1. Client's culture and religious background
2. About the separation
3. Managing conflict with the other parent
4. How the client is coping
5. How the other parent seems to be coping
6. About the client's baby/young child(ren) and school-aged child(ren)
7. Managing as a parent
8. Child(ren)'s safety
9. Parent's safety and safety behaviour
10. Other stresses

[1] The Commonwealth Attorney General's Department contracted The Australian Institute of Social Relations (AISR; the training division of Relationships Australia (SA)) with Family Transitions (Melbourne) to develop a standardised front line screening tool, to better enable identification of safety and wellbeing risks for clients across the family law system. It is empirically based and has been reviewed and refined by researchers and senior practitioners across Australia and internationally.

There are two formats for completing DOOR 1: computer-assisted, or via pen and paper. Either can be done by the client alone, given effective prior explanation and sufficient personal engagement. Alternatively, DOOR 1 screening and DOOR 2 follow-up can be done simultaneously via a personal interview. This takes longer but may be indicated in complex matters involving acute and immediate risk or trauma. Using DOOR 1 and DOOR 2 simultaneously is also an effective way of conducting a comprehensive screening process with clients with limited literacy and/or English proficiency.

DOOR 2 Practitioner Aide Memoire DOOR 2 takes the responses to DOOR 1, identifies areas of risk endorsed by the client that require further enquiry, and provides prompts to help the practitioner to establish an effective follow-up conversation with the client. Tools are provided to support effective listening, decision making, action planning, risk management and referral. DOORS 1 and 2 are designed to be used together in all cases.

DOOR 3 Resources for Responding to Risks This section provides a wealth of support for understanding case aetiology and for detailed evaluation of all domains covered in DOOR 1. Resources here include current demographic profiles of risk, comprehensive literature summaries, specialist follow-up tools and links to other risk assessment frameworks. DOOR 3 can be used flexibly to educate practitioners and keep their knowledge up to date; it can act as a basis for risk assessment training, and can help practitioners to tailor their risk management resources and keep referral networks current.

What is the purpose of the DOORS?

The DOORS framework supports a cross-disciplinary understanding in the family law system of factors that combine to create a climate of elevated risk for families. As a common screening framework that can be used across multiple services in the family law arena, the DOORS will help professionals to detect and respond to safety and wellbeing risks at the client's point of entry into their services.

In contrast to specific domestic violence screens, the DOORS takes a broad definition of risk, covering adult, infant and child wellbeing, conflict and communication, parenting stress, and collateral stressors, encouraging the practitioner to evaluate the contribution of all these factors to imminent personal and interpersonal safety risks. The framework facilitates the identification of risk factors and provides pathways towards an effective, coordinated response.

How is the DOORS different from other risk screening frameworks?

We note that other family violence risk identification and management frameworks have been developed[2]. With the exception of Winkworth and McArthur's screening and assessment tool (2008), no other family law-specific screens have been developed to date in Australia. In contrast to family violence-focused screens, the DOORS offers the practitioner a means to conduct a comprehensive, whole-of-family screening process that covers adult and child, relationships, parenting and systemic factors that pose a risk to safety and wellbeing.

[2]The main frameworks are summarised in DOOR 3, 'Elaboration on other Risk Screening Frameworks', and a distinction made between family law frameworks and those specific to risks associated with family and domestic violence. We encourage practitioners to review these.

The DOORS provides:

- a means for effectively engaging parents in a standardised screening process.
- a structured, empirically-based self-completing screen for parents that can be used across the family law sector.
- screening for a matrix of historical and recent risk factors that combine to create significant safety risks for children and for former intimate partners, including:
  - the contribution of parenting stress, mental health and drug and alcohol problems to risk profiles
  - specific needs arising from the cultural and religious background of family members
  - developmental risk factors for infants and children
  - ancillary stressors that may require attention
- prompts to guide professionals' conversations with parents about their unique risk profile, and to evaluate the information provided by the parent.
- guidelines for follow-up, safety planning, appropriate referrals and ethical information sharing.

The DOORS can be used in isolation or in conjunction with other frameworks, such as the Common Risk Assessment Framework (CRAF; Family Violence Coordination Unit, 2007) or The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework (Department for Child Protection, 2011).

Risk — What do we mean by it?

Within the DOORS framework, risk is broadly defined as physical or psychological harm to self and/or other family members, and in the case of children, developmental harm. The DOORS framework is built on the idea that risk is multiply determined, and includes personal characteristics, historical and situational variables, and systemic hazards that increase the likelihood of adverse safety outcomes. Risk needs to be viewed from many perspectives , including the nature, timing and magnitude of the risk, the roles played by victims and perpetrators and the confidence or accuracy with which risk outcomes can be predicted.

When considering the screening for risk in family law, attention understandably focuses on the 'big five' safety risks: familicide, suicide, family violence, child abuse or neglect, and child abduction. The jeopardy of personal safety is the central issue, namely the likelihood that a client — or someone connected to the client or their case — may currently be or may become endangered. As many have documented, safety risks are rarely isolated and do not arise out of nothing. The DOORS framework works on the principle that major harm can be averted by noticing small but connected risks in the overall patterns of family and individual stress.

Risks to life, safety and wellbeing emerge out of a wide spectra of factors, some recent, and others historical (see Table 1, p. 5). Each factor can be understood as part of a continuum, and each, in turn, may exert a protective or amplifying influence in the presence of other related factors. The following group of significant factors has informed the development of the DOORS framework.

Domino effects of risk in family law cases

1. **The psychology of the individual parent:** How the current separation might affect the individual, given, for example, their mental health history and current state; any history of violence/impulse control problems; drug and alcohol use; history of safety in childhood; parenting qualities (specifically availability); attunement and warmth; regard for/attributions to the other parent; ancillary stressors such as employment, finances, housing; the personal meanings of culture and religion.

2. **The ex-couple relationship:** A couple's history of communication, cooperation, decision making and power balance; circumstances of the separation, including who initiated the separation and involvement of new partners; conflict tactics and the use of violence; family and friends' roles in resolution or perpetuation of conflict.

3. **The history and nature of the current dispute(s):** The perceived and actual complexity of the issues in dispute; history of decision making to date; sensitivities to notions of winning, losing or entitlement; the parents' perceptions of fairness and equity in time and property divisions; systemic interventions in resolution or perpetuation of dispute.

4. **The development of the infant/child:** The physical health and developmental wellbeing of the child to date; their emotional security with each parent; temperament, cognitive development and learning attainment; sibling relationships; friendships and social functioning; availability of family and social resources.

5. **The role of social, cultural and professional support:** The nature of engagement with supports and services, their appropriateness, effectiveness, timeliness; connection versus isolation; support of family and friends; containing or inflaming social and professional responses. Lack of sensitivity to culturally-specific perspectives is a significant threat to safety.

All the above individual and interpersonal factors sit within a framework of social and cultural influence.

The following diagram places these factors within a pathway of risk, illustrating how the same historical and recent factors can align in various ways to create normative, risky or lethal outcomes, depending on the direction and combined effect of their influence.

Table1. Pathways of risk

Screening and risk assessment: Definitions and rationale

In the DOORS framework, screening of safety refers to the early identification of potential risks to the physical safety of adults, children and infants, as well as significant risks to their psychological wellbeing.

Screening and assessment are terms used for the connected and overlapping phases of a risk evaluation process. Screening in the DOORS framework refers to the first, universal level of this process, including a structured client self-report (DOOR 1) and practitioner evaluation (DOOR 2). Assessment is a phase of further, in-depth enquiry into safety and wellbeing risks (DOOR 3). All clients need to be screened for safety and wellbeing risks, but not all clients require further assessment.

For the effective early identification of risk the literature strongly supports a tiered approach to screening, which begins with structured, routine questions that are asked of all clients. Holtzworth-Munroe et al. (2010) have shown the importance of those questions being reasonably detailed, then followed up by a tailored conversation with a practitioner. In that follow-up, the practitioner briefly explores and evaluates risks identified by the client on the universal screen, and any other risks apparent to the practitioner, from carefully attending to the client's account. The need for any further action is assessed. Again, in the DOORS framework, DOOR 1 is the structured client self-report component; DOOR 2 is the first evaluation of risk by the practitioner, determining whether a more comprehensive assessment needs to be conducted; DOOR 3 provides literature and tools to support comprehensive assessment where needed.

Why screen?

Without doubt, separation and divorce are critical events that increase the risk of mental health problems, drug and alcohol abuse, parenting distress, harassment and threats from former intimate partners and their families/new partners, possibly leading to physical violence, abduction of children, intimate partner homicide, suicide or familicide.

The DOORS framework was built upon a comprehensive literature search which documented the pathways of risk development in each of these areas (see later in this section and literature summaries in DOOR 3: The Risk Domains in Detail pp.105-145). The research team was sobered by the weight of evidence from the reliable literature that highlighted the noxious, concomitant risks to the wellbeing of every family member post-separation. This evidence takes the need for early screening and intervention beyond platitudes or political correctness, to acknowledgement that this is an essential process for protecting the safety and wellbeing of all who enter the family law system.

Separation and divorce are processes designed in their healthiest form to liberate and reduce the daily stress of dysfunctional relationships. While this remains an arrival point for many, the process for most nonetheless brings with it many layers of stress. For some adults, separation-related stress is compounded by diminished coping resources and a history of other risk factors to create unmanageable distress, and with that comes the real possibility that a family member may be unsafe, or may act unsafely.

The DOORS screening and risk identification processes are based on the belief that there are points in a family's separation journey where the translation of stress into an assault on safety or wellbeing may be preventable. Early identification, triage to counselling support, together with sensitive legal processes, can combine in the right time and place to protect safety and can ultimately lead to healthier management of difficult times.

Early screening will never predict 100% of serious risks to safety or wellbeing. It will, however, assist the practitioner to recognise patterns of behaviour associated with serious risk, to plan accommodations to the dispute resolution process, and to provide other follow-up or referral services as needed.

The DOORS system endorses the responsibility shared by the whole family law system to minimise the negative impact of family separation and, where possible, identify disrupting risk pathways.

A snapshot of current practices and attitudes to screening

The attitudes practitioners currently hold about a field of practice are a reasonable indication of how they are likely to react to developments or changes in that field. For this reason our first step in developing a risk screening framework was to consult with the family law sector, to better understand perceptions of, ideas about and practices of risk screening and to survey for concerns or tensions about the introduction of a standardised framework.

The Attitudes Survey, a 42-item voluntary and anonymous survey, was created and hosted by Relationships Australia (SA) (RASA) on their Australian Institute of Social Relations website. The survey addressed participant demographics (years of experience, gender, age group, profession, workplace and highest qualification), and attitudes and practices in relation to risk screening. Participants were invited to respond via an e-mail letter circulated through their affiliated professional bodies.

A total of 366 professionals responded to the survey. Respondents were grouped as follows:

- Legal profession (n = 95; including lawyer, paralegal and judge)
- Therapist (n = 40; including psychologist, family therapist)
- Social worker (n = 102)
- Mediator (n = 32; including family dispute resolution practitioner)
- Other direct service professional (n = 49; including welfare worker, aboriginal liaison worker, case manager, counsellor and those who simply listed an undergraduate social science degree)
- 'Other' (n = 17; including administration workers, conference organisers, nurses, etc.)

More professionals working in family dispute resolution and family relationship centres (36%) completed the survey than any other group. Legal (19%) and family services (17%) were the next most common workplaces.

Summary of themes

1. Overall, 84% of practitioners did not believe that screening would interfere with or compromise their work (100% for family dispute resolution practitioners), and to a slightly lesser extent, did not believe their clients would resent the process (65% lawyers to 80% therapists).
2. Very few thought that asking about safety would make the practitioner uncomfortable (0% therapists, to 6% family dispute resolution practitioners).
3. Therapists were most likely to report risk screening as an area of expertise for them.
4. Most respondents (76% to 91%) agreed they were satisfied with their ability to assess past history of risk. They were less confident regarding their ability to assess likely risks to safety in the future.
5. Over half of all surveyed were not confident about weighing up factors that might elevate risk for clients of Aboriginal or Torres Strait Islander (ATSI) backgrounds, or those from culturally and linguistically diverse (CALD) backgrounds.
6. Most respondents regarded safety screening as necessary for every family (70% lawyers to 93% therapists).
7. The majority of therapists and counsellors were confident about making safety plans for clients and indicated that their workplace had effective procedures for responding to imminent risks to the safety of their clients.
8. Differences for the legal profession:
    - More than a third of lawyers were not confident about making safety plans and did not agree they had effective procedures for risk response.
    - Lawyers were the least likely to have attended formal training in risk screening (55%) and therapists, family dispute resolution practitioners and social workers the most likely (68% to 84%).
    - Safety or risk screening was not compulsory for almost half of all participating lawyers (47%) but was for the majority of other professionals (82% to 94%).
    - All participants were asked whether legal practitioners could effectively screen for safety. More than half of lawyers (63%) and 83% to100% of other professionals disagreed with the statement or were not sure.
    - Most practitioners (70%) spent half-an-hour on risk assessment in face-to-face or telephone discussion with clients, with lawyers taking the least time (38% reported ten minutes or less) and family dispute resolution practitioners taking the most (28% taking up to an hour).
    - Lawyers were less confident about information sharing (70% said they were confident about their policies and procedures) and therapists the most confident (90%).
9. There was strong support for standardised tools and protocols across all disciplines (80% agreed).
10. Computer-assisted screening was viewed positively by 72% overall.
11. There was general strong agreement across the professions (82% lawyers to 92% other professionals) that a common framework for screening safety risks was important.

When all the responses are considered together, a picture emerges of a family law sector that is actively thinking about risk for their client group and about factors that relate to screening. There is a need for differentiated training in order to unify practitioners' confidence in first-level risk screening across the system. Clearly, there is a consensus that this is important territory and that a universal tool may assist in developing a shared understanding of risk, leading to the provision of stronger support for clients and their children.

What should be screened?

The DOORS framework supports a culturally-sensitive screening of risks to the physical and psychological wellbeing and safety of parents and children. Central to the endeavour is a focus on protecting clients from *significant risks*: these range from severe threats to psychological security, through to fatality.

Family violence, familicide and suicide

The DOORS framework embraces the view that family violence and the families affected by it are not all alike (Ver Steegh & Dalton, 2008)[3] . The DOORS regards family violence as a complex phenomenon which incorporates physically violent and emotionally abusive experiences that occur between immediate family (former intimate partners and children) and extended family members (families of origin, new partners). These include serious physical, sexual, emotionally abusive, controlling, neglectful or threatening behaviours between one or more family members. At the extreme end of the spectrum, this includes suicide, homicide and familicide.

Despite methodological difficulties that limit our ability to aggregate data across studies and populations, current research leaves no doubt that relationship separation increases the risks of family violence manyfold.

- Amongst separated couples who make applications to a family law court, serious allegations of violent and abusive behaviours are made in 50% to 60% of cases (Kaspiew et al., 2009; Moloney et al., 2007).
- Of 134 domestic homicides in Australia in 2007–2008, 60% involve intimate partner homicides. Women are disproportionately represented: 78% of female victims were killed by an offender with whom they shared a domestic relationship (Virueda & Payne, 2010).
- Recent separation is an important factor in predicting suicide (Ide et al. 2010; Kõlves et al., 2010, 2011), and current 'Causes of Death' data from the Australian Bureau of Statistics (ABS) indicate increasing rates of suicide amongst divorced and separated adults, particularly women, in the past five years.
- See DOOR 3: The Risk Domains in Detail (pp.105-145) for a detailed literature review.

[3]Problems with definitions of violence in separated and divorced families are well treated elsewhere (e.g. Moloney et al., 2007).

Mental health, drug and alcohol use, parenting stress and other stressors

Intrinsic to family violence is a range of mental health and drug and alcohol issues that link to an escalating risk of violence. In their own right, each of these risks deserves careful appraisal. Statistics commissioned from the ABS for this project (see Table 2) provide a clear and compelling pattern of the mutually reinforcing nature of mental health and drug and alcohol risk for divorced and separated adults. Some of the major findings include:

- In 2007–08, divorced/separated individuals were nearly five times more likely to have a substance use disorder than married individuals, and nearly twice as likely as never married individuals.
- Divorced/separated adults were more likely to have an anxiety disorder than married and never married individuals, and were twice as likely to have an affective (emotional or mood) disorder compared to married or never married individuals.
- Divorced/separated men were twice as likely as women to have a substance use disorder and women somewhat more likely to have an affective disorder than men.

Table 2. Long-term mental disorders[(a)] by marital status and sex, 2007– 08

	Divorced/separated	Married	Widowed	Never married	Total [(b)]
		% Males			
Substance use disorder	3.3	0.6	**1.8	2.3	1.5
Anxiety disorder	4.5	3.1	**1.2	3.1	3.2
Affective disorder	11.3	6.4	*7.7	8.6	7.6
Total	100.0	100.0	100.0	100.0	100.0
		% Females			
Substance use disorder	*1.6	*0.3	-	*0.9	0.6
Anxiety disorder	5.3	3.4	4.8	4.9	4.1
Affective disorder	16.0	8.1	10.6	13.8	10.8
Total	100.0	100.0	100.0	100.0	100.0
		% Persons			
Substance use disorder	2.3	0.5	**0.4	1.7	1.0
Anxiety disorder	4.9	3.2	4.0	3.9	3.7
Affective disorder	14.0	7.3	9.9	11.0	9.2
Total	100.0	100.0	100.0	100.0	100.0

– Denotes nil or rounded to nil
* Estimate has a relative standard error between 25% and 50% and should be used with caution.
** Estimate has a relative standard error greater than 50% and is considered too unreliable for general use.

(a) Disorders that had lasted or were expected to last for six months or more.
(b) Persons aged 18 years and over.
Source: Australian Bureau of Statistics (2011).

Research in the area of mental health and separation (Gibb et al., 2011) suggests a bidirectional relationship between the emergence of mental health problems and separation — in other words, mental health problems are predictive of separation, and separation is predictive of mental health problems. While relationship separation can for some have a positive influence on mental health with the ending of taxing or poor quality relationships, general population data suggest a pattern of increased risk for mental health and, related to this, drug and alcohol misuse, especially for men. See DOOR 3: The Risk Domains in Detail (pp.105-145) for a detailed literature review of this domain.

Parental stress within the post-separation context has been strongly linked with a number of risk factors for children. Qualities of parental warmth, sensitivity and responsiveness are widely accepted as essential for children's wellbeing (Osofsky & Thompson, 2000). The literature on stress points to the need to screen for ancillary stressors that exacerbate risks to both parenting and general coping capacity. The DOORS framework offers an efficient means of screening a range of stressors, such as social isolation, housing difficulties, financial hardship, and so on.

Infant and child safety and wellbeing

The DOORS framework promotes robust enquiry about the wellbeing and safety of children in the knowledge that effective early intervention, by minimising risk and alleviating stress, serves to improve children's longer-term mental health outcomes.

Separation poses genuine risks to children's physical safety and wellbeing, particularly with co-occurring risks of violence. Specific risks include:

- heightened normative risks for children in divorced families across multiple psychological, social, developmental and educational domains
- heightened abduction risks, with children under five years at highest risk of being unlawfully removed from one parent's care by another
- heightened risk of lethal events for children: 16% of domestic homicides involve the killing of a child or infant by a parent (Dearden & Jones, 2008)
- high rates (40%–55%) of child abuse co-occurring with intimate partner violence. Children are present and witness at least 50% of critical incidents that happen between their parents (Moloney et al., 2007).

See DOOR 3: The Risk Domains in Detail (pp.105-145) for a detailed literature review of this domain.

Post-separation risks in the context of culture and religion

The DOORS begins by emphasising the role of culture and religion in either buffering or escalating risk, post-separation. Australia's increasing cultural diversity flows into and shapes community attitudes to safety, rights, family responsibility, gender relations and parenting practices. Cultural understanding and respect are therefore an important foundation for the effective promotion of family wellbeing during separation and divorce events. Without this foundation, the family law system can itself create barriers to effective access and involvement and become an added risk factor for many families.

The high incidence of family violence among Aboriginal families highlights the importance of effective screening and risk identification in that group.

- Rates of family violence-related victimisation for Aboriginal women may be as high as 40 times the rate for non-Aboriginal women (Schmider & Nancarrow, 2007).
- Despite representing just over 2% of the total Australian population, Aboriginal women accounted for 15% of homicide victims in Australia in 2002–03.
- Alcohol abuse is strongly associated with Aboriginal family violence, and alcohol and drug-related mental health issues are prevalent within Aboriginal communities.

See DOOR 3: The Risk Domains in Detail (pp.105-145) for a detailed literature review of this domain.

There is consensus among Aboriginal commentators, researchers and practitioners that careful screening and culturally sensitive risk assessment is required to counteract Aboriginal family violence. However, these processes need to avoid assumptions and stereotypes about Aboriginal families and ensure that the unique protective factors and vulnerabilities of individuals are recognised. In this context, the historic, multigenerational and ongoing impact of Aboriginal cultural dispossession, which has substantially harmed Aboriginal families, needs to be taken into consideration; however, this knowledge should not be used as a basis to excuse family violence nor to regard it as inevitable.

Culturally and Linguistically Diverse (CALD) families are also in need of effective screening and risk identification.

- The emotional impact of migration, particularly forced migration and refugee experiences, combined with the impact of adjustment to Australian society, leads to family breakdown and family violence for many CALD families.
- Awareness of the compounding nature of migration history, social marginalisation and beliefs about family, as well as other shaping historical factors, is crucial to risk assessment with CALD groups (Burman et al., 2004; Okenwa et al., 2009; World Health Organization, 2010).

See DOOR 3: The Risk Domains in Detail (pp.105-145) for a detailed literature review of this domain.

Who should conduct screening?

The Robinson and Moloney (2010) review provides a good background to the issues surrounding who in the family law system should be involved in safety and wellbeing screening. The authors raise many important questions. Should screening be a segregated task that is assigned to someone at the front end of the system or service, and then followed up by others? Or should screening be one continuous process that flows into assessment? Should lawyers and mental health practitioners undertake the same front-line screening? The empirical literature does not provide easy answers to these questions. Robinson and Moloney (2010) explain:

> *It cannot be assumed that a second worker will be able to simply build on where the other left off. Revelations, even at the screening phase, are made by a client within the context of some level of trust in the competence and integrity of the individual conducting the screening. This dynamic will*

not always repeat itself with another individual. Difficulty in re-establishing trust and rapport is also likely to be greater if there is a delay between the screening and the assessment phase and/or if there is no active handover or facilitated referral between workers. It can indeed be argued that the very fact of beginning a screening process brings clear ethical and professional obligations on the part of the practitioner and the organisation to ensure that risks that are thought to be there even at this phase are acted upon and not "left" to the assessment phase (p.4).

The DOORS framework is designed for application in a variety of contexts, including suburban law firms, FRCs, contact centres, and the courts. Clients are encouraged to self-complete DOOR 1 (with effective engagement and support of an administrative person), then move on to their practitioner for the crucial DOOR 2 follow-up conversation.

While pragmatism dictates a flexible approach to who and how many people should be involved in supporting a screening process, best practice indicates that wherever possible a single, well-trained practitioner with expert understanding of the DOOR 1 and 2 process is the optimal approach. The prime consideration is how to enable the client to identify, discuss and elaborate on difficult aspects of their life, usually on first meeting in a new service situation. Following Robinson and Moloney (2010), the DOORS framework is based on the premise that when a client is well engaged, understands the screening rationale, is practically supported to complete the structured component (DOOR 1) and then empathically supported to elaborate on that with their practitioner, best outcomes are achieved.

Some services may elect to conduct the entire screen face-to-face for some or all clients. In many cases, clients will need to be referred on to specialists for follow-up, and the transition between practitioners needs to be carefully managed for maximum benefit. These are some of the tensions in any risk screening process that need to be resolved within service systems and by individual practitioners. Ultimately, the responsibility for how the DOORS is implemented rests with each service and with individual practitioners.

The accompanying guide to using the DOORS (Learning Guide, pp.147-172) emphasises and illustrates the skills required for effective screening, transitioning to assessment processes. Careful listening, empathic engagement, evaluation of content and process, knowledge of family violence dynamics, basic crisis response and clear action planning are all essential skills for practitioners using DOORS 1 and 2, while specialist skills and expertise are necessary for those following up with assessment at DOOR 3 level.

Each stage of screening needs to conclude with a decision about 'what next'. This includes deciding whether someone with a different skill set should review the profile. It is likely and desirable that, in many high-risk cases, multiple practitioners will be involved in risk assessment in relation to one client or family. However, the notion that 'someone else will get involved' should not be used to defer or deflect responsibility for recognising the evident risks and determining the most appropriate, risk-minimising actions within each practitioner's context of involvement with the client. Coordination is the key to avoiding ineffective, disjointed, or repetitive screening processes. The dynamic nature of collaborative screening and risk management by multiple practitioners can create a purposeful focus on family safety and wellbeing at a time of escalating family stress.

Engagement: philosophy and skills

The DOORS is designed to help practitioners screen for both perpetration and victimisation. This is based on our belief that engagement must occur not only with victims or risk, but also with potential or actual perpetrators, in order to prevent the escalation of violence. Enlisting the cooperation of clients in risk screening is the first and crucial step. This phase involves:

- offering clear information about rationale, process and follow-up.
- providing easy to use tools.
- engaging in effective dialogue with clients when 'risks to self' or 'risks from self' are evident.
- rather than lecturing or imposing solutions, engagement offers an avenue for:
  - testing and validating concerns
  - considering why risk patterns have emerged in the way that they have
  - detailing options for safety and safe behaviour
  - engaging the client in effective self-management of risk where possible
  - promoting effective use of support services.

For both victims of violence and potential or actual perpetrators of violence, engagement with the practitioner provides a counteracting opportunity to develop strategies for moving outside violence and for establishing a process of healing from its causes and effects.

The importance of engagement cannot be overstated; it allows the practitioner to establish their credibility as a source of support, understanding, information, reality checking and guidance - with both vulnerable and hostile clients. Rather than making uniform statements or recommending pre-determined action plans, family law professionals can use effective, sensitive screening to affirm a stronger position against family violence.

When a practitioner uses a proactive prevention rationale as the basis for engagement with clients affected by family violence, greater role clarity and collaboration is achievable. The practitioner can be confident that their responses are more clearly directed when they carefully establish a meaningful dialogue with the client, paying attention to the particulars of the individuals concerned, whilst maintaining a focus on negotiating pathways of safety.

A practitioner's credibility with a client may in some instances be assigned by the client simply through his or her professional role. Legal and judicial professional roles have traditionally been afforded considerable authority and status by the community. Such authority, in the context of family violence, can be useful to deploy, especially with people for whom power relations form the basis of respect. However, sustainable change usually requires credibility and respect that is established through forms of relating that demonstrate a skilled, nuanced understanding of the context and of the individual(s) involved.

Through commitment to effective engagement, the family law system affirms its responsibility for promoting and safeguarding the mental health and wellbeing of adults and children who require its services. This type of engagement requires a perspective that sees family mental health and family violence issues as shared community responsibilities, rather than individual or family

group pathologies. A common framework for understanding risk, and one that is shared across disciplines, is a key component of effective engagement, allowing multiple support services to be systematically involved in solving complex situations.

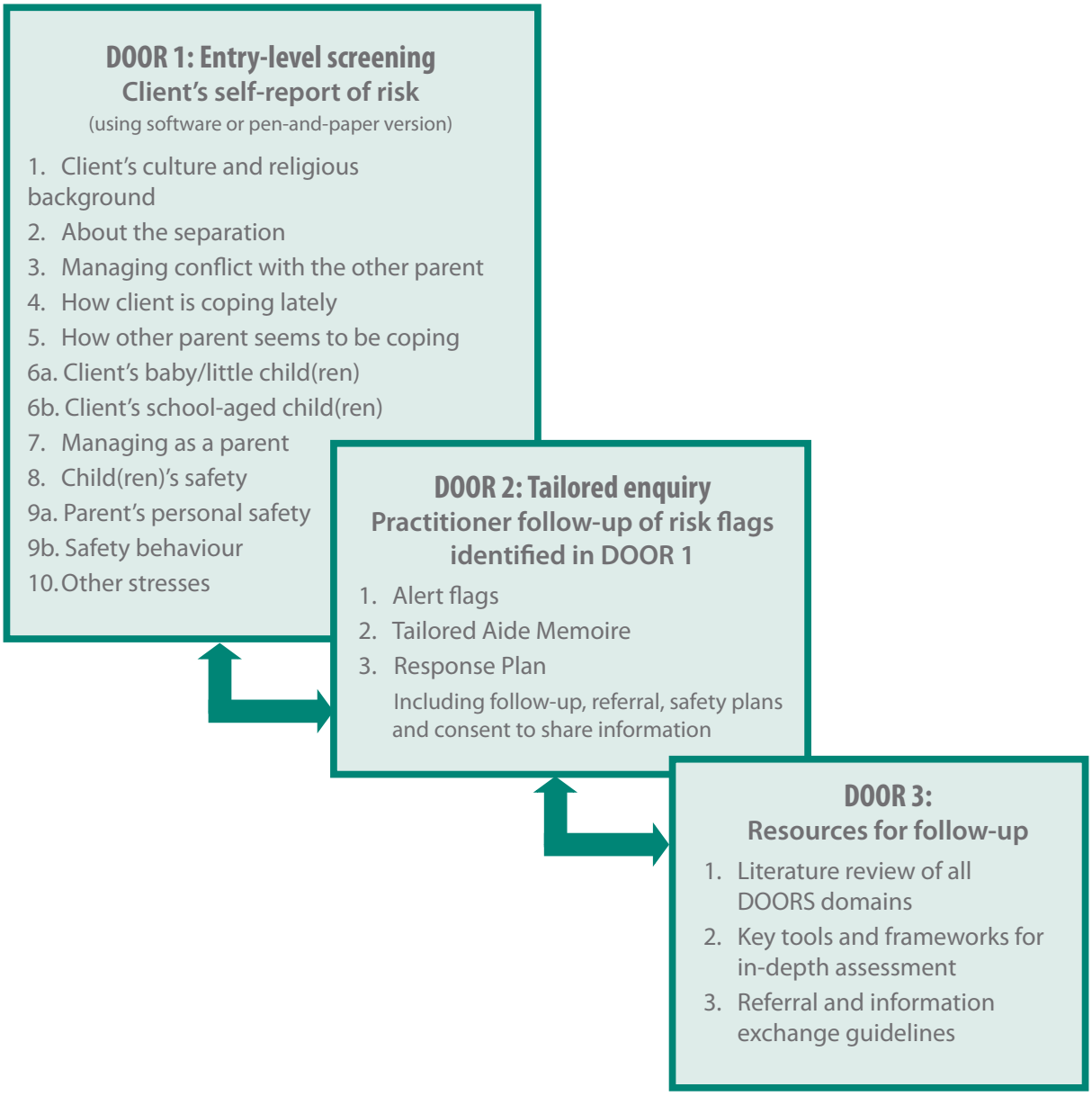
The DOORS creates a context for shared support and also for public scrutiny. Just as legal systems convey social obligation through their mechanisms for law enforcement, we could say that, through genuine engagement, the DOORS conveys a commitment to family safety and wellbeing, addressing the isolation of clients caught in the family law system who often feel powerless in the face of mental health and family violence issues.

Using the DOORS

Overview

The Family Law 'Detection Of Overall Risk Screen' (DOORS) is a framework that helps separating parents and family law professionals to detect and respond to wellbeing and safety risks that family members may be experiencing following a separation. The framework has three levels: DOORS 1 and 2 are screening processes that we advocate be used in all cases; DOOR 3 offers further resources for use in complex cases that require specialist follow-up assessment. The DOORS was designed primarily for families in which former intimate partners have or seek an ongoing parenting role with their children. It can be adapted for use with clients whose dispute is with a non-biological carer, e.g. grandparents, although an empirical basis for this application is not yet established. Resources are also available for former couples who are not parents.

Table 3. The DOORS framework



Each DOOR within the framework addresses ten domains of family functioning post-separation, with a focus on identification of risks to safety, wellbeing and development. The ten domains are:

1. Client's culture and religious background
2. About the separation
3. Managing conflict with the other parent
4. How the client is coping
5. How the other parent seems to be coping
6. About the client's baby/young child(ren) and school-aged child(ren)
7. Managing as a parent
8. Child(ren)'s safety
9. Parent's safety and safety behaviour
10. Other stresses

Defining the three DOORS

DOOR 1 of the framework is step one in the process of mapping a safety and wellbeing profile, as reported by individual parents, and then proceeding to your own analysis of the family's needs. DOOR 1 is designed for clients to self-complete in a quiet space in the practitioner's premises. Alternatively, it can be completed during a personal interview with the practitioner. The practitioner may determine which of the ten domains the client should complete. In most cases involving children, we recommend that all ten domains are completed to help the practitioner detect patterns of concerns that may need further attention. In some cases where the practitioner has access to other comprehensive history or relevant information about the client, only some domains may be relevant.

DOOR 2 is an aide memoire for the practitioner; it supports clinical decision making about any required follow-up. When DOOR 1 is completed using the program software, DOOR 2 appears as an automated summary of the client's responses, together with an aide memoire giving suggestions for follow-up discussion on areas identified by the client as potentially problematic. Pop-up safety plans and consent forms for information sharing are provided in the software tool, together with a pro-forma for response planning. These tools are all available in a pencil-and-paper version. If a practitioner deems it appropriate to conduct the whole screening process in person, they could skip DOOR 1 and begin with DOOR 2, to screen and follow up simultaneously. While DOOR 2 provides guidelines to support clinical judgement, as with all risk assessment, decisions and responses remain the practitioner's responsibility.

DOOR 3 provides a wealth of support for understanding the aetiology of each area of risk profiled in the DOORS framework. This includes recently commissioned general population statistics for the separated and divorced population, comprehensive literature summaries, specialist follow-up tools and links to other risk assessment frameworks. Resources are provided to help practitioners review legislation relevant to their work, to review mandatory reporting guidelines, and to tailor and update their risk management resources and referral networks. DOOR 3 can be used to educate and update practitioners, or as a basis for training in comprehensive risk assessment for the family law system.

How to use the DOORS

Using DOOR 1

Your service context will determine the precise stage of an assessment in which you would use this screening tool. Most would complete the DOOR 1 questionnaire at or just prior to a private appointment with their practitioner, and DOOR 2 would be an immediate follow-up. DOORS 1 and 2 can be completed by telephone interview, provided the client feels safe to discuss confidential matters at the time. Given the very sensitive nature of the information, caution should be taken in mailing DOOR 1 to a client to complete prior to an appointment, and we would generally advise against this until such time as safe online methods for prior completion are established.

Discussing screening with clients

As far as possible, it is important to normalise the process of risk screening with clients:

- Ensure they understand this is a routine part of every assessment.
- Stress that everyone answers the same questions in every service setting.

These points are included on the DOOR 1 introductory page. The practitioner's introductory remarks to the client can echo these ideas, as below:

> *The DOORS screen is used in family law services across Australia. It is a routine part of early assessment. Separation and family law disputes are stressful, and it can be a time of increased risk for parents and children. The DOORS asks you about your wellbeing and safety, and that of other family members.*
>
> *Just as a doctor asks questions in order to figure out what treatment is best for you, the DOORS asks a number of questions to help us understand how we can support you best. Some questions will not be relevant to you, and others will be. The questionnaire will take you about 15-20 minutes to complete. I/your practitioner will discuss your responses with you once you've completed it.*

Discussing confidentiality

A parent's self-reported DOORS information is subject to the same principles of confidentiality that apply to other forms of self-reported client information. Subsequent follow-up screening and assessment are also subject to the same information sharing restrictions and freedoms as all other screening and assessment procedures. These limits need to be clearly explained to the client prior to completing the screen. The section Information Sharing in DOOR 3 (p. 96) contains detailed information about privacy and information sharing.

Determining the best method for completing DOOR 1

The DOOR 1 parent self-report screen can be completed in one of two ways, and practitioners are invited to identify the most appropriate method for their client. Choosing how to complete the

screen will depend on the resources available to the service. If computers and full support are available, this part of the discussion between a practitioner and client could go something like this:

> *There are two options for completing the first part of the screen. You can choose the way that feels most comfortable for you.*
>
> - *Option 1: I will set you up at a private computer to answer these screening questions on your own. I will then quickly get an automatic report, and I will talk with you about that further today as needed.*
> - *Option 2: If using a computer or reading is difficult for you, this is no problem — we can help you to use the computer or you can have a pencil-and-paper version.*
>
> *I will talk with you in person to follow up on this. If filling this form out seems to be too hard for any reason, and you would prefer to talk with me in person, we can arrange that too. What do you think? What seems most comfortable for you today?*

This explanation assumes the practitioner is introducing DOOR 1 to the client. In some settings another person may be designated to do this (e.g. an administrative worker) who would liaise with the practitioner.

Methods for completing DOOR 1

Option 1: Parent self-complete using computer-assisted program

At the practitioner's office, the client completes DOOR 1 using the **computer-based program**. The steps in this process are:

1. The practitioner (or a trained assistant) provides the client with a private, quiet space in his/her office, with access to a computer.
2. DOOR 1 is accessed by the practitioner via secure login.
3. The practitioner selects the domains he/she would like the client to complete, and gives basic instructions on how to operate the program to answer the questions.
4. Completion of the full questionnaire takes approximately 20 minutes.
5. The practitioner can also ask the questions verbally and record the client's responses directly into the program.
6. When completed, the practitioner then generates the DOOR 2 reports and enters the client ID and password again. These reports can be printed as PDFs.
7. The DOOR 2 Practitioner Aide Memoire is then produced. (See below, Using DOOR 2, p. 21)

Option 2: Parent self-complete, pen-and-paper version

While there are numerous advantages to the computer-based format of DOOR 1 and DOOR 2, paper versions may be more suitable for some parents or practitioners. In this option, a parent individually completes the DOOR 1 screen, using the **pen-and-paper** version of the questionnaire. The practitioner should allow time to consider the raw item responses, noticing items and patterns that indicate the need for follow-up (on the DOOR 2 paper form provided for this purpose) before opening discussions with the parent. Alternatively, the practitioner could enter the item responses manually into the computer later, enabling access to the summary report and DOOR 2 prompts.

Option 3: Practitioner-facilitated completion, using computer or pen and paper

Because of the needs of certain clients (e.g. some CALD clients), or practitioner preference, DOOR 1 may be included by the practitioner as a structured phase within an intake/assessment **interview**. This may be conducted in person or over the telephone, and may or may not include the use of the computer program. If done by hand, the combined DOOR 1 and DOOR 2 format is best used for this purpose.

Using DOOR 2

The DOOR 2 Reports can be generated in two ways: **computer-based**, or **pencil and paper**. The DOOR 2 Reports consist of the Practitioner Aide Memoire and Response Planning pages. If the client has completed the software version of DOOR 1, the DOOR 2 Pracitioner Aide Memoire will be automatically created. Practitioners may like to allow themselves a few minutes to review the summary, and then begin follow-up discussion with the client.

- Prompts will appear for each risk item nominated by the client to guide further enquiry. This will assist the practitioner to explore the severity of risk and the tenor and veracity of the client's report.
- DOOR 2 Practitioner Aide Memoire reminds the practitioner to incorporate multiple factors in their appraisal; for example, to consider how the client seems when discussing the issues in person, and so forth.
- The DOOR 2 Response Planning will then prompt the practitioner to consider their response plan, with options such as "no risk management action required", through to "gain consent to share information" and "needs immediate safety plan".
- DOOR 2 also provides examples of safety plans and a consent form for information sharing.
- The practitioner's notes need to be taken manually and will not be recorded in the DOORS program.

A response plan may be obvious (e.g. no further follow-up required, or safety planning needed) or you may need to allow a few minutes to review the material and consider what your first steps should be. DOOR 2 is the gateway to making professional judgements about what to do. These actions may need to be reviewed and adjusted, depending on the needs of the case.

Using DOOR 3

DOOR 3 provides a set of resources that can be used in various ways by all practitioners in the family law system. It includes a series of literature reviews covering each risk domain, response to risk, information about privacy, information sharing, and referral management. We recommend that everyone should familiarise themselves with these resources. Further, there is a table providing links and resources to support comprehensive risk assessment in each domain (see Table 6, p. 72).

Practitioner Forms

- DOOR 1: Parent Self-Report Form
- DOOR 1: Non-Parent Self-Report Form
- DOOR 2: Practitioner Aide Memoire
- DOOR 2: Practitioner's Action Plan
- Safety Planning: Family Violence
- Safety Planning: Suicide
- Consent Form

Forms are available in PDF for printing from the DVD-ROM (found at front of Handbook).
Instructions on how to use the DVD-ROM are on pp. 175-178.

Parent Self-Report Form

Client ID .....

Practitioner .....

Date .....

Introduction

Welcome to the DOORS. This screen helps you to tell us about your wellbeing and safety and that of your children. Separation and family law disputes are stressful, and it can be a time of increased risk for parents and children.

Like a doctor who asks a range of questions in order to figure out what treatment is best for you, this screen also asks a number of questions to help us understand how to support you best. Some questions will be more relevant to you than others — however, please try to answer all questions.

The questionnaire will take up to 20 minutes. Your practitioner will discuss your responses with you once you have completed it.

About you

In relation to the children involved in the dispute, are you:

☐ Mother ☐ Same-sex parent ☐ Donor
☐ Father ☐ Step-parent ■ Other

1. Your culture and religious background

1. Is there anything about your culture or religion that is important for us to understand in order to help you with this dispute? Yes ☐ No ☐

2. About the separation

1. How many months/years ago did you separate from the other parent?

   ☐ Years ☐ Months ☐ Never lived together

2. In your view, who decided to end the relationship?

   ☐ Me ☐ Other parent ☐ Both ☐ Never in a relationship

3. Please select any words below that describe how you feel these days about being separated/divorced from the other parent:

   ☐ fine/content ☐ accepting/resigned ☐ sad/down ☐ distressed/ upset
   ☐ frustrated/annoyed ☐ worried/anxious ☐ hopeless/powerless ☐ scared/afraid
   ☐ embarrassed/humiliated ☐ jealous/resentful ☐ angry/furious ☐ shocked/devastated

4. Have you spent regular time with your child(ren) in the past six months? Yes ☐ No ☐

5. In your view, does the current parenting arrangement work well for your child(ren)? Yes ☐ No ☐

   If no, regarding time arrangements, do you think:

   a. Your child(ren) would benefit from having more time with their other parent. Yes ☐ No ☐
   b. Your child(ren) would benefit from having less time with their other parent. Yes ☐ No ☐
   c. You personally deserve or are entitled to more time with your child(ren)? Yes ☐ No ☐

6. How was the current parenting arrangement decided?

   ☐ Decided together ☐ I decided ☐ Other parent decided ☐ Child(ren) decided
   ☐ Mediation ☐ Lawyer negotiations ☐ Court ☐ Other

7. How many times have you and the other parent taken your dispute(s) to court?

   ☐ None ☐ One ☐ Two ☐ Three or more ☐ Don't know

3. Managing conflict with your child(ren)'s other parent/carer

1. These days, do you feel hostile or hateful towards the other parent?

   ☐ Often ☐ Sometimes ☐ No

If you have not communicated with the other parent during the past 6 months, please skip the following questions and go on to the next section.

Over the past 6 months, how often did you and the other parent:

2. Discuss and agree on decisions about your child(ren)?

   ☐ Often ☐ Sometimes ☐ Not often / Never

3. Have angry disagreements

   ☐ Often ☐ Sometimes ☐ Not often / Never

4. How you are coping

1. Do you have any *major* worries about how you have been coping in the past six months? Yes ☐ No ☐
2. **In the past 6 months**, have you:
   a. felt *very* anxious or fearful? Yes ☐ No ☐
   b. felt *very* angry or irritated? Yes ☐ No ☐
   c. felt *very* sad/empty/depressed? Yes ☐ No ☐
   d. done or felt things that are unusual or out of character for you? Yes ☐ No ☐
3. **In the past year**:
   a. have you drunk alcohol and/or used drugs more than you meant to? Yes ☐ No ☐
   b. have you felt you wanted or needed to cut down on your drinking and/or drug use? Yes ☐ No ☐
   c. is anyone else worried about your alcohol and/or drug use these days? Yes ☐ No ☐
4. **In the past 2 years**, have you seen a doctor, psychologist or psychiatrist for a mental health problem or drug/alcohol problem? Yes ☐ No ☐
5. Are you getting enough emotional support now (e.g. from friends, family, professionals)? Yes ☐ No ☐

5. How your child(ren)'s other parent/carer seems to be coping

If you have not communicated with the other parent during the past six months, please skip these questions and go on to the next section.

1. **In the past 6 months**, have you had any *major* worries about how the other parent has been coping/behaving? Yes ☐ No ☐
2. **In the past 6 months**, has the other parent behaved in a way that seemed:
   a. *very* anxious/fearful? Yes ☐ No ☐
   b. *very* angry/irritated? Yes ☐ No ☐
   c. *very* sad/depressed? Yes ☐ No ☐
   d. out of character or unusual for them? Yes ☐ No ☐
3. **In the past year**, have you been worried about the other parent's drinking and/or drug use? Yes ☐ No ☐
4. **In the past** 2 **years**, to your knowledge, has the other parent seen a doctor, psychologist or psychiatrist for a mental health problem or a drug/alcohol problem? Yes ☐ No ☐

6a. About your baby/young child(ren)

Please skip these questions if you do not have a child under 5 years, OR if you have not spent time with your young child(ren) during the past 6 months.

These questions are about babies and pre-school children, under 5 years. If you have more than one child under 5 years, tick 'yes' if any question is true for ANY of your young children.

1. Does your young child(ren) have any *serious* health or developmental problems? Yes ☐ No ☐
2. **In the past 6 months**, has any professional (teacher, doctor, etc.) been concerned about how your young child(ren) was doing? Yes ☐ No ☐
3. **In the past 6 months**, has your young child(ren) seemed:
   a. more distressed by normal separations than usual? Yes ☐ No ☐
   b. more fussy/aggressive/upset than usual? Yes ☐ No ☐
   c. distressed/angry/withdrawn when going to or from either parent? Yes ☐ No ☐
4. Has your child(ren) ever heard or seen very angry disagreements or violence at home? Yes ☐ No ☐

6b. About your school-aged children

Please skip these questions if you do not have a child over 5 years, OR if you have not spent time with your school-aged children during the past 6 months.

These questions are about your school-aged children, ages 5 to 17 years. If you have more than one child 5 years and older, tick 'yes' if any question is true for ANY of these children.

1. Does your child(ren) have any *serious* health or developmental problems? Yes ☐ No ☐
2. **In the past 6 months**, has any professional (teacher, doctor etc.) been concerned about how your child was doing? Yes ☐ No ☐
3. **In the past 6 months**, compared to how they usually are, do any of your children seem:
   a. more anxious/worried? Yes ☐ No ☐
   b. more aggressive/angry? Yes ☐ No ☐
   c. more sad/withdrawn? Yes ☐ No ☐
   d. more defiant/disobedient? Yes ☐ No ☐
   e. behaving in concerning ways? Yes ☐ No ☐
4. **In the past 6 months**, did any of your children strongly resist seeing either parent? Yes ☐ No ☐
5. Has your child(ren) *ever* heard or seen very angry disagreements or violence at home? Yes ☐ No ☐
6. **In the past 2 months**, have any of your children missed more than 4 days at school? Yes ☐ No ☐

7. Managing as a parent

If you have <u>not</u> spent time with your child(ren) during the past 6 months, please skip these questions and go on to the next section.

Given all that goes on at these times, parenting can be hard work.

Thinking about the **past 6 months**:

1. Was it difficult to know how your child(ren) was feeling? ☐ No ☐ Sometimes ☐ Often
2. Was it difficult to comfort and be warm with each of your children? ☐ No ☐ Sometimes ☐ Often
3. Was it difficult to set limits and deal with problem behaviour? ☐ No ☐ Sometimes ☐ Often
4. Was it difficult to support your child(ren)'s activities and interests? ☐ No ☐ Sometimes ☐ Often
5. Were you harsher towards your child(ren) than you wanted or meant to be? ☐ No ☐ Sometimes ☐ Often

The following questions are about your child(ren)'s safety, your safety, and your child(ren)'s other parent's safety. Working things out after separation can be stressful, and many people need extra support at this time. Some people need extra help to feel safe and be safe. Your practitioner will talk about this further with you. If you'd like any extra time to consider these questions, or help to answer them, your practitioner will be willing to assist.

8. Your child(ren)'s safety

Consider all of your children, and tick 'yes' if any question is true for ANY of your children.

1. **In the past 6 months**, did you have any concerns about your child(ren)'s safety:
   - a. when they were with their other parent? Yes ☐ No ☐
   - b. when they were with you? Yes ☐ No ☐
   - c. when they were in the care of any other adult (e.g. step-parent, relative?) Yes ☐ No ☐
2. Has *anyone else* said they were worried about your child(ren)'s safety with anyone? Yes ☐ No ☐
3. Have any child protection reports ever been made about your child(ren)? Yes ☐ No ☐
   - a. Is there a current investigation into child protection matters? Yes ☐ No ☐
4. **Since separation:**
   - a. Has the other parent threatened to or actually taken the child(ren), or kept them without consent, *far beyond* the agreed time? Yes ☐ No ☐
   - b. Have you threatened to or actually taken the child(ren), or kept them without consent, *far beyond* the agreed time? Yes ☐ No ☐

9a. Your safety

1. **In the past year,** have you *in any way* been frightened of, or concerned for your own safety because of the other parent? Yes ☐ No ☐
2. Are you **now** *in any way* afraid for your own safety because of the other parent, or anyone else? Yes ☐ No ☐
3. **In the past year**, has anyone else said they were worried for your safety? Yes ☐ No ☐
4. If the other parent is disappointed with the outcome of the dispute, are you afraid that s/he would try to hurt someone or hurt him/herself? Yes ☐ No ☐
5. As a result of the other parent's behaviour, have the police **ever** been called, a criminal charge been laid, or intervention/restraining order been made against him/her? Yes ☐ No ☐
   - a. Is there **now** an intervention/restraining order against him/her? Yes ☐ No ☐
6. **In the past year**, has the other parent:
   - a. Followed you or watched your movements in a way that felt worrying (e.g. driving by or watching your home, being in the same place when s/he had no business there)? Yes ☐ No ☐
   - b. Tried to control you or acted in a very jealous way (e.g. controlling your money, where you went, who you saw)? Yes ☐ No ☐
   - c. Threatened your safety? Yes ☐ No ☐
   - d. Hurt you in a way that wasn't an accident or used force to get you to do something you did not want to do? Yes ☐ No ☐
7. Has the other parent *ever* threatened to or actually tried to hurt or kill him/herself? Yes ☐ No ☐
8. Does the other parent have access to a gun or other weapon? Yes ☐ No ☐
9. If yes to any of the above: Are these, or similar behaviours by the other parent, becoming worse or more frequent recently? Yes ☐ No ☐

9b. Behaving safely

1. As far as you know, has anyone expressed concern about the safety of your behaviour toward the other parent or towards your child(ren)? Yes ☐ No ☐
2. If you are disappointed with the outcome of the dispute, would you consider hurting someone, or yourself? Yes/Maybe ☐ No ☐
3. As a result of your behaviour, have the police **ever** been called, a criminal charge been laid, or intervention/restraining order been made against you? Yes ☐ No ☐
   a. Is there **now** an intervention/restraining order in place against you? Yes ☐ No ☐
4. Would the other parent likely to say that you have done any of the following things **in the past year**:
   a. You followed or watched his/her movements in a way that felt worrying to him/her (e.g. driving by or watching his/her home, being in the same place when you had no business there)? Yes ☐ No ☐
   b. Tried to control him/her, or acted in a very jealous way (controlling his/her money, where s/he went, who s/he saw)? Yes ☐ No ☐
   c. You threatened his/her safety? Yes ☐ No ☐
   d. Hurt him/her in a way that wasn't an accident, or used force to get him/her to do something s/he did not want to do? Yes ☐ No ☐
5. Do you think either the other parent or your child(ren) are afraid of you in any way? Yes ☐ No ☐
6. Have things in your life *ever* felt so bad that you have thought about hurting yourself, or even killing yourself? Yes ☐ No ☐

   If yes, do you feel that way lately? Yes ☐ No ☐
7. Do you have access to a gun or weapon? Yes ☐ No ☐

10. Other stresses

Are these things happening **now** and causing *major* stress for you?

1. Being unemployed/under-employed Yes ☐ No ☐
2. Financial difficulties Yes ☐ No ☐
3. Property/asset settlement Yes ☐ No ☐
4. Child support payments Yes ☐ No ☐
5. Getting legal advice/representation Yes ☐ No ☐
6. Housing problems Yes ☐ No ☐
7. Transportation problems Yes ☐ No ☐
8. Feeling lonely/isolated Yes ☐ No ☐
9. Feeling harassed by the other parent's family/new partner/other Yes ☐ No ☐
10. Illness/sickness/physical disability Yes ☐ No ☐
11. Problems in your neighbourhood with safety, crime, drugs etc. Yes ☐ No ☐
12. Are there any other stresses that are a *serious* problem for you at the moment? If so, please tell us what they are. Yes ☐ No ☐

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DOOR 1 | Australian Institute of Social Relations | Family Transitions | Australian Government Attorney-General's Department

Non-Parent Self-Report Form

Client ID .....

Practitioner .....

Date .....

Introduction

Welcome to the DOORS. This screen helps you to tell us about your wellbeing and safety. Separation and family law disputes are stressful, and it can be a time of increased risk for the parties involved.

Like a doctor who asks a range of questions in order to figure out what treatment is best for you, this screen also asks a number of questions to help us understand how to support you best. Some questions will be more relevant to you than others— however, please try to answer all questions.

The questionnaire will take up to 20 minutes. Your practitioner will discuss your responses with you once you've completed it.

1. Your culture and religious background

1. Is there anything about your culture or religion that is important for us to understand in order to help you with this dispute? Yes ☐ No ☐

2. About the separation

1. How many months/years ago did you separate from your former partner?

   ☐ Months ☐ Years

2. In your view, who decided to end the relationship?

   ☐ Me ☐ Former partner ☐ Both

3. Please select any words below that describe how you feel these days about being separated/divorced from your former partner:

   ☐ fine/content ☐ accepting/resigned ☐ sad/down ☐ distressed/upset
   ☐ frustrated/annoyed ☐ worried/anxious ☐ hopeless/powerless ☐ scared/afraid
   ☐ embarrassed/humiliated ☐ jealous/resentful ☐ angry/furious ☐ shocked/devastated

4. How many times have you and your former partner taken your dispute(s) to court?

   ☐ None ☐ One ☐ Two ☐ Three or more times ☐ Don't know

3. Managing conflict with your former partner

1. These days, do you feel hostile or hateful towards your former partner?

   ☐ Often ☐ Sometimes ☐ No

2. **Over the past 6 months**, how often did you and your former partner have angry disagreements?

   ☐ Often ☐ Sometimes ☐ Not often / Never ☐ Had no communication

4. How you are coping

1. Do you have any *major* worries about how you have been coping in **the past 6 months**? Yes ☐ No ☐
2. **In the past 6 months**, have you:
   a. felt *very* anxious/fearful? Yes ☐ No ☐
   b. felt *very* angry/irritated? Yes ☐ No ☐
   c. felt *very* sad/empty/depressed? Yes ☐ No ☐
   d. done or felt things that are unusual or out of character for you? Yes ☐ No ☐

3. **In the past year**:
   a. have you drunk alcohol and/or used drugs more than you meant to? Yes ☐ No ☐
   b. have you felt you wanted or needed to cut down on your drinking and/or drug use? Yes ☐ No ☐
   c. is anyone else worried about your alcohol and/or drug use these days? Yes ☐ No ☐
4. **In the past 2 years**, have you seen a doctor, psychologist or psychiatrist for a mental health problem or drug/alcohol problem? Yes ☐ No ☐
5. Are you getting enough emotional support now (e.g. from friends, family, professionals)? Yes ☐ No ☐

5. How your former partner seems to be coping

If you have not communicated with your former partner during the past 6 months, please skip these questions and go on to the next section.

1. **In the past 6 months**, have you had any *major* worries about how your former partner has been coping or behaving? Yes ☐ No ☐
2. **In the past 6 months**, has your former partner behaved in a way that seemed:
   a. *very* anxious/fearful? Yes ☐ No ☐
   b. *very* angry/irritated? Yes ☐ No ☐
   c. *very* sad/empty/depressed? Yes ☐ No ☐
   d. out of character or unusual for them? Yes ☐ No ☐
3. **In the past year**, have you been worried about your former partner's drinking and/or drug use? Yes ☐ No ☐
4. **In the past 2 years**, to your knowledge, has your former partner seen a doctor, psychologist or psychiatrist for a mental health problem or a drug/alcohol problem? Yes ☐ No ☐

The following questions are about your safety, and your former partner's safety. Working things out after separation can be stressful, and many people need extra support at this time. Some need help to feel safe and be safe. Your practitioner will talk about this further with you. If you'd like any extra support or time to consider these questions, your practitioner will be willing to assist.

6a. Your safety

1. **In the past year**, have you *in any way* been frightened of or concerned for your own safety because of your former partner? Yes ☐ No ☐
2. Are you **now** *in any way* afraid for your own safety with your former partner or anyone else? Yes ☐ No ☐
3. **In the past year**, has anyone else said they were worried for your safety? Yes ☐ No ☐
4. If your former partner is disappointed with the outcome of the dispute, are you afraid that s/he would try to hurt someone or hurt him/herself? Yes ☐ No ☐
5. As a result of your former partner's behaviour with anyone, have the police **ever** been called, a criminal charge been laid, or intervention/restraining order been made against him/her? Yes ☐ No ☐
   a. Is there **now** an intervention/restraining order against him/her? Yes ☐ No ☐
6. **In the past year**, has your former partner:
   a. Followed you or watched your movements in a way that felt worrying (e.g. driving by or watching your home, being in the same place when s/he had no business there)? Yes ☐ No ☐
   b. Tried to control you or acted in a very jealous way (e.g. controlling your money, where you went, who you saw)? Yes ☐ No ☐
   c. Threatened your safety? Yes ☐ No ☐
   d. Hurt you in a way that wasn't an accident, or used force to get you to do something you did not want to do? Yes ☐ No ☐

7. Has your former partner *ever* threatened to or actually tried to hurt or kill him/herself? Yes ☐ No ☐
8. Does your former partner have access to a gun or other weapon? Yes ☐ No ☐
9. If yes to any of the above: Are any of these or similar behaviours by your former partner becoming worse or more frequent recently? Yes ☐ No ☐

6b. Behaving safely

1. As far as you know, has anyone expressed concern about the safety of your behaviour toward your former partner? Yes ☐ No ☐
2. If you are disappointed with the outcome of the dispute, would you consider trying to hurt someone or yourself? Yes /maybe ☐ No ☐
3. As a result of your behaviour, have the police **ever** been called, a criminal charge been laid, or intervention/restraining order been made against you? Yes ☐ No ☐
   a. Is there **now** an intervention/restraining order in place against you? Yes ☐ No ☐
4. Would your former partner likely to say that you have done any of the following things **in the past year**: Yes ☐ No ☐
   a. Followed or watched his/her movements in a way that felt worrying to him/her (e.g. driving by or watching their home, being in the same place when you had no business there)? Yes ☐ No ☐
   b. Tried to control him/her, or acted in a very jealous way (controlling their money, where s/he went, who s/he saw)? Yes ☐ No ☐
   c. You threatened his/her safety? Yes ☐ No ☐
   d. Hurt him/her in a way that wasn't and accident or used force to get him/her to do something s/he did not want to do? Yes ☐ No ☐
5. Do you think your former partner is afraid of you in any way? Yes ☐ No ☐
6. Have things in your life *ever* felt so bad that you thought about hurting yourself, or even killing yourself? Yes ☐ No ☐
   a. If yes, do you feel that way lately? Yes ☐ No ☐
7. Do you have access to a gun or weapon? Yes ☐ No ☐

10. Other stresses

Are any of the following issues happening **now** and causing *major* stress for you?

1. Being unemployed/under-employed Yes ☐ No ☐
2. Financial difficulties Yes ☐ No ☐
3. Property/asset settlement Yes ☐ No ☐
4. Getting legal advice/representation Yes ☐ No ☐
5. Housing problems Yes ☐ No ☐
6. Transportation problems Yes ☐ No ☐
7. Feeling lonely/ isolated Yes ☐ No ☐
8. Feeling harassed by your former partner's family/new partner/other Yes ☐ No ☐
9. Illness/sickness/physical disability Yes ☐ No ☐
10. Problems in your neighbourhood with safety, crime, drugs etc. Yes ☐ No ☐
11. Are any other stresses a *serious* problem for you at the moment? Yes ☐ No ☐
    If so, please tell us what they are.

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DOOR 2 Practitioner Aide Memoire

For DOOR 1 follow-up or interview based screening

Client ID .....

Practitioner .....

Date .....

The DOORS provides a guide for follow-up. Once a parent has completed DOOR 1, the practitioner meets with him/her to discuss and evaluate any items of risk that were endorsed by the parent (here shown as the shaded responses). DOOR 2 can also be used when the screen is completed face-to-face, with ready-to-hand follow-up questions.

Domain 1. Your culture and religious background

Domain-specific notes

Specific cultural and religious factors may be protective, or may elevate risk.

- Genograms can be helpful in mapping sources of stress and support, and lines of responsibility (e.g. financial, care-giving), both here and in country of origin.
- See DOOR 3 for further detailed analyses and follow up options.
- Review this domain in conjunction with risks on other domains; patterns and combined stressors are important in determining the best overall response.

DOOR 1: Parent Self-Report Items	DOOR 2: Example prompts for follow-up
1.1 Is there anything about your culture or religion that is important for us to understand in order to help you with this dispute? ☐ Yes ☐ No	• *What would you like me to understand about your background?*

Domain 2. About the separation

Domain-specific notes

- Risks are often higher for women leaving a relationship, or recently separated clients.
- Note how openly, coherently and rationally the client talks about their feelings or how restricted and cut-off they seem.
- Normalise a range of feelings that occur post-separation. Enquire further when normative feelings (e.g. sadness) are absent.
- Note extreme or irrational responses and consider links to safety. Note unbalanced assertions about parent's perception of their entitlements and rights.
- Consider need for legal advice if the client has not yet sought this.
- Consider current use of legal process. Is the legal process being used by one parent (at least in part) to stay engaged with/control/harass the other parent?
- Review this domain in conjunction with risks on other domains; patterns and combined stressors are important in determining the best overall response.

DOOR 1: Parent Self-Report Items	DOOR 2: Example prompts for follow-up
2.1 How many months/years ago did you separate from the other parent? ☐ Years ☐ Months ☐ Never lived together	• *Is this the first time you have separated?*
2.2 In your view, who decided to end the relationship? ☐ Me ☐ Other parent ☐ Both ☐ Never in a relationship	• *Is the decision final?*

2.3 Please select any words below that describe how you feel these days about being separated/divorced from the other parent: ☐ fine/content ☐ accepting/resigned ☐ sad/down ☐ distressed/ upset ☐ frustrated/annoyed ☐ worried/anxious ☐ hopeless/powerless ☐ scared/afraid ☐ embarrassed/humiliated ☐ jealous/resentful ☐ angry/furious ☐ shocked/devastated	• *How manageable are these feelings now?* • *Are you getting enough support with this?*
2.4 Have you spent regular time with your child(ren) in the past 6 months? ☐ Yes ☐ No	• *How do you feel about that? What are the circumstances?*
2.5 In your view, does the current parenting arrangement work well in the interests of your child(ren)? ☐ Yes ☐ No If no, regarding custodial time arrangements, do you agree or disagree with the following statements: a. Your child(ren) would benefit from having more time with their other parent. ☐ Yes ☐ No b. Your child(ren) would benefit from less time with their other parent. ☐ Yes ☐ No c. You personally deserve or are entitled to more time with your child(ren). ☐ Yes ☐ No	• *What's leading you to say that?*
2.6 How was the current parenting arrangement decided? ☐ We decided together ☐ I decided ☐ Other parent decided ☐ Child(ren) decided ☐ Mediation ☐ Lawyer negotiations ☐ Court ☐ Other	• *Were decisions always made this way?*
2.7 How many times have you and the other parent taken your dispute(s) to court? ☐ None ☐ One ☐ Two ☐ Three or more ☐ Don't know	• *What's led to these frequent court applications?*

Domain 3. Managing conflict with your child(ren)'s other parent/carer

Domain-specific notes

- Explore the severity of anger and hostile attitudes, and patterns of communication, noting escalating conflict and hostility.
- Note the manner with which the parent describes problems — overly constricted and poorly restricted emotional responses need to be considered further.
- See DOOR 3 for further follow-up and referral options.
- Review this domain in conjunction with risks on other domains; patterns and combined stressors are important in determining the best overall response.

DOOR 1: Parent Self-Report Items

3.1. These days, do you feel hostile or hateful towards the other parent? ☐ Sometimes ☐ Never	• *What do you do with these feelings?* • *Is this getting worse lately?*

If you have not communicated with the other parent during the past 6 months, please skip the following questions and go on to the next section. **Over the past 6 months**, how often did you and the other parent: 3.2 Discuss and agree on decisions about your child(ren)? ☐ Often ☐ Sometimes ☐ Not often / Never	• *What usually happens when you try discuss things or make decisions?*
3.3 Have angry disagreements ☐ Often ☐ Sometimes ☐ Not often / Never	• *How frequent? How severe?* • *Is this getting worse lately?*

Domain 4. How you are coping

Domain-specific notes

- Consider connections between coping difficulties and surrounding stressors on Domain 10.
- Consider overflow into parenting and safety problems raised in Domains 7, 8 and 9.
- Note the parent's ability to talk openly and coherently; overly constricted or poorly restricted emotional responses indicate a need for further assessment.
- Explore the nature and effectiveness of support they are receiving.
- Receiving psychological treatment is not in itself a risk factor.
- Untreated, ongoing or worsening mental health or drug and alcohol problems need to be further assessed (see DOOR 3).
- Note the high prevalence of mental health and alcohol/drug issues in family violence.
- If severe distress/depression is noted, follow up carefully on suicide risk (see Domain 9b).
- Consider specialist referral options when multiple risks are evident, or when downward escalation of problem behaviour is apparent.
- Review this domain in conjunction with risks on other domains; patterns and combined stressors are important in determining the best overall response.

DOOR 1: Parent Self-Report Items	DOOR 2: Example prompts for follow-up
4.1 Do you have any *major* worries about how you have been coping in **the past 6 months?** ☐ Yes ☐ No	• *What are the concerns? History and severity of the problem?* • *Is this getting worse lately?*
4.2 **In the past 6 months**, have you: a. felt *very* anxious/fearful? ☐ Yes ☐ No b. felt *very* angry/irritated? ☐ Yes ☐ No c. felt *very* sad/empty/depressed? ☐ Yes ☐ No d. done or felt things or had feelings that are unusual or out of character for you? ☐ Yes ☐ No	• *Is this affecting how you are managing everyday tasks?* • *Are you getting any professional help?*
4.3 **In the past year**: a. have you drunk alcohol and/or used drugs more than you meant to? ☐ Yes ☐ No b. have you felt you wanted or needed to cut down on your drinking and/or drug use? ☐ Yes ☐ No c. is anyone else worried about your alcohol and/or drug use these days? ☐ Yes ☐ No	• *Have drug and alcohol problems led to legal or work-related problems (e.g. road accidents, losing a job)?* • *Are you receiving professional help for this?*

4.4 **In the past 2 years**, have you seen a doctor, psychologist or psychiatrist for a mental health problem or drug/alcohol problem? ■ Yes ☐ No	• *Was this helpful? Is there a formal diagnosis?*
4.5 Are you getting enough emotional support now (e.g. from friends, family, professionals)? ☐ Yes ☐ No	• *Would you like any help with this?*

Domain 5. How your child(ren)'s other parent/carer seems to be coping

Domain-specific notes

- Explore any problems in light of safety problems raised in Domains 7, 8 and 9.
- Note the high prevalence of alcohol/drug usage in family violence (see literature in DOOR 3).
- Receiving psychological treatment is not in itself a risk factor.
- Untreated, ongoing or worsening mental health or drug and alcohol problems need to be further assessed (see DOOR 3).
- Consider specialist referral options when multiple risks are evident, or downward escalation of problem behaviour is apparent (see DOOR 3).
- Review this domain in conjunction with risks on other domains; patterns and combined stressors are important in determining the best overall response.

	DOOR 2: Example prompts for follow-up
If you have not communicated with the other parent during the past 6 months, please skip these questions and go on to the next section.	
5.1 **In the past 6 months**, have you had *major* worries about how the other parent has been coping/behaving? ■ Yes ☐ No	• *What are the concerns? History and severity of the problem?* • *Is this getting worse lately?*
5.2 **In the past 6 months**, has the other parent behaved in a way that seemed: a. *very* anxious/fearful? ☐ Yes ☐ No b. *very* angry/irritated? ☐ Yes ☐ No c. *very* sad/empty/depressed? ☐ Yes ☐ No d. out of character or unusual for them? ☐ Yes ☐ No	• *Is this affecting their ability to function on a day-to-day basis?* • *Is s/he getting professional support?*
5.3 **In the past year**, have you been worried about the other parent's drinking and/or drug use? ☐ Yes ☐ No	• *Have drug/alcohol problems led to legal or work related problems (e.g. road accidents, losing a job?) or problems with safe parenting?*
5.4 **In the past 2 years**, to your knowledge, has the other parent seen a doctor, psychologist or psychiatrist for a mental health problem or a drug/alcohol problem? ☐ Yes ☐ No	• *Is there a formal diagnosis? Is s/he getting professional support?*

Domain 6a. About your baby/young child(ren)

Domain-specific notes

- Any recent signs of severe stress in the young child should be further explored.
- Consider these in light of other stressors identified in parent's coping, conflict, parenting and safety issues.
- Consider specialist referral options for parent when multiple risks are evident, or downward escalation of problem behaviour is apparent (see DOOR 3).
- Review this domain in conjunction with risks on other domains; patterns and combined stressors are important in determining the best overall response.

DOOR 1: Parent Self-Report Items	DOOR 2: Example prompts for follow-up
Please skip these questions if you do not have a child under 5 years, OR if you have not spent time with your young child(ren) during the past 6 months. **These questions are about babies and pre-school children, under 5 years.** **If you have more than one child under 5, tick 'yes' if any question is true for ANY of your young children.**	
6a.1 Does your young child(ren) have any *serious* health or developmental problems? ☐ Yes ☐ No	• *Nature of problem(s)? Diagnosis? Prognosis?*
6a.2 **In the past 6 months**, has any professional (teacher, doctor, etc.) been concerned about how your young child(ren) was doing? ☐ Yes ☐ No	• *Nature of the problem(s)?*
6a.3 **In the past 6 months**, has your young child(ren) seemed: a. more distressed by normal separations than usual? ☐ Yes ☐ No b. more fussy/aggressive/upset than usual? ☐ Yes ☐ No c. distressed/angry/withdrawn when going to or from either parent? ☐ Yes ☐ No	• *Nature and severity of concerns?* • *Why do you think that is happening?*
6a.4 Has your child(ren) *ever* heard or seen very angry disagreements or violence at home? ☐ Yes ☐ No	• *Nature and severity of exposure?*

Domain 6b. About your school-aged child(ren)

Domain-specific notes

- Any recent and ongoing signs of severe stress/behavioural disturbance in the child should be further explored.
- Consider these in light of other stressors identified in parent's coping, conflict, parenting and safety issues.
- Consider specialist referral options for the child and/or parents when multiple risks are evident or downward escalation of problem behaviour is apparent (see DOOR 3).
- Review this domain in conjunction with risks on other domains; patterns and combined stressors are importantin determining the best overall response.

DOOR 1: Parent Self-Report Items	DOOR 2: Example prompts for follow-up
Please skip these questions if you do not have a child over 5 years, OR if you have not spent time with your school-aged child(ren) during the past 6 months. **These questions are about your school-aged child(ren), ages 5 to 17 years.** **If you have more than one child 5 years and older, tick 'yes' if any question is true for ANY of your children.**	
6b.1. Does your child(ren) have any *serious* health or developmental problems? ☐ Yes ☐ No	• *Nature of problem(s)? Diagnosis? Prognosis?*

6b.2 **In the past 6 months**, has any professional (teacher, doctor etc.) been concerned about how your child(ren) was doing? ☐ ■ No	• *Nature of the problem(s)?*
6b.3 **In the past 6 months**, compared to how they usually are, do any of your children seem: a. more anxious/worried? ☐ Yes ☐ No b. more aggressive/angry? ☐ Yes ☐ No c. more sad/withdrawn? ☐ Yes ☐ No d. more defiant/disobedient? ☐ Yes ☐ No e. behaving in concerning ways? ☐ Yes ☐ No	• *Nature, history, severity of concerns?* • *Why do you think this is occurring?*
6b.4 **In the past 6 months**, did any of your children strongly resist seeing either parent? ☐ No	• *History and nature of the child's resistance?*
6b.5 Has your child(ren) *ever* heard or seen very angry disagreements or violence at home? ☐ No	• *Nature, history and current severity of exposure?*
6b.6 **In the past 2 months**, have any of your children missed more than 4 days of school? ☐ No	• *What led to the frequent absences?*

Domain 7. Managing as a Parent

Domain-specific notes

- High levels of parenting stress, harsh parenting and difficulty with warmth indicate a need for support, especially when a child's wellbeing appears compromised (Domain 6).
- See DOOR 3 for other follow-up tools and referral options.
- Review this domain in conjunction with risks on other domains; patterns and combined stressors are important in determining the best overall response.

DOOR 1: Parent Self-Report Items	DOOR 2: Example prompts for follow-up
If you have <u>not</u> spent time with your child(ren) during the past 6 months, please skip these questions and go on to the next section.	
Given all that goes on at these times, parenting can be hard work. Thinking about **the past 6 months**: 7.1 Was it difficult for you to know how your child(ren) was feeling? ☐ No ☐ Sometimes ☐ Often	• *Why do you think this happens? History, severity of the difficulty? Supports/ professional help received?*
7.2 Was it difficult to comfort and be warm with each of your children? ☐ No ☐ Sometimes ☐ Often	• *Why do you think this happens? History, severity of the difficulty? Supports/professional help received?*
7.3 Was it difficult to set limits and deal with problem behaviour? ☐ No ☐ Sometimes ☐ Often	• *Why do you think this happens? History, severity of the difficulty? Supports/professional help received?*

7.4 Was it difficult to support your child(ren)'s activities and interests? ☐ No ☐ Sometimes ☐ Often	• *Why do you think this happens? History, severity of difficulty? Supports/professional help received?*
7.5 Were you harsher toward your child(ren) than you wanted or meant to be? ☐ No ☐ Sometimes	• *Why do you think this happens? History, severity of behaviour? Supports/professional help received?*

The following questions are about your child(ren)'s safety, your safety, and your child(ren)'s other parent's safety. Working things out after separation can be stressful, and many people need support at this time. Some people need extra help to feel safe and be safe. Your practitioner will talk about this further with you. If you'd like any extra time to consider these questions, or help to answer them, your practitioner will be willing to assist.

Domain 8. Your child(ren)'s safety

Domain-specific notes

- Note carefully the client's openness and ability to discuss these issues.
- Note any disparity of facts against referral information.
- Immediate threats to safety require immediate follow-up including safety planning and may require rapid referral to specialist services. See DOOR 3 for further assessment tools.
- Mandatory reporting to the relevant child protection authority may apply (see DOOR 3).
- Abduction risks are higher when the threatening parent sees no value in the child's contact with the other parent, and when the child is under 5.

DOOR 1: Parent Self-Report Items	Door 2: Example prompts for follow-up
Consider all of your children, and tick 'yes' if any question is true for ANY of your children.	
8.1 **In the past 6 months**, did you have any concerns about your child's safety: a. when they were with their other parent? ☐ Yes ☐ No b. when they were with you? ☐ Yes ☐ No c. when they were in the care of any other adult (e.g. step-parent, other relative?) ☐ Yes ☐ No	• *What is the concern?* • *History, nature and severity of the concern?*
8.2 Has *anyone else* said they were worried about your child(ren)'s safety with anyone? ☐ Yes ☐ No	• *Who is concerned? What is their concern?*
8.3 Have any child protection reports ever been made about your child(ren)? ☐ Yes ☐ No a. Is there a current investigation into child protection matters? ☐ Yes ☐ No	• *History, nature, substantiation and current status of report(s)? Any current concerns not being addressed?*
8.4 **Since separation:** a. Has the other parent threatened or actually taken the child(ren), or kept them without consent, *far beyond* the agreed time? ☐ Yes ☐ No b. Have you threatened or actually taken the children, or kept them without consent, *far beyond* the agreed time? ☐ Yes ☐ No	• *History, nature and current severity of the threat?* • *Does the parent have foreign/dual citizenship?* • *Is the country covered by the Hague Convention (see Appendix 3 for list)?*

Domain 9a. Your safety

Domain-specific notes

- Note carefully the client's openness and ability to discuss these issues. Patterns of being dismissive, minimising, avoiding, or appearing overwhelmed, or fearful to talk are important to notice. Note any disparity of facts against referral information.
- If in doubt about comfort to disclose, a useful question is '*If you had ever been threatened/hurt, would you feel worried about telling someone?*'.
- Has the client spoken to a professional or authorities about any concerns?
- Immediate threats to safety require immediate follow-up, including safety planning, and may require further, coordinated referral to specialist services.

DOOR 1: Parent Self-Report Items	DOOR 2: Example prompts for follow-up
9a.1 **In the past year**, have you *in any way* been frightened of or concerned for your own safety because of the other parent? ☐ Yes ☐ No	• *What has happened?* • *History and current severity of concern?*
9a.2 Are you **now** *in any way* afraid for your own safety because of the other parent, or anyone else? ☐ Yes ☐ No	• *Who and what is causing the fear?*
9a.3 **In the past year**, has anyone else said they were worried for your safety? ☐ Yes ☐ No	• *Who and what was the concern?*
9a.4 If the other parent is disappointed with the outcome of this dispute, are you afraid that s/he might try to harm someone else or him/herself? ☐ Yes ☐ No	• *What is your fear about what might happen?*
9a.5 As a result of the other parent 's behaviour, have the police **ever** been called, a criminal charge been laid, or intervention/restraining order been made against him/her? ☐ Yes ☐ No a. Is there **now** an intervention/restraining order against him/her? ☐ Yes ☐ No	• *What happened?* • *Current status of order and any breaches?* • *Request copy of order.*
9a.6 **In the past year**, has the other parent: a. Followed you or watched your movements in a way that felt worrying (e.g. driving by or watching your home, being in the same place when s/he had no business there)? ☐ Yes ☐ No b. Tried to control you or acted in a very jealous way (e.g. controlling your money, where you went, who you saw)? ☐ Yes ☐ No c. Threatened your safety? ☐ Yes ☐ No d. Hurt you in a way that wasn't an accident or used force to get you to do something you did not want to do? ☐ Yes ☐ No	• *What happened?* • *History and current severity of concern?* • *Are you changing anything about your life as a result of these behaviours (e.g. taking a different route to work, not answering the phone or other more extreme solutions)?*
9a.7 Has the other parent *ever* threatened to or actually tried to hurt or kill him/herself? ☐ Yes ☐ No	• *History, nature, current severity of threat?*
9a.8 Does the other parent have access to a gun or other weapon? ☐ Yes ☐ No	• *What is the weapon? Where is it kept?*

9a.9 If yes to any of the above: Are any of these or similar behaviours by the other parent, becoming worse or more frequent recently? ☐ No	• *What is happening now?*

Domain 9b. Behaving safely

Domain-specific notes

- Note carefully the client's openness and ability to discuss these issues.
- Note any disparity of facts against referral information.
- Patterns of being dismissive, minimising, avoiding, or appearing overwhelmed, or fearful to talk are important to notice.
- References to entitlements or justified behaviours need to be considered carefully, with specific reference to any relevant cultural or religious factors.
- Immediate threats to safety require immediate follow-up, including safety planning and may require rapid referral to specialist services.

DOOR 1: Parent Self-Report Items	DOOR 2: Example prompts for follow-up
9b.1 As far as you know, has anyone expressed concern about the safety of your behaviour toward the other parent or towards your child(ren)? ☐ Yes ☐ No	• *Who and what is/was the concern?*
9b.2 If you are disappointed with the outcome of the dispute, would you consider hurting someone, or yourself? ☐ Yes/Maybe ☐ No	• *What do you think might happen?*
9b.3 As a result of your behaviour, have the police **ever** been called, a criminal charge been laid, or intervention/restraining order been made against you? ☐ Yes ☐ No a. Is there **now** an intervention/restraining order in place against you? ☐ Yes ☐ No	• *History, nature and current status of order?* • *Any breaches of safety/protection orders?*
9b.4 Would the other parent say that you have done any of the following things **in the past year**: a. Followed or watched his/her movements in a way that felt worrying to him/her (e.g. driving by or watching his/her home, being in the same place when you had no business there)? ☐ Yes ☐ No b. Tried to control him/her, or acted in a very jealous way (e.g. controlling his/her money, where s/he went, who s/he saw)? ☐ Yes ☐ No c. Threatened his/her safety? ☐ Yes ☐ No d. Hurt him/her in a way that wasn't an accident, or used force to get him/her to do something s/he did not want to do? ☐ Yes ☐ No	• *What happened?* • *History, nature and current severity of concern?*
9b.5 Do you think either the other parent or your child(ren) are afraid of you in any way? ☐ Yes ☐ No	• *Why do you think this may be the case?*
9b.6 Have things in your life *ever* felt so bad that you have thought about hurting yourself, or even killing yourself? ☐ Yes ☐ No If yes: do you feel that way lately? ☐ Yes ☐ No	• *Current thoughts about this? Prior attempts?* • *Do you have a plan about how you would do that?* • *What is the plan? (see Safety Plan form)*
9b.7 Do you have access to a gun or weapon? ☐ Yes ☐ No	• *What weapon? Where is it kept? Is it possible you would use this?*

Domain 10. Other stressors	
Domain-specific notes • Cumulative stress is a trigger for post-separation safety incidents. • Explore the effectiveness of supports the parent has in place. Consider what else you can assist them with, directly or by referral. • When multiple or severe stressors co-occur with risks on other domains, coordinated response by a network of services is recommended.	
DOOR 1: Parent Self-Report Items	DOOR 2: Example prompts for follow-up
Are any of these things happening **now**, and causing *major* stress for you?	
10.1 Being unemployed/under-employed ☐ Yes ☐ No	• *Would you like support with this?*
10.2 Financial difficulties ☐ Yes ☐ No	• *Would you like support with this?*
10.3 Property/asset settlement ☐ Yes ☐ No	• *Would you like support with this?*
10.4 Child support payments ☐ Yes ☐ No	• *Would you like support with this?*
10.5 Getting legal advice/representation ☐ Yes ☐ No	• *Would you like support with this?*
10.6 Housing problems ☐ Yes ☐ No	• *Would you like support with this?*
10.7 Transportation problems ☐ Yes ☐ No	• *Would you like support with this?*
10.8 Feeling lonely/isolated ☐ Yes ☐ No	• *Would you like support with this?*
10.9 Feeling harassed by the other parent's family/new partner/other ☐ Yes ☐ No	• *Would you like support with this?*
10.10 Illness/sickness/physical disability ☐ Yes ☐ No	• *Would you like support with this?*
10.11 Problems in your neighbourhood with safety, crime, drugs etc. ☐ Yes ☐ No	• *Would you like support with this?*
10.12 Are there any other stressors that are a *serious* problem for you at the moment? ☐ Yes ☐ No if so, please tell us what they are.	• *Would you like support with this?*

Practitioner's Action Plan
DOOR 2: Response Planning

Client ID .....

Practitioner .....

Date .....

A. In response to the identified wellbeing and/or safety risks, I have agreed to. . . . . Possible actions include:

- ☐ No action required
- ☐ Discussion with supervisor/manager
- ☐ Follow-up phone call to client
- ☐ Contract for further assessment in-house
- ☐ Contract for external referral/s
- ☐ Dispute resolution (FDR) to proceed as usual
- ☐ Dispute resolution (FDR) to proceed with safety accommodations
- ☐ Dispute resolution (FDR) contra-indicated/not to proceed at this time
- ☐ Complete a safety plan with the client
- ☐ Report to relevant authority
- ☐ Other response

B. In response to the identified wellbeing and/or safety risks, the client has agreed to. . . . . Possible actions include:

- ☐ No action required
- ☐ Undertake further assessment
- ☐ Pursue social and community supports
- ☐ Follow up any external referral/s given
- ☐ Make available relevant documents (e.g. intervention orders)
- ☐ Safely store and implement the relevant safety plan
- ☐ Inform agreed support person/s about the identified risks/safety plan
- ☐ Report to relevant authority
- ☐ Other response

- ☐ Informed consent to share information obtained
- ☐ Informed consent to share information not required

Safety Planning: Family Violence Risks

(see DOOR 3: Resources for Responding to Risk, page 61 for details)

A guide for discussion with the client

Example introduction:

From what you have been telling me, I am concerned about your safety. I would like to clarify some ways we could increase your safety. It is often best to plan how you would cope with a risky situation at a time when you are calm and supported. I'd like to begin by talking through with you some specifics about the situations that may be risky for you, and the supports we could put in place to help keep you and your child(ren)safe.

The situations of risk

- *What sorts of situations might occur in the next day/week that would put your safety at risk and/or make you feel afraid and unsafe?*
- *What situations will place you into contact with XX (the person you are afraid of/the person who has hurt you), or are likely to prompt an aggressive reaction from him/her?*
- *Do you have access to a phone – (mobile) and transport?*

Identify supports and action

- *What can and will you do to maximise your safety in these situations? (e.g. ways of avoiding these situations, informing supportive friends and family, informing the police, having others around, being in a public place, leaving – planning where to go and how to leave safely).*
- *Are there any trusted people who could help you deal with these situations?*
- *Do you know about any services that can assist you? Would you like ideas about that?*
- *Do you need help making contact with these services or these people?*
- *What else can I do to help you with this?*

Encourage preparation

If you needed to leave suddenly, what sorts of things would be useful to have discretely packed (where is a safe place to keep them), ready to take with you? Examples are:

- *Passports/Identification, Medicare details, Banking/financial details*
- *Phone, Car keys, Address books, Medication, Sentimental items*

In working with a CALD person, discuss the following questions with the client:

- *What would you do if this was occurring in your country of origin?*
- *Where would you go for help? Who would you take with you?*
- *What would you expect to happen?*
- *What do you believe about why this is happening?*

Documentation

- *Please keep an accurate record of the situations that happen, that make you feel afraid or worried about your safety. Record dates and times accurately.*
- *Keep this safety plan and your record safe and private. Where will you keep them?*
- *I will keep this safety plan filed here for you too.*

☐ Informed consent to share information obtained

☐ Informed consent to share information not required

Safety Planning: Suicide

A guide for discussion with the client

(see DOOR 3: Resources for Responding to Risk, page 61 for details)

From what you have been telling me, I am concerned about your safety. I would like to discuss ways to increase your safety. It is often best to plan how you would cope with a risky situation at a time when you are calm and supported. I'd like to talk with you some more about this now.

Is there a current plan, and who knows about the risk?

- *How often do you think about hurting or killing yourself?*
- *Do you have a plan about how you would hurt or kill yourself?*
- *Is anyone aware of how bad you feel, and that you have considered killing yourself?*
- *Do you feel safe to go home today?*
- *How would you keep yourself safe?*

Identify immediate safety and supports

- *Are there any people you know and trust who could help you deal with this?*
- *Do you know any services that can assist you? Would you like ideas about that?*
- *Do you need help making contact with these services or these people?*
  (If there is any doubt) Because I believe you may not be safe at the moment, I will notify a professional/one of your support people myself, today.

Documentation

- *The actions the client has committed to*
- *The actions the practitioner has committed to*
- *Note the professional/s to whom you are referring or making a notification.*

☐ Informed consent to share information obtained
☐ Informed consent to share information not required

Consent Form

Client Consent for Sharing of Information

To ensure that you (and your children) receive the best service possible it is sometimes helpful for us to exchange information with other services outside our own, such as your doctor, a therapist, your child's school or counsellor, or any new service we refer you to.

In signing this form, you give permission for your practitioner (as specified) to contact the professionals listed below, to share information from the DOORS screen, and to exchange any other information that will assist us in helping you. This consent is valid for 12 months from the date of signing. You may withdraw consent in writing at any time.

I give my consent for my DOORS information to be forwarded to the professional/ organisation listed below, and for other information exchange between these professionals for the purposes of assessment, case management and referral.

Name of client (print): .....

Date of birth: ...../..... /.....

Address: .....

.....

.....

I give my permission for (name and service): .....

to exchange information for the purposes of: .....

.....

with the following professional/organisation: .....

Name and address: .....

.....

.....

Client signature: ..... Date: ...../..... /.....

Practitioner signature: . ..... Date: ...../..... /.....

The DOORS Software User Guide

The DOORS software provides consistent, evidence-based information from the client's response in the shape of a tailored report that can act as a guide for further enquiry and that links to additional resources for follow-up. The relevant decision makers in any organisation will determine how the DOORS software will be integrated into their everyday practice. The purpose of this guide is to run through the practicalities of using the software.

System Requirements

The DOORS software only operates on Windows operating system. It is a Microsoft Excel spreadsheet, and requires Microsoft Office 2007 or later software to run. The DOORS software also requires Adobe Reader, which is available for free download (http://get.adobe.com/reader).

Notes about organisational use

Due to each individual organisation having their own procedures, policies and software, in order to implement the DOORS software efficiently, organisations may need to consider:

- Writing a step-by-step guideline on how to download and save the DOORS software template that fits their organisational procedures
- Naming convention about how to save the software for each client
- Selection of password for use within organisation or program.

Preparation

Preparation Step 1: Download and save the DOORS software from the website to your computer

1. Create a dedicated DOORS folder on the computer(s) from where you will access the software
2. Click to download the software template
3. A prompt will appear and to ask you to 'open' or 'save' the document
4. Choose 'save' and then select your dedicated DOORS folder and save the software template to this folder
   - **Note:** This saved file will act as the **Master file** of the DOORS software on your computer.
5. Once the DOORS software template has been saved, you do not need to repeat this process again.

Important notes:

- Make sure you have chosen the **dedicated folder** you have created for DOORS.
- Before starting, choose your client Reference/ID and password in line with your organisational use.

Preparation Step 2: Copy and rename the DOORS

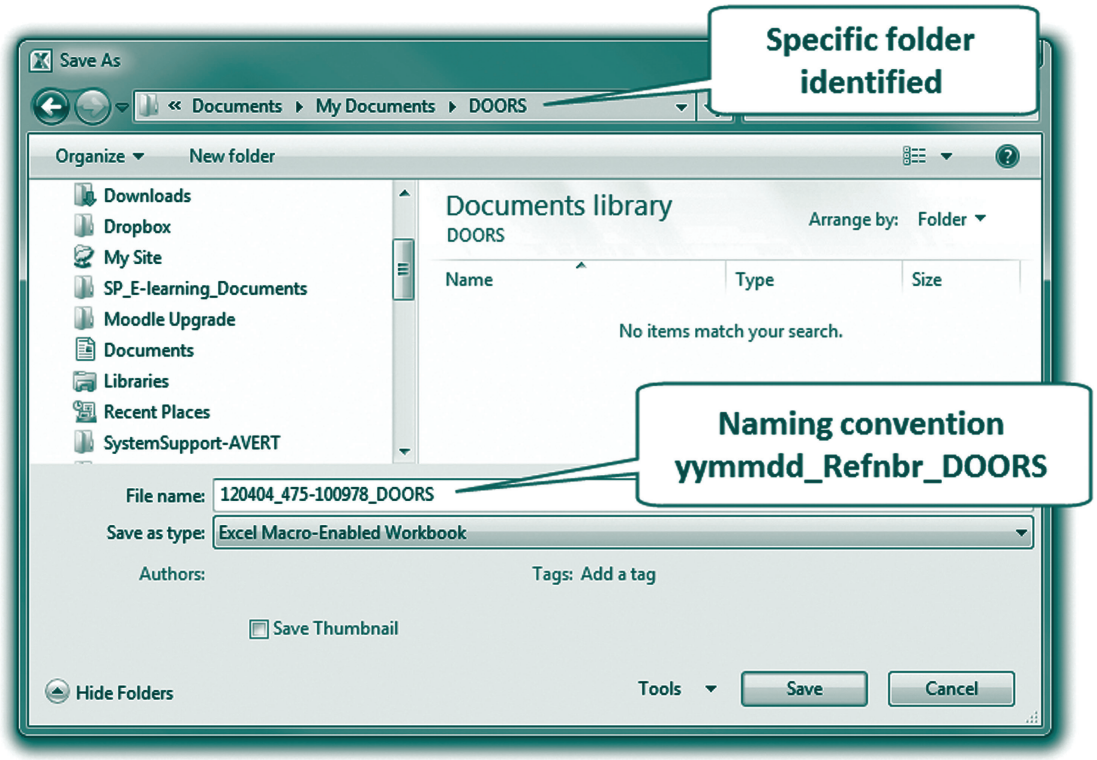
A new copy of the program needs to be crea
to do this every time you open the **Master file**.

1. Go to the folder where you saved the Master file of the DOORS software and double-click it.

You may see the following Security Warning message:

Click the "Enable Content" button to enable Macros. This process might appear differently depending on your version of Microsoft Excel. You will need to enable Macros every time you open a DOORS file.

2. A pop-up window will appear asking you to choose a file/folder location to which you will save the automatically created file. Highlight the default file name and type in a new name.



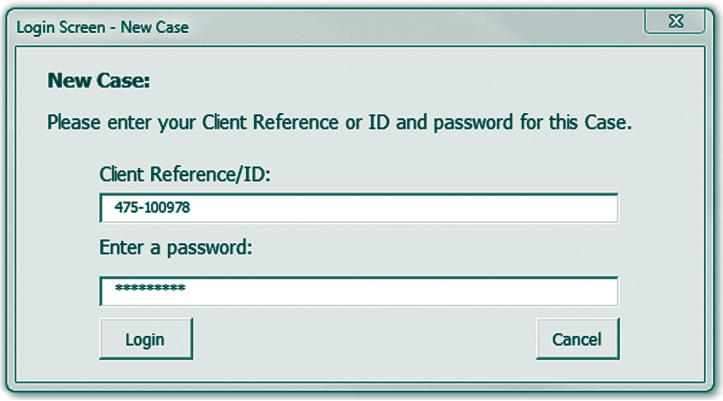
Note: This file has now been saved as your **unique file** for the client.

Preparation Step 3: Set up the unique file for the client

1. Create a Client Reference/ID number and password.

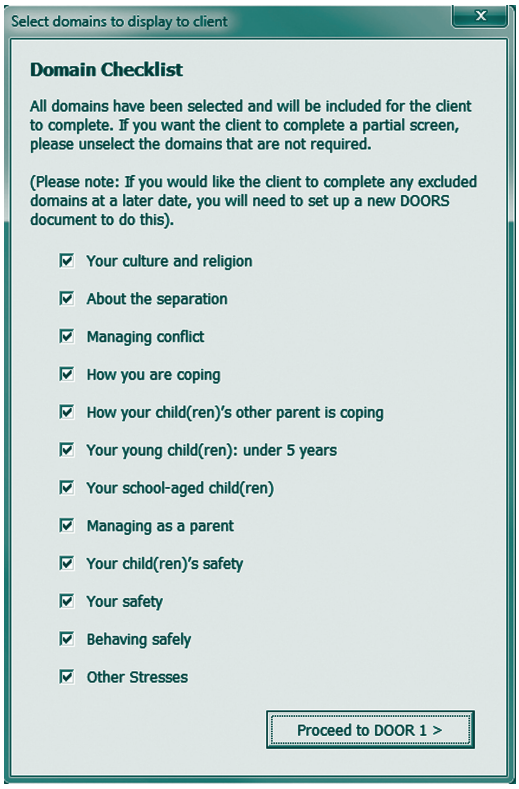
Important notes:

- Passwords are advised not to be identical to the Client Reference/ID
- Passwords cannot be changed after logging in.



2. The next step is to select the Domains that you wish to include in the client screen. **By default, all domains are selected**. Keep in mind that if you wish to expand the selection in future, you will need to create a new DOORS document to do so.

When you are satisfied with the domains selected, click the "Proceed to DOOR 1" button at the bottom.



You will be taken to the opening screen of the Parent Self-Report. You can click the black SAVE and Close button to exit the DOORS document.

Preparation Step 4: Make the DOORS document available for the client

There are a number of ways you can make the DOORS document available for your client to complete depending on how you or your organisation decides to integrate the DOORS program into your existing procedures.

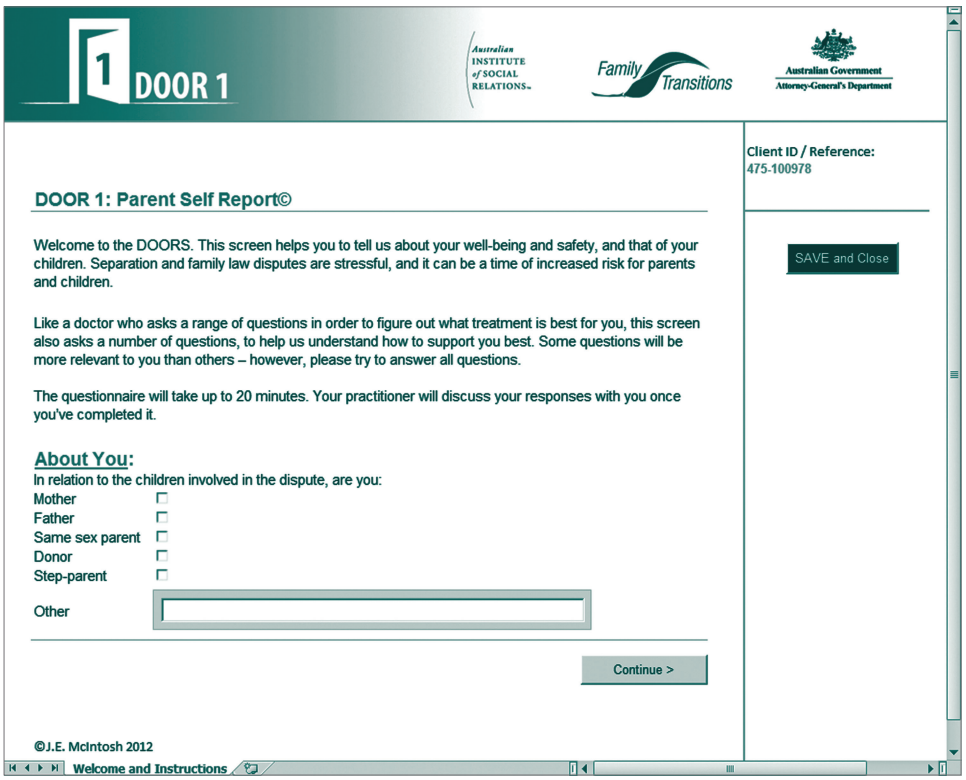
Recap of key steps

- Each time you start a new client, use your original DOORS software **Master file** and follow the instructions as above.
- The DOORS will automatically create a new copy of the program for every client when opened from the DOORS software **Master file**.
- As stated above, ensure that you choose a dedicated folder and that you save to this folder every time.
- Each client will need their own Client Reference/ID and a password. (Passwords can be the same to enable access of file by other practitioners; please discuss what is appropriate for you within your organisation).

DOOR 1: Parent Self-Report

When clients are ready to complete DOOR 1, the DOORS document should be open, ready for them to fill in.

PLEASE NOTE: If you suspect there may be any barrier to a client being able to successfully complete the DOORS document, such as physical or cognitive impairments, literacy problems or poor English comprehension skills, you or someone from your organisation should read the questions to the client and record the responses on the client's behalf.

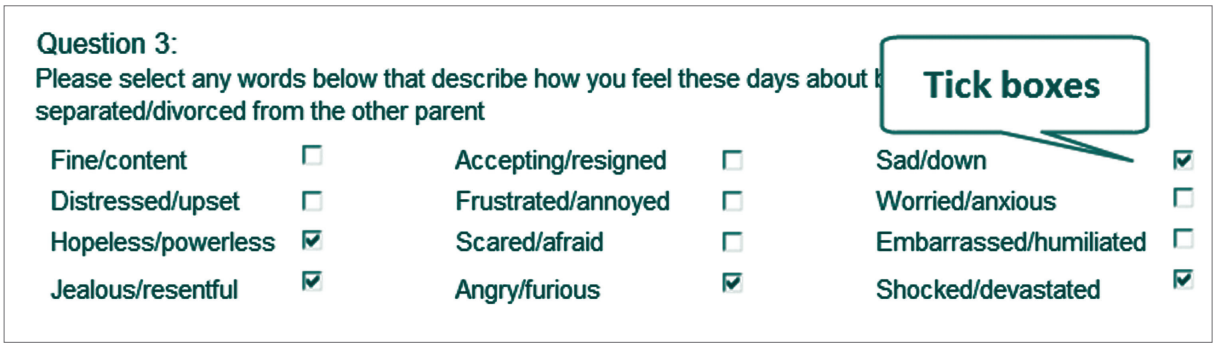


Question types

There are three main methods for clients to enter information reflecting types of question:

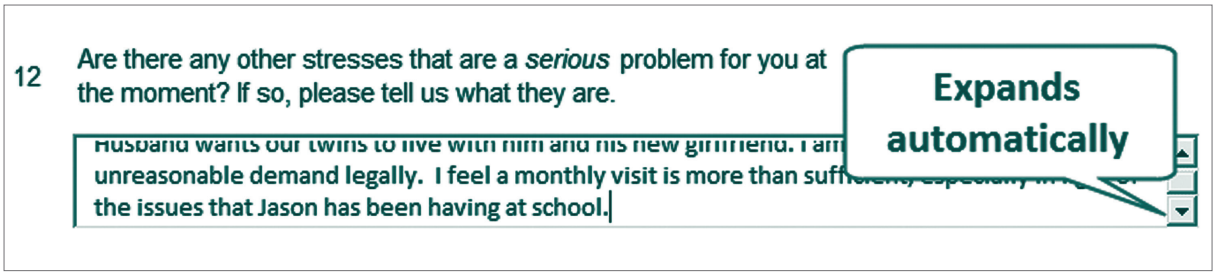
1. Tick box

"Tick the box" questions require the client to choose one or more answers and respond by clicking the empty box(es) next to the relevant response(s).



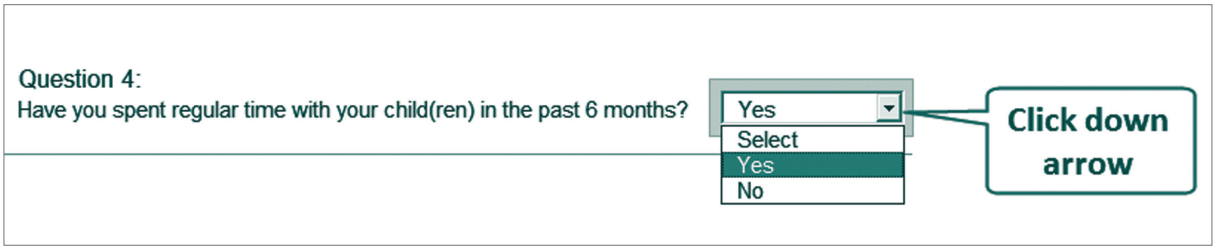
2. Fill in the blanks

There are just a few "fill in the blank" questions and one open-ended question that occurs near the end of DOOR 1. To insert a response, the client simply clicks the empty box next to the question and types in their answer. For the open-ended question that may require a lengthy response, the box will expand to accommodate more text.



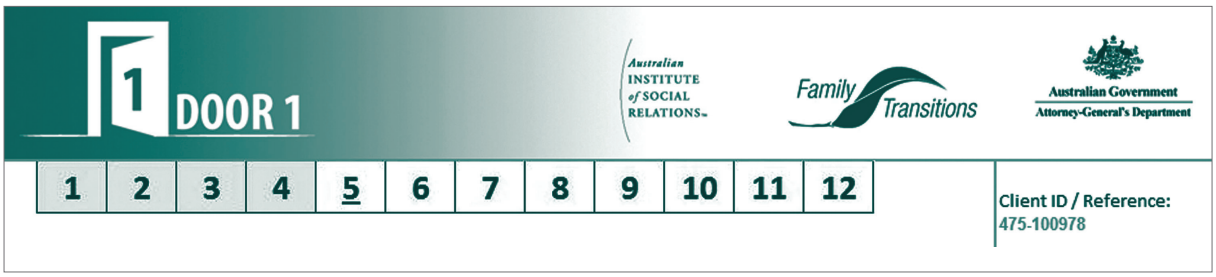
3. Multiple choice

This will usually be a "Yes/No" question. To choose an answer, the client clicks the down arrow and selects an answer from the drop-down menu.



Progress bar

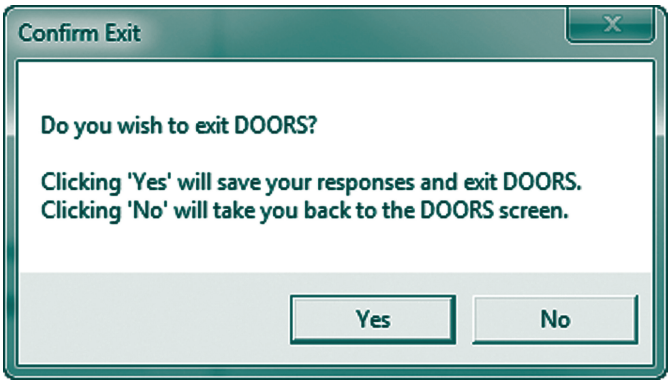
As clients work their way through the DOOR 1 Self-Report form, a progress bar indicates how far into the process they are and how much is left to complete.



Saving in mid-session

If for any reason a client needs to stop in the middle of filling in the client screen, they can click the "SAVE and Close" button.

The client will be asked to confirm that action. They simply click the "Yes" button to save and exit the document.



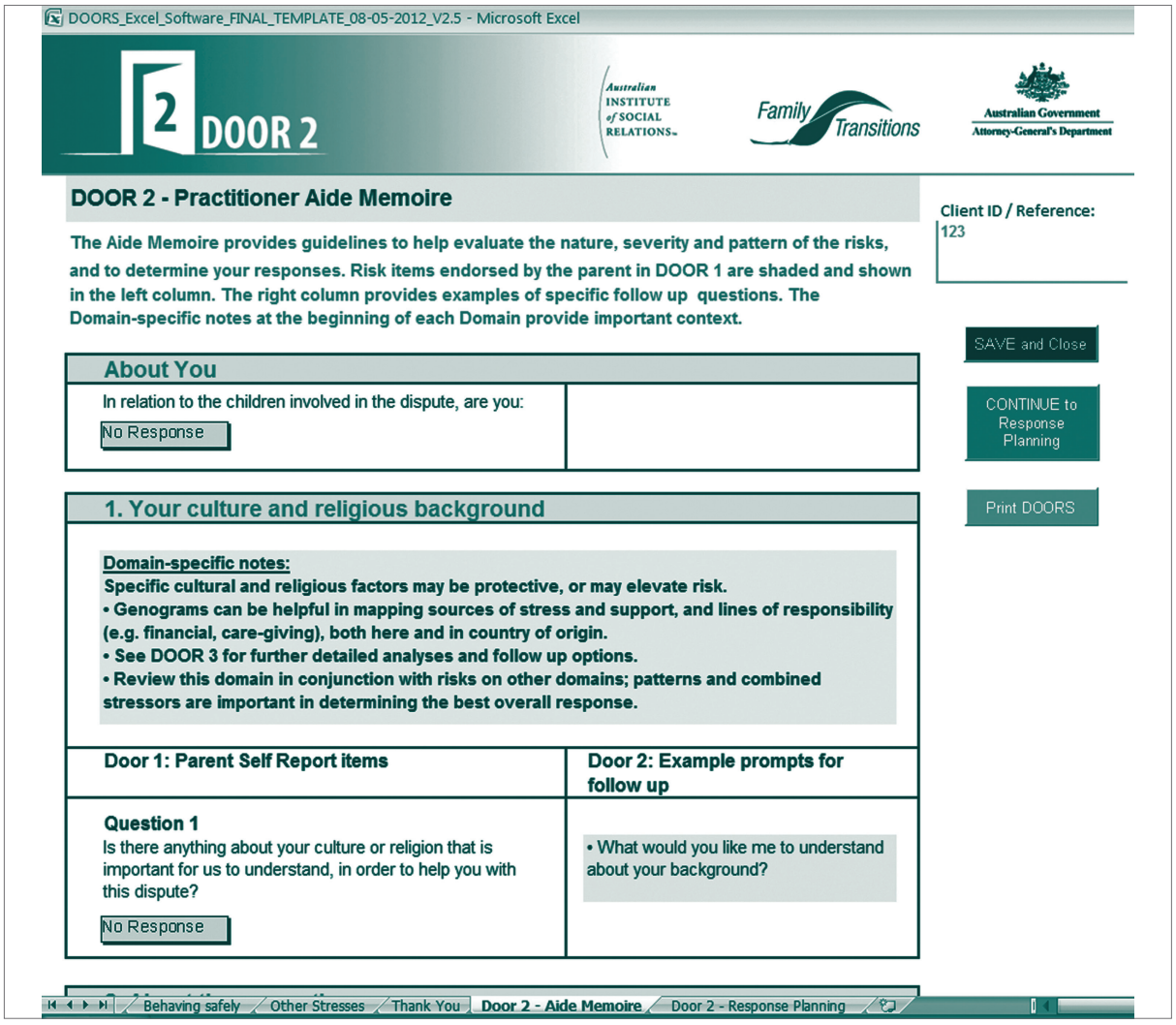
When you or a member of your staff enters the Client Reference/ID and password to allow the client back into the document, the client will be taken to the screen they finished on and can resume entering information where they left off.

Completion

When the client has finished entering information, they "SAVE and Close" the document.

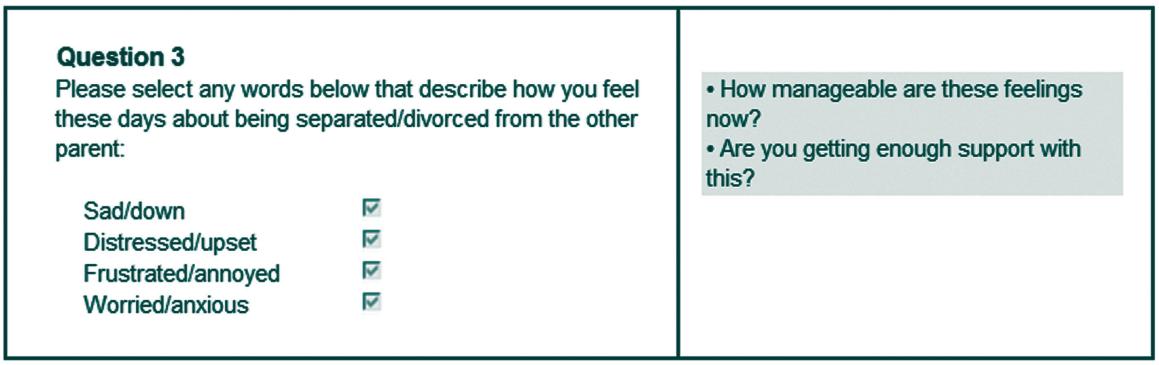
Using the DOOR 2 Practitioner Aide Memoire

The DOOR 2 Practitioner Aide Memoire report opens with notes explaining its purpose and how best to use it.



The report organises the answers the client provided in DOOR 1 into domains and provides discussion or guidance advice at the start of each domain.

The report also provides specific prompts next to the client's responses to help you as a practitioner to draw out additional information.



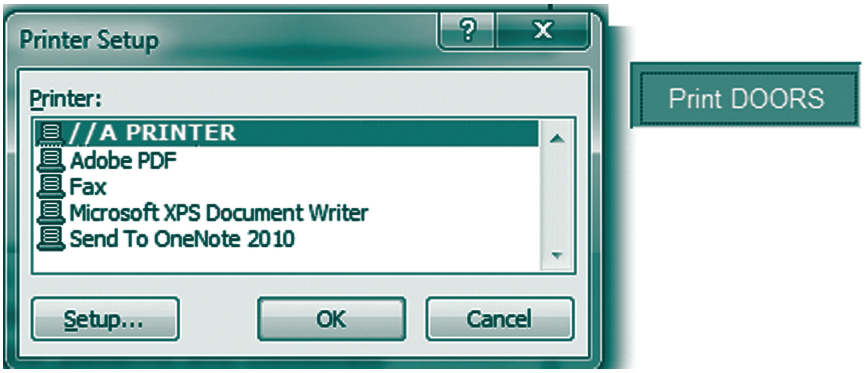
Please note that additional information can only be added once the DOOR 2 Aide Memoire has generated the DOOR 2 Response Planning (see page 58).

You will now see that two new buttons have appeared under the "SAVE and Close" button.

If you wish to print the report to refer to during your face-to-face client interview, click the "Print DOORS" button.

You can also refer to the report straight from your computer screen; however, you cannot enter any further notes into it.

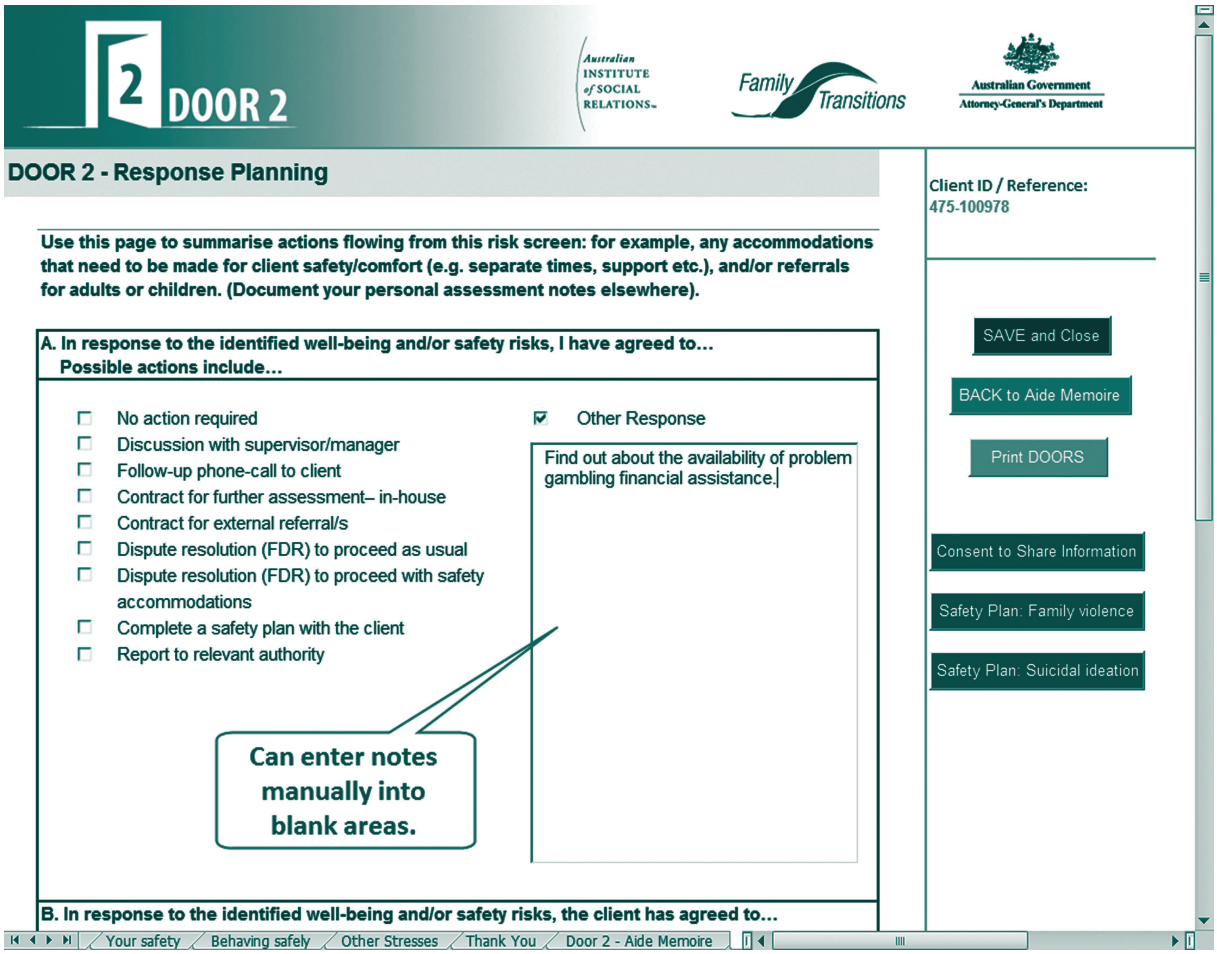
When you click the "Print DOORS" button, you will be asked to select a printer. Select your printer from the list and click the "OK" button. Clicking the "Setup" button allows you to customise how your printer prints the document.



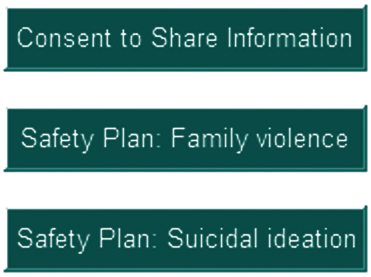
Print the report as you would any other confidential document. The resulting document will include the DOOR 2 Practitioner Aide Memoire and the Response Planning screen.

DOOR 2: Response Planning

The Response Planning screen allows you to enter notes on screen. When you print the DOOR 2 Aide Memoire, the Response Planning information is also printed.



Included on the Response Planning page are links to three PDF documents that will open in Adobe Reader when clicked on.



Consent to Share Information

The "Consent to Share Information" button opens a form that needs to be printed out and signed by the client in order to grant the practitioner the right to share client information with organisations listed on the document.

Safety Plan: Family violence

The "Safety Plan: Family violence" document is designed to act as a guide for practitioners when discussing management of any family violence risks that emerged from the Parent Self-Report (DOOR 1) and resulting discussion.

Safety Plan: Suicide

The "Safety Plan: Suicide" document is designed to act as a guide for practitioners when discussing management of any suicide risks that emerged from the Parent Self-Report and resulting discussion.

DOOR 3: Resources for Responding to Risks

Using DOOR 3: Responding to risks

As emphasised throughout this handbook, response to risk involves professional judgement. The DOORS system is designed to support detection of risk factors and provide guidance for interpretation of the nature and urgency of the risk and appropriate responses. Without a common framework for identifying risk, services and practitioners are more likely to work in isolation. Through a common framework, coordination within the family law system is facilitated, thereby avoiding duplication in services, misunderstanding about what has or has not been identified, and disjointed safety responses for families.

The ability to respond effectively is based on four key factors.

1. Personal experience and individual skill: that is, the ability to engage clients in discussion, interpret the interplay of key historical and recent risk factors, assess the need for follow-up, consider all options and take the most appropriate actions
2. Shared values in the workplace and a culture supporting risk screening practices
3. Well-established networks and effective multidisciplinary partnerships that enable relevant and realistic responses to individual clients and families
4. A common language and shared understanding of risk and its management identification practices.

Endorsing the need for universal screening practices does not of course equate with the idea that a universal response to safety risks is possible or desirable. A 'one size fits all' approach significantly undermines effective collaboration because it fails to recognise the unique dynamics of individual families and the range of responses that may be required. While the DOORS encourages a tailored response to individuals who are either at risk from a family member or who present a risk to their ex-partner and family, the framework necessarily stops short of recommending what specific responses should be.

Contracting with clients about what they are prepared to do and transparency about what the practitioner intends to do are important aspects of effective engagement in the interest of safety. Through these forms of contracting, the differentiated yet mutually supportive responsibilities of practitioners and clients indicate the shared responsibility involved in managing risk.

Thresholds

Given the multi-faceted nature of family violence, establishing thresholds of concern is important. Practitioners strive not to over-include families in a risk bracket, so as not to devote unnecessary time and effort to solving difficulties or ambit claims that may be minor. Equally, underestimating risks is possible, leaving individuals distressed or unsafe. While the DOORS enables identification of risks, sound interpretation of the severity and veracity of claims about potential harm is crucial. Differentiating the existence of isolated risk from the imminence of urgent and escalating risk patterns is key to ensuring the system is not burdened by the sheer weight of numbers requiring specialised follow-up.

The following table depicts a threshold of concerns and differentiates the responses and actions required.

Table 4. Levels of risk and response

A: ISOLATED LOW-LEVEL RISKS Recently low level or 'cool' risks evident for client and/or their children. Low or moderate general wellbeing risks; isolated and clearly situational risks to safety which are adequately managed and not likely to become dangerous as the family law process progresses; client and/or their children is supported. The pattern of risk across the domains does not amount to a need for immediate action.	■ Comment on minor risks and consult client about additional supports or contacts they or their children may find useful ■ Information brochures, referral contacts, education program and /or facilitated referral for relevant support may all be appropriate ■ Documentation	■ Interventions to assist wellbeing ■ Follow-up phone call with client if a referral is made for client or children
B: MODERATE PATTERN OF RISK Recent moderate or 'warm' risks evident for client and/or their children. Includes a clear pattern of wellbeing risks to parents or their children, with possible escalating risk as family law processes continue. Usually involves concomitant risks, where adequate assistance is not already in place, and risks are likely to intensify without support.	■ Discussion with client ■ Decision to follow up or refer for additional assessment ■ Contract actions to be taken by both practitioner and client ■ Provide information and relevant contact details for client to act on ■ Consider accommodations needed for dispute resolution processes to ease strain and risk ■ Safety planning may or may not be necessary ■ Consent for information sharing ■ Documentation	■ Further assessment (see DOOR 3 resources) or referral for assessment ■ Interventions to assist wellbeing and to allay safety risks ■ Case management responses include consultation with or referral to other professionals (e.g. client's GP, mental health specialist, children's services, CALD or family violence specialists) ■ Strategies to remain engaged with persons at risk of being unsafe and/or behaving unsafely ■ Notification for weapon removal (check state-specific police policies) ■ Follow up with client post-referral

Nature of Risk as identified by DOOR 1 and verified through DOOR 2	**Immediate Response** congruent with level of concern held by practitioner	**Follow-up Actions** congruent with level of concern held by practitioner (see DOOR 3 resources)
C: ACUTE AND SEVERE RECENT RISKS, ISOLATED OR PATTERNED Recent acute or 'hot' risks evident for client and/or their children. Often involves a pattern of historical risks, recently increasing in intensity where adequate assistance is not in place and risks are recent. May include recent-onset acute mental health issues. Includes anything that requires a notification to the relevant authority.	■ Appropriate immediate discussion (determining any additional risks to the client, others or self in so doing) ■ Contract actions to be taken by both practitioner and client ■ Safety planning involving cross-agency strategies for keeping victims safe ■ Notification of relevant authorities may need to be immediate ■ Consent for information sharing (not required for notifications of crimes or imminent risks to adult or child safety) ■ Provide information and relevant contact details for client to act on ■ Documentation	■ Ensure rapid, coordinated multidisciplinary responses, including family violence*, mental health** and legal specialists ■ Sustained engagement with people at risk ■ Sustained engagement with people who use violence or pose a safety risk to others. ■ Notification for weapon removal (check state-specific police policies) ■ Follow up with client post-referral

*Most states in Australia have family violence frameworks in place to guide local responses to safety concerns.

**The DOORS strongly encourages attention to wellbeing risks for adults and children that may or may not be associated with recent family violence risks.

- The Australian Psychological Society (www.psychology.org.au) has many relevant resources and links to accredited adult and child psychologists.
- The Australian Association of Social Workers has links to accredited mental health social workers (www.aasw.asn.au).
- Family Relationships Services Australia can help to locate a relevant service (www.frsa.org.au).
- Family Relationships Online allows families to find out about a range of services that can assist them to manage relationship issues (www.familyrelationships.gov.au).

See Directory of State-wide Services (pp. 90-94)

Safety planning with at-risk clients

Safety planning, whether for family violence or suicide risks, is a structured process undertaken with an at-risk client, aimed at de-escalating risk and maintaining the safety of the client, children and others. It is usually undertaken with a potential victim when risk is clear and current.

Safety planning is a collaborative process of developing strategies that are consistent with what is possible for the client in terms of practicalities and the client's capacity to act in a self-protective manner. Some clients will need more assistance with and/or direction about making plans for safety than others. Planning always needs to do more good than harm. A good safety plan increases protection from further harm (e.g. physical or sexual assault) by putting strategies in place that reduce access for perpetrators, decrease danger and increase the client's capacity to take action.

In developing a safety plan, the practitioner should consider the following questions[4]:

- What is the safety issue?
- How severe, potent and recent is this issue? How restricted has the victim's life become?
- Is there an active or 'hot' risk? How does the client perceive the risk(s)? How do the client's supporters perceive the risk(s)? Clients may not perceive a risk, but others might. Does anyone else know about the risk(s)?
- Who will be affected by the risk(s)?
- What can be done to alleviate danger to the client and increase their freedom to make choices and take action? If something can be done, what risks might increase or decrease, and would any actions create new risks?
- Does the client have any supports available? If yes, are they adequate?
- Does anyone else need to be notified (e.g. police)? If yes, when and how?
- Does anything need to be put in place urgently today (e.g. supporters or police contacted to escort client from the appointment)?

Contracting for action

Practitioner and client should reach an agreement about their mutual and individual responsibilities and subsequent actions pertaining to the safety concern(s).

Specific actions relevant for family violence risks and for suicide risks are given below, and are part of the DOOR 2 automated report.

Revising and updating plans

As with the concept of continual risk assessment, it is necessary that safety plans are revised over time. Serious suicidal ideation and separating from intimate relationships are not single events — they are processes. Risk for some clients elevates as time goes on.

[4] Information in this section has been adapted from the Victorian Common Risk Assessment Framework (CRAF). For more specific information, please refer to the CRAF (2007, p. 77).

Safety planning for family violence risks: a guided conversation

An effective safety planning discussion can be formed along these lines:

From what you have been telling me, I am concerned about your safety. I would like to work out with you some ways we might be able to increase your safety. It is often best to plan how you would cope with a risky situation at a time when you are feeling calm and supported. Thinking through your options before unsafe situations occur can really assist you when and if they actually happen. I'd like to talk with you more now about your safety.

Ascertain the situations of risk

- *What sorts of situations are likely to occur in the next day/week or so that would put your safety at risk and/or make you feel afraid and unsafe?*
- *What are the situations that will place you in contact with XX (the person you are afraid of/the person who has hurt you), or are likely to prompt an abusive reaction from XX?*

Taking action

- *What would help to create the greatest context of safety for you?*

Suggestions for action include:
- Exploring ways of avoiding certain situations
- Informing supportive friends and family (support may be required to overcome possible feelings of shame, blame, guilt in disclosing their distress to others)
- Informing the police (ask a woman how she feels about calling the police and whether she has done it in the past; normalise and emphasise the necessity of this action)
- Having others around; being in a public place
- Leaving — planning where you will go and how to leave safely (see next page).

Identify supporters

- *Are there any people who would be available to help you deal with these situations?*
- *In what way can these people support you?*
- *Do you know about any services that can assist you?*
- *Do you need help making contact with these services or those people you have identified as supportive?*
- *Do you have access to a phone (mobile) and transport?*

Encourage preparation

If you needed to leave suddenly, what sorts of things would be useful to have discreetly packed ready to take with you? What might be a safe place to keep them?

- Passports/identification papers
- Medicare details
- Banking records/financial details
- Phone,
- Car keys
- Address book
- Medication
- Sentimental items, photos

If working with a CALD client, discuss the following questions with them:

- *What would you do if this was occurring in your country of origin?*
- *Where would you go for help? Who would you take with you?*
- *What would you expect to happen?*
- *What do you believe about why this is happening?*
- *Are there particular community organisations here in Australia that should be notified of your difficulties?*
- *Are there 'safe houses' within your community that would be available to you?*

Documentation

- *Please keep a detailed record of any situations that make you feel afraid or worried about your safety.*
- *Keep this record safe and private. Where would you keep it?* (Brainstorm with the client how they might do this.)
- *Be sure to write down accurate dates, times and descriptions of situations. This helps with police reports and also helps you to notice patterns.* (Restate the key elements of the safety plan generated with the client and keep a record of it for the client.)

Safety planning: suicide

The Australian Psychological Society provides the following advice:

> *People at risk of suicide are often desperately trying to make sense of their situation, or to change it in some way. They frequently feel isolated and unheard. Showing your concern and giving time to listen to them is important in reducing the sense of aloneness and desperation. Supportive action is needed to ensure that they are able to improve their situation and reduce the concerns in their life.*

Below is a list of basic management strategies for professionals and for family and friends of the person. They are adapted from the websites:

www.psychology.org.au/community/suicide
www.bipolarworld.net/Family&SOS/suicide_safety_plan.htm

Guidelines for family law practitioners when suicidal ideation is detected:

1. Listen carefully. Keep calm and be supportive. Let them know it is okay to talk about things that may be painful. Establish an expectation that they can be helped.
2. Refer them for professional mental health help if appropriate. The APS Psychologist Referral Service (1800 333 497), their GP, or community mental health centre, are good places to begin.
3. Have them make a list of trusted friends to contact (in order of priority) if suicidal thoughts begin to intrude. Contract with them to inform these people and enlist their support.
4. If the client will not commit to doing this themselves, offer to contact these people yourself (ideally with the client present), and obtain consent from the client to do so.
5. If risks are judged to be imminent, you do not need to obtain consent of the client to discuss the risks with medical or mental health professionals, hospitals or police, or to alert trusted family or friends of the client.

Advice for practitioner to give to client's support network

1. Have a supportive conversation with the person at risk. Acknowledge the problem but negate suicide as a solution. Instil hope and offer support.
2. Recommend attending a mental health professional and if needed, accompany them there.
3. Support them in problem solving and in planning for supportive action.
4. Support them to avoid drugs and alcohol during this time. These may need to be removed from the home.
5. When risks are high, locate potentially life-threatening items in the house and car and dispose of them. This includes all means of committing suicide impulsively: guns, rope, sharp knives, large amounts of pills, and so on.
6. Learn to recognise the earliest signs of suicidal thinking. Many people who take their life give clear indications of their intention — take any statements seriously. Be suspicious if the person makes a point of saying goodbye or giving away possessions.
7. Know when its time to take them to the hospital or call the emergency mental health team, and act.

Useful contacts:

- APS Psychologist Referral Service: 1800 333 497 or see APS Psychologist Referral Service
- Kids Help Line: 1800 551 800 or visit www.kidshelpline.com.au
- Lifeline: 13 1114 or visit www.lifeline.org.au
- Local emergency mental health team

Child-specific safety planning

The questions that practitioners should consider for general safety plans also apply to child-specific safety planning. However, additional steps might need to be taken when a child is involved. Specifically, child abuse and child abduction are two major safety concerns commonly found in divorced/separated families. The safety plan for potential child abuse should include mandatory reporting (see Appendix 1 for further details on the various states' requirements for reporting child abuse, pp. 192-194). For managing abduction risk, see the DOOR 3 section on 'Child Abduction' (p.129) for further information.

Practitioners should consider whether the child is currently supported by any other professional (e.g. psychologist, counsellor), and, in the absence of professional supports, explore some options with the parent and provide them with the appropriate referrals. As with the general safety plan, both the practitioner and client would then form an agreement on their individual responsibilities and subsequent actions pertaining to the child-specific safety concern.

Further response considerations:

Safe processes in family dispute resolution services

If a practitioner deems it appropriate to see a client after identifying risk issues, s/he should also consider ways in which the professional process may need to be changed to accommodate the identified safety concern(s). The MASIC (Holtzworth-Munroe, et al., 2010)[5] provides a series of questions for family dispute resolution practitioners in determining how to work with adults who have identified intimate partner violence, within single-session family dispute consultations.

1. If you think the case is not appropriate for family dispute resolution, what are your concerns?
2. If you determine not to mediate nor to terminate family dispute resolution because of concerns about intimate partner abuse or violence, are there any ethical constraints and/or any safety concerns in how you should communicate this decision with the parties and/or the court?
3. If you think the case may be mediated, should any of the following accommodations be implemented, and why:
    - Parents to be in separate rooms at all times (shuttle family dispute resolution)
    - Parents to be in separate rooms pre and post family dispute sessions and only together in a joint session in the presence of the practitioner(s)
    - Staggered arrival and departure times for parents
    - Support person necessary (for which parent(s)?)

[5]Holtzworth-Munroe, A., Beck, C. J. A., & Applegate, A. G. (2010). The Mediator's Assessment of Safety Issues and Concerns (MASIC): A screening interview for intimate partner violence and abuse available in the public domain. *Family Court Review*, 48(4), 646-662. Doi: 10.1111/j.1744-1617.2010.001339.x. Requests for the MASIC should be sent to Amy Applegate (apa@indiana.edu), or can be obtained in the Appendix of the article. The article is available through a Google search of "Mediator's assessment of safety issues and concerns".

- Lawyer necessary (for which parent(s)?)
- Referral to family violence service, program or shelter
- Family dispute resolution at secure facility required, e.g. presence of security cameras/ guards
- Parent needs escort to/from car
- Parent needs way to leave the building without being seen by the other parent
- Parents to appear for family dispute resolution on separate days
- Telephone or on-line family dispute resolution
- Other accommodation

Other extended frameworks would enlist education, counselling and support services prior to and throughout a dispute resolution process. The Australian Coordinated Family Dispute Resolution Pilot is an example of a systems response to supported family dispute resolution with families with a notable history of violence. This is a current pilot, now operating in the field across several sites. The model is a case-managed process that has four phases of continuing risk assessment involving a range of professionals with defined roles and responsibilities:

1. Participation in a specialist family dispute resolution process
2. Advocates for each client
3. Tailored follow-up
4. Regular case management meetings

This pilot, announced by the Attorney-General in March 2011, is being evaluated by Australian Institute of Family Studies.

When accounts of two parents don't align

As with all subjective accounts of separation and dispute, the accounts of a former couple on DOOR 1 are not likely to be entirely consistent with each other and indeed discrepant views will be common. Some practitioners working only with one parent will not face this dilemma, but most family dispute resolution services will.

Numerous studies have documented gender differences in the ways in which men and women experience and report conflict. The practitioner's task is to determine when the discrepancies are important to the understanding of safety and wellbeing. Contrasting the DOOR 1 and 2 accounts of the parents/clients is a good place to begin. The practitioner might find the following questions useful to consider:

- Is there a pattern in how the parents' accounts differ?
- Is there any marked denial in one account?
- Is there anything that would lead you to doubt the veracity of claims by one parent?
- Is there a need for corroborating evidence from collateral sources?
- Does the discrepancy itself add up to a risk factor (e.g. one parent reports feeling very angry with a desire for revenge if the resolution doesn't go their way, while the other reports no concern for their own safety)?

Responding to perpetrator risk

Effective engagement with potential or actual perpetrators is an important step in prevention. In addition to the identification of risks to safety and wellbeing in DOOR 1 and 2, risks for perpetrating are also flagged. This can include risks of self-harm, suicide, abduction; or harassing, threatening, hurting or otherwise targeting an ex-partner and/or children.

Many models emphasise the need for perpetrators to recognise and accept their actions and take responsibility for the use of violence in its many forms. This goes without question. The DOORS framework emphasises the importance of engagement and ensuring that the family law system proactively takes responsibility for identifying and responding to risks associated with family violence. An engagement with perpetrators that involves consideration of the historical and recent triggers for the client involved is an important public responsibility as well as an opportunity to suggest or model alternative behaviours and responses.

Perpetrators of violence have often experienced historical incidences of victimisation themselves, which does not justify or excuse their behaviour but nonetheless in the current context of loss and separation, may lead them to act unsafely, or report that they have already acted unsafely. De-escalating stress and offering support in these cases may be crucial steps in preventing future harm. Increasing isolation through blaming, shaming, or cold referrals to silo services (e.g. for anger management) without any other practitioner intervention may increase the likelihood of further and intensified violence.

Given the silence and isolation that surrounds many mental health difficulties and family violence scenarios, engagement with potential perpetrators is in itself an important practitioner response. In cases of severe character and personality disorders, the client's capacity for insight and reflection is impaired, resulting in the need for substantial expert treatment. However research also indicates that timely interventions do create opportunities for change. It is important that validation of the client's distress underlying the problem behaviour isn't confused with validation of the maladaptive behaviour itself. An unquestioning sense of justification or entitlement for violent behaviour expressed by perpetrators should be challenged within a safe process of engagement by a skilled practitioner. In addition, presumed privacy regarding an intimate relationship and subjective justifications of potentially threatening behaviours need to be addressed by the practitioner. In this context, some potential perpetrators of safety risks may find enough support to manage their distress without violating the comfort and safety of others.

Following DOOR 1 and as part of DOOR 2 and 3 follow-ups, steps toward effective engagement and risk management are outlined in Table 5.

Table 5. Steps towards effective engagement and risk management

1. Acknowledging	Recognise/acknowledge the client's honesty in completing DOOR 1.
2. Validating	Validate the client's experience of loss, hardship, stress or feeling on edge, and perhaps that they are finding it hard to behave safely.
3. Naming	Name the risks that have been flagged and check whether the client thinks they are accurate — Are there other concerns the client has about their ability to be safe with themself or others?
4. Exploring	Explore the current potency of the risks.
5. Identifying	Identify ways to manage these risks. This can involve linking client to supports or alerting the authorities.
6. Contracting	Make a contract (verbal or documented) with the client about: a) How you are going to follow up with support and safety management (e.g. further assessment, making a referral, follow-up phone call), as well as b) What the client is going to do about the specific risk(s) (e.g. accepting a referral, attending a program, notifying support people, and so on).
7. Linking	Encourage or assist the client to link with supports. Support can be sought within the client's current environment (e.g. family, friends, religion) and/or introduced through referral (e.g. mental health services).
8. Alerting	Alert the authorities if necessary (e.g. police if risk is high). Consider whether it is necessary or helpful to inform the client that you are alerting the authorities, and if it is, think of safe and appropriate ways to discuss this with the client and others. It is important to consider your personal safety and that of the client in making this decision.
9. Follow-up	Follow up with the client according to the level of risk involved. If necessary, re-contract, facilitate linking the client to supports, or involving other professionals (see Guidelines for Working with Perpetrators of Domestic and Family Violence[6]).

[6]Available at:
http://www.community.nsw.gov.au/DOCSWR/_assets/main/LIB100044/BRIGHTER_FUTURES_DOMESTIC_VIOLENCE_GUIDELINES.PDF

Table 6. Summary of tools and frameworks to support further risk assessment in each risk domain

1a. Existing family law frameworks	Framework for Screening, Assessment and Referrals in Family Relationship Centres and the Family Relationship Advice Line	Attorney-General's Department, Australia	http://www.ag.gov.au/www/agd/agd.nsf/Page/Families_FamilyRelationshipServicesOverviewofPrograms_ForFamilyRelationshipServicesPractitioners_FamilyRelationshipCentreResources	■ Association of Family and Conciliation Courts. (2005). *Family Civil Intake Screen.* Connecticut: AFCC. ■ NRG Research Group. (2007). *Family Justice Information Assessment Tool* – Evaluation. British Columbia: B.C. Ministry of the Attorney General. ■ Winkworth, G., & McArthur, M. (2008). *Framework for screening, assessment and referrals in Family Relationship Centres and the Family Relationship Advice Line*. Canberra: Attorney-General's Department.
	Family Civil Intake Screen	Association of Family and Conciliation Courts, Connecticut	http://www.afccnet.org/resources/innovations_in_court_services_.asp	
	Family Justice Information Assessment Tool	Family Justice Services Division, British Columbia	http://www.ag.gov.bc.ca/justice-reform-initiatives/publications/pdf/SymposiumIntakeEvaluation.pdf	

DOMAIN	TOOL/FRAMEWORK	DEVELOPED BY	SOURCE	KEY REFERENCES
1b. General risk management frameworks	The Family Violence Risk Assessment and Risk Management Framework , also known as Common Risk Assessment Framework (CRAF)	Family Violence Coordination Unit, Department for Victorian Communities	http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/reports-publications/family-violence-risk-assessment-and-risk-management-framework	■ Robinson, E. & Moloney, L. (2010). Family violence: towards a holistic approach to screening and risk assessment in family support services (AFRC Briefing Paper, No. 17). Retrieved from http://www.aifs.gov.au/afrc/pubs/briefing/b017/ ■ Holtzworth-Munroe, A., Beck, C., & Applegate, A. (2010). The family dispute resolution practitioner's assessment of safety issues and concerns (MASIC): A screening interview for intimate partner violence and abuse, available in the public domain. *Family Court Review*, 48(4), 646–662.
	The Family Violence Risk Assessment and Risk Management Framework - also known as the Common Risk Assessment Framework:	Department for Child Protection	http://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Pages/WhatsNew.aspx	
	Cross-Agency Risk Assessment and Management – Domestic and Family Violence Framework (CARAM-DFV Framework)	New South Wales Health		
	Family dispute resolution practitioner's Assessment of Safety Issues and Concerns	Amy Holtzworth-Munroe, Connie Beck & Amy Applegate	http://www.law.indiana.edu/lawlibrary/services/bibliography/applegatea.shtml	

DOMAIN	TOOL/FRAMEWORK	DEVELOPED BY	SOURCE	KEY REFERENCES
2a. Mental Health (Adult)	WHO-5 Wellbeing Index	World Health Organization	http://www.who-5.org/	■ Bruce, M. L. (1998). Divorce and psychopathology. In B. P. Dohrenwend (Ed.), *Adversity, stress, and psychopathology* (pp. 219–232). London: Oxford University Press. ■ Bulloch, A. G., Williams, J. V., Lavorato, D. H., & Patten, S. B. (2009). The relationship between major depression and marital disruption is bidirectional. *Depression and Anxiety*, 26, 1172-1177. doi: 10.1002/da.20618. ■ Gähler, M. (2006). To divorce is to die a bit...: A longitudinal study of marital disruption and psychological distress among Swedish women and men. *The Family Journal, 14*, 372-381. doi: 10.1177/1066480706290145. ■ Gibb, S. J., Fergusson, D. M., & Horwood, L. J. (2011). Relationship separation and mental health problems: Findings from a 30-year longitudinal study. *Australian and New Zealand Journal of Psychiatry, 45*(2), 163-169. doi: 10.3109/00048674.2010.529603. ■ Overbeek, G., Vollebergh, W., de Graaf, R., Scholte, R., de Kemp, R., & Engels, R. (2006). Longitudinal Associations of Marital Quality and Marital Dissolution with the Incidence of DSM–III–R Disorders. *Journal of Family Psychology, 20*(2), 284-291. doi: 10.1037/0893-3200.20.2.284.
	Composite International Diagnostic Interview (CIDI)	World Health Organization	http://www.hcp.med.harvard.edu/wmhcidi/index.php	
	K10 and K6 scales	United States Government's National Center for Health Sciences	http://www.hcp.med.harvard.edu/ncs/k6_scales.php	
	Brief Symptom Inventory (BSI)	Leonard Derogatis	http://psychcorp.pearsonassessments.com/HAIWEB/Cultures/en us/Productdetail.htm?Pid=PAbsi	
	Narcissistic Personality Inventory (NPI)	Daniel Ames, Paul Rose & Cameron Anderson	http://www.columbia.edu/~da358/npi16/	

DOMAIN	TOOL/FRAMEWORK	DEVELOPED BY	SOURCE	KEY REFERENCES
2a. Mental Health (Adult)	WHO-5 Wellbeing Index	World Health Organization	http://www.who-5.org/	■ Bruce, M. L. (1998). Divorce and psychopathology. In B. P. Dohrenwend (Ed.), *Adversity, stress, and psychopathology* (pp. 219–232). London: Oxford University Press. ■ Bulloch, A. G., Williams, J. V., Lavorato, D. H., & Patten, S. B. (2009). The relationship between major depression and marital disruption is bidirectional. *Depression and Anxiety*, 26, 1172-1177. doi: 10.1002/da.20618. ■ Gähler, M. (2006). To divorce is to die a bit...: A longitudinal study of marital disruption and psychological distress among Swedish women and men. *The Family Journal, 14*, 372-381. doi: 10.1177/1066480706290145. ■ Gibb, S. J., Fergusson, D. M., & Horwood, L. J. (2011). Relationship separation and mental health problems: Findings from a 30-year longitudinal study. *Australian and New Zealand Journal of Psychiatry, 45*(2), 163-169. doi: 10.3109/00048674.2010.529603. ■ Overbeek, G., Vollebergh, W., de Graaf, R., Scholte, R., de Kemp, R., & Engels, R. (2006). Longitudinal Associations of Marital Quality and Marital Dissolution with the Incidence of DSM–III–R Disorders. *Journal of Family Psychology, 20*(2), 284-291. doi: 10.1037/0893-3200.20.2.284.
	Composite International Diagnostic Interview (CIDI)	World Health Organization	http://www.hcp.med.harvard.edu/wmhcidi/index.php	
	K10 and K6 scales	United States Government's National Center for Health Sciences	http://www.hcp.med.harvard.edu/ncs/k6_scales.php	
	Brief Symptom Inventory (BSI)	Leonard Derogatis	http://psychcorp.pearsonassessments.com/HAIWEB/Cultures/en us/Productdetail.htm?Pid=PAbsi	
	Narcissistic Personality Inventory (NPI)	Daniel Ames, Paul Rose & Cameron Anderson	http://www.columbia.edu/~da358/npi16/	

DOMAIN	TOOL/FRAMEWORK	DEVELOPED BY	SOURCE	KEY REFERENCES
2b. Suicide	Internalised Shame Scale	David Cook	http://www.mhs.com/product.aspx?gr=cli&prod=iss&id=overview	■ De Leo, D., Cerin, E., Spathonis, K., & Burgis, S. (2005). Lifetime risk of suicide ideation and attempts in an Australian community: prevalence, suicidal process, and help-seeking behaviour. *Journal of Affective Disorders, 86*(2-3), 215–224. doi: 10.1016/j.jad.2005.02.001. ■ Graham, A., Reser, J., Scuderi, C., Zubrick, S., Smith M., & Turley, B. (2000). Suicide: An Australian psychological society discussion paper. *Australian Psychologist, 35*(1), 1-28. doi: 10.1080/00050060008257463. ■ Ide, N., Wyder, M., Kõlves, K., & De Leo, D. (2010). Separation as an important risk factor for suicide: A systematic review. *Journal of Family Issues, 31*(12), 1689-1716. doi: 10.1177/0192513X10365317. ■ Kõlves, K., Ide, N., & De Leo, D. (2010). Suicidal ideation and behaviour in the aftermath of marital separation: Gender differences. *Journal of Affective Disorders, 120*(1-3), 48-53. doi: 10.1016/j.jad.2009.04.019. ■ Kõlves, K., Ide, N., & De Leo, D. (2011). Marital breakdown, shame, and suicidality in men: A direct link? *Suicide and Life-Threatening Behaviour, 41*(2), 149-159. doi: 10.1111/j.1943-278X.2011.00021.x. ■ Wyder, M., Ward, P., & De Leo, D. (2009). Separation as a suicide risk factor. *Journal of Affective Disorders, 116*, 208-213. doi: 10.1016/j.jad.2008.11.007
	Suicide Items	Eugene Paykel, Jerome Myers, Jacob Lindenthal & Janis Tanner	Paykel, E. S., Myers, J. K., Lindenthal, J. J., Tanner, J. (1974). Suicidal feelings in the general population: A prevalence study. *British Journal of Psychiatry, 124*, 460–469.	
	Beck Scale for Suicide Ideation (BSS	Aaron Beck	http://www.pearsonassessments.com/HAIWEB/Cultures/enus/Productdetail.htm?Pid=015-8018-443&Mode=summary	
	Suicide Prevention Skills Training	Jacinta Hawgood & Diego De Leo	http://www.opendoors.net.au/wp-content/uploads/2009/10/suicide-prevention-manual.pdf	

DOMAIN	TOOL/FRAMEWORK	DEVELOPED BY	SOURCE	KEY REFERENCES
2c. Alcohol & Drug Use	The Alcohol Use Disorders Identification Test (AUDIT)	World Health Organization	http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf http://www.health.nt.gov.au/library/scripts/objectifyMedia.aspx?file=pdf/63/68.pdf&siteID=1&str_title=Alcohol%20Screen%20(AUDIT)%20Tool.pdf	■ Brown, R. L., Leonard, T., Saunders, L. A., & Papsouliotis, O. (2001). A Two-Item Conjoint Screen for Alcohol and Other Drug Problems. *Journal of American Board of Family Practice, 14*(2), 95–106. ■ Caces, M. F. E., Harford, T. C., Williams, G. D., Hanna, E. Z. (1999). Alcohol Consumption and Divorce Rates in the United States. *Journal of studies on Alcohol, 60*, 647-652. ■ Clarke-Stewart, A. (2006). *Divorce: Causes and Consequences*. New Haven: Yale University Press. ■ Lowenstein, L. F. (2005). Causes and associated features of divorce as seen by recent research. *Journal of Divorce & Remarriage, 42*(3/4), 153-171. doi: 10.1300/J087v42n03_09 ■ Orgilés, M., & Pinero, J. (2006). Does a relationship exist between substance abuse and marital separation? Analysis of the perceived main reason for divorce of both spouses. *Health and Addictions, 6*(2), 215-228. ■ Dawe, S., Loxton, N. J., Hides, L., Kavanagh, D. J., & Mattick, R. P. (2002). *Review of diagnostic screening instruments for alcohol and other drug use and other psychiatric disorders.* Canberra: Department of Health and Ageing, Australian Government.
	Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)	World Health Organization	http://www.who.int/substance_abuse/activities/assist/en/index.html	
	Two-item Conjoint Screen (TICS)	Richard Brown, Tom Leonard, Laura Saunders & Orestis Papsouliotis	http://www.mirecc.va.gov/visn22/TICS.pdf http://www.jabfp.com/cgi/reprint/14/2/95.pdf	
	Cut down, Annoyed, Guilty, Eye-opener – Adapted to Include Drugs (CAGE-AID)	Richard Brown & Laura Rounds	http://www.associatedneurologists.com/cage.html http://www.partnersagainstpain.com/printouts/A7012DA4.pdf http://www.amhd.org/About/ClinicalOperations/MISA/CAGEAid%20Form.pdf	
	Michigan Alcohol Screening Test (MAST); Drug Abuse Screening Test (DAST)	Department of Health and Ageing, Australian Government	http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-publicat-document-mono48-cnt.htm	

DOMAIN	TOOL/FRAMEWORK	DEVELOPED BY	SOURCE	KEY REFERENCES
2d. Parenting Stress & Capacity	Parental Stress Scale	Judy Berry & Warren Jones	http://www.personal.utulsa.edu/~judy-berry/parent2.htm	■ Australian Institute of Family Studies (2011). *Growing Up in Australia: The Longitudinal Study of Australian Children Annual Statistical Report 2010*. Retrieved from http://www.aifs.gov.au/growingup/ ■ Kaspiew, R., Gray, M., Weston, R., Moloney, L., Hand, K., Qu, L., & the Family Law Evaluation Team. (2009). Evaluation of the 2006 family law reforms. Melbourne: Australian Institute of Family Studies. ■ Pryor, J., & Rodgers, B. (2001). Children in changing families: Life after parental separation. Oxford: Blackwell Publishers. ■ Sroufe, L.A., Egeland, B., Carlson, E., & Collins, W.A. (2005). The development of the person: The Minnesota study of risk and adaptation from birth to adulthood. New York: Guilford Publications.
	Parenting Stress Index	Richard Abidin	https://shop.acer.edu.au/acer-shop/group/QAJ/28	
	Relationship Breakdown and Stressor Questionnaire	Kairi Kolves, Naoko Ide & Diego De Leo	Kõlves, K., Ide, N., & De Leo, D. (2010). Suicidal ideation and behaviour in the aftermath of marital separation: Gender differences. Journal of Affective Disorders, 120(1-3), 48-53. doi: 10.1016/j.jad.2009.04.019	
	Adult-Adolescent Parenting Inventory (AAPI-2)	Stephen Bavolek & Richard Keene	http://www.nurturingparenting.com/aapi/aapi2_info.php	

DOMAIN	TOOL/FRAMEWORK	DEVELOPED BY	SOURCE	KEY REFERENCES
3a. Mental Health (Child & Infant)	Zero to Three	Zero to Three: National Center for Infants, Toddlers and Families	http://www.zerotothree.org	■ Amato, P. R. (2000). The consequences of divorce for adults and children. *Journal of Marriage and the Family, 62*, 1269-1287. ■ Amato, P. R., & Cheadle, J. (2005). The long reach of divorce: divorce and child wellbeing across three generations. *Journal of Marriage and Family, 67* (Feb), 191-206. ■ Buchanan, C. M., Maccoby, E. E., & Dornbush, S. M. (1996). *Adolescents after divorce*. Cambridge, MA: Harvard University Press. ■ Grych, J., & Fincham F. (2001). *Inter-parental conflict and child development*. New York: Cambridge University Press. ■ Kelly, J. B. (2000). Children's adjustment in conflicted marriage and divorce: A decade review of research. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 963-983. ■ McIntosh, J. M. (2003b). Children living with domestic violence: Research foundations for early intervention. *Journal of Family Studies, 9*(2), 219-234. ■ McIntosh, J. M. (2003c). Enduring conflict in parental separation: Pathways of impact on child development. *Journal of Family Studies, 9*(1), 63-80. ■ Strohschein, L. (2005). Parental divorce and child mewntal health trajectories. *Journal of Marriage and Family, 67(*December), 1286-1300.
	WHO-5 Wellbeing Index	Psychiatric Research Unit, Mental Health Centre, North Zealand	http://www.who-5.org	
	Child Behavior Checklist	Thomas Achenbach	http://www.aseba.org/preschool.html	
	Strength & Difficulties Questionnaire (SDQ)	Robert Goodman	http://www.sdqinfo.com/	
	Composite International Diagnostic Interview (CIDI)	World Health Organization	http://www.hcp.med.harvard.edu/wmhcidi/index.php	
	Brief Infant Toddler Social Emotional Assessment (BITSEA)	Margaret Briggs-Gowan & Alice Carter	http://www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8007-352	

DOMAIN	TOOL/FRAMEWORK	DEVELOPED BY	SOURCE	KEY REFERENCES
3b. Child Abuse & Neglect	ISPCAN Child Abuse Screening Tool – Parent and Child (ICAST-P and ICAST-C)	International Society for the Prevention of Child Abuse and Neglect	http://www.ispcan.org/?page=ICAST	■ Australian Research Alliance for Children and Youth. (2010). *Working together to prevent child abuse and neglect — a common approach for identifying and responding early to indicators of need*. Canberra: Australian Research Alliance for Children and Youth. ■ Lamont, A. (2011). *Child abuse and neglect statistics (NCPC Resource Sheet)*. Retrieved from http://www.aifs.gov.au/nch/pubs/sheets/rs1/rs1.html ■ Lund, T. R., & Renne, J. (2009). *Child safety: A guide for judges and attorneys*. North Carolina: ACTION for Child Protection. ■ Moloney, L., Smyth, B., Weston, R., Richardson, N., Qu, L., & Gray, M. (2007). *Allegations of family violence and child abuse in family law children's proceedings: A pre-form exploratory study (Research Paper No. 15)*. Melbourne: Australian Institute of Family Studies. ■ Mudaly, N., & Goddard, C. R. (2006). *The truth is longer than a lie: Children's experiences of abuse and professional interventions*. London, UK & Philadelphia, USA: Jessica Kingsley Publishers. ■ National Association of Public Child Welfare Administrators. (2009). *A framework for safety in child welfare.* Washington, DC: American Public Human Services Association.
	Clinical Assessment Package for Assessing Client Risks and Strengths	Jane Gilgun	http://www.scribd.com/doc/38663928/The-CASPARS-Professional-Manual-Clinical-Assessment-Package-for-Client-Risks-Strengths	
	Comprehensive Child Maltreatment Scale	Darryl Higgins & Marita McCabe	Higgins, D. J., & McCabe, M. P. (2001). The development of the Comprehensive Child Maltreatment Scale. Journal of Family Studies, 7(1), 7-28. doi: 10.5172/jfs.7.1.7	
	Framework for Safety in Child Welfare	National Association of Public Child Welfare Administrators (NAPCWA)	http://www.napcwa.org/home/safety_framework_download.asp	
	Child Safety: A guide for judges and attorneys	American Bar Association	www.nrccps.org/documents/2009/pdf/The_Guide.pdf	
	Child Abuse Potential Inventory	Joel Milner	http://www4.parinc.com/Products/Product.aspx?ProductID=CAP	

DOMAIN	TOOL/FRAMEWORK	DEVELOPED BY	SOURCE	KEY REFERENCES
3c. Child Abduction	No currently validated tools available			■ Alanen, J. (2007). Remedies and Resources to Combat International Family Abduction. *American Journal of Family Law, 21*(2), 11-27. ■ Grasso, K. L., Sedlak, A., Chiancone, J., Gragg, F., Schultz, D., & Ryan, J. (2001). *The criminal justice system's response to parental abduction*. Washington, DC: U.S. Dept. of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. ■ Greif, G. L., & Hegar, R. L. (1993). *When parents kidnap: The families behind the headlines.* New York: Free Press. ■ Johnston, M., & Girdner, L. (1998). Early identification of parents at risk for custody violations and prevention of child abduction. *Family and Conciliation Court Review, 36*(3), 392-409. doi: 10.1111/j.174-1617.1998.tb00521.x. ■ Johnston, J. R., Girdner, L. K., & Sagatun-Edwards, I. (1999). Developing Profiles of Risk for Parental Abduction of Children from a Comparison of Families Victimized by Abduction with Families Litigating Custody. *Behavioral Sciences and the Law, 17*, 305-322. ■ Johnston, J., Roseby, V., & Kuehnle, K. (2009). *In the name of the child. A developmental approach to understanding and helping children of conflicted and violent divorce* (2nd ed). New York: Springer Publishing Company.

DOMAIN	TOOL/FRAMEWORK	DEVELOPED BY	SOURCE	KEY REFERENCES
4a. Family Violence	Revised Conflict Tactics Scales (CTS)	Murray Straus and colleagues	http://portal.wpspublish.com/portal/page?_pageid=53,70488&_dad=portal&_schema=PORTAL	■ Holtzworth-Munroe, A., Meehan, J. C., Herron, K., Rehman, U., & Stuart, G. L. (2000). Testing the Holtzworth-Munroe and Stuart (1994) batterer typology. *Journal of Consulting and Clinical Psychology, 68*(6), 1000-1019. doi: 10.1037//0022-006X.68.6.1000. ■ Kelly, J. B., & Johnson, M. P. (2008). Differentiation among types of intimate partner violence: Research update and implications for interventions. *Family Court Review, 46*(3), 476-499. doi: 10.1111/j.1744-1617.2008.00215.x. ■ Moloney, L., Smyth, B., Weston, R., Richardson, N., Qu, L., & Gray, M. (2007). *Allegations of family violence and child abuse in family law children's proceedings: A pre-form exploratory study (Research Paper No. 15)*. Melbourne: Australian Institute of Family Studies.
	Spousal Assault Risk Assessment (SARA)	P. Randall Kropp, Stephen Hart, Christopher Webster & Derek Eaves	http://www.mhs.com/product.aspx?gr=saf&prod=sara&id=overview	
	Domestic Violence Ended (DOVE)	DOVE Inc.	http://www.doveinc.info/	
	Dangerousness Scale	Jacqueline Campbell	http://www.dangerassessment.org/	

DOMAIN	TOOL/FRAMEWORK	DEVELOPED BY	SOURCE	KEY REFERENCES
4b. Family Violence & ATSI				■ Australian Institute of Health and Welfare. (2011). *The health and welfare of Australia's Aboriginal and Torres Strait Islander people: An overview 2011*. Retrieved from http://www.aihw.gov.au/publicationdetail/?id=1073741899 ■ Memmott, P., Stacy, R., Chambers, C., & Keys, C. (2001). *Violence in Indigenous communities: Full report*. Retrieved from http://www.crimeprevention.gov.au/agd/www/Ncphome.nsf/Page/3AF90A4576B81394CA256B430001AF24?OpenDoc-ument ■ Ratnavale, D. (2007). *An understanding of Aboriginal experience in the context of collective trauma: A challenge for healing.* Paper presented at the Aboriginal and Torres Strait Islander Mental Health Services, Central Northern Adelaide Health Service. ■ Schmider, J., & Nancarrow, H. (2007). *Aboriginal and Torres Strait Islander family violence: Facts and figures*. Retrieved from www.noviolence.com.au/public/factsheets/indigenousfactsheet.pdf. ■ Wundersitz, J. (2010). *Indigenous perpetrators of violence: Prevalence and risk factors for offending*. Retrieved from http://www.aic.gov.au/publications/current%20series/rpp/100-120/rpp105.aspx.

DOMAIN	TOOL/FRAMEWORK	DEVELOPED BY	SOURCE	KEY REFERENCES
4c. Family Violence & CALD				■ Bonar, M., & Roberts, D. (2006). *A review of the literature relating to family and domestic violence in culturally and linguistically diverse communities in Australia*. Retrieved from http://www.adfvc.unsw.edu.au/dbtw-wpd/exec/dbtwpub.dll?BU=http%3A//www.adfvc.unsw.edu.au/research.html&QB0=AND&QF0=ID&QI0=3561&TN=CATALO~1&AC=QBE_QUERY&RF=Record_display_new2&DL=0&EL=0&RL=0&NP=3&MR=20. ■ Burman, E., Smailes, S. L., & Chantler, K. (2004). 'Culture' as a barrier to service provision and delivery: Domestic violence services for minoritized women. *Critical Social Policy, 24*(332-357). doi: 10.1177/0261018304044363 ■ James, K. (2010). Domestic violence within refugee families: Intersecting patriarchal culture and the refugee experience. *The Australian and New Zealand Journal of Family Therapy, 31*, 275-284. ■ Walshe, L. (2010). *'I lived in fear because I knew nothing': Barriers to the justice system faced by CALD women experiencing family violence.* Melbourne: InTouch Multicultural Centre Against Family Violence Victoria. ■ World Health Organization. (2010). *Violence prevention: The evidence*. Retrieved from www.who.int/violenceprevention/publications/en/index.html

4d. Familicide	Dangerousness Scale	Jacqueline Campbell	http://www.dangerassessment.org/	■ Dabby, C., Patel, H., & Poore, G. (2010). *Shattered lives: Homicides, domestic violence and Asian families*. Retrieved from http://www.apiidv.org/files/Homicides.DV.AsianFamilies-APIIDV-2010.pdf ■ Dobash, R. E., & Dobash, R. P. (2008). The Murder in Britain Study: Broadening the analysis of men who murder an intimate woman partner, in *Domestic-related homicide: Keynote papers from the 2008 International Conference on Homicide*. Canberra: Australian Institute of Criminology. ■ Easteal, P. W. (1993). *Killing the beloved: Homicide between adult sexual intimates*. Retrieved from http://www.aic.gov.au/publications/previous%20series/lcj/1-20/beloved.aspx. ■ Johnson, C. H. (2006). Familicide and family law: A study of filicide-suicide following separation. *Family Court Review, 44*(3), 448-463. doi: 10.1111/j.1744-1617.2006.00099.x ■ Websdale, N. (2010). *Familicidal Hearts*. New York: Oxford University Press.

Other risk screening frameworks

Several comprehensive risk management frameworks have been developed at a state level in response to the need to better identify risk within families in the wider community. Several of these frameworks are summarised below and in Table 6 (pp. 72-84).

A distinction is made between family law frameworks and those specific to risks associated with family and domestic violence. With the exception of Winkworth and McArthur's (2008) screening and assessment tool, no other screen specific to the family law context has been developed to date.

Family law frameworks

Framework for screening, assessment and referrals in family relationship centres and the family relationship advice line (Winkworth & McArthur, 2008)

(Available at:
http://www.ag.gov.au/www/agd/agd.nsf/Page/Families2_FamilyRelationshipServices_Familyrelationshipcentreresources)

This framework is a guide that has been developed for both FRC and Advice Line staff conducting screening and assessment, and for supervisors and managers responsible for the development of policy and procedures. The framework does not include a standardised tool, but does provide information in six main areas:

1. Framework foundations and principles
2. Screening and assessment across all functions
3. Referral guidelines
4. Three main risk domains — domestic and family violence, child abuse and abduction, and self-harm
5. Supervision and support for practice
6. Practice tools and questions to assist practitioners' intake and screening processes.

Family Civil Intake Screen (Association of Family and Conciliation Courts, 2005)

(Available at: http://www.afccnet.org/resources/innovations_in_court_services_.asp)

This screen was developed in Connecticut as an assessment and triage tool for family relations counsellors to determine level of service required and to improve referral processes. The 26-item screening tool involves an oral interview (22 minutes to administer) with both separating parents. The screen contains seven areas of assessment: general case information, level of conflict, ability to communicate/cooperate, complexity of issues, level of danger, disparity of facts and service selection.

Family Justice Information Assessment Tool (Family Justice Services Division, 2007)

(Available at: http://www.ag.gov.bc.ca/justice-reform-initiatives/)

This assessment tool was developed in British Columbia for use in the Family Justice Services Centre, with the main objective to determine the types of services most appropriate for clients. The tool covers five content areas: level of conflict, financial management, substance use and mental health issues, family violence, and child protection and adjustment. The assessment tool has three components: a) a self-administered intake form, b) a questionnaire consisting of 22 questions to be completed by the client whenever possible, followed by an in-person interview with a practitioner where areas of concern are explored more fully, and c) a summary where the practitioner scores the client's responses and identifies appropriate options and referrals.

General risk screening and management frameworks

The Family Violence Risk Assessment and Risk Management Framework, also known as the Common Risk Assessment Framework (CRAF: Family Violence Coordination Unit, Department for Victorian Communities, 2007)

(Available at: http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/reports-publications/family-violence-risk-assessment-and-risk-management-framework)

This framework seeks to provide an integrated approach to identifying risks of family violence and was developed through an extensive consultation process with over 500 members of family violence service providers.

The framework can be used by:

- Mainstream professionals (to identify family violence)
- Professionals who work with victims of family violence (to conduct a preliminary assessment)
- Specialist family violence professionals (to conduct a comprehensive assessment)

The framework consists of six components:

- Shared understanding of risk and family violence across all service providers
- Standardised risk assessment to recognise and assess risk
- Referral pathways and information sharing
- Risk management strategies (ongoing)
- Data collection and analysis to ensure system is able to respond to changing priorities
- Quality assurance strategies that reflect a philosophy of continuous improvement

The Western Australian Family and Domestic Violence Common Risk Assessment and Risk Management Framework (Department for Child Protection, 2011)

(Available at: http://www.dcp.wa.gov.au/CrisisAndEmergency/FDV/Pages/WhatsNew.aspx)

This framework is based on the Victorian CRAF with particular attention given to its application within the Western Australian context. Sections of the manual include:

- A background to the Framework
- Risk assessment
- Introduction to family and domestic violence
- Supportive legislation for integrated responses to manage risk and improve safety
- Practice guide for family and domestic violence screening and risk assessment

This framework was developed for use by a range of service providers categorised within three groups:

- Specialist family and domestic violence services
- Mainstream services (including mental health, parenting, education, AOD)
- Legal and statutory services (including police, legal, child protection, courts, family law)

Working together to prevent child abuse and neglect: A common approach for identifying and responding early to indicators of need (Australian Research Alliance for Children and Youth, 2010)

(Available at: http://www.aracy.org.au/index.cfm?pageName=the_CAARS_project)

The broad vision of the Common Approach is to promote the safety and wellbeing of children, young people and families. It is child-centred, family-focused, universal services-focused, and provides a holistic response to child and family needs.

The Common Approach is represented by a 'wheel', with six wellbeing domains (physical health, mental health and emotional wellbeing, safety, material wellbeing, learning and development, and relationships). Each domain is further clustered into three spheres (child, family and community). Strengths and needs can be identified in each domain and each sphere. The wheel is complemented by a professional judgement reference point, conversation prompts, and a self-assessment questionnaire for older children.

Cross Agency Risk Assessment and Management – Domestic and Family Violence Framework (CARAM-DFV Framework: New South Wales Health, 2010)

The CARAM-DFV Framework is used with victims of domestic and family violence who are 16 years and above. It is intended to guide frontline professionals as they assess the risk of domestic and family violence to individuals. Assessment is based on persistent risk factors, the victim's own perception of their risk status and the practitioner's professional judgement. The Framework aims to guide interventions to manage and reduce levels of risk. Consistency in assessing risk under the Framework is obtained by applying the same set of evidence-based risk factors between and within agencies.

The CARAM-DFV is a two-tiered framework:

1. Initial Risk Assessment and Management: This tier is conducted by frontline staff in agencies, and aims to quickly determine the level of risk, urgently address safety needs of those at high risk, refer all victims to a specialist assessor and provide clients with an information card.

2. Specialist Risk Assessment and Management: This tier is conducted by staff with specialist qualifications and/or experience and expertise in addressing the needs of victims of domestic and family violence. It aims to comprehensively determine level of risk, urgently address safety needs of those at high risk, develop safety plans for those assessed at elevated risk or at risk, offer advice to those assessed to be at risk, and provide an information card.

Mediator's Assessment of Safety Issues and Concerns (MASIC: Holtzworth-Munroe, Beck & Applegate, 2010)

(Available at: Family Court Review Volume 48, Issue 4, October 2010, Pages: 646–662 and http://www.law.indiana.edu/lawlibrary/services/bibliography/applegatea.shtml)

The MASIC is a behavioural-specific screen of intimate partner violence and/or abuse (IPV/A) that assesses various types of abuse over the course of the relationship and in the past year: psychological abuse, coercive control, threats of severe violence, physical violence, severe physical violence, sexual violence, and stalking. It is administered as an interview and seeks to assess lethality indicators and offer optional recommendations for procedural changes in family dispute resolution based on IPV/A. The MASIC includes questions that determine level of IPV/A and potential danger. Additionally, the MASIC requires mediators to check for risk factors that might apply to their client.

The MASIC consists of three sections:

1. Background questions
2. Client's relationship with their ex-partner and their ex-partner's behaviour
3. Any other issues that the mediator should know.

Referral Agencies

Family Court of Australia	1300 352 000 (except WA: 9224 8222)	http://www.familycourt.gov.au
Police Assistance Line	131 444 (except VIC: contact local police station)	http://www.afp.gov.au/
Relationships Australia	1300 364 277	http://www.relationships.org.au/
Australian Psychological Society	1800 333 497	http://www.psychology.org.au
Australian Association of Infant Mental Health		http://www.aaimhi.org
Lifeline	131 114	http://www.lifeline.org.au
Mental Health Advice Line	1300 280 737	http://www.health.vic.gov.au/mhal/
SANE Australia Helpline	1800 18 7263	http://www.sane.org
BeyondBlue	1300 22 4636	http://www.beyondblue.org.au
MensLine	1300 78 99 78	http://www.mensline.org.au
Women's Information & Referral Exchange	1300 134 130	http://www.wire.org.au
Maternal & Child Health Line	13 22 29	http://www.education.vic.gov.au/earlychildhood/support/mchline.htm
Kids Helpline	1800 55 1800	http://www.kidshelp.com.au/
Suicide Callback Service	1300 659 467	http://www.suicidecallbackservice.org.au/
National Association for the Prevention of Child Abuse and Neglect		http://www.napcan.org.au
On Track		http://www.ontrack.org.au
Reach Out		http://au.reachout.com

Directory of state-wide services

ACT		
Services	**Phone Contact**	**Website**
Alcohol and Drug Information	(02) 6205 4545	http://www.adf.org.au
Child Protection Services	1300 566 728	http://www.dhcs.act.gov.au/ocyfs/services/care_and_protection
Parent Line	(02) 6287 3833	http://www.parentline.com.au
Children, Youth and Family Mental Health Services	13 2281	http://health.act.gov.au/health-services/mental-health-act/mental-health-services/children-youth-families
Legal Aid	1300 654 314	http://www.legalaidact.org.au/

NSW		
Services	**Phone Contact**	**Website**
Alcohol and Drug Information Service (ADIS)	1800 422 599	http://www.adf.org.au
Child Protection Services	132 111	http://www.community.nsw.gov.au/preventing_child_abuse_and_neglect/reporting_suspected_abuse_or_neglect.html
Parent Line	1300 1300 52	http://www.parentline.com.au
NSW Health Service – MH-Kids	(02) 9816 0397	http://www.health.nsw.gov.au/mhdao/programs_initiatives.asp
Legal Aid	1300 888 529	http://www.legalaid.nsw.gov.au/
Mental Health Association	1300 794 991	http://www.mentalhealth.asn.au

SA		
Services	**Phone Contact**	**Website**
Alcohol and Drug Information Service (ADIS)	1300 131 340	http://www.adf.org.au
Child Protection Services	131 478	www.dfc.sa.gov.au/pub/tabid/485/itemid/1433/default.aspx
Parent Line	1300 364 100	http://www.parentline.com.au
Child & Adolescent Mental Health Service	1800 022 222	http://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+services/Mental+health/Infants%2C+children+and+young+people
Legal Services Commission	1300 366 424	http://www.lsc.sa.gov.au/
Crisis Care	131 611	
Domestic Violence Crisis Service	1300 782 200	
Domestic Violence Helpline	1800 800 098	http://www.acm.asn.au
Aboriginal Family Support Services	1300 365 712	http://www.afss.com.au/
Mental Health (Assessment & Crisis Intervention Service – ACIS)	13 14 65	

VIC		
Services	**Phone Contact**	**Website**
Alcohol and Drug Information (DirectLine)	1800 888 236	http://www.adf.org.au
Child Protection Services	131 278	http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection
Child FIRST		http://www.cyf.vic.gov.au/every-child-every-chance
Parent Line	13 22 89	http://www.parentline.com.au
Child and Adolescent Mental Health Service		http://www.health.vic.gov.au/mentalhealth/services/child/
Legal Aid	Melbourne: (03) 9269 0120	http://www.legalaid.vic.gov.au
Legal Aid	Rural: 1800 677 402	http://www.legalaid.vic.gov.au
Suicide Line	1300 651 251	http://www.suicideline.org.au/
Mens Referral Service (No to Violence)	1800 065 973	http://www.ntv.org.au
Mental Illness Fellowship of Victoria	(03) 8486 4250	http://www.mifellowship.org/

NT		
Services	**Phone Contact**	**Website**
Alcohol and Other Drug Information Services (ADIS)	1800 131 350	http://www.adf.org.au
Child Abuse/Child Protection Hotline	1800 700 250	
Parent Line	1300 301 300	http://www.parentline.com.au
Mental Health Services	(08) 8999 2553	http://www.health.nt.gov.au/Mental_Health/index.aspx
NT Crisis Assessment Telephone Triage and Liaison Service (CATT)	1800 682 288	

QLD		
Services	**Phone Contact**	**Website**
Alcohol and Other Drugs Information Services (ADIS)	1800 177 833	http://www.adf.org.au
Child Protection Services	1800 811 810	http://www.communities.qld.gov.au/childsafety/protecting-children/reporting-child-abuse
Parent Line	1300 30 1300	http://www.parentline.com.au
Children and Youth Mental Health Services	(07) 3310 9444	http://www.health.qld.gov.au/rch/professionals/cymhs.asp
Legal Aid	1300 65 11 88	http://www.legalaid.qld.gov.au
Domestic Violence Telephone Service	1800 811 811	
Crisis Care	1800 177 135	http://families.qld.gov.au

TAS		
Services	**Phone Contact**	**Website**
Alcohol and Drug Information Service (ADIS)	(03) 6233 6722	http://www.adf.org.au
Child Protection Services	1300 737 639	http://www.dhhs.tas.gov.au/children/child_protection_services
Parent Line	1300 808 179	http://www.parentline.com.au
Children and Adolescent Mental Health Services	1800 332 388	http://www.dhhs.tas.gov.au/mentalhealth/mhs_tas/gvt_mhs/child_and_adolescent_mental_health_services
Legal Aid Commission	1300 366 611	http://www.legalaid.tas.gov.au

WA		
Services	**Phone Contact**	**Website**
Alcohol and Drug Information Service	1800 198 024	http://www.dao.health.wa.gov.au
Child Protection Services	9492 5444	http://www.police.wa.gov.au/Yoursafety/Childprotection/Howtoreportchildabuse/tabid/1241/Default.aspx
Parent Line	1800 654 432	http://www.parentline.com.au
Child and Adolescent Mental Health Services		http://www.health.wa.gov.au/services/category.cfm?Topic_ID=5
Legal Aid	1300 650 579	http://www.legalaid.wa.gov.au
Crisis Care Unit	1800 199 008	

Practitioner's list of local services/contact details

Type of Service	Name of Service	Phone Contact	Address/Website
Police			
Hospital			
Ambulance			
Child protection services			
Mobile crisis psychiatry services			
Adult mental health services			
Infant welfare services			
Child welfare and mental health services			
Family violence services			
Drug and alcohol services			
Community health service			
Courts and court services			
Legal services			
Housing services			

Information sharing

The effective management of client safety and wellbeing risks relies on effective communication and coordination with the client and often between services involved with the client. This section deals with conundrums of information sharing between services. These are not unique to risk screening, but are common throughout the family law system.

Information sharing as a philosophy

Information sharing is the foundation for cooperative action between practitioners within and across organisations. That said, practitioners are often understandably conservative about sharing information for a host of reasons. Common among these may be their level of understanding of the relevant legislative or ethical exceptions, concerns about remaining engaged with the client or uncertainty about the response they may receive from other agencies. Organisations have a responsibility to train and support staff to assist them with client confidentiality in a responsible but flexible manner. In particular, practitioners ideally should be mindful of legitimate opportunities to share information where this may enhance service delivery or protect people from harm.

Sharing information between conflicted partners is highly problematic and generally post-separation services within the family law system work hard to avoid any inappropriate information sharing. The complexity of being intricately involved with all parties usually involves well established policies and procedures that enshrine vigilance and clarity about keeping information about other parties separate. However in situations of extreme or 'hot' safety concerns in relation to the children or ex-partner or other family members, initiating the sharing of information about imminent harm to the vulnerable ex-partner, as well as to other services, needs to be considered.

Avoiding the destructive impact of referral to other services within complex family dynamics is undoubtedly a major concern. Yet failure to act when there is a well founded concern about safety and wellbeing is increasingly recognised as irresponsible and often tragic. The guidance provided in the DOORS is designed to assist with these significant decisions. Given that many victims are highly attuned to the risks involved, strategies to engage the vulnerable ex-partner may focus on detailed exploration with them about their perception of the current risks and safety planning, rather than sharing information about the practitioner's concerns. Nonetheless in some circumstances clear reflection to the vulnerable party about the practitioner's safety concerns may be the most protective action to take.

Whenever possible, decisions, on whether to refer concerns to others or speak directly to the vulnerable party should not be taken alone. Practitioners need the support and guidance of their particular service. Sharing the burden of these decisions with relevant and responsible colleagues is an important feature of the collaboration encouraged throughout DOORS. To assist practitioners with these decisions, a summary of the information sharing laws and frameworks across Australia is presented below.

Privacy and its limits in the family law system

Privacy is a fundamental civil and legal right. Practitioners are ethically bound within many family law connected services to keep clients' personal information from intake, assessment and treatment phases confidential. In this way, the client's sense of trust is maintained and sensitive information is not disseminated or abused.

Before information is shared or exchanged with another professional, a practitioner normally must follow several steps: discussing the need for information sharing with the client, gaining their informed consent, and adhering to the limits of information exchange when in consultation with others about the case.

As outlined in the Common Risk Assessment Framework (CRAF) (Family Violence Coordination Unit, 2007, p. 28), and elaborated below, in the screening of risk there are a few but important circumstances in which client consent to share information is not legally required:

1. When a crime has been committed or is going to be committed, (police must be contacted)
2. When it is believed that a child is suffering significant harm, or there are significant concerns about a child's wellbeing (the state child protection authority or associated service must be contacted)
3. A person is in need of urgent medical or psychiatric care (the relevant hospital or mental health crisis team must be contacted)

Multiple layers of confidentiality

There is no single law that spells out all the privacy obligations a practitioner must meet in the course of their duties. Obligations may be simultaneously contained in an employment contract or oath of confidentiality, a professional code of ethics (e.g. legal professional privilege), a confidentiality agreement with a client, or in various pieces of state or Commonwealth legislation. Multiple privacy obligations will often apply to a particular practitioner or work-related situation, for example, where a client provides personal information concerning a third party. A client confidentiality agreement in such a case may cover any statements made by the client personally, while the *Privacy Act 1988* (Cth) creates an additional layer of confidentiality over personal information received in relation to a third party.

Appendix 5 (p. 209) includes a list of the relevant Commonwealth and state privacy related legislation (courtesy of the Privacy Victoria website).

Typical exceptions to a principle of strict confidentiality

The *Privacy Act*, which applies to Commonwealth (but not state) government agencies, and to private practitioners and non-government organisations across Australia, contains exceptions to a principle of strict confidentiality that are reflected in most legislative schemes, ethical codes and client confidentiality agreements.

The *Privacy Act* states that a person "must not use or disclose personal information about an individual for a purpose … other than the primary purpose of collection" unless one of a number of exceptions are met. These include:

i. The individual to whom the information relates has consented to the use or disclosure - Schedule 3 2(b);
ii. One reasonably believes the use or disclosure is necessary to lessen or prevent a serious and imminent threat to an individual's life, health or safety - Schedule 3 2(e);
iii. The use or disclosure is for the purpose of reporting unlawful activity - Schedule 3 2(f);
iv. The use or disclosure is required or authorised by law - Schedule 3 2(g);
v. The use or disclosure is reasonably necessary for the enforcement of the criminal law or a law imposing a pecuniary penalty - Schedule 3 2(h).

Information sharing by consent

The *Privacy Act* - Schedule 3 2(b), states that a person to whom information relates can consent to that information being disclosed. In practice, this is often the foundation for most information sharing and even where a legislative exception exists, e.g. to protect a person from harm, it is often best practice to still discuss information sharing with the client and to seek their consent if appropriate.

Obtaining consent from a person to share information must be informed consent in the sense that the person clearly understands:

i. their right to confidentiality (and the exceptions to this right);
ii. the information to be disclosed; and
iii. the nature and purpose of the proposed disclosure.

Protecting people from harm

The *Privacy Act* - Schedule 3 2(e), permits the disclosure — without consent — of personal information collected in the course of one's duties where one reasonably believes the use or disclosure is necessary to lessen or prevent a serious and imminent threat to an individual's life, health or safety. This test applies equally to the protection of adults and children and tends to be reflected in other legislative schemes (e.g. the Family Law Act), ethical codes and client confidentiality agreements.

Disclosure for the purpose of reporting unlawful activity

The *Privacy Act* - Schedule 3 2(f), states that information may be disclosed where a person has reason to suspect that unlawful activity has been, is being or may be engaged in, and uses or discloses the personal information … in reporting its concerns to relevant persons or authorities.

A similar exception exists for family counsellors and family dispute resolution practitioners, who can disclose information for the purpose of reporting or preventing violence or the threat of violence, and preventing property damage or the threat of property damage (see s10D(4)(c) and (e), and s10H(4)(c) and (e) of the Family Law Act 1975).

The use or disclosure is required or authorised by law

The *Privacy Act* - Schedule 3 2(g), permits the disclosure of information where such disclosure is required or authorised by or under law. An important example of this is the mandatory reporting of child neglect or abuse under state based child protection legislation. A further relevant example in the context of the family law system is the framework of confidentiality and disclosure which applies to family relationships counsellors (s10D-E) and family dispute resolution practitioners (s10H-J) pursuant to the *Family Law Act* 1975. This scheme replaces any obligations the practitioner may otherwise have pursuant to *Privacy Act* and includes for example an obligation to provide information to an independent children's lawyer to assist them in performing their functions.

Disclosure in response to a request by an enforcement body

The *Privacy Act* - Schedule 3 2(h), permits the disclosure of information to an enforcement body, e.g. the state or federal police, for the purpose of preventing, investigating or prosecuting offending.

No similar provision exists in relation to family counsellors and family dispute resolution practitioners. In such cases, the relevant question may be whether such disclosure is necessary for the purpose of complying with a law of the Commonwealth, a State or Territory - see s10D(2) and s10H(2).

Information sharing — why, who, what, when, and how?

Information sharing with or without a client's consent is a significant action and must be effected with consideration and precision. One way of approaching this may be to think in terms of why, who, what, when, and how.

i. **Why** – Why the information is being shared is in many respects the key issue and governs the who, what and when. The precise purpose for sharing the information should be clearly articulated and must guide how the information sharing is carried out.

ii. **Who** – Information should be shared with the minimum number of organisations and individuals, and, more particularly, with only those organisations or individuals who are clearly related to the purpose of the information sharing.

iii. **What** – What information is to be shared — i.e. what parts of the total information possessed of the organisation - is a key consideration. In particular, the information to be shared must be clearly related to the purpose of the information sharing and must be only that information.

iv. **When** – Information sharing should occur at the most appropriate time by reference to the purpose of the information sharing and the safety of any individuals involved. Generally speaking, information must be shared in the most timely manner possible and before the purpose behind sharing the information has expired.

v. **How** – In large part how the information is to be shared is a question of the security of the information sharing; for example, information sharing by email may in some circumstances be considered insecure and therefore inappropriate.

Frameworks to promote and structure information sharing

A variety of state and federal (e.g. Magellan and Columbus projects[7]) frameworks exist to promote collaboration and facilitate information sharing in certain areas or situations (please contact your state-based privacy commissioner for more information in this regard). In South Australia, for example, a range of organisations, including police, domestic violence services and health services, meet, share information and work collaboratively in connection with high-risk domestic violence cases — the Family Safety Framework[8]. A key element of this framework is a mutual adherence to an information sharing protocol built around the validity of sharing confidential information (with or without consent) where 'one reasonably believes the use or disclosure is necessary to lessen or prevent a serious and imminent threat to an individual's life, health or safety'.

An additional framework for information sharing in South Australia, in this case focused on protecting children from harm, is known as the 'Information Sharing Guidelines for promoting the safety and wellbeing of children, young people and their families'. The Information Sharing Guidelines (ISG) is a framework for information sharing adhered to by the SA Government and written into service contracts with various state NGOs. It is a set of 'overarching principles and practice which bring together [for the purpose of protecting children from harm] all relevant government agencies and non-government organisations in the interests of early intervention, better coordination of services, and consistent information sharing across the state'. It modifies the *Privacy Act* test for information sharing to protect people from harm by removing the requirement of imminence, i.e. the test becomes 'the use or disclosure is necessary to lessen or prevent a serious threat to an individual's [child's] life, health or safety'. The operation of the ISG in South Australia is informative in the sense that it highlights a number of important issues around information sharing in practice; for example:

i. The importance of common and well-established inter-agency practices, backed by education, training, forms and written resources, as a foundation for information sharing.
ii. That informed consent lies at the heart of information sharing and is often a good starting point when considering this issue. The ISG, for example, establishes a comprehensive foundation for sharing information without client consent [to protect children from harm], yet builds this around a mandatory requirement that all agencies first consider and evaluate seeking client consent.
iii. The legal complexity of information sharing, and in particular the interplay between the various sources and layers of confidentiality; For example:
    - Although NGOs are *prima facie* bound by the Privacy Act, these requirements can be over-ridden by a service contract entered into with a state government.
    - State government agencies, by contrast, are not bound by the Privacy Act but may be bound other legislation, e.g. the *Information Privacy Act* 2000 (Victoria) or in South Australia's case a set of Information Privacy Principles established and modified by Cabinet Instruction.
    - Organisations, services and practitioners will often be subject to different confidentiality obligations. For example, many NGOs in South Australia will have programs that operate

[7] The Magellan program was developed to deal with Family Court cases involving serious allegations of physical and sexual child abuse, and similarly, the Columbus project in West Australia.

[8] The Family Safety Framework (the Framework) was developed under the auspice of the South Australian Government's Women's Safety Strategy and Keeping Them Safe - Child Protection Agenda, to drive improved, integrated service responses to violence against women and children in South Australia.

pursuant to state government contracts (ISG applies); Commonwealth FaHCSIA contracts (ISG may not apply); and AGD family law services funding (e.g. family relationship counsellors and family dispute resolution practitioners), in which the *Family Law Act* 1975 applies (see sections 10B to 10K).

- Client confidentiality agreements should ideally be modified to suit different programs and may need to contain a relatively detailed and technical statement of the client's right to privacy and the situations in which their personal information may be shared without their consent.

Steps to consider when approaching information sharing in practice

The steps presented in this section are loosely based on those incorporated into the ISG in SA, the order being only a very rough guide.

i. Are there any mandatory reporting requirements that must be met?
ii. Is the information confidential?
iii. Is there a legitimate purpose for sharing the information?
iv. Has consent been given?
v. Is it safe to seek consent?
vi. Is there a legitimate basis for sharing the information without consent?
vii. Is there sufficient reason to share the information without consent; i.e. might this be outweighed by safety considerations?
viii. If the information is to be shared without consent, should the client still be informed about the disclosure?
ix. Are information sharing processes appropriate, e.g. S.T.A.R. – Secure, Timely, Accurate, Relevant?
x. Has the information sharing decision been recorded?

Some common ways in which information may be shared

Listed below are some common ways in which information may be shared. It is not an exclusive list and is only intended to provide some concrete examples to assist in thinking about this topic. Different considerations will apply to different types of information sharing, for example assisting an independent children's lawyer vs. providing information to a family lawyer representing a client's former partner.

Information sharing in connection with service provision

i. **Active referral:** The referring organisation, with the client's consent, provides the second organisation with information it has collected about the client or with its professional assessment of the client's needs.

ii. **Warm referral:** A live three-way conversation in the presence of the client in which the referring organisation introduces the client and explains what has already been done to assist the client and why the client is being referred.

iii. **Sharing information and opinions between service providers:** The sharing of background information and professional opinions between service providers (interagency or intra-agency) after the referral stage and by consent.

iv. **Interagency cooperation between service providers:** This will generally occur with the consent of the client. It may encompass case conferences, coordination of services, the development of a joint case management plan etc.

v. **Intra-agency cooperation between service providers:** This will generally occur with the consent of the client and may be addressed in the client confidentiality agreement. It may encompass case conferences, the development of a joint case management plan etc.

vi. **Family conferences in relation to children:** Coordinated action between multiple service providers to promote the welfare of children, such cooperation incorporating a family conference with multiple services providers, the child and their family.

vii. **Engaging with the family of a client:** This may involve engaging with the parents of a child, the extended family of an adult etc.

Information sharing specific to Family Law Court proceedings

(See s10D(4)(c) and (e), and s10H(4)(c) and (e) of the *Family Law Act 1975*.)

i. **Independent children's lawyer:** Providing information to an independent children's lawyer to assist them in representing the interests of a child.

ii. **Family consultant:** Providing information to a family consultant to assist them in advising the family law courts, aiding a family etc.

iii. **Family Law Courts (reports):** Providing reports to the family law courts to assist the court in making findings, formulating parenting and other orders etc.

iv. **Legal practitioner:** Providing information to a legal practitioner to assist the practitioner in representing the interests of their client.

v. **Subpoena:** A legal document issued by a court at the request of a party to a case. A subpoena compels a person to produce documents or give evidence at a hearing or trial.

vi. **Child-inclusive family dispute resolution:** Family dispute resolution incorporating input obtained from the parties' child(ren).

vii. **Magellan Proceedings:** The established framework of information sharing and collaboration associated with family court cases involving child abuse.

Information sharing in connection with investigations, unlawful activity and protecting life and safety

i. **Mandatory reporting:** The mandatory reporting of child abuse or neglect under the *Children's Protection Act 1993*.

ii. **Ongoing child protection matter:** The provision of information in connection with an ongoing child protection matter.

iii. **Protecting life and welfare:** Protecting a person from a serious and imminent threat to their life, health or safety. This may involve making a report to the police.

iv. **Reporting unlawful activity:** This may relate to family violence or other offending.

v. **Enforcement purposes:** Providing information to assist in the prevention, investigation and enforcement of unlawful activity.

vi. **Family Safety Framework:** The established framework of information sharing and collaboration associated with high-risk family violence cases referred to the Family Safety Framework.

Other forms of information sharing

Clients requesting their own information: Under the *Privacy Act 1988*, clients have a right to access their own files (subject to certain exceptions).

Letters of referral/support for clients: Letters of referral/support may be requested in connection with employment, housing, financial and other issues.

DOOR 3: The Risk Domains in Detail

DOOR 3 contains an overview of our current knowledge about the aetiology and expression of safety and wellbeing risks for families post-separation. It provides detailed literature reviews of each risk domain covered by the DOORS, highlighting patterns of risk within and across domains. We encourage practitioners to take the time to read and consider these reviews.

The literature has various ways of describing the factors associated with elevated risk across all areas examined in the DOORS framework. Some talk about 'static and dynamic' factors, 'proximal' and 'distal', 'historical and recent' and so on. Here we use the terms 'historical factors' to identify patterns of risk emerging from childhood through to pre-separation, and 'recent factors' when referring to separation and post-separation-related stressors. Where possible, the research outlined pertains specifically to separated and divorced populations of men and women, while some segments extrapolate more generally from what is known about risks common across populations.

Adult mental health

The ending of a cohabiting relationship (either marital or de facto) is a significant life event, in itself a potential trigger for the emergence of a range of maladjustment and mental health issues. Research in the area of mental health and separation suggests a bi-directional relationship — in other words, mental health problems are predictive of separation, and separation is predictive of mental health problems (Gibb et al., 2011). Prior research and demographic profiles confirm significant association between separation and increased rates of depression (Bruce, 1998; Gibb et al., 2011), suicidal ideation and behaviour, and total number of mental health problems (Gibb et al., 2011). It is important to note that not all relationship separations have a negative association with mental health. Poor marital and relationship quality prior to separation can also be negatively associated with mental health and in these contexts ending the relationship may have health benefits for both parties. Practitioners need to balance these considerations.

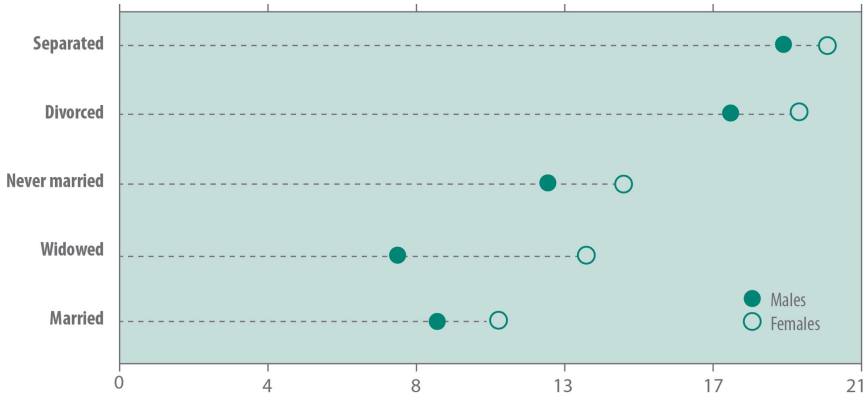
Definitions

A mental health disorder is 'conceptualised as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom...it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual' (American Psychiatric Association, 2000).

Prevalence statistics

- In 2004–05 (see Table 7 below), among those aged 15 and over, mental or behavioural problems were most commonly reported by those who were separated (20% of males and 20% of females) or divorced (17% of males and 19% of females).
- Married persons reported far lower rates of mental or behavioural problems (9% of males and 11% of females).
- High/very high levels of psychological distress were reported more frequently by adults who were separated (22%) and divorced (18%) than by adults who were married (9%).
- Separated women aged 18 and over most frequently reported high/very high levels of psychological distress (25%). The lowest rates of psychological distress were among married men (9.4%).

Table 7. Prevalence of mental and behavioural problems [(a) (b)], by marital status



(a) Self-reported mental and behavioural problems which have lasted or are expected to last for six months or more.
(b) For persons aged 18 years or more.
Source: ABS National Health Survey 2004-5

As outlined earlier in this handbook (see Table 2, p.10) the most recent ABS figures from 2007–08 indicate a similar trend when data are disaggregated by nature of disorder: affective disorders, drug and alcohol disorders and anxiety disorders.

ATSI-specific considerations

The Aboriginal and Torres Strait Islander Health Performance Framework was first developed in 2006 to provide the basis for measuring the impact of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (NSFATSIH). In 2008 the third report for the framework found that:

- 32% of Indigenous Australians aged 18 years and over reported high levels of psychological distress (Department of Health and Ageing, 2010).
- After adjusting for age, these rates are 2.5 times higher for Aboriginal and Torres Strait Islander adults than for non-Indigenous adults.
- Indigenous women (35%) were significantly more likely than Indigenous men (28%) to report high/very high levels of psychological distress and to have seen a health professional about their feelings.
- Indigenous men were 2.2 times more likely to be hospitalised for mental health-related conditions than non-Indigenous men, and Indigenous women 1.5 times more than non-Indigenous women (Department of Health and Ageing, 2010).
- The most common reasons for mental health-related hospitalisation were mental and behavioural disorders due to psychoactive substance use (37% of episodes), schizophrenia (26%), mood disorders (14%), and neurotic, stress-related disorders (14%).
- Psychological distress levels were associated with lower income, uncertain housing tenure, lower educational attainment and unemployment.

Recent and historical risk factors for mental health concerns post-separation[9]

Recent

- Recent, partner-initiated separation (self or jointly-initiated separations can be considered a protective factor)
- Adverse personal meanings of the separation, especially feelings of hopelessness, experiences of abandonment and adverse role change or loss
- Multiple life changes and associated stress brought about by the separation
- Strong, ongoing unresolved emotion about loss/change
- Concurrent problem use of drugs or alcohol
- Absence of effective supports, including social and professional help
- Presence of other acute stressors

Historical

- Presence of marital discord pre-separation is a better predictor of the onset of clinical symptoms than separation or divorce in itself.
- Untreated mental health conditions
- Previous diagnosis of mental health condition — especially diagnosis of major depression prior to separation — associated with post-separation mental health problems
- History of problem use of drugs or alcohol
- History of suicidal ideation

[9]Sources: Amato (2000), Blekesaune (2008), Bulloch, Williams, Lavorato and Patten (2009), Gahler (2006), Hewitt and Turrell (2011), Overbeek et al. (2006).

Gender differences in mental health in the post-separation context

The literature is mixed regarding gender differences in mental health outcomes post-separation.

- Some studies link separation/divorce with increased depression in men (Scott et al., 2010) and others in women (Aseltine & Kessler, 1993) or report similar results across both genders (Gähler, 2006).
- Gibb et al. (2011) found the association between separation and mental health problems were similar for men and women.
- Psychological distress may more often precede divorce amongst women, but last longer following divorce amongst men (Gähler, 2006).

Links to other risk domains

Suicidal ideation

- There is a higher prevalence of serious suicidal ideation in men (28.3%) during separation compared with women (15.5%) after taking into account age, education and employment situation (Kõlves et al., 2010).
- Dieserud et al. (2001) identified a direct relationship beginning with low self-esteem, loneliness, and separation or divorce, which advanced to depression, hopelessness and suicidal ideation, which led to suicide attempts.

Implications for screening in the post-separation population

In the family law context, important considerations for assessing mental health vulnerabilities within the post-separation population include an understanding of recent and historical risk factors and the management of stress. The emotional quality with which the client describes their experiences is important to gauge, with extremes of dismissiveness and denial through to traumatised states of grief, rage or obsessional thinking important to note and follow up.

See Table 6 (p.72) for further assessment tools and key references.

Suicide

Definition of risk domain

Suicide definitions encompass death resulting from injury, suicide-related behaviour and suicidal ideation.

- Death resulting from injury if both self-inflicted and intentionally inflicted (O'Carroll, Berman, Maris, Moscicki, Tanney, & Silverman, 1996).
- Suicide-related behaviour is 'potentially self-injurious behaviour for which there is explicit or implicit evidence either that the person intended to kill themselves or the person wished to use the appearance of intending to kill themselves in order to attain some other end' (O'Carroll et al., 1996, p.247).
- Suicidal ideation is 'any self-reported thoughts of engaging in suicide-related behaviour' (O'Carroll et al., 1996, p.247).

Prevalence statistics

Current Australian prevalence rates of suicide in the separated and divorced population were commissioned by the DOORS project from the Australian Bureau of Statistics and are presented in Table 8 below.

Table 8. Suicide [(a)] by marital status and sex in Australia, 2000, 2005 and 2009[(b)]

	Marital Status							
	Never married		Married		Divorced/separated		Total[(c)]	
2000								
Males	883	47.4	617	33.1	190	10.2	1864	100
Females	180	35.8	178	35.4	75	14.9	503	100
Persons	1063	44.9	795	33.6	265	11.2	2367	100
2005								
Males	764	46.1	542	32.7	201	12.1	1658	100
Females	158	35.6	145	32.7	70	15.8	444	100
Persons	922	43.9	687	32.7	271	12.9	2102	100
2009[(b)]								
Males	691	42.3	521	31.9	255	15.6	1633	100
Females	188	37.7	138	27.7	115	23.0	499	100
Persons	879	41.2	659	30.9	370	17.4	2132	100

(a) 'Suicide' is defined as ICD-10 codes X60-X84, Y87.0. Care needs to be taken in interpreting figures relating to suicide. See Causes of Death, Australia, 2009 (cat.no. 3303.0) Explanatory Notes 80-83.

(b) Causes of death data for 2009 are preliminary and subject to a revisions process. See ABS Causes of Death, Australia, 2009 (cat. no. 3303.0) Technical Note: Causes of Death Revisions.

(c) 'Total' includes marital status of not stated/unknown, widowed, tribally married (2000 and 2005 only) and de facto (2000 and 2005 only).

Source: *Australian Bureau of Statistics (2011).*

The ABS 2009 statistics indicate that:

- 2,132 deaths were registered as intentional self-harm.
- Suicide was ranked as the 14th leading cause of all deaths.
- Males accounted for 76.6% of these deaths.
- Proportionally more men commit suicide than women (at average rates of 3.5 to 1).
- That said, the statistics indicate an increase in the percentage of divorced and separated women committing suicide since 2005.

Other Australian research has consistently found a high prevalence of serious suicidal ideation during the separation process.

- Suicidal ideation reported by 28.3% males and 15.5% females in those recently separated (Kõlves et al., 2010).
- Young adult men aged 15–24 years are at highest risk (Wyder, Ward, & De Leo, 2009).
- Recent separation (within the last three months) is an important factor in predicting suicide (Kõlves et al., 2006), particularly for men (Cantor and Slater, 1995).

ATSI-specific considerations

In the third report for the Aboriginal and Torres Strait Islander Health Performance Framework:

- Deaths due to self-harm (suicide) accounted for 4% of Indigenous deaths between 2004 and 2008 (NSW, Qld, WA, SA and the NT (Department of Health and Ageing, 2010, p.46).
- After adjusting for age differences, this was twice the rate of non-Indigenous Australians.

Historical and recent risk factors for suicide and suicidal ideation

Ide, Wyder, Kõlves and De Leo (2010) find that separation is an independent risk factor for suicide, operating separately from a range of demographic and socioeconomic factors, including race, employment status, income, education, migration, religion and alcohol consumption. Other related factors include[10]:

Recent

- Recent separation
- Mental health problems in the year before separation
- Mood disorders and substance abuse in the year before separation
- Experience of shame, a transient acute feeling triggered by a specific life event such as separation

[10]Sources: Baca-Garcia et al. (2007), Barker & Adelman (1994), Courtenay (2000), Davis, Matthews, & Twamley (1999), De Leo, Cerin, Spathonis and Burgis (2005), Goss, Gilbert & Allan (1994), Grossman & Wood (1993), Halstead, Johnson, & Cunningham (1993), Ide et al. (2010), Kõlves et al. (2010; 2006), Kõlves, Ide & De Leo (2011), Moller-Leimkuhler (2002a), Moller-Leimkuhler (2002b), Murphy (1998), Oliver, Reed, Katz, & Haugh (1999), Wyder, Ward & De Leo (2009).

Historical

- History of suicide attempts
- Lower self-esteem, especially in men
- Previous personal knowledge of somebody who had committed suicide
- Diagnosed psychiatric disorders, specifically depressive disorders

Gender-specific risks

Separated men

- Younger men
- Avoidance of demonstration of emotion or vulnerability
- Men who choose aggression and risk taking as responses to stressful events
- Avoidance of coping strategies
- Reluctance to seek help
- Low educational attainment
- Men who report legal and/or financial negotiations as stressful
- Diagnosis of anxiety disorders
- Partner-initiated separation

Separated women

- Termination of a de facto relationship, as compared to a marriage

Links to other risk domains

Mental health

- Studies have found more than 90% of suicide victims and attempters had at least one current Axis I (mainly untreated) major mental disorder: most frequently major depressive episode (MDE) (56–87%), substance use disorders (26–55%) and schizophrenia (6–13%) (Rihmer, 2007).
- Divorce occurring within the last year is linked with increased likelihood of first time psychiatric admission with a diagnosis of depression (Kessing et al., 2003).
- Depression increases by three times the probability of experiencing all levels of suicidal ideation and also attempted suicide (De Leo et al., 2005).
- For people with a dual diagnosis of psychiatric disorder and substance abuse/dependence, there is a particularly high risk for suicide (Moscicki, 1995, cited in Graham et al., 2000).
- Sisask, Värnik, Kõlves, Konstabel and Wasserman (2008) found severity of the attempted suicide was associated with increased levels of depression and hopelessness.

Implications for screening in the post-separation population

Ide et al. (2010) discuss the importance for all practitioners to develop a greater understanding about the process of separation and how it links to the development of suicidal behaviours. Such an understanding may serve to reduce suicide risk. Based on their findings, we can judge that central factors include a clear gender-specific assessment, and identification of:

- who was the initiator and who the non-initiator of the separation and what is the impact of relationship loss and re-partnering, especially for the non-initiator
- broader psychological factors related to the separation (e.g. depression, low self-esteem, feelings of shame, coping styles)
- psychiatric diagnoses pre- and post-separation
- contextual factors (e.g. social circumstances, presence of children, living arrangements, economic change, nature of legal processes) and how these are impacting the client
- social, cultural and societal supports and pressures (e.g. attitudes toward divorcees, traditional notions of masculinity), and how these impact on the meaning of separation, and attitudes towards support for the client, particularly in the case of culturally or religiously diverse clients.

See Table 6 (p.72) for further assessment tools and key references.

Drug and alcohol use issues

Definition of risk domain

The term 'substance use' refers to:

- The consumption of alcohol and other drugs for recreational purposes
- The use of stimulant drugs (e.g., cocaine, amphetamines, ecstasy, caffeine, nicotine), depressants (e.g., alcohol, heroin, benzodiazepines, morphine, cannabis, glue and petrol sniffing) and hallucinogens (e.g. LSD, 'magic mushrooms' and ketamine). Note there is some overlap in the categories; for example, cannabis and ecstasy are also capable of inducing hallucinogenic effects. These are psychoactive substances, which alter mood, perception, cognitive processes and behaviours and may be taken individually, serially, in combination or alternately. They cause various effects depending on how they are consumed and the characteristics and habits of the person consuming them.

The Diagnostic and Statistical Manual of Mental Disorders Version IV – Text Revision (DSM-IV-TR: American Psychiatric Association, 2000) provides the following guideline for the diagnosis of alcohol and substance use issues.

- *'A maladaptive pattern of alcohol (or substance) use leading to clinically significant impairment or distress'* (DSM-IV-TR: American Psychiatric Association, 2000).
- In the case of abuse, this is further articulated to describe recurrent use that interferes with role obligations, is physically hazardous, and creates legal problems as well as persisting/recurrent interpersonal problems.

Alcohol or drug dependence is compounded by problems of developing tolerance to the substance (increased need and decreased effect), withdrawal symptoms when substance use is discontinued, other substance use to manage or avoid withdrawal, escalating, prolonged use, cessation of harm-reducing activities, unsuccessful attempts to stop usage, and continued use despite knowledge of harm.

Colloquially, the terms 'addiction' and 'substance abuse' also apply to drugs such as nicotine and prescribed medications, but the former is not generally a concern in a safety risk assessment. Wrongful use of prescription medication does constitute risk, for example when not taken as prescribed, taken in larger amounts, or in a manner that is harmful (such as injecting oral medication) or mixed with other substances without a doctor's sanction.

Alcohol is usually identified separately from other drugs of addiction because of its ubiquity and unique position in many cultures. Alcohol is the most commonly used intoxicating drug globally. For many that use is minimally problematic, yet internationally it is responsible for significant direct and indirect harm (including motor vehicle accidents, family violence, public violence, traumatic injury, cirrhosis, cancer, alcohol-related brain injury). It is legal, readily accessible and socially acceptable in most countries and has historically been available in a majority of cultures since early civilisation (see Australian Psychological Society Working Group Paper on Substance Use, 2005, and National Survey of Mental Health and Wellbeing, ABS, 2007).

Prevalence statistics

Australia

In considering available estimates about prevalence, it is important to bear in mind that illicit drug users are likely to under-report actual use because of the illegal status of the drugs.

In 2010, 26,648 Australians aged 12 and over were surveyed for the National Drug Strategy Household Use on their drug use patterns, attitudes and behaviours (Australian Institute of Health and Welfare, 2011a). Across the sample:

- Men were more likely to use alcohol or drugs than women, with the exception of non-prescription use of pharmaceuticals.
- Men were more likely than women to engage in risky activities while under the influence of alcohol/drugs.
- Illicit drug use and risky alcohol use were most common in the 18–29 age group.
- Those living in remote/very remote regions reported higher levels of risky alcohol use but lower levels of illicit drug use.
- One in five Australians drank at levels that put them at risk of lifetime harm (i.e., more than two standard measures of alcohol per day).
- A higher proportion (28.4%) drank more than four standard measures of alcohol per drinking episode at least once a month. This level of consumption is considered to put someone at risk of accident or injury according to National Health and Medical Research Council guidelines (2009).

Harmful alcohol use is significantly implicated in morbidity and mortality, being estimated at 3.8% of the disease burden for males and 0.7% for females. Alcohol abuse, anxiety, depression and personality disorders were all subsumed under 'mental disorders' and that category was the highest contributor to non-fatal disease burden (24%) (see Begg et al., 2007).

Table 9 (p. 115) was commissioned for the DOORS project. Using National Drug Strategy Survey 2010 data, it reports on comparative alcohol, illicit drug and tobacco use by parents of dependent children. In summary:

- Divorced or separated females with dependent children were twice as likely as married/de facto females to have used an illicit drug in the last 12 months (17% compared with 8.4% respectively) despite similar proportions reporting a previous history of use (41.2% and 40.2% respectively).
- This was also true for men (22.1% compared with 12.7% for current use and 44.2% versus 41.4% for past use respectively).

ATSI-specific considerations

Alcohol and drug issues are of great concern within Aboriginal communities in Australia.

- Indigenous males are five times more likely to die of alcohol-related conditions than non-Indigenous men, and Indigenous women are four times more likely to die from alcohol-related causes than non-Indigenous women (Schlesinger et al., 2007).
- The most recent statistics from the NHDS indicates that ATSI people are more likely to engage in risky alcohol use and to smoke than the general population (ABS, 2006).
- Compared to non-Aboriginal populations, Aboriginal populations also have a higher percentage of people who do not drink alcohol at all.
- Illicit drug use of non-rural ATSI people is more than twice the level of the general population in Australia. This is true for all categories of drugs including alcohol and volatiles (e.g. petrol) and was increasing at the time of reporting (The National Aboriginal and Torres Strait Islander Health Survey, 2004–2005).

CALD-specific considerations

Substance use brings specific challenges across different cultures and religious groups.

- CALD clients are significantly under-represented in drug treatment services (Drug and Alcohol Multicultural Education Centre, 2007). This may reflect lower rates of problem behaviours, but also may be attributable to increased levels of shame and isolation over substance use issues, and a lack of understanding of treatment options available.
- In some cultures, counselling or psychological treatment for substance use issues is not an accepted form of intervention, with people more often sent to their religious or community leaders for guidance.

Table 9. Comparison of substance use by marital status (separated/divorced vs. married/ de facto) of parents aged 14+ years.

	Divorced/ separated with dependent children	Married/de facto with dependent children	Divorced/ separated with dependent children	Married/de facto with dependent children	Divorced/ separated with dependent children	Married/de facto with dependent children
Alcohol Lifetime Risk	**Males**		**Females**		**Persons**	
Abstainer/ ex-drinker[a]	*8.0%	11.9%	21.8%	16.9%	18.9%	14.5%
Low risk[b]	54.4%	58.5%	63.8%	73.2%	61.9%	65.9%
Risky[c]	37.6%	29.5%	14.3%	9.9%	19.2%	19.6%
Single Occasion Risk (binge drinking)						
Low risk[d]	28.0%	30.8%	42.0%	50.5%	39.1%	40.8%
At least yearly but not weekly[e]	32.9%	34.9%	25.4%	25.8%	27.0%	30.3%
At least weekly[f]	31.1%	22.3%	10.8%	6.8%	15.0%	14.5%
Any Illicit Drug						
Never used	33.7%	45.9%	41.8%	51.5%	40.1%	48.7%
Ex-user[g]	44.2%	41.4%	41.2%	40.2%	41.9%	40.8%
Recent user[h]	22.1%	12.7%	17.0%	8.4%	18.1%	10.5%
Tobacco						
Never used[i]	38.2%	50.7%	45.1%	55.5%	43.6%	53.1%
Ex-smoker[j]	32.3%	28.9%	24.2%	28.9%	25.9%	28.9%
Smoker[k]	29.5%	20.4%	30.7%	15.7%	30.4%	18.0%

Source: The above Table was commissioned by the DOORS project, from the Drug Surveys and Services Unit, Australian Institute of Health and Welfare, using the National Drug Strategy Survey 2010 data.

*Estimate has a relative standard error of 25% to 50% and should be used with caution.

(a) No alcohol in the last 12 months.

(b) On average, no more than 2 standard drinks per day.

(c) On average, more than 2 standard drinks per day.

(d) Never had more than 4 standard drinks on any occasion

(e) More than 4 standard drinks at least once a year but not as often as weekly

(f) More than 4 standard drinks at least once a week

(g) No use in the previous 12 months.

(h) Used in the previous 12 months.

(i) Never smoked 100 cigarettes or equivalent amount of tobacco.

(j) Smoked at least 100 cigarettes or equivalent amount of tobacco in their life, and reports no longer smoking.

(k) Smoked daily, weekly or less than weekly.

Risk factors for substance use disorders

Recent

- Adverse events exacerbating or resulting in acute or chronic stress, or trauma, including marital breakdown
- Mental illness including personality disorders
- Drug availability

Historical

- Family history of substance use
- Peer exposure
- Interpersonal trauma, especially violent conflict (war-fare, family violence)
- Family breakdown

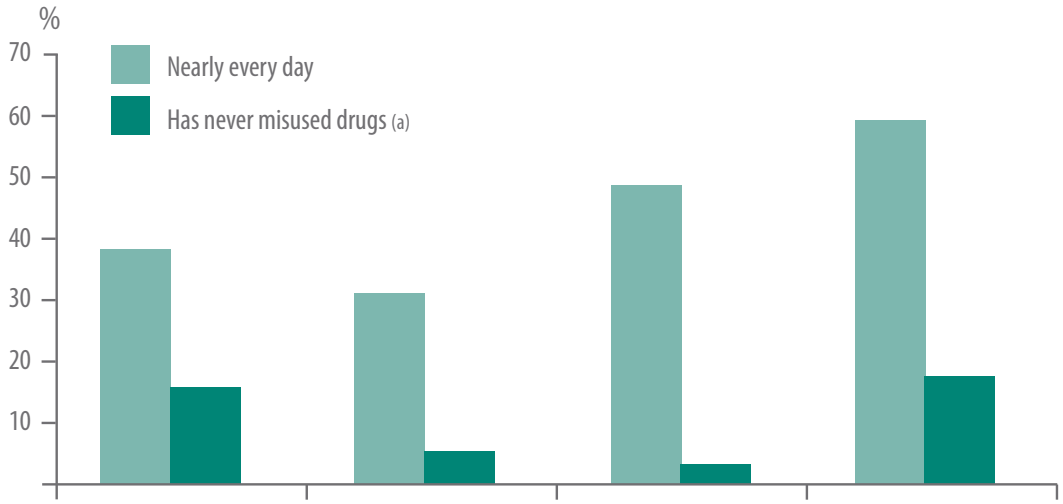
Links to other risk domains

Mental illness

Data from the National Survey of Mental Health and Wellbeing (ABS, 2007) show:

- There is a high probability that someone with a substance use problem will have one or more co-occurring mental health disorders, most often anxiety, depression (and suicide) and/or post traumatic stress and/or personality disorder.
- 63% of those who reported regular drug use in the last 12 months also reported a concurrent mental illness.
- International estimates of co-morbidity from mental health/substance use problems vary from 50% to 90%.

Table 10. Misuse of drugs by mental health disorder in the previous 12 months



(a) Includes persons who have never used drugs and persons who may have used the same drug less than 5 times in their lifetime.

Source: *National Survey of Mental Health and Wellbeing (ABS, 2007).*

In Victoria (since 2008) alcohol and substance treatment facilities are required to screen for high levels of mental health issues (e.g. anxiety, depression) and to provide assertive referral as a minimum for all mental illnesses. Mental health facilities are required to do the same for substance use disorders.

Marital breakdown, violence, criminal behaviour, poor health

- Alcohol misuse and illicit drug use are heavily implicated in marital breakdown and family violence.
- This is particularly true for co-occurring substance use and mental health issues.
- Treatment for either disorder independent of the other is often less effective; clients are less likely to attend appointments and the risk of relapse is higher[11].

Gender differences

There are established gender differences in substance use prevalence, harm and co-morbidity[12].

- Men have a higher incidence of substance abuse and dependence than women, particularly with alcohol.
- Men and women have significant physiological differences in their capacity to consume alcohol.
- Women have less total body water than men and are usually physically smaller, resulting in higher blood alcohol concentrations for the same quantity of alcohol consumed. Women possess less alcohol dehydrogenase, an enzyme that metabolises alcohol within the body. These factors increase female vulnerability to alcohol-related harm compared with men, including increased risk of cirrhosis, alcohol-related brain injury and breast cancer.
- Gender differences in the physiological response to other drugs are less thoroughly researched.
- Women tend to be more culturally stigmatised for substance use than men and their substance use is more likely to disrupt their family life, leading to separation and divorce.
- Women tend to begin drug use later in life than men, transition to alcohol dependence quicker than men, and enter alcohol and drug treatment earlier.

See Table 6 (p.72) for further assessment tools and key references.

[11]Sources: Australian Psychological Society Working Group (2005), Croton (2011), Wolcott & Hughes (1999).

[12]Sources: Australian Institute of Health and Welfare (2011a), Australian Psychological Society Working Group (2005), Brady & Randall (1999), Kessler et al. (1994).

Parenting stress and capacity

Definition of risk domain

Parenting capacity refers to a parent's ability to create and maintain both a physical and psychological experience of comfort, safety and healthy psycho-social growth for their child.

Parenting that is warm, reflective, sensitive and responsive (each in a 'good enough' way) is widely accepted as essential for children's optimal wellbeing (Osofsky & Thompson, 2000; Slade et al., 2005).

- While for some separation brings relief from stress and conflict, for many grief and stress compromise the ability to be available and attuned to their child(ren)'s needs, at least for short periods of time.
- Ongoing inter-parental conflict often heralds more damaging forms of parenting stress (McIntosh & Long, 2003).
- Lengthy periods of compromised parenting or acute and severe episodes of harsh parenting both have significant developmental implications for children.
- Correlates of stress include a parent's dependence on the child for emotional support (parentification), pressuring the child to form alliances against the other parent and decreased ability to recognise, prioritise and meet children's needs.
- Both infants and children are able to recognise and react to a parent's distress and conflict.
- Effects of ongoing or severe conflict and compromised parenting for infants can be profoundly de-stabilising influences on an infant's developmental pathway.

Recent and historical risk factors for parenting stress[13]

Recent

- Parental conflict in the pre- and post-separation context
- Domestic violence
- Being the non-initiating partner of a recent separation
- Unexpected separation, engendering shock, humiliation or trauma
- Financial hardship and deterioration in economic conditions
- Social isolation
- Stressful work or high number of hours worked per week
- Unemployment
- Mental health and substance abuse difficulties
- Health problems, illness

Historical

- Experiences of harsh or unresponsive parenting in client's own family
- Histories of violence and trauma

[13]Sources: Amato & Booth (1997), Emery (1988), Gerstel, Riessman & Rosenfield (1985), Hope, Power and Rodgers (1999), Johnston, Gonzalez & Campbell (1987), McIntosh (2008), Menaghan & Lieberman (1986), Pettit & Bloom (1984), Pryor & Rodgers (2001), Strohschein (2005), Wallerstein & Blakeslee (1989), Weston (1986).

Links to other risk domains

Drugs and alcohol

Divorced/separated individuals have substantially higher rates of alcohol consumption and substance abuse disorders than their married counterparts (Hall et al., 1999; see also Table 2 p.10 and Drug and Alcohol Use Issues, p.112). There is an established pathway between problem drinking and decreased parental warmth and increased parental control (Keller et al., 2008).

Mental health (Adult and Child/Infant)

Many studies have found associations between inter-parental conflict and parental depression (Whisman, 2001).

- Depressive symptoms in parents are associated with diminished parental capacity evidenced by increased negative demeanour, withdrawal and hostility (Du Rocher Schudlich et al., 2004).
- In turn, there is an association between parental depression, interparental conflict and child adjustment problems (Repetti et al., 2007; Kouros et al., 2008; Pryor & Rodgers, 2001).

Implications for the post-separation population

Screening for parenting stress is a useful entry point into understanding a host of stressors for both parent and child. When stress is high, practitioners need to consider interventions which:

- facilitate coping strategies for parents and children
- minimise stress
- increase support
- foster a positive nurturing environment, including effective co-parenting.

See Table 6 (p.72) for follow-up tools and key references.

Infant and child mental health

Definitions

The stage of infancy ranges from birth to approximately three years of age (ZERO TO THREE Infant Mental Health Task Force, 2002), while the period of childhood generally refers to the ages of four to twelve, and adolescence from thirteen to eighteen.

- There is variability within infancy in rates of maturation across physical, cognitive, language and psychosocial functioning; however, the period of infancy is universally regarded as a time of significant development and concurrent vulnerability.
- At no other time is the growth of the human brain so rapid and expansive (Schore & McIntosh, 2011).
- Key stages of infancy include forming close and secure care-giving relationships, forming a subjective sense of self, exploring the environment and discovering early agency, learning to regulate bodily needs and emotional states, and developing and managing a rich intra-psychic and interpersonal life.

A baby's mental health cannot be well understood without considering the quality of their care-giving relationships, particularly the warmth, consistency and sensitivity of parenting they receive, and the nature of support or stress experienced in these and other relationships.

- Infants are not born with the capacity to self-regulate stress.
- The baby's early attachment relationships become the vehicle through which strong needs and feelings are first co-regulated by the parent through predictable patterns of response to the baby's signals. Subsequently, the baby learns how to self-regulate stress states.
- Babies' temperaments vary, with some being more easy-going than others across a range of situations.

The World Health Organization (WHO, 2005) upholds both the concept of infant mental health, and its centrality in shaping the child's optimal psychosocial functioning and wellbeing.

- For most infants, signs of difficulty with early mental health include ongoing irritability, upset, unsettledness, marked separation distress, early communication problems, feeding and sleeping problems, and distressed or disturbed interactions with others.
- A useful resource for further exploration of infant mental health is the Zero to Three website: www.zerotothree.org.

The pre-school years are a crucial period for consolidating the ability to self-regulate stress, to overcome normative challenges and to form a number of trusted relationships to facilitate growth. The development of mental health of children through the school years involves:

- the expansion of the self into a growing social world
- the growth of identity and self-worth
- healthy sociability
- creating and sustaining strong family and peer relationships
- developing the ability to focus, be productive and learn
- developing autonomy.

Mental health in divorce and separation[14]

By age 15 about 40% of children in Australia and the US experience the dissolution of their parents' partnership. Acrimonious divorces with ongoing levels of poorly resolved or uncontained conflict between parents constitute about one third of these separations.

For older children, divorce often represents the collapse of an important structure in their world and their sense of family and self.

- Most children experience considerable sadness in the first stages of separation, with anxiety, anger, resentment, confusion, guilt, loyalty tensions and somatic symptoms being common responses in the first six months post-separation.
- The re-structuring of family life necessitated by divorce involves multiple and complex adjustments for parents and children, including transitions of home and school, change in parent and extended family contact, economic strain, periods of diminished parenting, parent conflict, sadness and grief.
- These factors combine to elevate risks of poor outcomes for children of divorce, across psychological, social, health and academic domains, extending to adulthood, with increased risk of diminished emotional, economic and educational attainment.
- There is no age, stage, or gender immune to the impacts of entrenched parental discord associated with separation (Buchanan & Heiges, 2001).
- Mental disturbances at a young age can lead to continuing impairment in adult life; as such, poor outcomes for children of divorce can carry on into adulthood, with increased risk of diminished emotional, economic and educational attainment (Amato, 1999; Cherlin et al., 1998).

As Pedro-Carroll (2001, p. 994) wrote: 'These sobering outcomes raise important questions about the inter-generational transmission of divorce and the extension into adulthood of vexing problems that cast a shadow on life satisfaction. Yet these outcomes are not inevitable, nor are they uniformly applicable to all children'.

Protective factors can buffer the risks for children; these include:

- parental warmth and responsiveness
- resolution of conflict
- secure attachment with both parents
- supportive relationship with sibling(s)
- consistent, supportive environment for the child
- effective adult support and peer friendships beyond the family
- Ongoing commitment and support of both parents.

Over time, adjustment and robustness generally improve as parental conflict subsides, within a stable, supportive care-giving environment (McIntosh, Smyth, Wells, & Long, 2010). The fact that some children from high-conflict marriages have been shown to prosper following parental divorce (Amato & Booth, 1997) suggests that divorce may be helpful or harmful depending on whether it adds or removes stress from children's lives.

[14]Sources: Crockenberg & Langrock (2001), Dixon, Charles & Craddock (1998), Kneale (1999), McIntosh (2003, 2008), Mullender, Kelly, Hague, Malos & Imam (2000), Wallerstein & Lewis (1998), Zill, Morrison & Coiro (1993).

Prevalence statistics

- According to the 1998 Child and Adolescent Component of the National Survey of Mental Health and Wellbeing, 14% of young people aged between 4 and 17 years were reported to have a mental health problem, with significantly higher rates for children in low-income, step/blended and one-parent families (Sawyer et al., 2001).
- In a review of the US statistics, McLanahan (1999) found that children in divorced families were more likely to experience greater economic, social and health difficulties, more likely to use alcohol and drugs and to rely on peer groups who use substances, and were twice as likely to give birth to a child as a teenager.
- Other studies find significantly higher risks for dropping out of school early and earlier marriages with increased propensity to divorce (Buchanan & Heiges, 2001; McLanahan & Sandefur, 1994).

ATSI-specific considerations

In the Western Australia Aboriginal Child Health Survey (WAACHS) (Zubrick et al., 2005)[15], 24% of Aboriginal children aged between 4 and 17 years surveyed were assessed as being at high risk of clinically significant emotional or behavioural difficulties compared with 15% of all children, with boys having twice the risk of girls.

Recent and historical risk factors for mental health difficulties in children and infants[16]

Recent

- Domestic violence
- Child abuse and neglect
- Hostile or punitive parenting styles
- Poor emotional availability/sensitivity of parents
- Frequent, intense, threatening or poorly resolved conflict between parents
- Significant levels of acrimony, anger and distrust between parents
- Sabotage of otherwise healthy relationship with children's other parent
- Disruptions to schooling and loss of social supports
- Frequent, lengthy separation of infant from attachment figures

Historical

- Parents' mental health problems
- Poverty
- Parental substance abuse

[15]The WAACHS is the largest and most comprehensive study of Aboriginal child health and development in Australia. It explores the physical health, social and emotional wellbeing, education experiences and the role of families and communities in supporting the healthy development of Aboriginal children and young people.

[16]Sources: Amato (2000), Amato & Cheadle (2005), Buchanan, Maccoby & Dornbush (1996), Cummings & Davies (1994), De Bellis (2001), Grych & Fincham (2001) Hughes et al. (2002), Kelly (2000), Lieberman & Van Horn (1998), Johnston (2002), Main, Hesse and Hesse (2011), Margolin & Gordis (2000), Mathias et al. (1995), Mertin & Mohr (2002), McIntosh (2003a, 2003b), Pfefferbaum & Allen (1998), Strohschein (2005).

- Parental unemployment
- Parents' education
- Frequent, intense, threatening or poorly resolved conflict between parents
- Child's learning, health or other developmental difficulties/disorders

Parenting warmth and sensitive, consistent response are crucial buffers for children of all ages when faced with any taxing and distressing circumstances. Thus, close attention to the capacity of parents to be responsive to their child is crucial to an understanding of the child's mental health and the likelihood of resilient responses to normative and sub-normative experiences of stress and change.

Links to other risk domains

The highest risk to children's mental health after parental separation may indeed be the behaviours of parents themselves.

- Inter-spousal violence is among the most catastrophic of traumas for children. When fear or terror is generated by or between the people upon whom the child is dependent, the child is left with a form of 'fear without solution'.
- When domestic conflicts are too frequent or too intense to deal with, when care givers are frightened or frightening, the dependent child is in a double-bind, especially when they are unsupported to make sense of and recover from the episode(s).
- Experiencing domestic violence leads to higher rates of disturbance in children than exposure to community violence.

Children who have witnessed domestic violence have fundamental similarities to children who have suffered direct abuse by their carers. The impacts of a violent family climate on a child's social world include:

- Increased aggression, impulsiveness, anxiety, poor social skills, and disrupted social schemas around power and gender (Darwish et al., 2001; Graham-Bermann, 2002).
- Poor decision-making in relation to romantic relationships and a high likelihood of repeating the cycle of violence in their adult lives are also likely (Carlson, 2000; Johnston, 2002).
- In extreme and protracted family violence, there is growing neurocognitive evidence for brain growth trauma (Beer & De Bellis, 2002; Medina et al., 2000; Orbach et al., 2001; Reviere & Bakeman, 2001).
- When conflict and family violence co-occurs with other risks, namely, mental health of parents, poverty, parental substance abuse, unemployment, or low education, greater developmental impact is evident (Crockenberg & Langrock, 2001; Dixon et al., 1998).

Implications for screening in the post-separation population

Early screening for potential mental health risks in children and infants is important in the post-separation population. Many studies document the benefits of early intervention, from one-off advice from a doctor or infant welfare nurse, to community-based supports, to comprehensive assessment and therapeutic support from an infant and child mental health specialist.

- The Zero to Three website (www.zerotothree.org) provides a range of tools for further follow-up on infant concerns.
- Readily available screening tools for children's mental health (ages 4–16 years) include the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997; see http://www.sdqinfo.com), and
- The Child Behaviour Checklist (pre-school and school aged versions) (Achenbach, 2009; see http://www.aseba.org).
- The SDQ is a briefer, generic tool that could be used across disciplines, where the Child Behaviour Checklist is best administered and interpreted by child mental health professionals.
- These measures include parent and teacher report forms and also children's report forms, and offer a screen for multiple dimensions of psycho-social functioning, with well-validated thresholds for identifying clinically concerning behaviours.

See Table 6 (p.72) for follow-up tools and key references.

Child abuse and maltreatment

Definition of risk domain

Child abuse, as with all forms of family violence, is a complex phenomenon and rarely sits in isolation to other forms of family dysfunction. Some distinctions offered in the literature may unfortunately promote notions of types of child maltreatment existing in isolation from each other, or from other forms of family violence and dysfunction. There is in fact a well-established relationship between family violence and child abuse (Moloney et al., 2007, p.11).

The term 'child abuse' refers to treatment of a child within care-giving relationships that causes the child to be physically or emotionally injured, and/or sexually abused.

- *Physical abuse* may be inflicted intentionally or inadvertently through punitive disciplinary actions or an aggressive outburst by the caregiver.
- Physical injury may also result from chronically neglectful treatment.
- *Sexual abuse* by a family member refers to a situation in which that family member or members have involved the child in any form of sexual activity.
- The National Child Protection Clearinghouse Resource Sheet (Lamont, 2011) states that any sexual behaviour between child and adult family member is abusive, and that the concepts of consent, equality and coercion do not apply.
- *Emotional abuse* accompanies all forms of abuse and neglect and may also occur in its own

right (e.g. through the experience of chronic derision, blame or exposure to emotionally harmful stimuli, such as severe parental conflict or violence, repeated rejection of the child or use of threats to frighten the child).

- *Neglect* refers to a chronic failure in the child's care giving environment to provide basic physical and/or emotional necessities of life, to the extent that the child's health and development is, or is likely to be, profoundly jeopardised. Again, these facets of maltreatment commonly interact and reflect a troubled and traumatised care-giving environment.

There is some disagreement within and between cultures about what constitutes dangerous or unacceptable forms of parenting, and with this, unclear thresholds for establishing parameters of harm to children. Suffice it to say that the DOORS framework advocates a conservative perspective and notes a now long line of literature documenting the effect on child development of low-grade chronic stress in the care-giving relationship, through to the devastating impacts to mental health of a single traumatic incident of parent-to-child violence (Lieberman et al., 2011). Of note, a significant predictor of perpetrating family violence or domestic homicide as an adult includes the experience of family violence and abuse as a child (see sections on Family Violence, p132 and Familicide, p.142).

Prevalence statistics

Naturally, the true prevalence of child maltreatment is impossible to gauge. One of the crude forms of measurement has been to take raw figures from official reports of child abuse and neglect made to statutory child protective services.

- In 2009–2010, 286,437 reports of suspected child abuse and neglect were made, and 131,689 reports were finalised (Lamont, 2011). Of these, there were 46,187 substantiations across Australia, which concerned 31,295 children (Lamont, 2011).
- Maltreatment types most commonly substantiated across Australia were emotional abuse and child neglect (Lamont, 2011).
- In the divorced population, 24 out of 109 cases in the Family Court of Australia (22.0%) and 28 out of 116 cases in the Federal Magistrates Court (24.1%) contained allegations of child abuse by a parent (Moloney et al., 2007).
- Consequences include problems with mental health stemming from trauma-induced neurological impairment (Perry, 2002), feelings of isolation, fear, and an inability to trust (Moloney et al., 2007). Substance abuse problems in later life are common in those who experienced significant abuse as children (Swan, 1998).

Collective studies within the family court population show a double-sided picture: a higher percentage of allegations of child abuse occur and are substantiated in the family court population, together with an increased proportion of allegations that are unsupported or indeed malicious (Moloney et al., 2007). It seems important that family law practitioners bear in mind the duality of this finding, but do not risk overlooking a child's significant distress because an element of it may occur in the context of an ambit claim.

ATSI-specific considerations

Findings of the 2009–2010[17] report:

- Aboriginal and Torres Strait Islander children were found to be 7.7 times as likely as non-Indigenous children to be the subject of substantiation of child abuse (Australian Institute of Health and Welfare, 2011c).
- In that year, 3.53% of Indigenous children were the subject of substantiation, compared to 0.46% of non-Indigenous children.
- For Indigenous children across Australia, the most common type of abuse was neglect.

Historical and recent risk factors for child abuse

There are no homogenous patterns of predictors, as risk factors build upon one another in a multitude of ways, and many causes and outcomes are circular; that is, a child having a difficult temperament can be both causative and an outcome of maltreatment. However, the following factors are clear correlates of a child experiencing abuse or neglect.

Physical child abuse: recent

- Parent perceives child as a problem
- Parents suffering personal stress/in crisis
- Parents with limited social support
- Parents who abuse alcohol/drugs
- Parents who are unemployed
- Child with poor social competence
- Presence of domestic violence
- Disability, medical fragility of child
- Unrealistic parental expectations of children

Physical child abuse: historical

- Unplanned pregnancy
- Parental use of corporal punishment
- Family and cultural attitudes accepting of violence
- Authoritarian parenting with impulse control difficulties
- Psychopathy of all forms
- Parents' own childhood experiences of abuse
- Parents with criminal behaviours
- Co-occurring stressors in parenting: age, employment, housing, resources
- Young children more likely than older children
- Inadequate knowledge of child development

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[17]An annual comprehensive report on child protection in Australia was conducted by the Australian Institute of Health and Welfare.

[18]Sources: Australian Institute of Health & Welfare (2011c), Cash (2001), Center for Sex Offender Management (2007), Cortoni & Marshall (2001), Family Violence Coordination Unit (2007), Lamont (2011), Milner (1994), Peter (2009), Stirpe & Stermac (2003), Stith et al. (2009).

Sexual child abuse: recent

- Parental psychopathy
- Participation in pornography
- Intimacy deficits and loneliness
- Access to children, including own and step-children
- Time and opportunity to groom the victim
- Actual or perceived cognitive vulnerability of child

Sexual child abuse: historical

- Girls more likely victims than boys
- Young children more likely victims than older children
- Aboriginal and TSI children more likely victims than non-indigenous children
- Perpetrator's sexual preoccupation/perversion during adolescence
- Use of sex as coping strategy later in life
- Perpetrator history of childhood sexual abuse and increased exposure to sex
- Extreme physical discipline in perpetrator's childhood household
- Personality disorders, substance abuse problems
- Difficulties in intimate relationships or absence of intimate relationships

Child neglect: recent

- Parent perceives child as problem
- High levels of personal stress
- Disability, cognitive or medical fragility of child

Child neglect: historical

- Younger parents
- Larger family size
- Lower socio-economic status
- Young children more likely victims than older children
- Aboriginal and TSI children more likely victims than other children
- Parents with high levels of anger/reactivity, depression
- Psychopathology
- Chronic unemployment
- Neglectful/traumatising relationship with their own parents

Links to other risk domains

- Domestic violence, parental substance abuse and parental mental health problems are strongly associated with the occurrence of child abuse and neglect (Bromfield et al., 2010).
- The impacts of child abuse are influenced by factors such as the age and developmental stage of the child when the abuse occurred, the type of abuse, the frequency, severity and duration of the abuse, and the quality of the relationship between the child and the abuser (Moloney et al., 2007), and the quality of repair possible subsequent to abusive or neglecting episodes.
- Rates of child abuse co-occurrence with intimate partner violence are as high as 40-55% (see Moloney et al., 2007, p.13). In a sample of children in the child protection unit of a metropolitan Australian hospital, intimate partner violence reports co-existed with 55% of physical abuse cases and 40% of sexual abuse cases (Goddard & Hiller, 1993).
- There are several ways in which intimate partner violence and child abuse co-occur: a) the perpetrator in intimate partner violence may also perpetrate against children in the family (Appel & Holden, 1998); b) victims of intimate partner violence may be abusive towards their children (Hartley, 2004; Margolin et al., 2003); and c) children may be injured when intervening in their parents' violence (Edleson et al., 2003).
- Risk factors for all three forms of child abuse include parent psychopathology, more specifically depression linked to child neglect, and anger-related symptomatology linked to physical child abuse (Stith et al., 2009).
- Children of parents with an untreated or poorly contained mental illness have a high risk of physical neglect, where their needs are not being met. In such situations, children might assume the role of a carer for their ill parent, resulting in significant levels of emotional stress (Huntsman, 2008).
- Parents' substance abuse is associated with child neglect and emotional abuse (Center for Sex Offender Management, 2007; Legano et al., 2009) due to poor parental supervision, impaired judgement and lowered impulse control (Dawe et al., 2002).
- Johnston, Roseby and Kuehnle (2009) proposed that child abduction may be considered a form of child abuse through its traumatic impact on the child.

Implications for screening in the post-separation population

- Practitioners need to be familiar with state laws (see Appendix 1, pp. 192-194) regarding mandatory reporting of child abuse. Because child abuse has a high occurrence with a number of other risk domains, screening across all domains is recommended.
- The Australian Research Alliance for Children and Youth (ARACY, 2010) has recently developed the Common Approach to Assessment, Referral and Support (CAARS), currently being piloted nationally. This framework provides a solid foundation for family law and other frontline professionals to further explore the nature of child abuse and neglect, and clusters of factors that create risk for dependent children.

See Table 6 (p. 72) for follow-up tools and key references.

Child abduction

Definition of risk domain

Parent abduction of a child is defined as 'the broad range of situations that involve one parent taking, detaining, concealing, or enticing away a child from the other parent who has custody and visitation rights' (Johnston & Girdner, 1998, p. 393). Johnston et al. (2009, pp. 335–337) note that:

- Parental abduction of a child occurs when a member of the child's family, or someone acting on behalf of a family member takes action to deprive a parent of his or her lawful rights to have custody or access to the child.
- Although abductors are usually one of the child's parents, they could also be grandparents, step-parents or other relatives.
- Abduction includes attempts to remove, conceal, or refuse to return the child, to deny a parent's access to the child indefinitely or permanently without good cause.
- Abducted children are not missing children — their whereabouts are known; however, one parent is refusing to allow the other rightful access.
- Mothers are more likely to abduct their children when there has been a family court order put in place, and fathers when there has not been a parent order put in place (Johnston et al., 2009).

The National Incidence Studies of Missing, Abducted, Runaway and Thrownaway Children (NISMART) (Hammer et al., 2002) in the US draws the following distinctions when defining abduction:

Broad-scope family abduction: A family member takes a child or fails to return a child when there is a legal agreement in place in relation to the arrangements and the child is kept at least overnight.

Policy-focal family abductions: In addition to the above, at least one of the following additional conditions is also met:

- abducting parent attempts to conceal the whereabouts of the taken child
- abducting parent travels with the child out of the state
- presence of evidence that the abducting parent had the intention to permanently disregard the other parent's ongoing right to a meaningful relationship with the child or to keep the child indefinitely.

Prevalence statistics

International abductions and returns of Australian children

Prevalence statistics for domestic interstate abductions were not available for this handbook. International abductions from 2007–2010 (Attorney-General's Department, 2011) are provided in Table 11 (p. 130). This table shows the number of children wrongfully removed from Australia to another Hague Convention country and, the number of children wrongfully removed from another Hague Convention country to Australia for whom the Australian Government has received an application for their return.

Table 11. Number of children wrongfully removed to/from Australia

Year	Removed		Returned	
	From Australia	To Australia	To Convention Countries	To Australia
2007	147	112	55	97
2008	136	100	70	56
2009	95	83	31	68
2010	125	89	49	74

Source: *Attorney-General's Department (2011). International parental child abduction*. (Available from http://www.ag.gov.au/www/agd/agd.nsf/Page/Families_Children_Internationalchildabduction)

Recent and historical risk factors for parent abduction of a child[19]

The available literature emphasises the accumulation of risk factors associated with child abduction. The majority of empirical research has been conducted by Johnston in the United States and the historical and recent risk factors identified in this handbook are taken from her extensive research.

Recent

- Parents (especially mothers) within the abducting family report escalating concerns about child abuse and neglect whilst the child is with the other parent. These concerns may lead to the perception by either the abducting parent or family member that they are rescuing or protecting the child from neglectful, unsafe or abusive contexts.
- Pervading parental perception that they cannot rely on authorities to administer justice and/or perception that the response was too often inadequate or inconsistent
- Transient or brief relationships between the parents where child had not been planned or parental commitments had not been made, leading to proprietary attitudes
- No/minimal awareness of legal obligations in relation to children and their needs post-separation
- Children younger than five years are at higher risk.

Historical

- Inability to afford legal or mental health support or to obtain legal advice on children's matters post-separation
- Unemployed or working in unskilled jobs, with no fixed assets (e.g., family home); few economic incentives to remain in one geographical area; has more anonymity and can more easily disappear without trace
- Parents who are highly dependent upon support from their family and friends
- Parents with a CALD background different from the other parent, particularly one that holds different beliefs and values

[19]Sources: Greif & Hegar (1994), Johnston et al. (1999, 2009).

- Parents who hold idealised ties to their own cultural heritage and/or extended family and denigrate the cultural context in which the child is currently living
- Parents with high likelihood of disrespecting the law and authority
- Narcissistic/sociopathic personality traits/disorders or related patterns of behaviours and attitudes; the following are typical:
  - They are exempt from social expectations and the rule of law
  - They have the right to control and exploit others
  - Only they know what is right and best for their children and therefore they do not have to consider other parent's rights or how their actions impact the other parent
  - Inability to differentiate children's needs from their own needs
- Prior arrests and criminal convictions
- Increased psychological disturbance, particularly parents who express paranoid ideas involving conspiracy and betrayal by the other parent, their supports, and/or the legal system
- Unsubstantiated allegations of sexual abuse by the other parent

Links to other risk domains

Family Violence

- Family violence features prominently in the background of child abduction cases (Greif & Hegar, 1994; Johnston et al., 1999; 2009).
- In the case of fathers abducting children, this has been linked with ongoing attempts to control and exert power over the partner who has initiated separation. In the case of mothers, it is an attempt to protect the children from their perception that the situation is abusive or neglectful.
- Greif and Hegar (1994) reported that where abduction occurred, almost half of the relationships were characterised by domestic violence.
- Substance abuse and family violence (usually perpetrated by the male) were reported in the majority of families in which children were subsequently abducted (Johnston et al., 2009).

Implications for screening in the post-separation population

Three specific conditions that indicate elevated risk for parent abduction of a child have been proposed. If these conditions are present, extra attention from the practitioner is warranted:

- Ongoing prior violations or breaches of family court orders and clear evidence to abduct, and/or overt threats to take the child.
- Obstacles to locating and recovering the child are particularly great, especially in countries that are not party to the Hague Convention (see Appendix 3, pp. 200-201) for Hague Convention countries).
- Child faces substantial potential harm from an abducting parent, such as a parent with a serious mental health/personality disorder, a history of abuse or violence, and/or little or no prior relationship with the child.

The Attorney-General's Department website contains information for parents about to what to do if they fear their child may be abducted. If a parent identifies safety concerns in regards to parent abduction, it is recommended that the parent contact:

- Family Relationship Advice Line: 1800 050 321.
- International abduction concerns should be referred to the Australian Central Authority for the Hague Convention on the Civil Aspects of International Child Abduction: (02) 6141 6666.

Refer to the Attorney-General's Department website for further information.
http://www.ag.gov.au/www/agd/agd.nsf/Page/Families_InternationalFamilyLaw_FrequentlyAskedQuestionsaboutInternationalParentalChildAbduction

Family violence

Definition of family violence

Family violence in divorced/separated families is a complex phenomenon. Within DOORS we use family violence to refer to violent experiences that occur between immediate family (former partner and children) and extended family members (families of origin, new partners). These include physically, sexually, emotionally abusive and neglectful behaviours as well as threatening behaviours. Other definitions relevant to this framework include domestic violence and intimate partner violence. In other sections we treat separately the associated fields of child abuse and familicide.

Problems with definitions of family violence are well treated elsewhere (e.g., Moloney et al., 2007). There is growing recognition that forms of family violence differ in significant ways. Recent research shows the importance of conceptualising family violence across a matrix of types, historical patterns, dynamics of instigation, severities and frequencies. Hence, current thinking cautions against imposing a definition of family violence that is either under- or over-inclusive, or that advocates uniform approaches to recognition or treatment.

In Australia there are many excellent compilations of the domestic and family violence literature, some available in well-organised practice frameworks (refer to Other Risk Screening Frameworks, pp. 85-88 for further details). Specifically related to divorced and separated populations, recent important contributions have come from Chisholm (2009) and Moloney et al. (2007) amongst others.

In the US one of the most significant advances in applied thinking about family violence within the family law system came out of the Wingspread Conference in 2007, and its associated publications (e.g., ver Steegh & Dalton, 2008; Salem & Dunford-Jackson, 2008). The Wingspread reports document important areas of consensus and dissent around the nature and causes of family violence and its legal management. The intensity and frequency of violent behaviour, the various forms of abuse present, the existence of mental illness or substance abuse are all factors in

determining the future risk of family violence (ver Steegh & Dalton, 2008, p. 456). While researchers agree that exposure to violence in the home is detrimental to children's development, multiple ameliorating and amplifying factors co-determine children's outcomes (ver Steegh & Dalton, 2008, p. 456).

A nuanced view of family violence is central to recognition and appropriate response. The assessment of family violence cannot be reduced to identifying isolated acts of physical harm or behaviours that exert control over family members. Reinforcing behavioural and attitudinal patterns also need to be noticed, as precursors to further violence. Low-grade, transient attitudes of control and entitlement toward children and the ex-partner can surface even in respectful family separation processes, but in more severe and protracted forms can also be a marker of family violence at the extreme.

The seminal paper from Kelly and Johnson (2008, p. 477) called for better differentiation among types of intimate partner violence, through development of screening instruments 'that more accurately describe the central dynamics of the partner violence, the context, and the consequences'. They distinguish the following patterns of intimate partner violence:

- **Coercive, controlling violence** — Presents in various constellations with some or all of the following features: intimidation, emotional abuse, isolation, minimising, denying, and blaming, use of children, assumption of male privilege, economic abuse, and coercion and threats (from the Power and Control Wheel: Pence & Paymar, 1993). Coercive Controlling Violence may or may not be accompanied by physical violence (Johnson, 2006).
- **Violent resistance** — Violence resulting from defensive behaviour that takes place as an immediate reaction to an assault, intended primarily to protect the victim or others from injury. Violent resistance by women in heterosexual relationships is associated with elevated risks of injury to them by their partner or former partner. Infrequently, violent resistance takes the form of homicide.
- **Situational couple violence** — Recent behaviour that is reactive to the stresses of separation and without a basis of power and control. Kelly and Johnson propose that this is instigated symmetrically by both men and women when couples have poor conflict resolution skills and conflict becomes physical. On the other hand, Beck et al. (2010) found no evidence of symmetrical patterns in situational couple violence in a large-scale study of family dispute resolution clients, with the data instead suggesting that all violent couple types had a distinguishable victim and perpetrator pattern.
- **Separation-instigated violence** — Of the 140 high-conflict parents who were in custody disputes in Johnston and Campbell's (1993) sample, 21% of the parents reported separation-instigated violence. Often seen as unexpected and uncharacteristic, isolated and unrepeated acts of violence (e.g., sudden lashing out, throwing or breaking objects, violence against the partner's lover) perpetrated by a partner with a history of civilised and contained behaviour. Men and women perpetrating separation-instigated violence are more likely to acknowledge their violence rather than use denial and are often embarrassed and ashamed of their behaviours (Kelly & Johnson, 2008). This kind of violence is more likely to be perpetrated by the non-initiating partner, is unlikely to occur again and intervention orders usually result in compliance.

Prevalence statistics

Despite methodological difficulties that hamper our ability to aggregate data across studies and population current research leaves us in no doubt that relationship separation increases the risks of family violence and child abuse manyfold.

- Women are at a much higher risk of being assaulted or killed after separating from a partner (Ellis & Stuckless, 2006; Campbell, 1992; Campbell et al., 2003; Hotton, 2001; Mahoney, 1991; Wilson & Daly, 1993) particularly women leaving a previously abusive relationship (Campbell et al., 2003).
- Fathers who are physically violent towards mothers also have a higher likelihood of being sexually violent towards them and violent toward their children (Straus & Gelles, 1990).
- Currently in Australia at least 50% of court cases meet the criteria for family violence (Chisholm, 2009; Kaspiew et al. 2009; Moloney et al., 2007; Sheehan & Smyth, 2000).
- Moloney et al. (2007) found more than half of the cases filed in 2003 in the Family Court of Australia and Federal Magistrates Court contained allegations of family violence (55% of general litigant matters and 79% of judicially determined matters contained allegations of partner violence).
  - These allegations were substantial and of a severe nature in 60% of judicial matters, and in approximately half of the general litigants sample.
  - The most common forms of alleged spousal violence were threatened or actual physical abuse, emotional abuse and/or verbal derogation, and property damage.
  - Applicant mothers were most likely to allege spousal violence and respondent fathers were least likely. Allegations of child abuse were fewer, but were almost always accompanied by allegations of spousal violence (see Child Abuse, p.124). In two-thirds of Family Court matters children were reported to have witnessed spousal violence.

Table 12. Experience of physical hurt before separation, or emotional abuse before or during separation for fathers and mothers (The Longitudinal Study of Separated Families Wave 1, 2008)

	Fathers (%)	Mothers (%)
Physical hurt*	16.8	26.0
Emotional abuse alone	36.4	39.0
No violence reported	46.8	35.0
Total	99.9	100.0
Number of respondents	4,918	4,959

*Note: Physical hurt includes those who experienced both physical hurt and emotional abuse, given that the majority of parents who experienced physical violence also experienced emotional abuse. Percentages may not total 100.0% due to rounding.

Source: *Kaspiew et al.* (2009, p. 26).

- In the US, coercive control with some physical violence is cited as the most common pattern of violence seen in courts and other emergency and law enforcement settings (Frieze & Browne, 1989; Johnson, 2006).
- Post-traumatic stress is a common marker of victim responses to coercive controlling forms of violence (Johnson & Leone, 2000).
- Within the family dispute resolution context, Beck and Raghavan (2010, p. 555) found that 40% to 80% of cases reported some type of intimate partner violence and that coercive controlling patterns accounted for a mixture of victim distress variables relevant to the family dispute resolution process (including victim fear, victim distress and the evident power imbalance).

Recent and historical risk factors for family violence[20]

Evidence about the multi-faceted nature of family violence has been growing in recent decades, and some consensus is emerging about antecedent risk factors. The results paint a complex picture with few, if any, homogenous causative factors and the data caution against the adoption of a 'checklist' approach to recognising and responding to risks. Guides to clinical judgment are nonetheless crucial and so accordingly researchers continue to refine the central indices of risk to which family law practitioners should be alert.

Separation, particularly that involving dispute and litigation, is a context in which many factors merge to create a hothouse climate for risk. In psychological terms, the relationship history of a family member, the current meaning of this separation to them, perceived stress, the nature of surrounding supports, and their capacity to manage their subjective emotional experience of separation combine to significantly amplify safety risks to self and others. In this sense, risk factors for family violence emerge from the same central 'stocks' as do resilient outcomes, and are determined by the weight, direction and unique interlocking of factors unique to each situation (see Table 12). Differentiating risk and expressions of violence is possible through a careful assessment of the interaction between all these factors.

Recent

- Recent separation, often instigated by the other person
- Unemployment or under-employment
- Access to weapons
- Ongoing patterns of coercion and control in the separation process
- Alcohol or drug abuse
- Sense of entitlement (often gendered)
- Concurrent stressors or traumas
- Severe coping deficits, current mental health issues, personality problems
    - Borderline/dysphoric men with a history of coercive controlling violence
    - Poor frustration tolerance affects regulation and impulse control
    - High dependence on the ex-partner
    - Feelings of abandonment and rejection
    - Feelings of intense jealousy, or humiliation

[20]Sources: Babcock, Costa, Green, & Eckhardt (2004), Campbell et al. (2003), Dutton (2007), Holtzworth-Munroe, Bates, & Smutzler (1997), Holtzworth-Munroe, Meehan, Herron, Rehman, & Stuart (2000), Jacobson, Gottman, Gortner, Berns, & Shortt (1998).

Historical

- Experience of violence and/or traumatising upbringing as a child
- Any violence within previous intimate relationships
- Violent acting out toward self, any other person, or animals
- Affiliations with peers or family who endorse or practise violent behaviours
- Problems with empathy and remorse
- Diagnosis of Borderline Personality Disorder, Antisocial Personality Disorder or Narcissistic Personality Disorder, especially in men

Links to other risk domains

Family violence and outcomes for children

Violence between a child's caregivers has an independent effect on children's adjustment. Accordingly, impacts of parental violence — even a single episode — can be more potent than living with high levels of marital conflict, although in reality the two frequently go hand-in-hand.

Witnessing acute episodes of violence, living with chronic fear, being caught up in violent acts, or being cared for by a frightened parent all in turn pose immediate and long-term developmental risks (Bancroft & Silvermann, 2004; Fantuzzo & Lindquist, 1989; Fantuzzo & Mohr, 1999; Graham-Bermann & Edleson, 2001; Holtzworth-Munroe et al., 1997; Jaffe et al., 2004; McIntosh et al., 2004; Sachmann, 2001; Wolak & Finkelhor, 1998).

Amongst children who have lived with significant levels of family violence, a cluster of symptoms is frequently noted by researchers at behavioural, cognitive, and emotional levels:

- Aggression, conduct disorders, delinquency, truancy, school failure, anger, depression, anxiety, and low self-esteem (Kelly and Johnson, 2008)
- Interpersonal problems marked by poor social skills, peer rejection, problems with authority figures and parents and an inability to empathise with others
- Profound developmental sequelae follow for infants and pre-school children (Siegel & McIntosh, 2011)
- Insecure and disorganised attachments generate a host of follow-on deficits in early childhood development, and while recovery is possible with effective protection and treatment of both parent and child, the costs of early trauma remain high indeed, especially when accompanied by other ongoing stressors (Ayoub et al., 1999; Sroufe et al., 2005)

Implications for screening in the post-separation population

Many factors contribute to the risk of various forms of family violence in the post-separation population. Along with the close links to other safety concerns such as child abuse and familicide, screening for family violence remains challenging. Clinical judgement guided by systematic, detailed information collection is crucial in recognising patterns of family violence (Holtzworth-Munroe, Beck & Applegate, 2010).

Family violence within the Aboriginal and Torres Strait Islander population

Human Rights and Equal Opportunity Commission (HREOC: more recently renamed the Australian Human Rights Commission) argues that the concept of 'family violence' rather than 'domestic violence' better reflects the broader experiences of violence in Aboriginal communities. Memmott et al. (2001, p. 1) suggest that 'family violence' more accurately 'encapsulates not only the extended nature of Indigenous families, but also the context of a range of violence forms occurring frequently between kinspeople in Indigenous communities'.

Prevalence statistics for family violence in the ATSI population

ATSI people are over-represented as both victims and perpetrators of all forms of violent crime in Australia (Bartels, 2010; Morgan & Chadwick 2009; Wundersitz, 2010).

- Willis (2011) reports that Indigenous people experience violence (as offenders and victims) at rates that are typically two to five times those experienced by non-Indigenous people and higher still in some remote communities.
- One in five Indigenous adults reported being a victim of violence in 2009 (Australian Institute of Health and Welfare (AIHW)).
- Indigenous females were 35 times more likely to be hospitalised due to family violence-related assaults, compared to their non-Indigenous counterparts. Indigenous males were 22 times more likely to be hospitalised for these reasons.
- Most hospitalisations for family violence-related assault for females were a result of partner violence (82%) compared to 38% among males (Willis, 2011).
- Indigenous people are less likely to disclose violence (Willis, 2011; Wundersitz, 2010).
- The International Violence Against Women Survey (IVAWS: Mouzos & Makkai, 2004) report the Australian rate of family violence victimisation for Aboriginal women may be as high as 40 times the rate for non-Aboriginal women.
- Despite representing just over 2% of the total Australian population, Aboriginal women accounted for 15% of all homicide victims in Australia in 2002–03.
- The IVAWS report classified violence in the last 12 months compared with lifetime violence as reported in Table 13 below.

Table 13. Percentage of Indigenous and non-Indigenous women experiencing physical, sexual or any violence by time/period

	Indigenous women			Non-Indigenous women		
	Physical violence	Sexual violence	Any violence	Physical violence	Sexual violence	Any violence
In last 12 months	20%	12%	25%	7%	4%	10%
Over lifetime	66%	32%	71%	48%	34%	57%

Caveat

It is widely acknowledged that an accurate measure of family violence among Aboriginal families is difficult to determine due to under-reporting by victims (Willis, 2011; Wundersitz, 2010), lack of appropriate screening by service providers, incomplete identification of Aboriginal people in many data sets and problems of quality and comparability of existing data (Schmider & Nancarrow, 2007).

Historical and recent risk factors for family violence in the ATSI population[21]

The latest report addressing Aboriginal welfare (AIHW, 2011b) highlights the extent of the disadvantage experienced by Aboriginal families and the multiple stressors implicated in Aboriginal family violence. Wundersitz (2010) suggests a cumulative historical context that gives rise to specific risks within the community setting, which in turn contributes to the individual perpetration or endorsement of violent acts against others.

Historical

Many Aboriginal commentators emphasise that the burden of family violence must be understood within the context of violence experienced by Aboriginal people since European invasion, manifest through generational experiences of racism, cultural destruction and the dispossession from traditional land. Viewed in this light, historical risk factors include:

- breakdown of traditional laws and systems of governance
- loss of religious practices and spirituality
- loss of traditional economic base
- loss of social structures and controls, including child rearing practices
- imposition of negative socio-political status, with attendant removal of rights and responsibilities, personal freedoms and social autonomy
- exploitation of traditional gender roles, resulting in marginalisation of Aboriginal males
- racism and ethnocentrism
- ineffective government initiatives which have limited or denied access to relevant services for many remote or urban Aboriginal people.

Recent

Key community and family risk factors are:

- lack of an economic base with welfare dependency
- high unemployment and poor long-term job prospects
- low levels of formal education
- poor housing and living conditions
- poor physical and mental health
- shorter life expectancy rates including high infant mortality.

[21] Sources: Atkinson (2006), Calma (2006), Memmott et al. (2001), Schmider & Nancarrow (2007), SNAICC (2010), Wundersitz (2010).

Interacting with these socio-economic conditions are family and community relations characterised by:

- low levels of social cohesion and inter-family involvement
- high levels of conflict
- disrupted parenting experiences through child removals and institutional care arrangements.

The impact on Aboriginal people living in communities and families burdened by such extreme disadvantage, as detailed above, is immense. Associated risk factors for individuals are:

- high levels of alcohol and illicit drug use
- high levels of stress and anxiety, with low coping skills
- psychological distress, including low self-esteem, feelings of powerlessness, alienation, marginalisation, frustration, depression and shame and apathy (pronounced in Indigenous males)
- high rates of petrol and glue sniffing, and alcohol use, resulting in neurological impairment
- difficulties with problem solving, often leading to incarceration and teenage pregnancies
- psychiatric and mental health problems (as with the general population)
- high levels of unresolved and generalised anger, particularly for Indigenous males
- boredom and peer group pressure.

Precipitating events that relate to specific acts of violence include:

- jealousy over relationships and material goods
- failure to pay debts
- alcohol-related arguments and conflict within the family.

Implications for screening in the post-separation ATSI population

Aboriginal family violence screening and risk identification presents a major challenge for family law system service providers. The indication from Aboriginal commentators, as well as the evidence from research, is that the family law system must find ways to support a process of cultural healing through identifying and responding to the overall accumulation of risk factors facing the ATSI population.

> *We need to adopt a holistic approach to address the causes and consequences of family violence [within Aboriginal communities]... if we treat it as simply a law and order matter or a matter of legal compliance, or a health matter, we will not achieve lasting improvements* (Calma, 2006, p. 24).

Family violence within the culturally and linguistically diverse (CALD) communities[22]

Cultural, social and political contexts are important factors to be understood when addressing family violence with CALD populations, including factors that limit the ability of CALD families to disclose and/or find assistance in relation to family violence. These include:

- policy issues pertaining to visas
- cultural expectations and gender beliefs
- language proficiency
- immigration status
- service access and equity issues.

Prevalence statistics of family violence within CALD communities

Amalgamating sound research in this area is made difficult through the same limitations met in the general family violence literature: problems with definitions, sampling, and disclosure. The available studies suggest that:

- Women from CALD backgrounds are generally less likely to report family violence (Morgan & Chadwick, 2009; Tually et al., 2008).
- Over 50% of refugee women arriving in Australia have already experienced rape and other forms of sexual abuse, often in the context of warfare in their country of origin (Mehraby, 2001).
- Consequently, refugee and humanitarian entrants (particularly those arriving from refugee camps) have highly complex needs and multiple stresses.

Recent and historical risk factors for family violence within CALD communities[23]

Burman, Smailes and Chantler (2004) note that for many CALD communities pre-existing values, practices, cultural expectations and immigration trauma mean that recent risk factors (age of marriage, psychological wellbeing etc.) are inextricably linked to historical factors (cultural beliefs about gender roles, history of abuse).

Recent

- Unemployment or under-employment for men, bringing lack of social status
- This stress is exacerbated for men if the culture holds traditional gender beliefs and expectations
- In some cultures, higher employment status of women escalates risk of family violence
- Geographical isolation from extended family
- Fear of deportation if abuse is reported, especially when women do not hold permanent residency
- Ongoing anxiety regarding family members remaining in country of origin

[22]Sources: Ahrens, Rios-Mandel, Isas & Lopez (2010), Australian Law Reform Commission (2011), James (2010), Pease & Rees (2007), Walshe (2010).

[23]Sources: Ahrens et al. (2010), Al-Nsour, Khawaia & Al-Kavvali (2009), Bartels (2010), The Benevolent Society (2009), Emery, Jolley & Wu (2010), Goodman & Dutton (2008), James (2010), Krause, Kaltman, Morgan & Chadwick (2009), Office of Women's Policy Victoria (2002), Okenwa, Lawoko & Jansson (2009), Pease & Rees (2007), Taylor & Mouzos (2006), WHO (2010).

- Ongoing psychological trauma from war and immigration experiences
- Limited language proficiency impacts ability to access help beyond the family
- Limited availability of appropriate translator/interpreter services
- Limited social supports and reluctance to confide in others
- Lack of awareness about the Australian law
- Continued abuse from the immediate family
- Experiences of racism and social isolation
- Intervention to address family conflict perceived as undermining traditional family structures
- Marrying young and having children is a risk particularly for women who are isolated from culture of origin networks
- Attitudes pertaining to family bonding, shame and cultural identity result in an 'endurance' of family violence

Historical

- Trauma experiences:
  - In country of origin, forced migration experiences, and during resettlement
  - Intergenerational 'collective trauma'
- Cultural beliefs that endorse gender roles supporting:
  - Male dominance, including 'wife punishment' and wife discipline
  - Perceptions that forced sexual acts are not acts of violence
- Cultural and/or religious shame:
  - Women's entitlements within Australia law may clash with their traditional role
  - This may increase women's reluctance to disclose and leave situations of family violence
- Beliefs about divorce:
  - Culturally engrained views of divorce as sinful and unacceptable, even when severe acts of violence are occurring
  - A heightened context for perpetration of gender-related violence and its acceptance
- Living arrangements and neighbourhoods:
  - Overcrowded housing, exposure to surrounding violence, alcohol and substance misuse
  - Communal settings where there is cooperation and social cohesion provide a protective factor

Implications for screening in the post-separation population within CALD communities

This complex picture of family violence within CALD families is often perceived as a barrier to effective intervention. However, it is worth noting that the practitioner's effort to engage with the client is itself an important preventative intervention. James's (2010) research suggests that psycho-education is an important intervention when addressing issues of family violence with CALD women. Screening for risk presents opportunities to find avenues to educate CALD clients so that both men and women from CALD communities may better recognise that mental health and family safety are human rights.

The capacity to engage with CALD families, such that the interlaced experiences of trauma, migration, and family distress are able to be appropriately discussed, is therefore a crucial aspect of effective risk identification. Identifying and responding to the specific CALD family's traditions, attitudes and behaviours requires the practitioner to ask directly about experiences of family violence (Bonar & Roberts, 2006; James, 2010; Walshe, 2010). This requires a focus on the history

and experiences of trauma, the family's adjustment to Australia and specifically, gender attitudes. Gender beliefs are one of the most significant predictors of family violence (Ahrens et al., 2010; Bhanot & Senn, 2007; Pease & Rees, 2007; WHO, 2010). So rather than culture itself being the risk factor, it is more precisely the cultural traditions and attitudes in relation to gender, which often entail violence against women, that are the unique risk factors to be understood in the CALD context.

Familicide

Definitions for risk domain

The suffix '-icide' is used to refer to the unlawful killing of someone. The following definitions are used in this handbook:

- **Homicide:** killing a person
- **Filicide:** killing of a child by their parent(s)
- **Uxoricide:** killing of a partner
- **Femicide:** killing of a woman
- **Parricide**: killing of a parent by their child(ren)
- **Siblicide:** killing of a sibling
- **Infanticide:** killing of an infant
- **Familicide:** killing of a current or separated partner and one or more of the couple's children, and/or children from a previous relationship, by a former/new partner, or step-parent
- **Familicide-suicide:** perpetrator kills a family member and also suicides.

Prevalence statistics

Homicide prevalence statistics

The National Homicide Monitoring Program (NHMP) documents all homicide-related statistics since its inception in 1989. Unless otherwise stated, all the following Australian statistics are taken from NHMP 2007–08 data (Virueda & Payne, 2010).

- Domestic homicides represented 52% of all homicides in the years 2007–2008.
- The majority (n = 80; 60%) were classified as intimate partner homicides, 20 (15%) were filicides, six (4%) siblicides, 18 (13%) parricides, two (1%) infanticides (1%) and eight (6%) as other family homicides.
- Reported motivation included domestic arguments and the termination of a relationship.
- The most common cause of death was stab wounds (43%), beatings (19%) and gunshot wounds (10%).

Victim by gender

There are notable gender differences in offender-victim relationships. Homicide rates with male victims are higher overall, but women are far more likely to be killed by those they were intimate with.

- In 2007–08, there were 161 male (59%) and 112 female (41%) homicide victims.
- 78% of female victims (n=87) of homicide were killed by an offender with whom they shared or had shared a domestic relationship.
- Police reports indicate that 43% of intimate partner homicides had some form of prior domestic violence history.
- In 2007–08, there were seven indigenous homicide victims per 100,000. This rate is seven times higher than for non-Indigenous Australians (Virueda & Payne, 2010).
- Of the total indigenous domestic homicides, 42% were killed by an intimate partner, and 11% were filicides.

Campbell (2011) reports a similar gender pattern in the US:

- Women are killed by their partners at nine times the rate they are killed by a stranger, most often using a gun (88%).
- For every successful femicide, there are nine attempts.
- Prior domestic violence precedes most (67–72%).
- Prior abuse by a male partner precedes 75% of women killing men.
- In only 30% of these cases was there a previous official record of domestic violence.
- Stalking and surveillance precede homicide (85%) and attempted homicides (95%).
- Both lower education and unemployment were predictive of fatal or near fatal attacks.

Research on familicide

The Murder in Britain Study (Dobash & Dobash, 2008) and the Violent Men Study (Dobash, Dobash, Cavanagh & Lewis, 1999, 2000)

The *Murder in Britain Study* involved quantitative and qualitative data from 866 case files and 200 in-depth interviews, and the *Violent Men Study* involved in-depth interviews and follow-up surveys of 122 men convicted of non-lethal violent offences and 134 female partners. The authors compared profiles of non-lethal abusers (*Violent Men Study*: Dobash, Dobash, Cavanagh & Lewis, 1999, 2000) with intimate murder perpetrators (*Murder in Britain Study*: Dobash & Dobash, 2008) to examine possible differences in risk factors between the two groups.

- Those men who murdered their victims generally had 'conventional' backgrounds and were in skilled professions compared with the abusers.
- The murderers were more likely to be separated from their victim at the time of the event.
- Murderers compared to abusers were more likely to use weapons, such as knives, to have conflicts around issues of jealousy and possessiveness and to sexually assault the victim.
- The historic profile of the abuser (non-lethal) group was akin to that of persistent offenders, including being more likely to have been physically abused by their fathers than the lethal group (33.6% vs. 14.8%) and to have witnessed physical violence towards their mothers (48.3% vs. 11.7 %), and to have alcohol dependence issues (36.1% vs. 11.5%).

Research within culturally and linguistically diverse populations

Dabby, Patel and Moore (2010) conducted substantial research into intimate partner homicide, familicide and domestic violence within Asian families.

- Of 125 intimate partner murder victims, 30% were separated from their partner.
- 78% of murder victims were women and girls, 20% were men and boys and 2% unknown.
- 83% were male perpetrators, 14% female and 3% unknown.

Recent and historical risk factors for familicide-homicide[24]

The research again paints a complex pattern of historical and recent risk factors for familicide-homicide. It is important for the practitioner to pay attention to contextual factors and to patterns across domains; individual client biographies from childhood through to adulthood, socio-demographic characteristics, personality types, attitudes and beliefs about women and marriage.

Recent factors: Perpetrator

- Separation/divorce, particularly from a violent relationship
- Obsessional behaviours pre-separation (e.g., monitoring and stalking)
- History of police and social service involvement
- Marked mental health deterioration post-separation
- Abandonment fears and a lack of individuation
- Premeditation and planning for the offences
- Recent prior threats to kill self (see p.145, 'Links to other risk domains')
- Ownership of or access to a weapon

Historical factors: Perpetrator

- Accumulating history of family violence
- History of childhood trauma particularly sexual abuse, separation from carers
- Violence during pregnancy
- History of actual harm or threats to harm self and others, including children, family members and pets
- History of mental illness (often unreported, undiagnosed or ineffectively treated)
- Perpetrator avoidance of conviction or arrest in relation to violent acts
- Profound emotional dependency on others
- Underlying proprietary attitudes and beliefs which validate and justify controlling, possessive and jealous behaviours
- History of obsession, egocentricity and pathological jealousy
- Lack of empathy or remorse

Women who kill their abusers are more likely to have experienced sexual abuse, frequent violence and previous severe injuries. They are also more likely to have attempted or seriously considered suicide.

[24]Sources: Browne (1987), Campbell, Glass, Sharps, Laughon & Bloom (2007), Dabby et al. (2010), Dobash & Dobash (2008), Easteal (1993), Johnson (2005, 2006, 2009).

Links to other risk domains

Family violence, intimate partner homicide, and childhood abuse and trauma

Johnson (2009) examined intimate partner homicide and familicide cases between 1996 and 2005, in which there were 121 intimate partner homicide offences. Detailed histories of ten cases of intimate partner homicide and one of familicide were collected. All cases reported a family context of violence and intergenerational childhood trauma, where substance abuse, mental illness and depression were common. Johnson (2006) conducted an in-depth qualitative study of family law-related matters in Western Australia, which examined seven cases of familicide-suicide. In all families there were disputed children's arrangements and in most cases, the father was the perpetrator. Carbon monoxide poisoning was the most frequent method used.

Suicide and suicidal ideation

Liem (2010) suggests that homicide-suicide individuals are different to homicide-only and to suicide-only in two main ways: A higher degree of psychopathology, particularly depression and personality disorders, and a degree of notable dependency upon the victim.

Implications for screening in the post-separation population

There is a clear need for services within the post-separation population to understand the patterning of risk associated with lethal outcomes for both a separated parent and their children, and to be able to recognise the relevant factors in high risk cases.

Learning Guide

Introduction

This guide is a suggested learning process for those new to the DOORS program. It offers a systematic way to become familiar with the DOORS resources and supports an interactive reading of the Handbook. The aims of the Learning Guide are to provide and explain the rationale for the DOORS program and to enable proficient use of it. The activities presented are self-directed exercises which include viewing short DVD examples of the DOORS being used in two different family law settings. All the activities are sequenced to develop familiarity with the DOORS resources and processes. You can do some or all of the suggested activities. Where suggested, completing the activities with a colleague will result in a richer learning experience for both.

Recommended prerequisites

Close reading of the DOORS handbook will provide the necessary foundation to use the program. The literature review presented in DOOR 3 (the Risk Domains in Detail, pp.105-145) section of the Handbook reflects a large body of research on the nature of risk and the development of effective screening procedures. Understanding this evidence is a cornerstone of informed practitioner judgement and practice. Reading this section of the Handbook is therefore essential to your effective use of the DOORS framework.

Understanding the concepts of wellbeing, safety and risk requires knowledge of mental health, trauma and psychological adjustment, child development, family violence and cultural diversity. While the handbook provides a substantial amount of background information and references to literature, practitioners not yet confident in their knowledge or skills in these areas are encouraged to participate in professional development provided by the family services sector (for example the AVERT Family Violence website, located at: http://www.avertfamilyviolence.com.au/) and/or training provided by a relevant professional association.

The Learning Guide Plan on the following page provides an overview of and a proposed sequence for the learning activities.

Other information

The Learning Guide refers to a DVD and a DVD-ROM which are available at the front of the Handbook. For information on how to use the DVD and DVD-ROM please see pp. 175-178.

Learning Guide Plan

Topic	Preparatory reading of the DOORS handbook	Learning activity	Complete
What is The Family Law DOORS?			
■ Definitions ■ Why screen? ■ What to screen	Read Introduction	1. Reflecting on the importance of screening 2. Analysing historical & recent factors	☐ ☐
Using The Family Law DOORS			
■ A philosophy of engagement ■ Introducing the DOORS ■ Pen-and-paper version of the DOORS 1 & 2 ■ Software version of the DOORS 1 & 2	Read 'Using the DOORS'	3. Considering client engagement 4. Introducing the DOORS to a range of clients 5. Analysing the DOORS introduction 6. Completing the pen-and-paper DOOR 1 Parent Self-Report form 7. Applying the DOOR 2 Practitioner Aide Memoire (pen-and-paper) 8. Using the software to set up a new client 9. Using the DOOR 2 Practitioner Aide Memoire 10. Exploring the DOOR 2 Practitioner Aide Memoire 11. Discussion follow-up based on the DOOR 2 Practitioner Aide Memoire	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Responding to Risk – DOOR 3			
■ An ethos of shared responsibility and coordinated response ■ Safety planning ■ Specialist risk assessment	Read 'DOOR 3: Resources for Responding to Risk'	12. Specialist response to the DOOR 2 Practitioner Aide Memoire 13. Safety planning	☐ ☐
Information Sharing			
■ Consent to share information ■ Mandated reporting	Read DOOR 3: Understanding the Risk Domains	14. Documenting your networks	☐
Summary			

What is The Family Law DOORS?

Preparation: Read the Introduction of the Handbook, pp. 1-15

The Family Law Detection Of Overall Risk Screen (known as the DOORS) has been developed especially for the family law system. It is a framework for identifying and responding to family safety and wellbeing specifically during or resulting from separation and divorce. The DOORS framework aims to:

- build a common understanding of risk across the family law system
- facilitate early and thorough identification of risk
- enable a coordinated response.

To achieve these aims, DOORS provides:

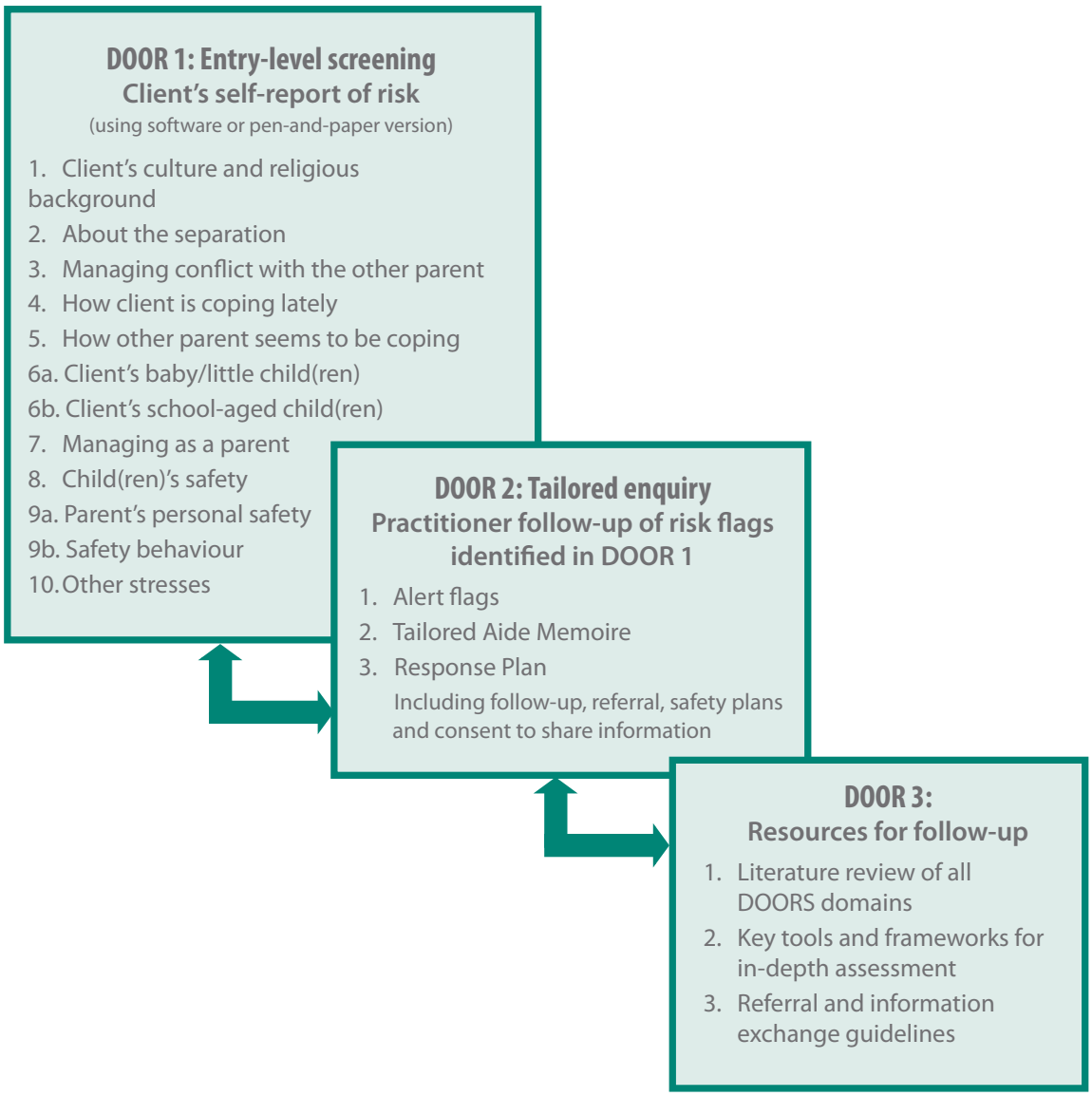
- a structured, empirically-based parent self-complete screen that can be used across the family law sector
- prompts to guide professionals' conversations with clients about their unique risk profiles and to evaluate the information provided by the client
- guidelines for follow-up, safety planning, appropriate referrals and ethical information sharing
- resources to support the standardised screening process
- screening across a matrix of historical and recent risk factors that combine to create safety risks for former intimate partners and children, including:
  - the contribution of parenting stress, mental health and drug and alcohol problems to risk profiles
  - specific needs arising from the cultural and religious background of family members
  - developmental risk factors for infants and children
  - ancillary stressors that may require attention.

The DOORS framework contributes to 'structured professional judgement' (Robinson & Moloney 2010, p. 10) made by family law practitioners about the risks that become current during and post separation or divorce. Robinson and Moloney (2010) note that 'structured professional judgement'

> *is more prescribed than clinical decision-making but more flexible than actuarial decision making; does not impose restrictions on the inclusion, weighting or combining of risk factors; and allows for a logical, visible and systematic link between risk factors and responses, as well as the ability to identify those who are at higher or lower risk for violence (p. 10).*

The DOORS is effectively a wide-angle lens that allows a holistic and comprehensive picture of family relations to become visible to the practitioner. The DOORS three-stage framework offers a flexible process for systematically screening risks to safety and wellbeing. The ten domains addressed in DOOR 1 (p.17 and overleaf) highlight the breadth of the screening focus.

Table 3. DOORS frameworks



The DOORS is structured around the following principles:

- Risk is not a static phenomenon; it is multi-faceted and changes over time.
- Risk assessment therefore needs to occur across many areas and over time.
- Best practice in risk identification involves three steps, with the emphasis at each step differing according to the needs of the case:
  1. Universal self-report screening
  2. Tailored professional follow-up interview, evaluation and response planning
  3. Implementation and monitoring of follow-up and response plan.

These are universal elements of risk screening regardless of the setting.

Definitions

Before we explore the DOORS further, let's clarify some key terms. Effective collaboration in practice requires the creation of commonly understood terms and a clear understanding of the distinction between different terms; for example, screening and risk assessment.

Screening is the first step in a client intake process. It typically involves a set of standard questions designed to alert the practitioner to concerns about a client's safety and wellbeing. DOOR 1 is the screening component of the DOORS framework and consists of a self-report form designed to gather information across a broad spectrum of domains, including an individual's mental health, parenting ability, safety, and the wellbeing and developmental needs of their children.

Risk identification is a more in-depth exploration of a client's safety and wellbeing status which often includes following up on concerns raised during initial screening. DOOR 2 supports practitioners to engage with clients about their safety and wellbeing and, in particular, to identify and interpret risk factors and protective factors. Practitioners can then develop initial responses to identified risks (such as safety planning and referral) and determine whether further risk assessment may be necessary.

Risk assessment means making a professional judgement about the form and potency of risks and gauging the likelihood that the identified risks may cause further harm. Risk assessment is the basis for planning responses and treatment pathways. DOOR 3 provides some specialist resources and references to help practitioners to assess and respond to identified risks.

Why Screen?

Learning Activity 1: Reflection on the importance of screening

Preparation: Read Veena Charan's case study below

Consider the reflective practice questions.

Case Study 1: Veena Charan

Veena was gunned down by her husband, Joseph Charan, in front of her son, teachers and other students. Joseph Charan then killed himself. Veena had been separated from her husband for 15 months and prior to her death, she had contacted six agencies regarding her husband's violence.

Some of these agencies were reported to have known that Joseph Charan owned a gun and had threatened to kill his wife.

In the weeks prior to the homicide/suicide, Joseph Charan was charged with felony, wife beating and malicious mischief and received a 12 months suspended sentence for the conviction on this offence. He was put on probation on condition he obtain domestic violence counselling, adhere to a stay-away order and do community service work. Veena Charan also obtained a restraining order through the civil courts which Joseph breached on several occasions.

A landmark investigation into this homicide/suicide was conducted by the San Francisco Women's Commission and the City and County of San Francisco. They found significant gaps in risk detection, information sharing, cultural understanding, translation services and management at a community and systems level. The Charan Report concluded that the community had failed to protect Veena Charan.

The recommendations from this report became a watershed which changed the way government and community responded to family violence. What started in San Francisco has spread across the USA with most states having established Family Domestic Violence Death Review processes as part of an overall coordinated systems response to family violence.

Reflective practice questions

Invite one or more colleagues to read the Veena Charan case study above (you may wish to make photocopies) and discuss the answers to the following questions with them (or you can write or type your responses for your own private reflection).

- If your service or organisation was one of the six services to which Veena had disclosed her situation, how might you have responded?
- What elements of your practice would have enabled you to identify and assess the risks confronting Veena and her son?

Historical and recent factors overview

Vena Charan's story is extremely distressing, and sadly is not an isolated case. Finding ways to successfully intervene in such situations and create sustainable safety lies at the heart of the DOORS program.

To this end, the DOORS screens for a spectrum of risks across multiple domains of concern for family wellbeing. Central to the DOORS approach is comprehensive yet succinct consideration of recent and historical factors that may exert a protective or escalating influence on each family's situation. In this way, the DOORS treats family violence as part of a constellation of factors that often combine to produce harm, especially during or after the events of separation and divorce. In so doing, the DOORS cultivates a broad understanding of risk, including the possibility of developmental harm to children through compromised parenting capacity, as well as acute risks relating to mental health, suicide and many forms of family violence.

The DOORS systematically screens extreme situations similar to Veena Charan's case study as well as less obviously harmful situations that are common within the family law jurisdiction. Overall, the DOORS is different from other screens because it:

- focuses on the whole family
- moves beyond family violence
- is very flexible for application in diverse situations
- is suitable for a range of family law services
- is tailored specifically for the post-separation context.

Learning Activity 2: Analysing historical and recent factors

Preparation: Read Jonathan's story below.

Then use the Pathways of Risk table (Table 1, p. 155) to identify and consider the historical and recent factors at play in his situation. In your opinion, is Jonathan's a **normative** or **critical** situation? Do you think it is likely to lead to self-harm or violence against others?

You can complete this activity with one or more colleagues, or on your own.

Case Study 2: Jonathan

Jonathan is 36 years old. He left school before completing year 12 and has worked off and on as a personal care assistant in aged care ever since. He was in a relationship with Peggy for three years before they separated the first time. Peggy is a nurse. According to Jonathan, Peggy left him because she had decided to move interstate on her own. For a complex set of reasons that doesn't make a lot of sense to Jonathan, she didn't move interstate permanently, and they resumed 'a fling' nine months after their first separation. Intermittently, they had a sexual relationship but, after six months stopped seeing each other altogether. Two months later Peggy told Jonathan she was pregnant.

Jonathan remains adamant that Peggy 'used him as a sperm donor'. As far as he was concerned, if she wanted to have the child they should have reunited and married. Given that Peggy wasn't prepared to, he thought she should have an abortion. Instead, Peggy gave birth to a healthy daughter named Tilly who has been passed between her embattled parents from the moment she was born. Currently at the age of four, Tilly refers to the Children's Contact Service (CCS) as 'one of daddy's places'.

Peggy is the only significant partner that Jonathan has ever had. He never knew his father. His mother and sister live in another city. He is very disappointed that Peggy didn't 'give it a proper go' with him. He believes that Peggy has been inappropriately influenced by her parents, who never liked him because he wasn't good enough. Her parents once took out a restraining order after he continually called and visited them to complain about how they had damaged Tilly's life by ruining his chances with Peggy.

Jonathan has now been to court twice. In the first court hearing, when Tilly was a three-month-old baby, he requested an order for regular overnight stays. In the second, when she was three years old, Jonathan sought further increased time. The current order involves a requirement to renegotiate when Tilly goes to school.

Jonathan was recently unable to take on a new position because it required him to work on a Saturday, which is part of his regular time with Tilly. According to Jonathan, Peggy is not willing to negotiate with him. In his words, 'she goes all pathetic and says I control her'. Jonathan is convinced she is just doing her best to keep him out of Tilly's life.

Jonathan wants to have more time with Tilly and wants more flexibility in the arrangements when they next renegotiate. Jonathan is convinced that they will need to go to court because nothing other than a judge will be able 'to sort Peggy out'.

Recently Tilly refused to see Jonathan and the CCS has called Jonathan and Peggy to review their use of the CCS. Jonathan explained that on a recent evening phone call Tilly said 'mummy doesn't like it if I go with you'. Jonathan believes 'the refusals are all Peggy's doing because Tilly really loves him'.

At this review, Jonathan reveals he has been made redundant and he just wants to go away and give up, because he can't stand Peggy any longer. And besides he is beginning to believe Tilly would be better off without him. Jonathan also believes this is what Peggy wanted all along, and this is making him very angry. In his review he reported: 'People just don't understand how she is manipulating everyone. She is nuts, she is ruining my life and Tilly's life, someone should stop her!'

Table 1. Pathways of risk

What to screen?

Safety and wellbeing risks in family law cases arise from an interlocking set of influences. These are identified in the DOORS as:

1. **The psychology of the individual parent:** How the current separation might affect the individual, given, for example, their mental health history and current state; any history of violence/impulse control problems; drug and alcohol use; history of safety in childhood; parenting qualities (specifically availability); attunement and warmth; regard for/attributions to the other parent; ancillary stressors such as employment, finances, housing; the personal meanings of culture and religion.

2. **The ex-couple relationship:** A couple's history of communication, cooperation, decision making and power balance; circumstances of the separation, including who initiated the separation and involvement of new partners; conflict tactics and the use of violence; family and friends' roles in resolution or perpetuation of conflict.

3. **The history and nature of the current dispute(s):** The perceived and actual complexity of the issues in dispute; history of decision making to date; sensitivities to notions of winning, losing or entitlement; the parents' perceptions of fairness and equity in time and property divisions; systemic interventions in resolution or perpetuation of dispute.

4. **The development of the infant/child:** The physical health and developmental wellbeing of the child to date; their emotional security with each parent; temperament, cognitive development and learning attainment; sibling relationships; friendships and social functioning; availability of family and social resources.

5. **The role of social, cultural and professional support:** The nature of engagement with supports and services, their appropriateness, effectiveness, timeliness; connection versus isolation; support of family and friends; containing or inflaming social and professional responses. Lack of sensitivity to culturally-specific perspectives is a significant threat to safety.

This focus on the interplay of influences that govern family wellbeing and safety ensures the DOORS screens across multiple risk domains and issues that relate to:

1. the 'big 5' safety risks — abduction, family violence, suicide, child abuse and familicide
2. contributing factors, such as parenting, drug and alcohol, mental health and other related stressors
3. a developmental perspective
4. cultural influences.

Using the Family Law DOORS

Preparation: Read the section 'Using the DOORS' in the Handbook, pp. 17-21.

The DOORS approach to effective early identification of risk involves a tiered approach to screening that begins with structured, routine questions that are asked of all clients. Holtzworth-Munroe et al. (2010) have shown the importance of the first-level self-report questions being reasonably detailed, and always followed up by a practitioner.

In the DOORS framework:

- DOOR 1 is the structured client self-report component.
- DOOR 2 is the Practitioner's Aide Memoire that guides follow-up and Action Plan that guides response.
- DOOR 3 provides literature and tools for additional assessment as appropriate.

In DOOR 2 the practitioner briefly explores and evaluates risks identified by the client in the DOOR 1 screen, and any other risks which become apparent to the practitioner from carefully attending to the client's account. The need for any further action and triage responses are identified at the DOOR 2 interview.

A philosophy of engagement

Underpinning the DOORS is a philosophy of engagement that seeks to prevent escalation of violence and harm; such engagement allows practitioners to:

- normalise stress and differentiate it from distress
- notice co-existing risk factors
- respond effectively
- stay alongside those at risk of harm, or of harming.

This approach relies on the practitioner's commitment to share responsibility for the creation of a climate of safety and wellbeing. Seen in this light, engagement offers a forum for:

- testing and validating concerns
- considering why risk patterns have emerged in the way that they have
- detailing options for safety and safe behaviours
- helping the client to self-manage risk where possible
- facilitating effective use of support services.

Learning Activity 3: Considering client engagement

Below are broad descriptions of four different client situations. Which techniques described above would you employ in order to engage effectively with each client in order to screen for risks to safety and wellbeing? Would your approach vary between these four clients? If so, how and why?

As this activity is expanded on in Learning Activity 4, it is worth recording your responses.

This activity can be completed with one or more colleagues, or on your own.

1. A man reports that he and his ex-partner have a very amicable separation.
2. An angry woman is fed up with being 'trapped' in the legal system.
3. A very upset man has not seen his children for over 12 months.
4. A woman is visibly shocked because her husband recently left her to live his life as a gay man.

Introducing the DOORS

The DOORS is a universal screening tool that provides a thorough screen and respectful basis for engagement with clients in terms of risk assessment.

The focus on broad wellbeing issues makes DOOR 1 (Parent Self-Report) suitable for all clients, including those using violence towards others, those living with violence, those where violence is not the key risk, or even separating parents who are respectful towards one another.

The DOORS 'Introduction to clients' is worded to be as neutral as possible. It normalises the fact that people separating experience a certain level of conflict and generally feel sad, hurt and angry. By accepting the likelihood of normative conflict and stress, and differentiating the harmful contexts from the normative, DOORS begins with a validation of a range of experiences.

Learning Activity 4: Introducing the DOORS to different clients

Preparation: For this exercise, you will need to print a hard copy of the DOOR 1 Parent Self-Report form for yourself and any colleagues participating in this learning activity with you. You can photocopy the Parent Self-Report form from the Handbook, pp.25-29, or you can download and print one from the accompanying DVD-ROM.

Refer to the notes you made earlier in Learning Activity 3 about the four clients. For each of these clients, answer the following questions:

1. Would you change the wording of the DOORS Self-Report Introduction for any of the clients described above? If so, how?
2. What further explanation and support for the process might be needed for these different situations?

You can do this by either discussing the guidelines, descriptions and potential responses with colleagues or by writing/typing out the answers for your own reflection.

Learning Activity 5: Analysing the DOORS introduction

Preparation: Watch DVD video segment 'Introducing the DOORS'

Load the DVD that accompanied the Handbook into your computer and under the heading 'Using the DOORS Software' select and watch the first segment 'Introducing the DOORS'.

By this stage, you will have read through the Introduction and thought about how the wording might need to be changed for different clients.

In this DVD segment the DOORS is being introduced to a client by a lawyer's receptionist. Although the receptionist is setting up the client to use the DOORS software, the introduction remains the same for the pen-and-paper version. After watching the video, answer the questions below. You can do this by either discussing the guidelines, descriptions and potential responses with colleagues or writing/typing out the answers for your own reflection.

- What do you notice about how Ruth introduces the DOORS to Richard?
- What aspects of this introduction would be suitable for your own work setting?
- How do you think the transition between administration/reception and lawyer would be experienced by Richard?
- How might you adapt this process to synchronise with your current intake procedures?
- How might your current intake practices need to change once the DOORS is established in your service?
- Are there any clients for whom you think this manner of completing the DOORS would not be appropriate? If yes, how would you use the DOORS differently with those clients?

Pen-and-Paper versions of the DOORS 1 and 2

DOOR 1: Parent Self-Report form

DOOR 1 is the first step in the process of mapping a safety and wellbeing profile, as reported by individual parents, and moving you towards an analysis of the family's needs. This stage is designed for clients to self-complete in a quiet space in the practitioner's premises before meeting with the practitioner. However, DOOR 1 can also be completed during a personal interview with the practitioner (if this is the case, it is advised that the practitioner use DOOR 2: Practitioner Aide Memoire for easy reference). This may be necessary for clients whom you suspect may have difficulty completing the form, such as those with certain physical or cognitive impairments, literacy issues and/or poor English comprehension skills.

The practitioner can determine which of the ten domains the client should complete. In most cases involving children we recommend that all ten domains are completed to help the practitioner detect patterns of concerns across domains that may need further attention. In some cases where the practitioner already has access to other comprehensive history or relevant information about the client (such as provided in affidavits or professional reports), only some domains may be necessary.

Learning Activity 6: Completing the pen-and-paper Parent Self-Report form

Preparation: You should have already printed out a paper copy of the DOOR 1 Parent Self-Report form for Learning Activity 4. Otherwise, photocopy the Parent Self-Report form, from the Handbook, pp.25-29, or download and print one from the accompanying Family Law DOORS DVD-ROM.

Even if you plan on using the software most of the time, it is still valuable to manually fill in the form so you get a feel for using the paper-based DOOR 2 Practitioner Aide Memoire.

You can do this exercise on your own or with a colleague (recommended).

If completing this on your own, you can draw on details from a colleague's recent case or use Case Study 2, Jonathan's story (pp. 153-154) as a basis. You are welcome to embellish the details from Case Study 2 with details of your own. If working with a colleague, each of you should use a composite/fictionalised client case to complete the form.

As you complete the form, put yourself in the role of the client. Did the introduction prepare you for the nature of the questions being asked? Are there any questions that might feel inappropriately intrusive or threatening to a client?

DOOR 2: Practitioner Aide Memoire (pen-and-paper version)

The DOOR 2 Practitioner Aide Memoire provides a structure for organising and analysing large volumes of complex client information.

The paper-based version acts as a discussion guide for reviewing and discussing the client's responses to the Parent Self-Report.

The emphasis of DOOR 2 is on evaluating the nature, pattern, severity and imminence of risk. At the beginning of each domain, DOOR 2 provides a succinct summary of factors to notice during follow-up enquiries. Client responses are recorded in the left-hand column, where risk-related responses are shaded. The right-hand column gives examples of prompts to explore when the client endorses a risk response for a particular question.

When DOOR 1 is used in a face-to-face interview (rather than the client self-completing), the paper-based format of the DOOR 2 Practitioner Aide Memoire is recommended. This includes the DOOR 1 questions, identifies the sorts of answers that represent an alert together with follow-up prompts, all on the one page.

If you suspect there may be any barrier to a client effectively completing the DOORS form, such as physical or cognitive impairments, literacy issues and/or poor English comprehension skills, you should either use the paper version of DOOR 1, assisting the client appropriately, or use the DOORS software but read the questions to the client and record the responses on the client's behalf.

This method is also recommended when multiple and complex risks or trauma are already evident, and the practitioner wants to personally support the client, or wishes to actively probe a client's answers to the screening questions as they go. This kind of interview will take longer but is more comprehensive.

Remember: being systematic and collecting information about all the relevant domains is an important aspect of thorough screening and risk identification. Becoming overwhelmed or lost in the detail of discussion can be a difficulty when the self-report information is collected at the time of interview. Therefore, the practitioner is cautioned against leaving out some domains because the interview takes an unexpected path. Likewise, not allowing time to reflect purposefully on the information obtained from the client could affect the quality of the screening.

Learning Activity 7: Applying the DOOR 2 Practitioner Aide Memoire (pen-and-paper)

Preparation: Photocopy the DOOR 2 Practioner Aide Memoire on pages 33-42 of the Handbook, or use the software template from the accompanying DVD-ROM.

Instructions if working with a colleague or colleagues

If you plan to work with a colleague or colleagues, ensure that each person has access to a copy of the DOOR 2 Practitioner Aide Memoire.

Schedule a time to role-play a practitioner/client discussion based on the answers provided in the DOOR 1 Parent Self-Report.

Prior to that role-play, review the Parent Self-Report form your colleague completed, using the DOOR 2 Practitioner Aide Memoire to analyse the information provided. You will need about 20–30 minutes to do this thoroughly. While reflecting on the report, begin to consider how you are going to discuss the issues raised in the report with the client. Consider these questions:

- Is there a preferable sequence for discussing the different issues that have been identified?
- In what ways could you ensure that your interaction with the client helps to de-escalate risks?
- What particular resources (leaflets, contact details or other information) would be useful to have immediately available?

During your role-play, use the DOOR 2 Practitioner Aide Memoire prompts to guide discussion. As you do so, consider the following questions:

- What sort of follow-up does the Aide Memoire indicate for your client?
- What follow-up questions might you ask to provide a more complete picture of their situation?
- Did the Aide Memoire prompts help you to engage with your client?

Once you have completed one role-play, switch roles and let your colleague interview you as the client.

Then, discuss your experiences in both roles.

As a practitioner, did you feel the Aide Memoire prompts and discussion guides helped to elicit the information you required? How do you think you were able to contribute to a de-escalation of risks?

As a client, what were your feelings about the process? Were the questions relevant, neutral and/or respectful? As a client did you feel supported by this process?

Instructions if working on your own

Review the Parent Self-Report form you completed and use the DOOR 2 Practitioner Aide Memoire to analyse the information provided. As you do so, consider the following:

- What follow-up questions might you ask to provide a more complete picture of the client's situation?
- What sort of follow-up does the Aide Memoire indicate for your client?
- If you used the Aide Memoire prompts and discussion guides in a client discussion, would they help you to engage respectfully?
- In your opinion, would clients see the questions as relevant, neutral and/or respectful?

The DOORS Software

Preparation: Read the Software User Guide in the Handbook, pp. 49-59.

The DOORS Software was developed in conjunction with L-Cubed and is available on the DVD-ROM included with this Handbook. The software enables clients to complete DOOR 1 quickly, and then generates an Aide Memoire to guide further enquiry by the practitioner, with links to resources for follow-up.

Remember the DOORS is **not** a data management system. How each organisation integrates the DOORS software into its practice is a matter for the relevant decision makers to determine. Data collected through the DOORS process should be treated like any other electronic or hard copy data you currently gather, and managed in ways that comply with your organisation's confidentiality and privacy policies.

Using the DOORS software has the advantage that it produces a tailored DOOR 2 Practitioner Aide Memoire in a matter of seconds after the client has completed the DOOR 1 Self-Report. This Aide Memoire offers the practitioner:

- Prompts for each risk item endorsed by the client, to guide further enquiry. These assist the practitioner to explore the potency of risk and to test the veracity of the client's report.
- Reminders to determine critical factors in their appraisal of risk; for example, considering the client's demeanour when discussing the relevant issues.
- Prompts to help formation of a response plan, with options such as 'no risk management action required', through to 'gain consent to share information' and 'immediate safety plan'.
- Examples of safety plans and a suggested consent form for information sharing.

Learning Activity 8: Using the software to set up a new client

Preparation: Download the DOORS software from the DVD-ROM provided.

As outlined in the Software User Guide pp.49-59:

- Create a new copy of the DOORS document
- Rename it to a fictitious client's name and save
- Create a Client ID/Reference and a password.

Instructions if working with a colleague

If you are working in partnership with a colleague, both of you should create a copy of the DOORS document. Do not share the password with your colleague. Open the document you created and ask your colleague to complete DOOR 1. Your colleague should do the same for you. Each of you should complete DOOR 1: Parent Self-Report. One of you should complete it using the persona of Case Study 3: Cheryl (see below), the other by using the persona of a client seen recently who was significantly at risk (obviously you will change names and some details to protect client privacy).

Instructions if working on your own

If you are learning on your own, keep in mind that as a client you would not be given the password for the software. Read Case Study 3: Cheryl below and then use the details provided to complete the DOOR 1 Parent Self-Report.

Case Study 3: Cheryl

Cheryl is 45 years old. She was a high school teacher but is currently working in a youth accommodation service. She separated from her husband Michael three months ago, after eight years of marriage. After a string of disappointing relationships, Cheryl had doubted that she would ever marry or have children, until she met Michael. They have 7-year-old twins, Emma and Jason.

Michael moved to the country and is now in a new relationship with Becky, who is 24. They live in a large house and he would like Emma and Jason to live with them. The children get on well with Becky, who is the local kindergarten teacher and is well known in the region.

Cheryl feels anger towards Michael and strongly dislikes Becky. Recently, Cheryl had a 'breakdown at work' that involved an episode of yelling at a teenage client and then sobbing and struggling to breathe. Her work colleagues, who are supportive, took her home. They took turns to stay with her over the weekend because they felt worried about leaving her alone. The twins were in the country with their father.

Jason's teacher recently rang Cheryl to express concern about Jason. Jason had instigated a schoolyard fight, was disruptive in class and showed a lack of interest in school activities. She felt his behaviour had changed since returning from the winter break and she was worried about him. Cheryl thinks that this is further evidence of the damage Michael has done.

Cheryl claims Michael has been violent toward people who cross him, has been rough with the children, and cannot maintain relationships because he grew up in foster care. She says he regularly had affairs, and he 'smashed the back door of the house' when Cheryl found out about this new relationship. She filed a police report regarding this incident, but didn't pursue a restraining order. However, she claims he is emotionally abusive to her and has printed out all the emails and texts that he has sent her, which swing between conciliatory gestures and angry threats.

Cheryl is determined to stop the twins from living with Michael. Fighting to stop this 'unreasonable demand' is consuming most of Cheryl's attention at present. Cheryl's mother is helping with financial support to ensure proper legal assistance is available. Cheryl is refusing to engage in any further communication with Michael because it simply 'does her head in'. The verbal agreement she made with Michael that the twins visit monthly is the only arrangement she is prepared to continue on with until there is a legally binding order.

Learning Activity 9: Using the DOOR 2 Practitioner Aide Memoire

Preparation: Watch the video segment 'DOOR 2: Practitioner Aide Memoire'.

Load the DVD that accompanied the Handbook into your computer and under the heading 'Using the DOORS Software' select and watch the second segment 'DOOR 2: Practitioner Aide Memoire'.

How do you think the DOORS process supported the lawyer to respond to Richard?

- What impact do you think the lawyer's interest in the emotional state of Heidi (his ex-partner) and Max (his son) would have on Richard?
- What impact did this meeting with his lawyer have on Richard's anxiety about the separation and about his own functioning?
- If you were using DOORS routinely, how would you incorporate its use? What changes to your current practices would be needed? For example:
  - How could the DOORS be incorporated into your current intake process?
  - How would your schedule of appointments need to be modified to give you time to review the DOOR 2 Practitioner Aide Memoire?

The DOOR 2 Practitioner Aide Memoire

The DOOR 2 Practitioner Aide Memoire, generated by the software automatically, provides client responses to DOOR 1 together with discussion and response prompts. The format of the Aide Memoire is the same for software and pen-and-paper versions of DOOR 2.

Allow ample time to systematically review the tailored Aide Memoire report to ensure that comprehensive screening has been carried out. The option within the DOORS to review the Aide Memoire prior to meeting with the client is often valuable.

To facilitate practitioners' use of the DOOR 2 Practitioner Aide Memoire, some adjustment to normal intake procedures and appointment scheduling may be necessary. While initially these changes may appear inconvenient, placing a focus on client wellbeing at the front end of family law services will provide benefits for all concerned, contributing to safety of clients and efficiency of service provision. In particular, organisations may need to adjust their intake processes and appointments to allow time between completion of the DOOR 1 Parent Self-Report and the DOOR 2 Interview so that the practitioner can fully review the DOOR 2 Practitioner Aide Memoire report.

Learning Activity 10: Exploring the Door 2: Practitioner Aide Memoire

Preparation: Before undertaking this activity it is expected that you have read the Software User Guide and have completed Learning Activities 8 and 9.

- Open the DOORS document completed in Learning Activity 8.
- Enter the unique Client ID and password to access the document.
- Click on the button to Generate Report.
- Enter the Client ID and password again to generate the report.

Review any alerts that are highlighted. **Use the Practitioner Action Plan on page 43 of the Handbook (or access via the software on the DVD-ROM) to record what follow-up you would recommend.**

- In which cases would you make a follow-up call to the client?
- What might prompt you to seek your supervisor's advice?
- What sort of social and community support might you recommend to this client?
- Do you have relevant information readily available or would you need to research relevant social and community supports?

Responding to Risks

Preparation: Read DOOR 3: Resources for Responding to Risks, pp. 61-96.

Skills required to respond effectively

Responses to risks identified through the DOORS will never be uniform, given the unique dynamics of individual families, and the different resources available to practitioners. The ability of a practitioner to respond effectively to safety and wellbeing issues is based on the following principles:

1. Personal experience and individual skill: the ability to engage clients in discussion, interpret the interplay of key historical and recent risk factors, assess the need for follow-up, consider all options, and then take the most appropriate actions.
2. Shared values in the workplace and a culture supporting risk screening practices.
3. Well-established networks and effective multidisciplinary partnerships that enable relevant and realistic responses to individual clients/families.
4. A common language and shared understanding of risk and its management identification practices.

Responding effectively to safety and wellbeing risks requires multidisciplinary collaboration. Building a shared and common understanding of the principles of risk assessment is an important aspect of this collaboration. The DOORS provides a framework for risk assessment that is relevant and accessible to all practitioners within the family law system. It enables role clarification, relevant referral and systematic follow-up as a foundation for creating effective multidisciplinary and collaborative partnerships. The information sharing implications of these partnerships are explored later in this learning guide.

Collaboration with the client is another vital aspect of effective response; without this, safety and wellbeing is unlikely to be preserved or created. Consequently, engaging readily and personally with clients at risk lies at the heart of the DOORS ethos. To this end, the DOORS tools and procedures have been carefully designed to support engagement with highly distressed families through to families who are normatively conflicted or stressed.

Learning Activity 11: Discussion follow-up for the DOOR 2 Practitioner Aide Memoire

Preparation: Complete Learning Activities 8 and 10

To access the example Aides Memoire and Safety Plans

To access example Aides Memoire for either Cheryl or Jonathan from the DVD-ROM:

- Click on the title of the report you require (eg Case Study 2 Jonathan Aide Memoire)
- A blank screen will appear – click 'Enable Content'

- A box will appear with the Client ID already filled in
- The password for both Jonathan's and Cheryl's Aides Memoire is **example**
- Enter **example** into the password line
- This will open the already completed DOOR 2 Aide Memoire.

The example safety plans are presented as PDFs. Click on the title to open the plan you want.

Instructions if working with a colleague

If you are learning with a colleague, make a time to complete a role-play with them.

Before your role-play appointment, use the DOOR 2 Aide Memoire completed in Learning Activity 8 to assess the levels of risk and suggested responses.

Conduct your role-play discussion with a colleague, using the completed Parent Self-Report form created and reviewed in Learning Activities 8 and 10. After performing one role play, switch roles. During your discussion, consider the following questions:After you complete one role play, switch roles. Then, discuss the following:

Client perspective

- How did you feel about the overall process?

Practitioner perspective

- As a practitioner, did the prompts and questions provided help you to engage with the client?
- Do you have the necessary networks and skills to respond to the risks identified?
- Is a safety plan required?
- If one of you completed DOOR 1 using Case Study 3: Cheryl's story, you may wish to compare your Aide Memoire and its analysis to one that we have already completed. You can view and download the 'Cheryl: DOOR 2 Practitioner Aide Memoire' from the DVD-ROM accompanying the Handbook (see instructions pp. 166-167).

Instructions if working on your own

If you are learning on your own, review the report and consider how it might support you in a follow up discussion with a client.

Ask yourself the following:

- As a practitioner, did the prompts and questions provided help you engage with the client?
- Do you have the necessary networks and skills to respond to the risks identified?
- Is a safety plan required?

You may wish to compare your Aide Memoire and analysis of Cheryl's case to one we've completed. You can view and download the 'Cheryl: DOOR 2 Practitioner Aide Memoire' from the DVD-ROM accompanying the Handbook (see instructions pp. 166-167).

An ethos of shared responsibility and coordinated response

Endorsing the need for universal screening practices does not of course equate with the idea that universal response to safety risks is possible or desirable. Indeed, a 'one size fits all' approach significantly undermines effective collaboration with the client through a failure to recognise the unique dynamics of individual families, and through missed opportunities to tailor responses.

Central to DOORS is the recognition that professional judgement must extend to identifying practical and relevant responses to identified risks. Contracting with clients about what they are prepared to do and transparency about what the practitioner intends to do are important aspects of effective engagement in the interest of safety. The practice of engagement and staying alongside those at risk of harm or of harming is an important response in itself.

Positive and respectful engagement with people entangled in complex separation is the basis for shaping alternative safety-oriented behaviours and articulating opportunities for change. This focus on the differentiated yet mutually supportive responsibilities of practitioners and clients in recognising and managing risk, creates a climate of shared responsibility.

Shared responsibility for creating change is built into the DOORS framework. Identifying risks but failing to share in the responsibility to build safety, in effect, can put those at risk in further difficulty. Failure to respond to identified risks implicitly reinforces the notion, common to both victims and perpetrators, that 'nothing can be done', a attitude that contributes to further risk and often despair. By contrast, the DOORS approach reinforces the shared practical steps that clients and practitioners can take together towards enabling safety and wellbeing. Rather than burdening individuals with responsibility for problems they have already demonstrated an inability to deal with, DOORS creates a dialogue and the possibility of creating a shared solution to the safety and wellbeing risks presented by separation and divorce events.

Learning Activity 12: Specialist response to DOOR 2: Practitioner Aide Memoire

Preparation: Watch DVD video – 'DOOR 2: Specialist response first meeting'.

This activity can be completed with a colleague or colleagues (recommended) or on your own.

While the DOORS encourages a tailored response to individuals who are at risk from, or who present a risk to their ex-partner and family, the framework necessarily stops short of recommending what specific responses should be. Instead, the DOORS helps the practitioner to quickly arrive at a well considered, multidisciplinary and coordinated response.

Load the DVD that accompanied the Handbook into a computer and select 'DOOR 2: Specialist response: first meeting'.

Open the Handbook to page 72 and refer to Table 6 'Summary of Tools and Frameworks' as you carry out further risk assessment in each risk domain. As you view the video, note how Beth uses

some methods for engagement as she discusses the DOOR 2 Practitioner Aide Memoire with Rachel. Can you see how the Aide Memoire has helped the practitioner to achieve effective client engagement by applying certain steps?

Safety planning with at-risk clients

The DOORS provides two safety plan forms: one for family violence situations and one for suicide risk (see pp. 44-45 of Handbook). Safety planning with an at-risk client aims to prevent escalation of risks and maintain the safety of the client, children and significant others. It is usually undertaken with a potential victim when risk is clear and current. In a similar way to systematic screening, safety planning for family violence or suicide risks needs to be a structured process.

Safety planning is a collaborative process, involving the development of protective strategies that are consistent with the client's real options and their capacity to act in an independent manner. Some clients will need more assistance with and/or direction about making and implementing plans for safety than others. A good safety plan increases protection from further harm (e.g. physical or sexual assaults) by implementing strategies that reduce access opportunity for perpetrators and increase the client's capacity to take appropriate action when in danger.

- In developing a safety plan, the practitioner should consider the following questions[25]: What is the safety issue?
- How severe, potent and recent is this issue? How restricted has the victim's life become?
- Is there an active or 'hot' risk? How does the client perceive the risk(s)? How do client's supports perceive the risk(s)? Clients may not perceive a risk, but others might. Does anyone else know about the risk(s)?
- Who will be affected by the risk(s)?
- What can be done to reduce the client's danger and increase their free choice and action? If something can be done, what risks might increase or decrease, and would any actions create new risks?
- Does the client have any supports available? If yes, are they adequate?
- Does anyone else need to be notified (e.g. police)? If yes, when and how?

[25]Information in this section has been adapted from the Victorian Common Risk Assessment Framework (CRAF). For more specific information, please refer to the CRAF (2007, p77).

Learning Activity 13: Safety Planning

For this activity, you will be using the Safety Planning forms on page 44 and page 45 of the Handbook or on the DVD-ROM.

Case Study 3 Extension: Cheryl

Cheryl phones you in distress. Her story tumbles out: when Michael arrived to pick up the twins this morning, he threatened that he would not return them if Cheryl continued to 'be difficult' about the living arrangements. The argument escalated, and Cheryl threw a heavy vase at Michael. Michael punched Cheryl, and she suspects her ribs are broken. Michael left when Cheryl threatened to call the police. Cheryl called her mother instead, who is with her and looking after the twins. Cheryl is worried that Michael will return, and does not know what to do about this scheduled visit, or about any of it.

Instructions if working with a colleague

Draw on the existing DOOR 2 Practitioner Aide Memoire details if you have:

- completed Learning Activity 8: the DOOR 1: Parent Self-Report form and
- completed Learning Activity 11: the follow-up discussion based on the DOOR 2: Practitioner Aide Memoire.

OR:

Draw on the DOOR 2 Practitioner Aide Memoire if you have:

- completed Learning Activity 2: Jonathan's case study
- completed Learning Activity 8: Cheryl's case study.

You and your colleague should both create separate safety plans based on the DOORS 2 Practitioner Aide Memoire and then meet to compare your safety plans. Do they differ significantly? What is different? What is similar?

Completed Aides Memoire and safety plans for both these case studies are available on the DVD-ROM that accompanies the Handbook (see instructions pp.166-167).

Instructions if working on your own

Using the DOOR 2 Practitioner Aide Memoire completed in Learning Activity 8, use the blank safety planning form to create a safety plan.

If your safety plan was based on Jonathan's or Cheryl's case study (Learning Activities 2 and 8), you can compare your safety plan to ones we have created. Completed safety plans for both these case studies are available on the DVD-ROM (see instructions pp.166-167).

Did the plan you created differ significantly from the plan on the DVD-ROM? What was different? What was similar?

Information sharing

Preparation: Read Information Sharing pp.96-103 of the Handbook

Information sharing is the foundation for cooperative action between practitioners within and across organisations. That said, practitioners are often understandably conservative about sharing information for a host of reasons. Common among these may be their level of understanding of the relevant legislative or ethical exceptions, concerns about remaining engaged with the client or uncertainty about the response they may receive from other agencies. Organisations have a responsibility to train and support staff to assist them with client confidentiality in a responsible but flexible manner. In particular, practitioners should always be mindful of legitimate opportunities to share information in order to improve service delivery or protect people from harm.

Sharing information from one client with their former partner is highly problematic and generally post-separation services try hard to avoid any inappropriate information sharing. Policies and procedures usually enshrine the need for vigilance and clarity about keeping information about other parties separate. However, in situations of extreme or 'hot' safety concerns in relation to the children or ex-partner or other family members, sharing information about imminent harm with the vulnerable ex-partner, as well as other services, must be considered and acted upon. The practitioner needs to weigh the risk of making a notification or referral that may increase tension between former partners with the risk of failing to act on well-founded concerns about safety. The latter option may lead to tragic outcomes.

Many vulnerable clients are highly attuned to the risks of their situation and can be supported to articulate these through detailed exploration of their perception of the current dangers, and through safety planning. Nevertheless, in some circumstances clear communication to the vulnerable party about the practitioner's safety concerns may be the most suitable protective action to take.

Whenever possible, decisions about whether to refer concerns to others or speak directly to the vulnerable party should not be taken alone. Sharing the burden of these decisions with relevant and responsible colleagues is an important feature of collaboration, as encouraged throughout the DOORS.

Learning Activity 14: Documenting your networks

Preparation: Photocopy the Practitioner's Personal List of Local Services on page 95 of the Handbook.

Take some time to research and build a list that is relevant to you. This will be an invaluable resource for many different situations.

Once your personal list of services is prepared, identify for which cases you would use the services you have listed. Then, look at the Client Consent form on page 46 of the Handbook.

Practice reflection questions:

- What policies and protocols are needed for information sharing?
- Are your current client consent approvals adequate for this type of information sharing?
- What sort of information should you have on hand?

Summary

The DOORS is a based on an extensive and close examination of the risks, adverse events and violence that people experience in the context of separation and divorce. This literature is documented in DOOR 3: Understanding Risk Domains and is essential reading.

The need for identifying and managing risk in the Family Law system is beyond question. Go back to the data outlined in the Introduction and DOOR 3: The Risk Domains in Detail in this Handbook for the graphic and sobering statistics. Family separation unequivocally increases risks for mental health difficulties, drug and alcohol abuse, parenting distress, harassment, threat and physical violence towards ex-partners and children, abduction of children, homicide, suicide and familicide. In addition, the AVERT Family Violence training package (www.avertfamilyviolence.com.au) has further information on family violence risk assessment, including a discussion paper, fact sheets and exercises that will enhance professional knowledge of this important topic. Systematically attending to the early warning signs is central to the role of the family law system.

The DOORS seeks to support improved identification and response of risk through:

- standardised screening of wellbeing and risk for children and parents
- prompts for practitioners that guide evaluation of risk through respectful discussion
- analysis of historical and recent risk factors, differentiating normative, high-risk, and potentially lethal risk factors
- supported processes for responding to risk.

It is recommended that you practise with the DOORS tools as often as you require to become proficient and comfortable in their application. When you feel confident in using the DOORS, the final step is to integrate the use of the DOORS into your existing procedures. At best this will be a flexible integration, using pen-and-paper versions or the software, or a combination of the two.

This learning guide has encompassed the nature and importance of screening and has presented a model for a three-level risk screening process; finally, it has given you the tools to respond effectively. The DOORS will help your client and you to share in the identification of risk, development of informed, effective responses and planning for safety where needed. Use of the DOORS will effectively detect the extremes of coercive controlling violence but also will highlight the more prevalent and insidious risks to the emotional wellbeing of individuals affected by family separation.

We hope the DOORS framework assists you to build the relevant professional networks and communication protocols, and thereby support the development of a shared approach to client safety within the family law system.

The Family Law DOORS DVD-ROM Contents

DVD-ROM – The DOORS software, forms and materials

1. The DOORS software

2. Practitioner forms

- DOOR 1: Parent Self-Report form
- DOOR 1: Non-parent Self-Report
- DOOR 2: Practitioner Aide Memoire
- DOOR 2: Practitioner's Action Plan
- Safety Planning: Family Violence
- Safety Planning: Suicide
- Consent form

3. Learning Guide resources

- Jonathan DOOR 1 Self-Report and DOOR 2 Practitioner Aide Memoire
- Cheryl DOOR 1 Self-Report and DOOR 2 Practitioner Aide Memoire
- Jonathan Safety Plan - Suicide
- Cheryl Safety Plan - Family violence
- Cheryl Safety Plan - Suicide

Instructions for loading DVD-ROM and opening software and documents

Hardware requirements

A desktop or laptop computer with a DVD-ROM drive and running a Windows XP Service Pack 3 or newer operating system. It will not function on Mac operating systems.

Software requirements

Microsoft Office 2007 software. A PDF reader, such as Adobe Reader. (Free download is available from http://get.adobe.com/reader/)

To access the DVD-ROM

- Carefully remove the disc from protective sleeve at the front of the handbook, making contact only with the centre hole and edge.
- Insert disc into the computer or laptop.
- Wait until the DVD-ROM fully loads, the main menu should appear.
- If the menu does not appear, eject the DVD and reinsert the DVD, give it some time to load.
- To exit the DVD-ROM menu press the 'Escape' (Esc) button on your computer keyboard.

To access the software template

- For full instructions see pp. 49-59, Software User Guide.

To access the Aides Memoire and Safety Plans

To access the Aides Memoire for either Cheryl or Jonathan from the DVD-ROM:

- Click on the title of the report you require (eg Case Study 2 Jonathan Aide Memoire)
- A blank screen will appear – click 'Enable Content'
- A box will appear with the Client ID already filled in
- The password for both Jonathan's and Cheryl's Aides Memoire is **example** (lower case)
- Enter **example** into the password line
- This will open the already completed DOOR 2 Aide Memoire.
- When you close the document (by clicking 'Save and Close') you will be returned to the main menu.

The example safety plans are presented as PDFs. Click on the title to open the plan you want.

The Family Law DOORS DVD Contents

Introduction and interviews

1. Using the DOORS Software (including segments as described below)	*run time: 16min 34sec*
Introducing the DOORS In this video Ruth, the receptionist shows Richard, the client how to complete DOOR 1 – Parent Self-Report on the computer. Ruth emphasises the importance of confidentiality. Richard fills in DOOR 1 on his own before his appointment with his lawyer.	*run time: 3min 53sec*
Door 2 Practitioner Aide Memoire Richard's lawyer, John McKay uses the Aide Memoire generated by the DOORS software to screen for Richard's and his son Max's safety and wellbeing. John McKay makes some referrals for Richard and suggests an action plan to follow up at their next appointment.	*run time: 11min 49sec*
2. DOOR 2: Specialist Response First Meeting Rachel, the client has two children under 5. She is experiencing intense feelings of betrayal and anger. The DOOR 1 identified the domains of concern with parenting issues emerging. Beth, the practitioner follows up with Rachel in DOOR 2 about parenting in post separation and makes some DOOR 3 referrals.	*run time: 11min 25 sec*

DISCLAIMER:
All characters appearing in this work are fictitious. Any resemblance to real persons, living or dead is purely coincidental.

Total run time: 27min 59sec
Subtitles: No
Audio: Dolby Digital 2.0
Aspect: 16:9

Instructions for loading DVD and watching videos

Hardware requirements

The video DVD will work on desktop and laptop computers with Windows and Mac operating systems.

Software requirements

Any recommended media player software will work.

- Carefully remove the disc from protective sleeve at the front of the handbook, making contact only with the centre hole and edge.
- Insert disc into the computer, laptop or DVD player.
- Wait until the DVD fully loads. When it has, either the Family Law DOORS main menu should appear or there will be a prompt to ask you to play the DVD using a media player.
- If the menu does not appear, eject the DVD and reinsert the DVD. Wait for it to load.
- To watch the whole video or segments of the video, hover your cursor over the title and click to load video or use the DVD remote control to select the video you would like to play.
- The video should start automatically after you select it.
- When the video stops it will return to the Family Law DOORS menu.

CARING FOR YOUR DVD and DVD-ROM:
TO ENSURE THAT THIS DVD AND DVD-ROM PROVIDES YOU WITH YEARS OF VIEWING ENJOYMENT WE SUGGEST YOU TAKE NOTE OF THE FOLLOWING ADVICE.

ONLY use the DVD and DVD-ROM for the purposes intended. Do not touch the disc surface. Do not stack discs. Keep away from extreme heat or direct sun. Ensure disc is correctly inserted into the player before closing drawer. Clean with a damp, lint-free non-abrasive cloth. Do not use harsh cleaning agents; warm soapy water is the preferred option. Do not use circular motions when cleaning. If you encounter playback problems, remove disc from player, check to see if it was properly inserted, clean as directed and try again.

Production by Australian Institute of Social Relations, a division of Relationships Australia (SA) and Family Transitions in conjunction with iPiXELMEDIA.

iPiXELmedia - *pixels are better than paper*

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Appendices

Appendix 1 - Child Abuse Mandatory Reporting Criteria

Appendix 2 - Family Law Pathways diagrams

Appendix 3 - Hague Convention countries

Appendix 4 - MASIC (Mediator's Assessment of Safety Issues and Concerns)

Appendix 5 - Privacy and related legislation in Australia

Appendix 1: Child Abuse Mandatory Reporting Criteria

The following Table from the National Child Protection Clearinghouse (2010, p. 2) contains information about the mandatory reporting criteria for child abuse, as of August 2010. Refer to the National Child Protection Clearinghouse (http://www.aifs.gov.au/nch/topics/index.html?tmm=cpsvmrg) for further information on reporting child abuse.

Table 1: Mandatory reporting requirements across Australia*

	Who is mandated to notify?	What is to be notified?	Maltreatment types mandatory to report	Relevant sections of the Act/Regulations
ACT	A person who is: a doctor; a dentist; a nurse; an enrolled nurse; a midwife; a teacher at a school; a person providing education to a child or young person who is registered, or provisionally registered, for home education under the *Education Act 2004*; a police officer; a person employed to counsel children or young people at a school; a person caring for a child at a child care centre; a person coordinating or monitoring home-based care for a family day care scheme proprietor; a public servant who, in the course of employment as a public servant, works with, or provides services personally to, children and young people or families; the public advocate; an official visitor; a person who, in the course of the person's employment, has contact with or provides services to children, young people and their families and is prescribed by regulation	▪ A belief, on reasonable grounds, that a child or young person has experienced or is experiencing sexual abuse or non-accidental physical injury; and ▪ the belief arises from information obtained by the person during the course of, or because of, the person's work (whether paid or unpaid)	▪ Physical abuse ▪ Sexual abuse	Section 356 of the *Children and Young People Act 2008* (ACT)
NSW	A person who, in the course of his or her professional work or other paid employment delivers health care, welfare, education, children's services, residential services or law enforcement, wholly or partly, to children; and a person who holds a management position in an organisation, the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children's services, residential services or law enforcement, wholly or partly, to children	▪ Reasonable grounds to suspect that a child is at risk of significant harm; and ▪ those grounds arise during the course of or from the person's work	▪ Physical abuse ▪ Sexual abuse ▪ Emotional/ psychological abuse ▪ Neglect ▪ Exposure to family violence	Sections 23 and 27 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW)
NT	Any person with reasonable grounds	▪ A belief on reasonable grounds that a child has been or is likely to be a victim of a sexual offence; or otherwise has suffered or is likely to suffer harm or exploitation	▪ Physical abuse ▪ Sexual abuse ▪ Emotional/ psychological abuse ▪ Neglect ▪ Exposure to physical violence (e.g., a child witnessing violence between parents at home)	Sections 15 and 26 of the *Care and Protection of Children Act 2007* (NT)
	Registered health professionals	▪ Reasonable grounds to believe a child aged 14 or 15 years has been or is likely to be a victim of a sexual offence and the age difference between the child and offender is greater than 2 years	▪ Sexual abuse	Section 26 of the *Care and Protection of Children Act 2007* (NT)

Note: *Section 67ZA of the *Family Law Act 1975* (Cth) applies to all states and territories.

	Who is mandated to notify?	What is to be notified?	Maltreatment types mandatory to report	Relevant sections of the Act/Regulations
QLD	An authorised officer, employee of the Department of Communities (Child Safety Services), a person employed in a departmental care service or licensed care service	■ Awareness or reasonable suspicion of harm caused to a child placed in the care of an entity conducting a departmental care service or a licensee	■ Physical abuse ■ Sexual abuse or exploitation ■ Emotional/ psychological abuse	Section 148 of the *Child Protection Act 1999* (Qld)
	A doctor or registered nurse	■ Awareness or reasonable suspicion during the practice of his or her profession of harm or risk of harm	■ Neglect	Sections 191–192 and 158 of the *Public Health Act 2005* (Qld)
	The Commissioner for Children and Young People	■ A child who is in need of protection under s10 of the *Child Protection Act* (i.e., has suffered or is at unacceptable risk of suffering harm and does not have a parent able and willing to protect them)		Section 20 of the *Commission for Children Young People and Child Guardian Act 2000* (Qld)
SA	Doctors; pharmacists; registered or enrolled nurses; dentists; psychologists; police officers; community corrections officers; social workers; teachers; family day care providers; employees/volunteers in a government department, agency or instrumentality, or a local government or non-government agency that provides health, welfare, education, sporting or recreational, child care or residential services wholly or partly for children; ministers of religion (with the exception of disclosures made in the confessional); employees or volunteers in a religious or spiritual organisations	■ Reasonable grounds that a child has been or is being abused or neglected; and ■ the suspicion is formed in the course of the person's work (whether paid or voluntary) or carrying out official duties	■ Physical abuse ■ Sexual abuse ■ Emotional/ psychological abuse ■ Neglect	Section 11 of the *Children's Protection Act 1993* (SA)
TAS	Registered medical practitioners; nurses; dentists, dental therapists or dental hygienists; registered psychologists; police officers; probation officers; principals and teachers in any educational institution; persons who provide child care or a child care service for fee or reward; persons concerned in the management of a child care service licensed under the *Child Care Act 2001*; any other person who is employed or engaged as an employee for, of, or in, or who is a volunteer in, a government agency that provides health, welfare, education, child care or residential services wholly or partly for children, and an organisation that receives any funding from the Crown for the provision of such services; and any other person of a class determined by the Minister by notice in the Gazette to be prescribed persons	■ A belief, suspicion, reasonable grounds or knowledge that: ■ a child has been or is being abused or neglected or is an affected child within the meaning of the *Family Violence Act 2004*; or ■ there is a reasonable likelihood of a child being killed or abused or neglected by a person with whom the child resides	■ Physical abuse ■ Sexual abuse ■ Emotional/ psychological abuse ■ Neglect ■ Exposure to family violence	Sections 13 and 14 of the *Children, Young Persons and Their Families Act 1997* (Tas.)
VIC	Registered medical practitioners, registered nurses, a person registered as a teacher under the *Education, Training and Reform Act 2006* or teachers granted permission to teach under that Act, principals of government or non-government schools, and members of the police force	■ Belief on reasonable grounds that a child is in need of protection on a ground referred to in Section 162(c) or 162(d), formed in the course of practising his or her office, position or employment	■ Physical abuse ■ Sexual abuse	Sections 182(1) a–e, 184 and 162 c–d of the *Children, Youth and Families Act 2005* (Vic.)

	Who is mandated to notify?	What is to be notified?	Maltreatment types mandatory to report	Relevant sections of the Act/Regulations
WA	Court personnel; family counsellors; family dispute resolution practitioners, arbitrators or legal practitioners representing the child's interests	■ Reasonable grounds for suspecting that a child has been: abused, or is at risk of being abused; ill treated, or is at risk of being ill treated; or exposed or subjected to behaviour that psychologically harms the child.	■ Physical abuse ■ Sexual abuse ■ Emotional/ psychological abuse ■ Neglect	Section 160 of the *Western Australia Family Court Act 1997* (WA);
	Licensed providers of child care or outside-school-hours care services	■ Allegations of abuse, neglect or assault, including sexual assault, of an enrolled child during a care session	■ Physical abuse ■ Sexual abuse ■ Neglect	Regulation 20 of the Child Care Services Regulations 2006; Regulation 19 of the Child Care Services (Family Day Care) Regulations 2006; Regulation 20 of the Child Care Services (Outside School Hours Family Day Care) Regulations 2006; Regulation 21 of the Child Care Services (Outside School Hours Care) Regulations 2006
	Doctors; nurses and midwives; teachers; and police officers	■ Belief on reasonable grounds that child sexual abuse has occurred or is occurring	■ Sexual abuse	Section 124B of the *Children and Community Services Act 2004* (WA)

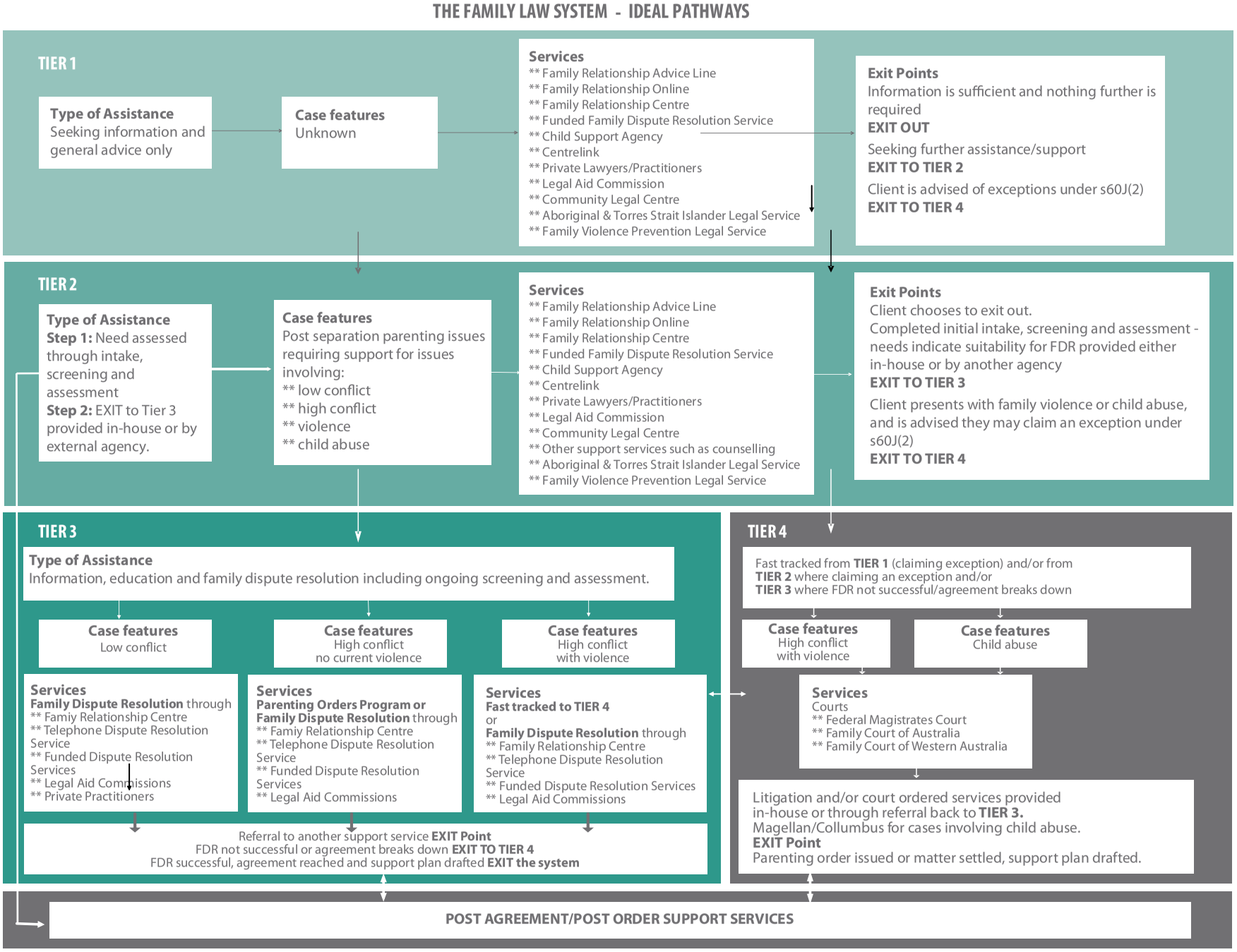
Note: *Section 67ZA of the *Family Law Act 1975* (Cth) applies to all states and territories.

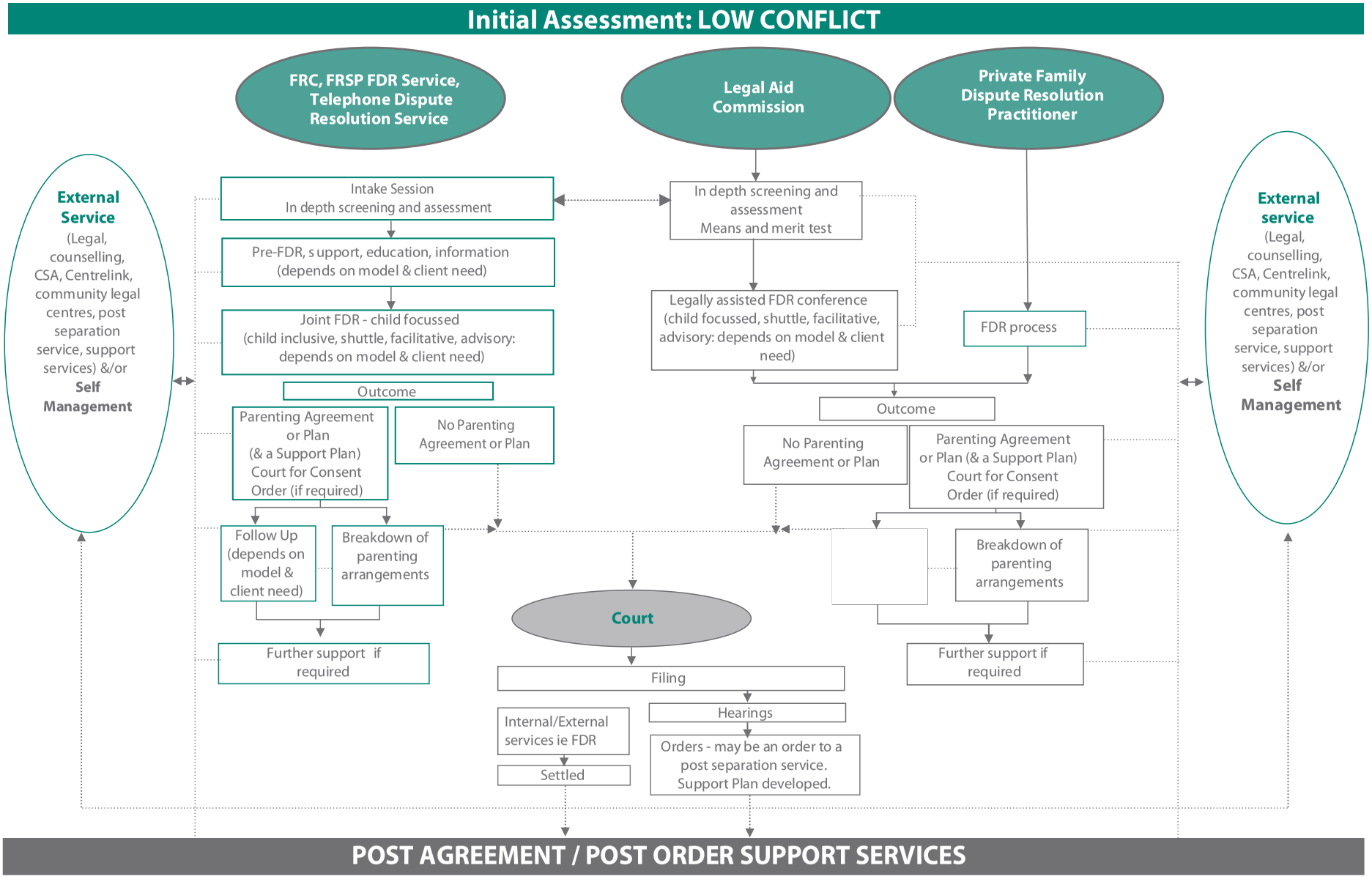
Source: *National Child Protection Clearinghouse (2010, p2)*.

Note: The Minister for Child Protection in WA is currently carrying out a review of the *Children and Community Services Act 2004*, including a review of the mandatory reporting of child sexual abuse provisions. A final report of the review will be presented at the end of 2012. (See http://www.dcp.wa.gov.au/ccsactreview/Pages/default.aspx)

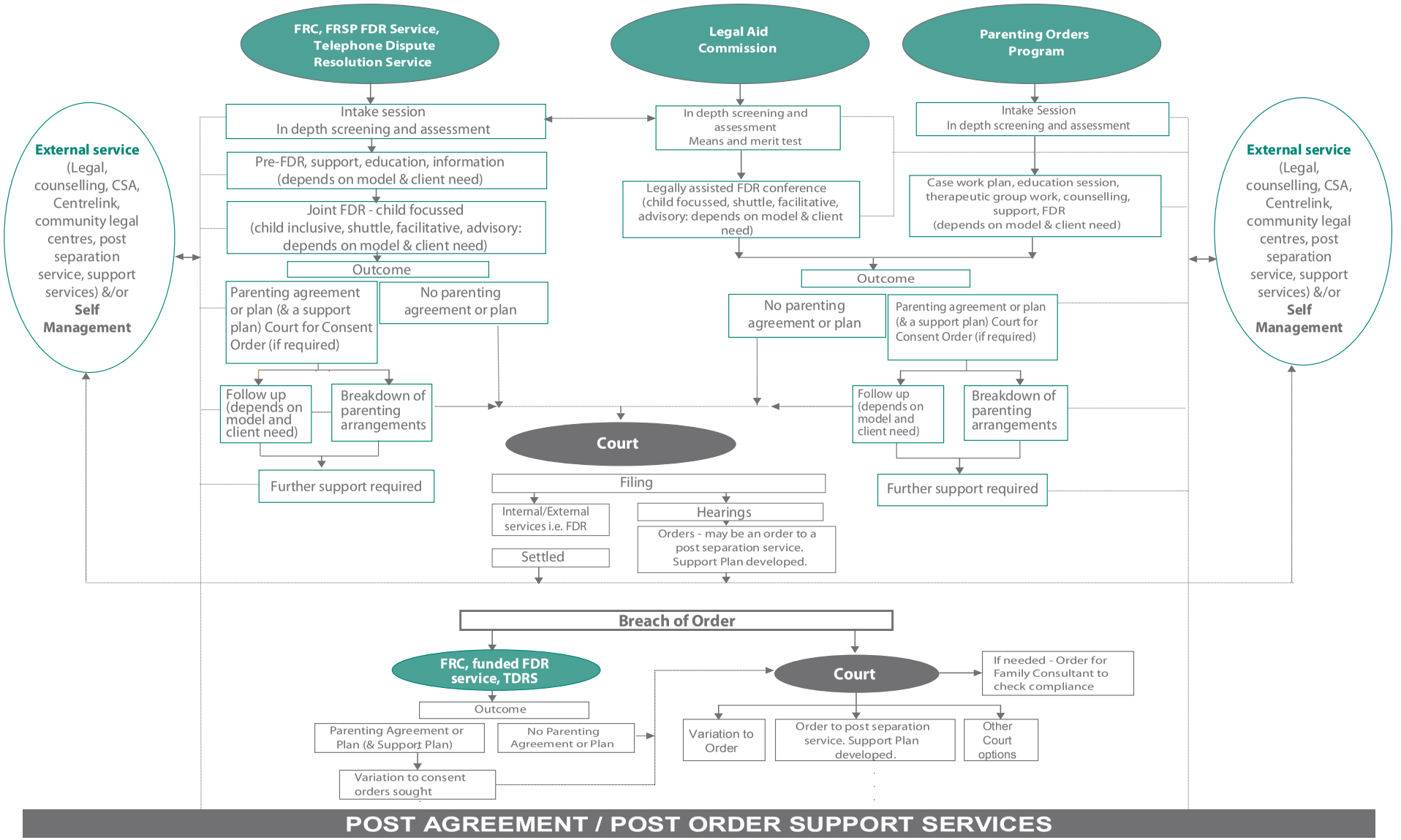
Appendix 2: Family Law Pathways diagrams

These diagrams are from the Attorney-General Department's report "Towards a national blueprint for the family law system" (2009, pp. 71-75).



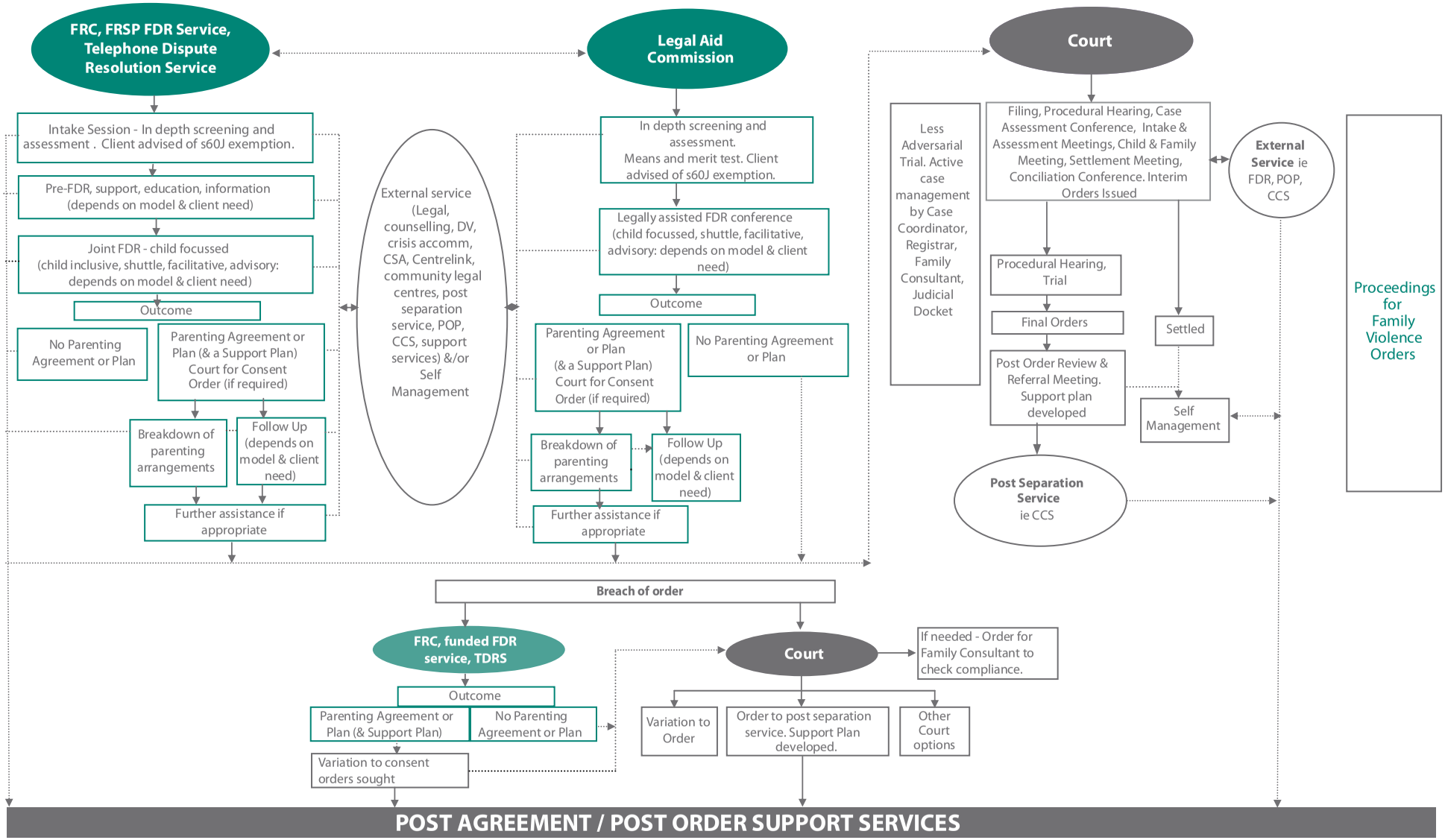

Initial Assessment: LOW CONFLICT
FRC, FRSP FDR Service, Telephone Dispute Resolution Service
Legal Aid Commission
Private Family Dispute Resolution Practitioner
External Service (Legal, counselling, CSA, Centrelink, community legal centres, post separation service, support services) &/or Self Management
Intake Session In depth screening and assessment
Pre-FDR, support, education, information (depends on model & client need)
Joint FDR - child focussed (child inclusive, shuttle, facilitative, advisory: depends on model & client need)
Outcome
Parenting Agreement or Plan (& a Support Plan) Court for Consent Order (if required)
No Parenting Agreement or Plan
Follow Up (depends on model & client need)
Breakdown of parenting arrangements
Further support if required
In depth screening and assessment Means and merit test
Legally assisted FDR conference (child focussed, shuttle, facilitative, advisory: depends on model & client need)
FDR process
Outcome
No Parenting Agreement or Plan
Parenting Agreement or Plan (& a Support Plan) Court for Consent Order (if required)
Breakdown of parenting arrangements
Further support if required
Court
Filing
Hearings
Internal/External services ie FDR
Settled
Orders - may be an order to a post separation service. Support Plan developed.
External service (Legal, counselling, CSA, Centrelink, community legal centres, post separation service, support services) &/or Self Management
POST AGREEMENT / POST ORDER SUPPORT SERVICES

Initial Assessment: HIGH CONFLICT WITH NO VIOLENCE

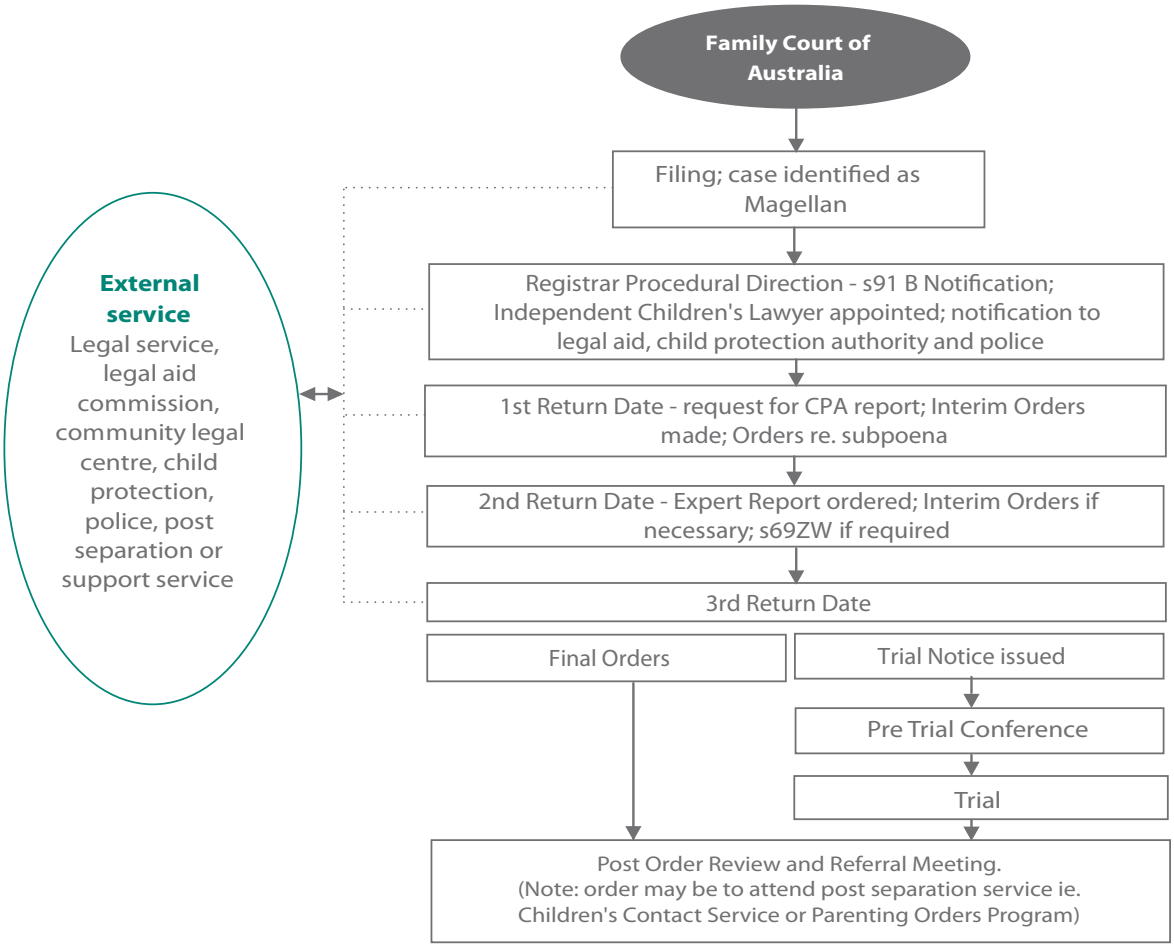


POST AGREEMENT / POST ORDER SUPPORT SERVICES

Initial Assessment: HIGH CONFLICT WITH VIOLENCE



Initial Assessment: CHILD ABUSE



POST AGREEMENT / POST ORDER SUPPORT SERVICES

Appendix 3 : Hague Convention countries

Countries in respect of which the Hague Abduction Convention is in force with Australia as of 1 April, 2010

Convention in force with 78 States - (Contracting states 86 including Australia)

Argentina	Luxembourg
Armenia	Macau (China)
Austria	Malta
Bahamas	Mauritius
Belarus, Republic	Mexico
Belgium	Moldova, Republic
Belize	Monaco
Bermuda	Montserrat
Bosnia and Herzegovina	Netherlands
Brazil	New Zealand
Bulgaria	Nicaragua
Burkina Faso	Norway
Canada	Panama
Chile	Paraguay, Republic of
Colombia	Peru
Costa Rica	Poland
Croatia	Portugal
Cyprus	Romania
Czech Republic	Saint Kitts and Nevis
Denmark	San Marino
Dominican Republic	Serbia and Montenegro, FYR
Ecuador	Slovak Republic
El Salvador	Slovenia
Estonia	South Africa
Fiji	Spain
Finland	Sri Lanka
France	Sweden
Georgia	Switzerland
Germany	Thailand
Greece	The Former Yugoslav Republic of Macedonia (FYROM)
Guatemala	Trinidad and Tobago
Honduras	Turkey
Hong Kong (China)	Turkmenistan
Hungary	United Kingdom
Iceland	United States of America
Ireland	Uruguay
Israel	Uzbekistan
Italy	Venezuela
Latvia	Zimbabwe
Lithuania	

Countries that have acceded to the Convention, but not yet in force with Australia

Convention country	Date acceded to Convention
Ukraine	June 2006
Albania	May 2007
Seychelles	May 2008
Singapore	March 2011
Morocco	March 2010
Russia	July 2011
Andorra	April 2011
Gabon	December 2010

Taken from the Attorney General's Department website (http://www.ag.gov.au/Families/Pages/Internationalfamilylaw-FAQaboutinternationalparentalchildabduction.aspx#countries)

Appendix 4: MASIC
Mediator's Assessment of Safety Issues and Concerns

Date: .....

Case Name: .....

Case No. .....

☐ **Mother** ☐ **Father**

MEDIATOR'S ASSESSMENT OF SAFETY ISSUES AND CONCERNS (MASIC) [i]
(ADMINISTERED VERBALLY BY THE MEDIATOR IN FAMILY LAW CASES WITH CHILDREN)

The authors of this instrument recommend that, if possible, the mediator should (a) obtain any court or police records that might address parties' violent or abusive conduct before completing this Assessment, (b) complete this Assessment in intake session(s) separate from negotiation session(s), and (c) complete this Assessment with each party privately (i.e., separately from the other party).

[Read introduction and questions to each party:] In mediation, parents work together to try to make decisions in their children's best interests outside of court. The mediators do not take sides and will not be making any decisions. Rather, the mediators assist both parents in exploring ways to resolve any disagreements in this confidential settlement process. Before the parents start negotiations, we ask parents to give us some background information and to complete a confidential intake form.[ii] Please answer the following background questions to the best of your ability, keeping in mind that we will keep your answers to these questions private and confidential from the court and the other parent:

Section 1

1. What is your age: .....
   What is the other parent's age: .....

2. Are you employed? ☐ Yes ☐ No
   Is the other parent employed? ☐ Yes ☐ No

3. If you have ever lived/stayed with the other parent, when was the last time that you lived or stayed together?
   [Focus here on whether the parents are currently living or staying together.] .....

4. If you have ever lived/stayed with the other parent, for how long did you live/stay together? .....

5. Which parent left the relationship? ☐ You ☐ The other parent ☐ Both parents decided to end relationship

6. Why did [you/the other parent] leave the relationship? .....
   .....

7. Do you have any children from another marriage or relationship who live with you? ☐ Yes ☐ No

8. If yes, how does the other parent get along with your other child or children? .....
   .....

[i] Amy Holtzworth-Munroe, Connie J.A. Beck, and Amy G. Applegate, Mediator's Assessment of Safety Issues and Concerns (MASIC) (2010). The questions in Section 2 of this assessment have been adapted from Marshall L.L., Development of the Severity of Violence Against Women Scale; Sullivan CM, Parisian JA, Davidson WS, Index of Psychological Abuse; and Tjaden P, Thoennes N, National Violence Against Women Survey. The Marshall, Sullivan, and Tjaden screens, in their entirety, have been validated; however, the adaptation and use of selected questions from validated screens does not validate this screen. The authors wish to acknowledge their law and psychology students who assisted, directly and indirectly, in the development of this Assessment.

[ii] To obtain a copy of the Confidential Intake Form used by mediators in the Viola J. Taliaferro Family and Children Mediation Clinic at the IU Maurer School of Law, contact Professor Amy G. Applegate at aga@indiana.edu.

9. Are you comfortable mediating with the other parent? ☐ Yes ☐ No

10. If not, what makes you uncomfortable? .....
.....

11. What, if anything, would make you feel more comfortable? .....
.....

12. Do you think there is any reason why you should not participate in this mediation? ☐ Yes ☐ No

13. If yes, please explain: .....
.....

14. Everyone fights or argues with family members and friends now and then. What happened when you fought or argued with the other parent involved in this mediation? .....
.....

15. Which of the following statements most correctly describes how you and the other parent have made decisions in the past twelve (12) months? *[If parents ask what kind of decisions, break out question into child/ren's care / finances / other kinds of decisions – ask them to clarify.]*

- ☐ Mother has made almost all decisions
- ☐ Mother has made the majority of the decisions
- ☐ We have shared equally in making decisions
- ☐ Father has made the majority of the decisions
- ☐ Father has made almost all of the decisions

16. How satisfied are you with your role in influencing and making decisions about your child/ren's care?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Neutral / it varies
- ☐ Unsatisfied
- ☐ Very unsatisfied

17. Do you have any of the following concerns about the other parent?

- ☐ Overuse of alcohol or prescription medications
- ☐ Illegal drug use
- ☐ Mental health problems
- ☐ Child abuse and/or neglect concerns
- ☐ Any criminal history

If yes, please tell me about your concerns: .....
.....
.....

18. Do you think the other parent will say that s/he has any of the following concerns about you?

- ☐ Overuse of alcohol or prescription medications
- ☐ Illegal drug use
- ☐ Mental health problems
- ☐ Child abuse and/or neglect concerns
- ☐ Any criminal history

19. During the mediation, would you prefer to sit in the same room with the other parent or in a different room?

- ☐ Same room
- ☐ Different room
- ☐ No preference

20. If in a different room, why?.....

.....

21. If in the same room, why? .....

.....

22. Are there any current or past protective orders, restraining orders, or orders of protection issued against the other parent in this case?
☐ Yes ☐ No

23. If yes, please explain: .....

.....

24. Does the other parent own or have access to any weapons? ☐ Yes ☐ No

25. If yes, what kind(s) of weapons? .....

26. Do you own or have access to any weapons? ☐ Yes ☐ No

27. If yes, what kind(s) of weapons? .....

28. If the Court ordered mediation, why do you believe that the Court ordered this matter to mediation?

.....

.....

29. What parenting plan or arrangements do you think would work best for your family? .....

.....

Section 2

Now, I am going to ask you a series of questions about your relationship with NAME [the other parent]. I am interested in things that [NAME] may have done during a conflict, disagreement, fight, or in anger, or to scare you or hurt you.

First, I will ask if something ever happened, and you should answer yes or no.

Second, if you answer yes, then I will ask how often it happened within the past 12 months. Please tell me how often based on the sheet I just gave you [explain sheet and ensure it is in front of them when answering].

A = never
B = once or twice
C = three to six times (approx. once every few months)
D = seven to twelve times (approx. every month or two)
E = weekly
F = daily

	A. Did the other parent ever (whether living together or not)		B. How often did that happen in the past 12 months?
1	Call you names?	☐ Yes ☐ No	A B C D E F
2	Insult or make you feel bad in front of others?	☐ Yes ☐ No	A B C D E F
3	Yell or scream at you?	☐ Yes ☐ No	A B C D E F
4	Forbid you to go out without him/her?	☐ Yes ☐ No	A B C D E F
5	Try to control how much money you had or spent?	☐ Yes ☐ No	A B C D E F
6	Try to control your activities in or outside the home?	☐ Yes ☐ No	A B C D E F
7	Try to control your contact with family and friends?	☐ Yes ☐ No	A B C D E F
8	Act extremely jealous, or frequently check up on where you've been or who you've been with?	☐ Yes ☐ No	A B C D E F
9	Demand that you obey him/her?	☐ Yes ☐ No	A B C D E F
10	Physically abuse or threaten to abuse pets to scare or hurt you, or when angry at you?	☐ Yes ☐ No	A B C D E F
11	Punish or deprive the children because he/she wasangry at you?	☐ Yes ☐ No	A B C D E F
12	Make threatening gestures or faces at you or shake afist at you?	☐ Yes ☐ No	A B C D E F
13	Threaten to take or have the children taken away from you?	☐ Yes ☐ No	A B C D E F
14	Destroy property, for example, hit or kick a wall, door, or furniture or throw, smash, or break an object?	☐ Yes ☐ No	A B C D E F
15	Drive dangerously to scare you, or when angry at you?	☐ Yes ☐ No	A B C D E F
16	Throw an object at you to scare or hurt you, or when angry at you?	☐ Yes ☐ No	A B C D E F
17	Destroy or harm something you care about?	☐ Yes ☐ No	A B C D E F
18	Threaten to hurt someone you care about?* (If yes, ask for details and write them here)	☐ Yes ☐ No	A B C D E F
19	Threaten to hurt you?* (If yes, ask for details and write them here)	☐ Yes ☐ No	A B C D E F
20	Threaten to kill him/herself?* (If yes, ask for details and write them here)	☐ Yes ☐ No	A B C D E F
21	Threaten to kill you?* (If yes, ask for details and write them here)	☐ Yes ☐ No	A B C D E F
22	Threaten you with a weapon or something like a weapon?* (If yes, ask for details, including, what kind(s) of weapon(s) or object(s); write details here)	☐ Yes ☐ No	A B C D E F

	I want to remind you that all my questions concern things that [NAME] may have done during a conflict, disagreement, or fight, or in anger, or to scare or hurt you.		
23	Hold you down, pinning you in place?	☐ Yes ☐ No	A B C D E F
24	Push, shove, shake or grab you?	☐ Yes ☐ No	A B C D E F
25	Scratch you, or pull your hair, or twist your arm, or bite you?	☐ Yes ☐ No	A B C D E F
26	Slap you?	☐ Yes ☐ No	A B C D E F
27	Hit or punch you?	☐ Yes ☐ No	A B C D E F
28	Kick or stomp on you?	☐ Yes ☐ No	A B C D E F
29	Choke or strangle you?	☐ Yes ☐ No	A B C D E F
30	Burn you with something?	☐ Yes ☐ No	A B C D E F
31	Use a weapon or something like a weapon against you? If yes, what kind(s) of weapon(s) or object(s)?	☐ Yes ☐ No	A B C D E F
32	Demand or insist that you engage in sexual activities against your will?	☐ Yes ☐ No	A B C D E F
33	Physically force you to engage in sexual activities against your will?	☐ Yes ☐ No	A B C D E F
34	Follow or spy on you in a way that made you feel frightened or harassed?	☐ Yes ☐ No	A B C D E F
35	Try to contact you against your will or in a way that made you feel frightened or harassed, for example, by unsolicited written correspondence, phone calls, or other ways of communicating, like text messages, or on Facebook or My Space?	☐ Yes ☐ No	A B C D E F
36	Stand outside your home, school, workplace, or other places where he/she had no business being, and in a way that made you feel frightened or harassed?	☐ Yes ☐ No	A B C D E F
37	Leave items for you to find in a way that made you feel frightened or harassed?	☐ Yes ☐ No	A B C D E F
38	Do anything else similar to the kinds of behaviors we've been discussing? If yes, what kind(s) of behavior(s)?	☐ Yes ☐ No	A B C D E F
	Now consider the things we've been discussing or similar kinds of things:		
39	*[If the parent endorsed any of items 22-31 ,and 33 above]:* You said that [NAME] [insert applicable behaviors, e.g., has slapped you and choked you] in the past 12 months. Have these types of behaviors been happening more often recently than before?	☐ Yes ☐ No	A B C D E F
40	*[If the parent endorsed any of items 22-31, and 33 above]:* Have these types of behaviors been getting worse recently than before?	☐ Yes ☐ No	A B C D E F
41	As a result of the other parent's behaviors, did you feel fearful, scared or afraid of physical harm to yourself or to others?	☐ Yes ☐ No	A B C D E F
42	As a result of the other parent's behaviors, have you ever had a physical injury? If yes, did you seek, or should you have sought medical attention?	☐ Yes ☐ No	A B C D E F
43	As a result of the other parent's behaviors, did you ever call the police? When and what specifically prompted the call?	☐ Yes ☐ No	A B C D E F

Section 3

1. Is there anything else you would like to share with me/us [the mediator(s)]? .....

   .....

2. Is there anything else you think I/we [the mediator(s)] should know? .....

   .....

PRIVATE INSTRUCTION TO MEDIATORS

Review the information obtained from each parent (with your supervisor, if applicable) to consider whether this case is appropriate for mediation, and if so, whether any accommodations should be made to the process.

In some relationships one partner commits all or most of the abuse or violence; in other relationships the abuse or violence may be committed by both partners. Identify the victim(s): ☐ Mother ☐ Father

Consider (and check) the different types of intimate partner abuse or violence that may be present:

____psychological abuse (e.g., Items 1-3 in Section 2),
____coercive control (e.g., Items 4-17 in Section 2),
____threats of severe violence (e.g., Items 18-22 in Section 2),
____physical violence (e.g. Items 23-27 in Section 2),
____severe physical violence (e.g., Items 28-31, and 42 in Section 2),
____sexual violence (e.g., Items 32-33 in Section 2), and/or
____stalking (e.g., Items 34-37 in Section 2).

There are also differing degrees of abuse and violence, and differing degrees of risk from abuse or violence. Some family situations pose serious safety risks to a parent, child, or others, regardless of whether the person at risk recognizes the risk. Although as mediators we need to maintain our impartiality, in order to consider the risk in a given situation, it may be helpful to identify the apparent "victim" and "abuser" in a relationship. The research tells us that a victim of intimate partner abuse or violence is at risk of serious injury or death when some or all of the risk factors below are present.

Check all risk factors that apply:

____ victim expresses fear of abuser (Questions 9-12 in Section 1, Item 41 in Section 2)**
____ abuser is highly controlling (Question 15 in Section 1, Items 4-17 in Section 2)
____ abuser uses drugs and/or alcohol (Questions 17-18 in Section 1)
____ abuser has access to guns or other weapons (note that guns are of particular concern)
(Question 24-27 in Section 1, Items 22 and 31 in Section 2)
____ abuser stalks victim (Items 34-37 in Section 2)
____ abuser threatens violence (Items 18-22 in Section 2) (note that threats of violence involving detailed plans are of particular concern)
____ abuser is physically violent towards victim, and the violence has been escalating in frequency and/or severity over the past 12 months
(Items 22-31, 33, 39, 40 in Section 2)

Check the following additional risk factors which increase the risk to the victim:

____ victim is a woman of child-bearing age (up to age 50) (Question 1 in Section 1)
____ victim has children from another partner/spouse living with her (Question 7-8 in Section 1)
____ victim is leaving her abuser for a new relationship (Question 5-6 in Section 1)
____ abuser is currently unemployed (Question 2 in Section 1)
____ victim and the other parent are still living or staying together (Question 3 in Section 1)

**As mediators, we should always accommodate someone who expresses fear of the other parent (Questions 9 and 12 in Section 1 and Item 41 in Section 2). Accommodation will vary depending on the circumstances, but a mediator should not insist that a party start or continue mediating when that party says that s/he does not want to mediate because of fear of the other party.

Some victims of intimate partner abuse or violence may not believe that they are at risk. Although we generally want to empower a victim of intimate partner abuse or violence who affirmatively wants to mediate, in making the decision whether or not to mediate we must also consider (a) the risks involved and (b) what accommodations to provide if we decide to mediate. In addition to safety risks, be sure to consider, among any other concerns presented in the specific situation, including balance of power issues, the possibility of coercion, the mediator's ethical duty not to facilitate involuntary and/or unconscionable agreements, and the mediator's ethical duty to remain impartial.

In considering the existence and effect of intimate partner abuse or violence in this case, please consider the questions below:

1) If you think the case is not appropriate for mediation, what are your concerns?

2) If you determine not to mediate or to terminate mediation[iii] because of concerns about intimate partner abuse or violence, are there any ethical constraints and/or any safety concerns in how you should communicate this decision with the parties and/or the court?

3) If you think the case may be mediated, should any of the following accommodations be implemented (check the ones you think should be implemented and indicate why)?

_____ parents to be in separate rooms at all times (shuttle mediation)
_____ parents to be in separate rooms if mediator not present (joint sessions possible, but only if the mediator is present with the parents)
_____ staggered arrival and departure times for parents
_____ support person necessary (for which parent(s)?)
_____ attorney necessary (for which parent(s)?)
_____ referral to DV program or shelter (e.g., Middle Way House in Bloomington, IN)
_____ mediation at secure facility, passing through security, presence of armed guards (e.g., Justice Center in Bloomington, IN)
_____ parent needs escort to/from car
_____ parent needs way to leave the building without being seen by the other parent
_____ parents to appear for mediation on separate days
_____ telephone or on-line mediation
_____ other accommodation?

[iii] Even with screening, there may be times when a mediator learns belatedly of intimate partner abuse or violence. If during the mediation, you become concerned about the possibility of intimate partner abuse or violence, take a break to consider how to proceed. Be sure to keep the parties separate while you determine the appropriate action to take.

Appendix 5: Privacy and related legislation in Australia

Western Australia:

No privacy law or administrative privacy regime. However, the following Western Australian legislation is of some relevance:

- *The Health Services (Conciliation and Review) Act* 1995 (contains guiding principles in relation to health records and patient privacy)
- *Freedom of Information Act* 1992
- *State Records Act* 2000
- *Spent Convictions Act* 1988
- *Surveillance Devices Act* 1998
- *Telecommunications (Interception) Western Australia Act* 1996

Northern Territory:

The following legislation can be accessed via the Northern Territory Legislation Database:

- *Information Act* 2002 (privacy, FOI and public records)
- *Criminal Records (Spent Convictions) Act* 1992
- *Surveillance Devices Act* 2007
- *Telecommunications (Interception) Northern Territory Act* 2001

Queensland:

The following legislation can be accessed via the Queensland Legislation site:

- *Information Privacy Act* 2009
- *Right to Information Act* 2009
- *Public Records Act* 2002
- *Criminal Law (Rehabilitation of Offenders) Act* 1986 (spent convictions)
- *Invasion of Privacy Act* 1971 (listening devices, invasion of privacy of the home)
- *Telecommunications Interception Act* 2009

Commonwealth:

The following legislation can be accessed via the Commonwealth of Australia Law site:

- *Privacy Act* 1988:
  - handling of personal information by Commonwealth & ACT public sector agencies;
  - handling of personal information by some private sector organisations
  - Part IIIA: credit worthiness info held by credit reporters & providers;
  - tax file number use by individuals & organisations.
- *Taxation Administration Act* 1953 (handling of tax file numbers)
- *National Health Act* 1953 (handling of Medicare and pharmaceutical benefits info)
- *Data-matching Program (Assistance and Tax) Act* 1990 (matching between ATO & other assistance agencies)
- *Freedom of Information Act* 1982
- *Archives Act* 1983
- *Crimes Act* 1914, Pt VIIC (spent convictions)
- *Surveillance Devices Act* 2004
- *Telecommunications Act* 1997 (personal information disclosed by telco providers)
- *Telecommunications (Interception and Access) Act* 1979

New South Wales:

The following legislation can be accessed via the New South Wales Legislation site:

- *Privacy and Personal Information Protection Act* 1998
- *Health Records and Information Privacy Act* 2002
- *Government Information (Public Access) Act* 2009
- *State Records Act* 1998
- *Criminal Records Act* 1991 (spent convictions)
- *Workplace Surveillance Act* 2005
- *Telecommunications (Interception and Access) (New South Wales) Act* 1987

Australian Capital Territory:

The following legislation can be accessed via the Australian Capital Territory Legislation Register:

- *Privacy Act* 1988 (Cth)
- *Health Records (Privacy and Access) Act* 1997
- *Freedom of Information Act* 1989
- *Territory Records Act* 2002 (public records)
- *Human Rights Act* 2004 (right to privacy)
- *Spent Convictions Act* 2000
- *Listening Devices Act* 1992

South Australia:

No privacy law, but see Cabinet Administrative instruction to comply with Information Privacy Principles (originally issued in 1989, re-issued in 1992), and note the Privacy Committee reports that it has the Minister's in-principle support to develop a consultation paper on strengthening privacy in SA and that work on a proposal for amendments to the IPP and development of model terms and conditions for contracts is ongoing. The following South Australian legislation is also of some relevance:

- *Freedom of Information Act* 1991
- *State Records Act* 1997
- *Criminal Law Consolidation Act* 1935, Part 5A (identity theft)
- *Listening and Surveillance Devices Act* 1972
- *Telecommunications (Interception) Act* 1988

Tasmania :

The following legislation can be accessed via the Tasmanian Legislation site:

- *Personal Information Protection Act* 2004
- *Right to Information Act* 2009
- *Archives Act* 1983
- *Annulled Convictions Act* 2003 (spent convictions)
- *Listening Devices Act* 1991
- *Telecommunications (Interception) Tasmania Act* 1999

Victoria:

The following legislation can be accessed via the Victorian Legislation and Parliamentary Documents site:

- *Information Privacy Act* 2000
- *Health Records Act* 2001
- *Freedom of Information Act* 1982
- *Public Records Act* 1973
- *Charter of Human Rights and Responsibilities Act* 2006
- *Surveillance Devices Act* 1999
- *Telecommunications (Interception) (State Provisions) Act* 1988
- No spent convictions law, but see Victoria Police policy on release of criminal history information