INTRODUCTION

I am pleased to launch the FRSA Conference 2019 e-Journal.

The publication of this document is both bold and ambitious, showcasing just some of the work being undertaken towards ‘new horizons’ in family and relationship services.

We ask all our presenters in our concurrent session program to consider submitting a paper of approximately 6000 words that builds on and presents the content of their abstract in a different form. The submitted papers undergo two rounds of blind peer review resulting in the strengthening and final publication of this year’s seven papers. Covering topics such as the relationship between parent and child mental health, kinship carers support, and universal risk screening in relationship counselling, the papers in this publication speak to the five conference themes:

1. Across the Lifecourse
2. Ageing
3. The first 1000 days
4. Relationship breakdown and re-partnering
5. Partnering and cohabitation.

To our authors—the time required to both write and submit the paper and then to go through the iterative review/amendment and final document phase is very time consuming. My sincere congratulations to all authors for being part of this year’s publication. Your effort and commitment to the task have been significant given that most of you have your ‘day jobs’ to do as well. I certainly hope you feel a strong sense of pride and achievement in seeing your paper published in this year’s journal.

To our readers, I hope you enjoy and benefit from reading this publication and share it widely with your colleagues.

With kind regards,

Jackie Brady
FRSA Executive Director
FRSA would like to thank the following members of the Conference Reference Committee for their assistance in the reviewing of papers for this year’s e-Journal. They have generously contributed their time and expertise, which is greatly appreciated by FRSA.

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Chairperson of the Strategic Leadership
Forum Committee
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Thank you also to Dr Marian Esler, Research Fellow, Australian National University; Fallon Roberts, Executive Manager Family, Wellbeing & Justice Services, Centacare New England North West; and, Lixia Qu, Senior Research Fellow, Australian Institute of Family Studies for assisting in the review process of the FRSA National Conference e-Journal.
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THE RELATIONSHIP BETWEEN PARENT AND CHILD MENTAL HEALTH: Taking a Family Systems Perspective in Support Services

Madeline Gibson (Centre for Family Research and Evaluation (CFRE) at drummond street services)
Shae Johnson (Centre for Family Research and Evaluation (CFRE) at drummond street services)
Karen Field (Centre for Family Research and Evaluation (CFRE) at drummond street services)

The purpose of this research was to explore the relationship between parent and child mental health with the role of family adjustment across all ages of child development except for infancy. The 399 adult participants commencing support at drummond street services (Victoria, Australia) completed the General Health Questionnaire to assess their levels of mental health distress, a Strengths and Difficulties Questionnaire about their child’s mental health distress, and the Parenting and Family Adjustment Scale. Parental mental health predicted child mental health at all ages. The direction of this relationship was unable to be determined by the cross-sectional design of the study. Analyses showed this relationship was mediated by parental adjustment. Overall, children’s conduct problems and hyperactivity were most consistently related to either parental mental health or family adjustment. In age 2 – 4 years there was no evidence of mediation and only parenting style factors were associated with mental health. At 5 – 17 years, both the parenting style factors and relationship dynamics predicted child mental health. For children 5 – 10 years, only the family relationship mediated the relationship between parent and child mental health, whilst for 11 – 17 years, several relationship dynamics played a mediating role. A greater number of associations overall (both direct and indirect effects) occurred in the 11 – 17 age group. The results provide support for situating interventions within a family system, particularly to not disregard these relationships occurring with 11 – 17 year-olds and their families and additionally targeting families early. Organisations that value evidence building are paving the way through collecting and analysing client data to inform an evidence base for practice and service delivery.

Introduction

The family as a setting for intervention

Drummond street (ds) is a service agency based in Victoria, Australia, across multiple site locations. As an organisation, ds recognises the importance of situating individual issues within contextual backgrounds, a major part of which is the role of family relationships in providing a strong and early influence on the mental health and wellbeing of the developing child as well as the wellbeing of adults.

Programs at ds include family-based services such as the Family Mental Health Support Service (FMHSS) program and the Family and Relationship Services program (FaRS), which are funded by the Department of Social Services. These programs focus on building family capability to improve outcomes for children and their family members. Despite increasing knowledge and awareness of the role of the family in individual mental health and wellbeing, the family as a setting for public health intervention can still be overlooked by social research, government policies and services, across sectors and prevention efforts.

Family systems theory

The concept of family influence on individual mental health originates primarily from family systems theory
(Bowen, 1966) and has influenced the practice of family and relationship support services. In this theory, the family contributes to both a relationship system and an emotional system. Through these systems, family members influence and are influenced by one another, so that the higher the degree of distress in one generation, the greater the vulnerability to dysfunction by an individual in another generation (Titelman, 1998, p. 232). The tendency for one generation to transmit affective distress to the next describes interactions of the family emotional system as a result of the relationship system (Titelman, 1998). As such, cross generational transmission of affective distress may be dependent on how family members relate to one another. The theory speaks to the importance of a whole-of-family approach in support services. The purpose of this study is to examine the relationship between parent and child mental health and the influence of the family relationship system.

Intergenerational transmission

Prevalence rates of mental health disorders suggest environmental and genetic predispositions to mental health risk in families where a mental health disorder is present (e.g. O’Hara, 1992; Silberg, 2002; Zimmerman, McGlinchey, Young, & Chelminski, 2006). There is limited research on the relationship between mental health distress between parents and children. Research has often focused on the prevalence of diagnosed child mental health disorders and has shown a relationship between these disorders and higher rates of parental mental health distress (Bennett, Brewer & Rankin, 2012; Office for National Statistics, 2000; Silberg, 2002, p. 14). For example, in a British sample of 10,252 parents, it was found that parents who scored above the mental health distress cut-off on the General Health Questionnaire (GHQ-12) were three times more likely to have a child with a mental health disorder than parents without signs of mental health distress (Office for National Statistics, 2000).

Parent and child distress are generally measured using varied scales or questionnaires which focus on mental health competency, externalising and internalising behaviour and subjective wellbeing. There is little consistency over how child mental health and wellbeing is measured. Additionally, most studies only involve children aged under 12, with a stronger focus on the preschool years. Longitudinal studies have shown how both maternal and paternal mental health at the infancy period is related to a form of child distress at preschool age (Essex et al., 2006; Ramchandani, Stein, Evans & Connor, 2005). However, contrary to these findings, Goldberg et al. (2014) demonstrated that only concurrent maternal psychological distress (rather than perinatal) was related to children’s mental health competency scores at preschool (average age: 4.7 years). Additionally, Australian longitudinal data of children 0 – 5 years old until aged 4 – 9 (Bayer et al., 2011) found that, amongst a series of predictors, parents’ harsh use of discipline was a consistent predictor of externalising behaviour and maternal emotional distress was a consistent predictor of children’s internalising symptoms. Another longitudinal study (Powdthavee & Vignoles, 2007) investigated mental health distress of parents and subjective wellbeing of their 11-year old children. They found that parental distress was an important determinant for the child’s life satisfaction in the same year and just paternal distress predicted the child’s life satisfaction in the following year.

Recent research has also demonstrated that the relationship between parent and child mental health distress and wellbeing may persist into adulthood. This study found that the adult child’s negative internalised cognitions, which are strongly related to mental health distress and psychopathology, were shown to be associated with their parents’ similar negative cognitions formed in childhood in mother-daughter dyads (Gibson & Francis, 2019). There was limited evidence that parenting styles in childhood mediated this relationship and further research was suggested to be undertaken on more complex parent and family relationship dynamics to help explain the relationships found.

Family adjustment

A variety of parent behaviours and family relationship dynamics have been associated with negative or positive outcomes for children’s mental health and wellbeing. For example, conflict in co-parenting, the closeness of the parent-child relationship, harsh parenting and parental inconsistency all have been shown to be related to negative mental health and wellbeing outcomes for children (Størksen, Røysamb, Moum & Tambs, 2005; Ackard, Neumark-Sztainer, Story, & Perry, 2006; Dwairy, 2010; Newland, 2015; Stallman & Ohan, 2016; Bayer et al., 2011). For example, Stallman and Ohan (2016) examined child outcomes for children aged 4 – 17 with parents who were divorced. The results showed that parental distress and co-parent conflict predicted emotional and behavioural problems. It has been proposed that family adjustment factors (such as parenting practices or parent-child interactions) explain the relationship between child wellbeing and parental experiences, including: parental depression, stress, interparental conflict, or other similar factors (Newland, 2015).

Current study

This study will examine important elements of family systems theory for parent and child mental health distress transmission and the role of family adjustment.
Studies have established a relationship between child and adult wellbeing and psychopathology, however little research has been undertaken on the nature of this relationship. When child mental health rather than diagnosed disorders has been researched, studies have commonly used scales that are not always comparable or widely used. Although the importance of different developmental stages has been well established (see Bjorklund, 2013), the research between child and adult mental health has not been examined for differences amongst age groups and relatively ignored for children over 11 years of age. Additionally, the relationship between parent practices or family dynamics and child mental health supports the role of the impact of the family on child mental health. It is commonly hypothesised that family adjustment plays a role in the transmission of mental health, yet to our knowledge the mediation of family adjustment across child age groups has not been explored.

The current study aims to determine the relationships between concurrent parent and child mental health distress across all ages of child development (aside from infancy) using a widely used measure of child mental health, within the relevant context of accessing a support service. Based on previous findings it is hypothesised that (1) there will be significant positive relationships between parent and child mental health distress. Additionally, (2) family adjustment will be significantly and positively associated to parent and child mental health distress. Finally, it is hypothesised that (3) family adjustment will mediate the relationship between parent and child mental health distress. Differences between age groups at each hypothesis will be explored.

Method

Client participation and consent

In 2016 ds services commenced collecting pre- and post- evaluation measures to assess the impact of support services for each program. The main programs involved in this study included FMHSS (67%) and FaRS (26%). Prospective participants were invited to take part in the study during the standard ds intake assessment process (conducted by telephone or face to face). The nature and the purpose of the research was explained verbally during the intake assessment. The evaluation was explained in more detail by the practitioner when the first appointment was made. Informed consent to participate was then confirmed in writing at the first session with the ds Client Consent Form. The questionnaires were collected only after signed consent was obtained for the use of de-identified data for research and evaluation purposes. Questionnaires were completed individually without the aid of the practitioner. To reduce client bias, the questionnaires remained confidential even from the practitioner. All questionnaires outlined purpose, voluntary participation and confidentiality at the introduction. All participants in the following study have consented to the use of their results for research.

Measures

The FMHSS and FaRS programs place important emphasis on the impact of families on child development and their future wellbeing in addition to the impact of families on the wellbeing of adults. To measure outcomes for these programs, questionnaires were developed to include measures on adult and child mental health as well as family adjustment. To ensure appropriateness, these questionnaires vary across each program type, age of client, or age of the client’s child. As such, the sample sizes across the measures used in the current study will differ. The current study measured participants’ results from three measures: the 12-item General Health Questionnaire (GHQ), the Strengths and Difficulties Questionnaire (SDQ) and the Parenting and Family Adjustment Scale (PAFAS).

The GHQ is a self-report measure of psychological morbidity, intended to detect psychiatric disorders in community settings and non-psychiatric settings. It is widely used in clinical practice, epidemiological research and for research in psychology. Each item is rated on a four-point scale (less than usual, no more than usual, rather more than usual, or much more than usual). The Likert scoring method (0-1-2-3) was used for this study. A higher score indicates a greater degree of psychological distress. The test author provides suggested default thresholds being a score of 11 or less indicating absence of a mental disorder and a score of 12 or more indicating the presence of a mental disorder.

The SDQ is one of the most widely and internationally used measures of child and young person’s mental health (Goodman & Goodman, 2009; Klein, Otto, Fuchs, Zenger & Von Klitzing, 2013) and consists of 25 items with five scales, of five items each. This study used the parent version of the SDQ. The scales include emotional symptoms, conduct problems, peer relationship problems, hyperactivity/inattention and pro-social behaviour and provides a total-difficulties score which is generated by summing four of the scales. This questionnaire has been found to be an acceptable measure of child mental health due to the strong association of total difficulty scores with psychopathology (Goodman & Goodman, 2009). This study utilised the parent report version of the measure.

The PAFAS was designed to assess parenting practices and parental adjustment in both public health and parenting interventions and reports good internal consistency, as well as construct and predictive validity (Sanders, Morawska, Haslam, Filus & Fletcher, 2014).
This measure uses a four-point Likert scale from: 0 = not true of my child at all, 1 = true of me a little, or some of the time, 2 = true of me quite a lot, or a good part of the time, 3 = true of me very much, or most of the time. For each subscale the items are summed to provide scores, with higher scores indicating higher levels of parenting dysfunction. Six subscales from the PAFAS were included in the evaluation: parental inconsistency, coercive parenting, positive encouragement, parent-child relationship, family relationships, and parental teamwork. Three of the PAFAS subscales related to parenting styles: parental inconsistency, coercive parenting and positive encouragement; whilst the remainder related to dynamics in the family relationship, including: the parent-child relationship, family relationships, and parental teamwork.

Analyses

Descriptive statistics and Pearson’s correlations between variables will be explored, see Figure 1. A mediated model will be examined using a bootstrapping method (Hayes, 2009; Hayes, 2013) to determine whether parental mental health influences child mental health scores indirectly through family adjustment. All analyses are conducted in SPSS v25 (IBM corporation, Armonk, New York) and mediation tested with the use of PROCESS V3.4 (Hayes, 2019). In this method, a total effect of the independent variable (variable X in Figure 1) on the dependent variable (Y) is composed of a direct effect of X on Y (controlling for M) and the indirect effect of X on Y through M (the mediator).

Results

Participants

A total of 399 parents had completed both the GHQ and SDQ at their first session. Of the total participants, 315 had basic demographic information available. Of these, 74% of parents were female and 26% were male. Almost a quarter of participants (22%) were born overseas and 1% identified as Aboriginal. The majority (96%) of participants were heterosexual. Additionally, 61% had a tertiary education and only 37% stated employment was their main source of income. The average age of parents was 40 years. As determining demographic differences was not the purpose of analysis, all participants (with or without demographic data available) were included in the results.

Testing assumptions

Missing data was previously screened and removed as part of the data cleaning process, so that incomplete subscales were not considered in the data set used for this research. Skewness and kurtosis ranged from −.07 to 1.06 and −.81 to 1.57, respectively. However, the analyses were considered to be robust against violations of normality (Norman, 2010).

Relationship between Parent (GHQ) and Child (SDQ) Mental Health Distress

Pearson’s correlations were conducted for the relationship between adult and child mental health. The results are displayed in Table 1.

<table>
<thead>
<tr>
<th></th>
<th>All Ages</th>
<th>2 - 4</th>
<th>5 - 10</th>
<th>11 - 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>r</td>
<td>.247***</td>
<td>.212*</td>
<td>.229**</td>
<td>.277***</td>
</tr>
<tr>
<td>n</td>
<td>399</td>
<td>86</td>
<td>169</td>
<td>133</td>
</tr>
</tbody>
</table>

r = Pearson’s correlation coefficient, *significant at α < .05, **significant at α < .01, ***significant at α < .001.

There was a positive and significant correlation between parent and child mental health distress scores (r = .247, p < .001, n = 399). Across each child’s age group, parents’ GHQ scores were positively and significantly correlated to SDQ scores. Correlations were slightly stronger for older age groups.

Parents with mental health distress were 3.5 times more likely to have a child with mental health distress than parents who had no signs of mental health distress (see Table 2). Additionally, the odds ratio for the values displayed in Table 2 were significant (OR = 2.14, p = .002).

<table>
<thead>
<tr>
<th></th>
<th>Child with MH distress</th>
<th>Child has no MH distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent with MH distress</td>
<td>234</td>
<td>71</td>
</tr>
<tr>
<td>Parent has no MH distress</td>
<td>63</td>
<td>41</td>
</tr>
</tbody>
</table>
The correlations between parent and child mental health by SDQ subscale and age are presented in Table 3. Only significant correlations are displayed for readability. At each of the age groups, parents’ mental health distress significantly predicted the child’s hyperactivity scores. Parents of children aged 11 – 17 had the strongest correlations with their mental health and the SDQ subscales, with all but emotional problems showing correlations to parental mental health scores. Emotional problems were only related to parental mental health for the 5 – 10 year-olds ($r = .188, p < .001$). Correlations for 5 – 10 year-olds were both at a small effect size (Cohen, 1992). For 2 – 4 year-olds, issues with conduct behaviour ($r = .248, p < .05$) and hyperactivity ($r = .249, p < .05$) were related to their parents’ mental health scores. The strongest relationship occurred for 11 – 17 year-olds prosocial behaviour being negatively correlated to their parents’ mental health ($r = -.329, p < .001$).

### Family adjustment and mental health

Pearson’s correlations were conducted between parent and family adjustment subscale scores (PAFAS) and parent and child mental health (SDQ and GHQ).

### Child mental health

A number of significant correlations were found between family adjustment and child mental health, these are displayed in Table 4. The strongest correlation was the positive association between coercive parenting and child’s conduct problems. This was followed by the positive associations between child’s overall mental health score and both coercive parenting and the parent-child relationship. There were no significant correlations between parental encouragement and child mental health. The majority of the significant relationships occurred with parent-child relationship scores, followed by the family relationship scores.

#### Table 3. GHQ and SDQ Pearson’s Correlations by Subscale and Age (years)

<table>
<thead>
<tr>
<th>Age</th>
<th>Emotional Problems</th>
<th>Prosocial Behaviour</th>
<th>Conduct Problems</th>
<th>Hyperactivity</th>
<th>Peer Relationship Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
<td>$r = .129^{**}$</td>
<td>-.192^{***}</td>
<td>.166^{**}</td>
<td>.216^{***}</td>
<td>.148^{**}</td>
</tr>
<tr>
<td></td>
<td>n 402</td>
<td>403</td>
<td>401</td>
<td>400</td>
<td>401</td>
</tr>
<tr>
<td>2 – 4</td>
<td>$r = .248^{*}$</td>
<td>.249^{*}</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n 86</td>
<td>86</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 – 10</td>
<td>$r = .188^{*}$</td>
<td>-.329^{***}</td>
<td>.220^{*}</td>
<td>.286^{**}</td>
<td>.187^{*}</td>
</tr>
<tr>
<td></td>
<td>n 169</td>
<td>169</td>
<td>133</td>
<td>133</td>
<td>133</td>
</tr>
<tr>
<td>11 – 17</td>
<td>$r = -.329^{***}$</td>
<td>.220^{*}</td>
<td>-.329^{***}</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>n 133</td>
<td>133</td>
<td>133</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$r = $ Pearson’s correlation coefficient, $^{*}$ significant at $\alpha < .05$, $^{**}$significant at $\alpha < .01$, $^{***}$significant at $\alpha < .001$.

#### Table 4. PAFAS and SDQ Pearson’s Correlations by Subscales

<table>
<thead>
<tr>
<th>Inconsistency</th>
<th>Total SDQ</th>
<th>Emotional Problems</th>
<th>Prosocial Behaviour</th>
<th>Conduct Problems</th>
<th>Hyperactivity</th>
<th>Peer Relationship Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>r</td>
<td>.262^{***}</td>
<td>.196^{**}</td>
<td>.163^{**}</td>
<td>.208^{***}</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>269</td>
<td>271</td>
<td>270</td>
<td>271</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coercive Parenting</td>
<td>r .320^{***}</td>
<td>-.231^{***}</td>
<td>.387^{***}</td>
<td>.277^{***}</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>265</td>
<td>269</td>
<td>267</td>
<td>266</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental Encouragement</td>
<td>r</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>291</td>
<td>293</td>
<td>295</td>
<td>293</td>
<td>292</td>
<td>293</td>
</tr>
<tr>
<td>Parent-Child Relationship</td>
<td>r .303^{***}</td>
<td>.160^{**}</td>
<td>-.254^{***}</td>
<td>.263^{***}</td>
<td>.201^{**}</td>
<td>.169^{**}</td>
</tr>
<tr>
<td>n</td>
<td>291</td>
<td>293</td>
<td>295</td>
<td>293</td>
<td>292</td>
<td>293</td>
</tr>
<tr>
<td>Family Relationship</td>
<td>r .256^{***}</td>
<td>-.229^{***}</td>
<td>.234^{***}</td>
<td>.209^{***}</td>
<td>.172^{***}</td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>431</td>
<td>434</td>
<td>432</td>
<td>431</td>
<td>433</td>
<td></td>
</tr>
<tr>
<td>Parental Teamwork</td>
<td>r .256^{***}</td>
<td>.113^{*}</td>
<td>.149^{**}</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>431</td>
<td>317</td>
<td>317</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$r = $ Pearson’s correlation coefficient, $^{*}$ Significant at $\alpha < .05$, $^{**}$significant at $\alpha < .01$, $^{***}$significant at $\alpha < .001$. Only significant correlations are displayed.
Family adjustment subscales and their relationships to SDQ subscales have been broken down by the three age categories in Table 5.

2 – 4 Years
There were no significant associations between children’s mental health at ages 2 – 4 years with relationship-based factors, this included: the parent-child relationship, the family relationship and parental teamwork scores. The majority of significant relationships with child mental health occurred with inconsistent parenting and coercive parenting (parenting styles); whilst the majority of significant relationships with family adjustment occurred negatively with prosocial behaviour and positively with conduct problems and hyperactivity. The strongest association was the significant relationship between coercive parenting and the child’s conduct problems at this age ($r = .487, p < .001, n = 78$).

5 – 10 Years
There were no significant relationships between child mental health and parental encouragement or parental teamwork at this age. The majority of relationships occurred between child mental health and a mix of parental practices and relationship dynamics: the parent-child relationship, the family relationship and coercive parenting. Similar to the 2 – 4 age group, the strongest relationships occurred negatively with prosocial behaviour and positively with conduct problems and hyperactivity. In this age group however, peer relationship issues were shown to be significantly related to family adjustment.

11 – 17 Years
The mental health scores of the 11 – 17 year age group showed the highest number of significant correlations to family adjustment. The strongest relationships to adolescent mental health occurred for inconsistent parenting, coercive parenting, the parent-child relationship and the family relationship. There was no relationship between adolescent mental health and parental encouragement. Most of the correlations are of a medium effect size (Cohen, 1992).

Table 5. PAFAS and SDQ Pearson’s Correlations by Subscales and Age (years)

<table>
<thead>
<tr>
<th>Age</th>
<th>PAFAS Subscale</th>
<th>Total SDQ</th>
<th>Emotional Problems</th>
<th>Prosocial Behaviour</th>
<th>Conduct Problems</th>
<th>Hyperactivity</th>
<th>Peer Relationship Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 – 4 Years</td>
<td>Inconsistency</td>
<td></td>
<td></td>
<td>.344**</td>
<td>.349**</td>
<td>.272*</td>
<td>.208**</td>
</tr>
<tr>
<td></td>
<td>n 79</td>
<td></td>
<td></td>
<td>79</td>
<td>79</td>
<td>79</td>
<td>152</td>
</tr>
<tr>
<td></td>
<td>Coercive Parenting</td>
<td></td>
<td></td>
<td>.392**</td>
<td>-.290**</td>
<td>.487***</td>
<td>.342**</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>78</td>
<td>78</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parental Encouragement</td>
<td></td>
<td></td>
<td></td>
<td>-.234*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 – 10 Years</td>
<td>Inconsistency</td>
<td></td>
<td></td>
<td>.271**</td>
<td>-.215**</td>
<td>.326**</td>
<td>.261**</td>
</tr>
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<td>.208**</td>
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<td>Parent-Child Relationship</td>
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<td>11 – 17 Years</td>
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<td></td>
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<td>.380*</td>
<td>-.420*</td>
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<tr>
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<td>.419*</td>
<td>.442*</td>
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<td>.285*</td>
<td>.338*</td>
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<td></td>
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<tr>
<td></td>
<td>Family Relationship</td>
<td></td>
<td></td>
<td>.272**</td>
<td>-.338***</td>
<td>.309***</td>
<td>.274**</td>
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<tr>
<td></td>
<td>Parental Teamwork</td>
<td></td>
<td></td>
<td>.266**</td>
<td>.268**</td>
<td>.283**</td>
<td></td>
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<tr>
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<td>n 105</td>
<td></td>
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<td>105</td>
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</tbody>
</table>

$r$ = Pearson’s correlation coefficient, *significant at $\alpha < .05$, **significant at $\alpha < .01$, ***significant at $\alpha < .001$. Only significant correlations are displayed.
**Parental mental health**

The Pearson's correlation coefficients for family adjustment and parental mental health are displayed in Table 6. Parental encouragement was not significantly related to adult mental health. The strongest relationship to adult mental health occurred with parental teamwork ($r = .408$, $p < .001$) as well as the family relationship ($r = .343$, $p < .001$).

**Mediation of family adjustment between parent and child mental health**

All mediation was tested using 10,000 bootstrapped samples. Due to the absence of relationships with parental encouragement, this variable was not considered in mediation testing.

Results are displayed in Table 7. There was evidence that inconsistency, coercive parenting, parent-child relationship, family relationship and parental teamwork all mediated the relationship between adult and child mental health.

The majority of significant mediations from family adjustment occurred with adult mental health and child conduct problems or hyperactivity. There was evidence to suggest that the parent-child relationship mediated the relationship between adult mental health and child mental health on all SDQ subscales and the family relationship mediated parent and child mental health on all SDQ subscales but emotional problems.

There was no evidence that parental mental health influenced child conduct problems independent of its effect with coercive parenting ($DE = .04$, $p = .07$).

---

**Table 6. PAFAS and GHQ Pearson’s Correlations**

<table>
<thead>
<tr>
<th>GHQ r</th>
<th>Inconsistency</th>
<th>Coercive Parenting</th>
<th>Parental Encouragement</th>
<th>Parent-Child Relationship</th>
<th>Family Relationship</th>
<th>Parental Teamwork</th>
</tr>
</thead>
<tbody>
<tr>
<td>.299***</td>
<td>.205**</td>
<td>.205**</td>
<td>.148*</td>
<td>.343***</td>
<td>.408***</td>
<td></td>
</tr>
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</table>

$n$ = 244, 240, 247, 259, 386, 295

$r$ = Pearson’s correlation coefficient, *Significant at $\alpha < .05$, **Significant at $\alpha < .01$, ***Significant at $\alpha < .001$.

---

**Table 7. Mediation of PAFAS subscales for the relationship between parent and child mental health, by SDQ subscales.**

<table>
<thead>
<tr>
<th>Mediator Variables</th>
<th>Outcome Variable</th>
<th>Inconsistency</th>
<th>Coercive Parenting</th>
<th>Parent-Child Relationship</th>
<th>Family Relationship</th>
<th>Parental Teamwork</th>
</tr>
</thead>
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<tr>
<td><strong>SDQ Total</strong></td>
<td>DE</td>
<td>.22***</td>
<td>.21***</td>
<td>.23***</td>
<td>.17**</td>
<td>.14*</td>
</tr>
<tr>
<td></td>
<td>IE</td>
<td>.05 CI [.016,.095]</td>
<td>.05 CI [.014,.100]</td>
<td>.04 CI [.009,.070]</td>
<td>.06 CI [.025,.103]</td>
<td>.04 CI [.008,.083]</td>
</tr>
<tr>
<td></td>
<td>TE</td>
<td>.27***, $r^2 = .10$</td>
<td>.26***, $r^2 = .09$</td>
<td>.26***, $r^2 = .09$</td>
<td>.23**, $r^2 = .06$</td>
<td>.17***, $r^2 = .04$</td>
</tr>
<tr>
<td><strong>Emotional Problems</strong></td>
<td>DE</td>
<td>.05*</td>
<td>.05*</td>
<td>.04*</td>
<td>.05*</td>
<td>.02</td>
</tr>
<tr>
<td></td>
<td>IE</td>
<td>.01 CI [-.01,.02]</td>
<td>.01 CI [-.004,.02]</td>
<td>.01 CI [.001,.02]</td>
<td>.004 CI [-.01,.02]</td>
<td>.01 CI [-.01,.03]</td>
</tr>
<tr>
<td></td>
<td>TE</td>
<td>.06*, $r^2 = .03$</td>
<td>.06*, $r^2 = .03$</td>
<td>.05*, $r^2 = .14$</td>
<td>.05*, $r^2 = .02$</td>
<td>.03</td>
</tr>
<tr>
<td><strong>Prosocial Behaviour</strong></td>
<td>DE</td>
<td>-.04*</td>
<td>-.04</td>
<td>-.04*</td>
<td>-.04*</td>
<td>-.04*</td>
</tr>
<tr>
<td></td>
<td>IE</td>
<td>.01 CI [-.02,.002]</td>
<td>.01 CI [-.03,.003]</td>
<td>.01 CI [.001,.002]</td>
<td>.02 CI [-.04,.01]</td>
<td>.01 CI [-.02,.011]</td>
</tr>
<tr>
<td></td>
<td>TE</td>
<td>-.05**, $r^2 = .17$</td>
<td>-.05**, $r^2 = .16$</td>
<td>-.05**, $r^2 = .03$</td>
<td>.06**, $r^2 = .19$</td>
<td>-.05**, $r^2 = .16$</td>
</tr>
<tr>
<td><strong>Conduct Problems</strong></td>
<td>DE</td>
<td>.05*</td>
<td>.04</td>
<td>.05*</td>
<td>.04*</td>
<td>.03</td>
</tr>
<tr>
<td></td>
<td>IE</td>
<td>.02 CI [.003,.03]</td>
<td>.02 CI [.007,.047]</td>
<td>.01 CI [.003,.023]</td>
<td>.02 CI [.007,.037]</td>
<td>.01 CI [-.01,.03]</td>
</tr>
<tr>
<td></td>
<td>TE</td>
<td>.06**, $r^2 = .03$</td>
<td>.06**, $r^2 = .03$</td>
<td>.06**, $r^2 = .04$</td>
<td>.06**, $r^2 = .03$</td>
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<td>.01 CI [.002,.02]</td>
<td>.02 CI [.002,.04]</td>
<td>.02 CI [-.001,.037]</td>
</tr>
<tr>
<td></td>
<td>TE</td>
<td>.10***, $r^2 = .27$</td>
<td>.10***, $r^2 = .07$</td>
<td>.10***, $r^2 = .07$</td>
<td>.08***, $r^2 = .04$</td>
<td>.06**, $r^2 = .03$</td>
</tr>
<tr>
<td><strong>Peer relationship issues</strong></td>
<td>DE</td>
<td>.04**</td>
<td>.05</td>
<td>.04**</td>
<td>.03*</td>
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</tr>
<tr>
<td></td>
<td>IE</td>
<td>.01 CI [.002,.03]</td>
<td>.03 CI [-.05,.013]</td>
<td>.01 CI [.001,.02]</td>
<td>.02 CI [.003,.03]</td>
<td>.001 CI [-.02,.02]</td>
</tr>
<tr>
<td></td>
<td>TE</td>
<td>.05**, $r^2 = .03$</td>
<td>.05**, $r^2 = .03$</td>
<td>.05**, $r^2 = .03$</td>
<td>.05**, $r^2 = .03$</td>
<td>.04*, $r^2 = .01$</td>
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</tbody>
</table>

*10,000 bootstrapped samples, X variable = GHQ-12. DE = Direct Effect, IE = Indirect Effect, TE = Total Effect. *Significant at $\alpha < .05$, **Significant at $\alpha < .01$, ***Significant at $\alpha < .001$. Confidence Intervals of the unadjusted indirect effect are at 95%, bold indirect effect represents significance. For readability, significant mediation models have been shaded grey.
Similarly, there was no evidence that parental mental health influenced child prosocial behaviour independent of its effect with coercive parenting (DE = -.04, p = .07). The strongest model involved the mediation of parental mental health and child prosocial behaviour by the family relationship, this model accounted for almost 20% of the variance in child mental health scores (r² = .19, p < .001).

**Mediation by Age**

Booting analyses were re-run for each age group to test for mediation for PAFAS subscales that were previously shown to be significantly correlated to SDQ subscales to minimise superfluous research.

**2 – 4 Years**

There was no evidence that family adjustment was involved in the relationship between adult and child mental health in children aged 2 – 4 years as all 95% confidence intervals of the indirect effects captured zero.

**5 – 10 Years H4**

In ages 5 – 10, only the family relationship had evidence of a mediating role in the relationship between parent and child mental health at this age. The family relationship helped to explain the association between adult mental health and total child mental health (DE = .14, p = .047; IE = .07, 95% CI [-.02, .13]) as well as their child’s prosocial behaviour (DE = -.07, p = .015; IE = -.03, 95% CI [-.056, -.013]).

Additionally, the family relationship mediated the relationship between adult mental health and child conduct problems (IE = .021, 95% CI [.002, .044]), as well as between adult mental health and child hyperactivity (IE = .02, 95% CI [.01, .05]) with no evidence of the effect on the child’s conduct problems (DE = .01, p = .73) or hyperactivity (DE = .03, p = .35) independent of the family relationship.

**11 – 17 Years**

For children aged 11 – 17, relationship factors including the parent-child relationship, the family relationship and parental teamwork all showed evidence for mediating the relationship between parental mental health and a subscale of child mental health. Due to the larger volume of significant mediations, adolescent

<table>
<thead>
<tr>
<th>Outcome Variable</th>
<th>Mediator Variables</th>
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<td>DE</td>
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</tr>
<tr>
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<td>.39**</td>
</tr>
<tr>
<td></td>
<td>.10 CI [.045, .261]</td>
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<td>.24</td>
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<td>.07 CI [.002, .143]</td>
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<tr>
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<td>.26***, r² = .09</td>
</tr>
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<tr>
<td>Emotional Problems</td>
<td></td>
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<tr>
<td>DE</td>
<td>.03</td>
</tr>
<tr>
<td>IE</td>
<td>.06 CI [-.031, .130]</td>
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<td>TE</td>
<td>.09</td>
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<td>.02 CI [.004, .08]</td>
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<td></td>
<td>.06</td>
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<td>.07**</td>
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<td>Conduct Problems</td>
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<td>.10*</td>
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<td>IE</td>
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<td>DE</td>
<td>.15**</td>
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<td>.04</td>
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<td>.02 CI [-.007, .044]</td>
</tr>
<tr>
<td>TE</td>
<td>.06*, r² = .04</td>
</tr>
</tbody>
</table>

* 10,000 bootstrapped samples, X variable = GHQ-12. DE = Direct Effect, IE = Indirect Effect, TE = Total Effect
   ** Significant at α < .05, *** significant at α < .01, **** significant at α < .001. Confidence Intervals of the unadjusted indirect effect are at 95%, bold indirect effect represents significance. For readability, significant mediation models have been shaded grey.
bootstrapping results are displayed in Table 8. There was no evidence to suggest parental inconsistency or coercive parenting played a mediating role. The effect of parent mental health on child total mental health scores were mediated only by the parent-child relationship, the family relationship and parental teamwork.

The results indicated that parental teamwork mediated the relationship between adult mental health and child conduct problems (DE = .035, p = .31; IE = .03, 95% CI [.004, .07]) as well as their child’s hyperactivity (DE = .07, p = .08; IE = .04, 95% CI [.01, .08]) with no evidence of adult mental health impacting the child’s conduct problems or hyperactivity independent of the effect of parental teamwork. Additionally, the family relationship mediated the relationship between adult mental health and child conduct problems (DE = .03, 95% CI [.008, .06]) with no evidence of adult mental health impacting the child’s conduct problems independent of the effect of the family relationship (DE = .04, p = .192).

The strongest model was the mediation of total adult and child mental health with the parent-child relationship, this model accounted for 31% of the variance in child mental health scores (r² = .31, p < .01). This was followed by the mediation of adult mental health and child hyperactivity scores with the parent-child relationship, this model accounted for 26% of the variance in child mental health scores (r² = .26, p < .01).

**Discussion**

The aim of this research was to explore the relationship between adult and child mental health where previous research has focused on the establishment of a relationship between the two. Our analyses demonstrated the involvement of family adjustment in the relationship between parent and child mental health and key differences were found between age groups. Support was gathered for all three hypotheses which contributed to the overall understanding of the relationship between parent and child mental health. This research has provided evidence in support of the family as a setting for intervention.

**Associations with parent and child mental health**

As expected, there was evidence of transference of mental health between parents and children. Similar to the Office for National Statistics study (2000), parents who scored above the mental health distress cut-off on the GHQ-12 were 3.5 times more likely to have a child with mental health distress than parents who had no signs of mental health distress. Adult mental health predicted SDQ scores at all subscales, but the degree and particular subscales differed across ages. At every age group hyperactivity was related to adult mental health and conduct disorders in the majority of the age groups.

**Family adjustment and adult or child mental health**

Child mental health was related to all subscales of the PAFAS except the degree of parental encouragement received from the parent. The strongest relationships occurred with coercive parenting. The parent-child relationship (followed by the family relationship) was most influential across all subscales on the SDQ. Similar to child mental health, parental mental health was also related to all PAFAS subscales except for parental encouragement. Parental mental health was most strongly related to the family relationship and parental teamwork.

These results demonstrated the relationship of family adjustment to both parent and child mental health. Analysis of the relationship between PAFAS subscales and either parent or child mental health has not previously been undertaken. However, these results aligned with previous research that has shown relationships between parenting styles and mental health (e.g. Bayer et al., 2011; Stallman & Ohan, 2016) as well as family relationships and mental health (e.g. Ackard et al., 2006).

**The role of family adjustment**

There was evidence that adult mental health indirectly predicted child mental health through the role of all subscales of family adjustment. This was a novel finding of this research. The indirect effect of the parent-child relationship was significant for all SDQ subscale outcomes; this showed the widespread influence of the parent-child relationship on the relationships between parent and child mental health. Similarly, the significant indirect effects of coercive parenting and the family relationship also revealed the importance of these elements of family adjustment in the relationships examined.

**Difference across age groups**

These results collectively informed the relationship between adult and child mental health at different age groups.

At age 2 – 4 years, parental mental health was related to child mental health with no evidence of this relationship going through family adjustment. Adult mental health was related to the child’s hyperactivity and conduct problems. However, family adjustment was still related to child mental health but only with the parenting style subscales (rather than relationship factors) including inconsistent parenting, coercive parenting and also parental encouragement to a lesser degree. The parenting style was related to conduct problems, hyperactivity and prosocial behaviour. This aligned with previous research where harsh discipline predicted negative child mental health outcomes in a similar age
group (Bayer et al., 2011). However, the absence of a significant association between family relationship factors and child mental health was a new finding.

At age 5 – 10, parental mental health was related to child mental health with evidence of just the family relationship mediating this relationship. Adult mental health was related to child hyperactivity and emotional problems. Similar to ages 2 – 4, parenting styles (namely coercive parenting and to a lesser degree inconsistent parenting) were also related to child mental health at this age but with the addition of two relationship factors: parent-child relationship and family relationship. Family adjustment overall was related to all areas of child mental health except emotional problems, including: prosocial behaviour, conduct problems, hyperactivity and peer relationship issues.

At age 11 – 17, parental mental health was related to a variety of child mental health issues and there was evidence of relationship factors mediating this relationship, including the parent-child relationship, family relationship and parental teamwork. Adult mental health was related to a much wider range of child mental health issues at this age than in the younger years, including prosocial behaviour, conduct problems, hyperactivity and peer relationship issues, but not emotional problems. Similar to 5 – 10 year-olds, family adjustment was related to child mental health with both the parenting styles and relationship factors, however this was the only age group where parental teamwork was also related to child mental health. Additionally, this was the only age group where emotional problems were related to family adjustment.

These results differentiated the importance of the influence of parenting styles in age groups, and the greater impact of family relationship dynamics in older years (5 – 17). The overall strength of relationships occurring for 11 – 17 year-olds shows the key importance of family adjustment for the presence and potential influence of mental health distress across generations.

Limitations and future directions

One of the most important limitations of this research to note was that the parent was rating both their own mental health and their child’s. However, the SDQ is designed to minimise parental bias as the questions are centred around incidence of behaviour rather than parental opinion of mental health distress as a concept. It is also possible that higher parental distress may influence the perception of child behaviour and wellbeing.

An important limitation of this research was the inability to establish the direction of mental health transmission. Parents are also likely to be impacted by child mental health distress. The relationship examined may take effect in reverse. This research does not try to eliminate the possible bi-directional relationship of parent and child mental health. However, by showing the intergenerational relationship of mental health through the familial relationship, this research also speaks to the possible impact of child mental health on parent wellbeing due to the involvement of the family system in mental health.

This study was cross-sectional in design; as such, causality cannot be inferred. However, the design of this study benefited from the cross-section approach by being able to examine concurrent mental health which was the purpose of completing this research. It would be valuable to be able to determine how the relationship between parent and child mental health unfolds over attendance to support services. Additionally, longitudinal data could provide insight into the trajectory of the nature and type of disorders over time.

Mental health is a small contributor to the functionality of the family system. It is hypothesised that multiple issues and events experienced by the parent will drive poor mental health of parents and will similarly impact the mental health of the child. To understand the drivers of adult mental health and their impact on child mental health, further research may examine the correlations between adverse experiences and events and the mental health of the parent and child.

Conclusions and implications

The results of this study provide support for a whole-of-family approach in improving the mental health and wellbeing of children and parents. As such, these findings support service intervention at a family level whilst informing differences across child development. This could help to shape interventions at different age levels to provide better outcomes for children and families. Practical interventions and social research on just child or just parent mental health alone may overlook understanding the family setting dimensions that drive poor mental health outcomes for children (including intergenerational transmission).

An important aspect of this research was the ability to differentiate across child age groups. A novel finding across all ages, but particularly in the later age groups, was that ‘problem behaviours’ including conduct problems and hyperactivity, showed the most consistent relationship to family adjustment and parental mental health. Additionally, a greater number of correlations occurred (and to a stronger degree) in the 11 – 17 year age group. Based on these findings, the influence of family and parental mental health on child behaviour may be particularly important for the later age group. As correlations were stronger at older ages than younger age groups, early and earlier in life family-based interventions targeted towards parenting and family dynamics may be the key to providing greater emotional and social outcomes for children and their families.
The implications of this research for service response are immensely important. Adolescent behaviour from a schooling, legal, and social perspective can often be treated as an issue of the individual. As found in this study, the relationship between parent and child mental health and family adjustment is a critical factor in determining child wellbeing, supporting our proposition that child mental health should be considered in the context of the family as a system, not the individual alone. As children age it is expected that there are additional influences on their emotional wellbeing such as community environments and peers. This research is showing the ongoing importance of the family environment across the age groups. It raises questions as to whether child and youth mental health systems that fail to address family and parental drivers of poor mental health for children and young people will be effective.

This study purposefully oversimplifies the experience of family mental health and wellbeing through the use of minimal variables. It is proposed that, for further research, a breadth of risk factors and adverse situations and events that drive poor mental health in parents will similarly impact the mental health of the child including absence of resources such as financial distress, secure housing, social isolation and events such as family violence.

Through demonstrating the relationships between parent and child mental health, this study highlights the importance of understanding child mental health, including behavioural issues, within a family system. The results provide support for a wide range of services to ensure a focus on family systems. This involves applying this approach in initial assessments and family level interventions when responding to child mental health issues, including behavioural issues (such as conduct behaviour or hyperactivity). Organisations that see themselves as evidence builders, rather than baseline data collectors, are paving the way with the ability to use data to inform an evidence base for practice and service delivery as reflected by this analysis.

References


Norman, G. (2010). Likert scales, levels of measurement and the “laws” of statistics. Advances in Health Sciences Education. https://doi.org/10.1007/s10459-010-9222-y


The abuse of older people by family members is an issue that is gaining attention in Australia. There are a number of factors that have been reported to increase the vulnerability of victims and thereby the risk of experiencing elder abuse. Cognitive impairment is one risk factor that has consistently been reported (Chen & Dong, 2017). Despite this, there has been little research into whether abuse experienced by older people with a cognitive impairment differs from that of victims who do not have a cognitive impairment. This study used 12 months of data from an elder abuse helpline to examine whether individual risk factors, relational risk factors, abuse types and behaviours, barriers to addressing abuse and the impact of abuse on victims differed as a function of whether the victim was reported to have a cognitive impairment.

Between-group differences regarding individual and relational factors were found. Victims who were identified as having a cognitive impairment (CI Group) had more complex support needs and were more likely to be dependent on perpetrators than victims who had no cognitive impairment (NCI Group). Victims in the CI Group were more likely to experience neglect and social abuse and less likely to experience physical or psychological abuse than victims in the NCI Group. The types of abuse behaviours used by perpetrators were also found to differ, as were the methods used to facilitate financial abuse. Further differences related to the reported impact of abuse and the barriers for victims in addressing abuse. The findings from this study may inform practice when working with victims of elder abuse and provide a basis for further research to be undertaken.

Elder abuse is increasingly recognised as an important issue in Australia and the rest of the world (Bedson, Chesterman & Woods, 2018; Dong, Simon, Rajan & Evans, 2011). Elder abuse is frequently defined as “a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person” (World Health Organization, WHO, 2002). There are various types of elder abuse, including financial abuse, physical abuse, psychological abuse, sexual abuse, social abuse and neglect (Elder Abuse Prevention Unit, EAPU, 2018). The scope of what constitutes ‘relationships of trust’ is somewhat contentious and varies between countries and even jurisdictions. Some conceptualisations of elder abuse classify formal care relationships as ‘relationships of trust’, whereas others define them as ‘positions of trust’ and, due to the contractual nature of interactions view abuse in these situations as consumer issues rather than elder abuse (Dixon et al., 2010).

Australia does not have a nationally agreed definition or framework underpinning understandings of elder abuse (Chesterman, 2016; Dean, 2019). In some areas, there has been increased recognition that elder abuse
is often perpetrated by family members and may be a form of family violence (Australian Law Reform Commission, ALRC, 2017; Chesterman, 2016; Seniors Rights Victoria, 2018). However, some work has also included abuse at the hands of service providers as elder abuse (Chesterman, 2016). Recent work as part of the Elder Abuse National Research Project has suggested further broadening the definition of elder abuse to include not only abuse in formal care relationships but also abuse by neighbours or government bodies (Carson, 2018). Despite this lack of consensus about what should or should not be included under definitions of elder abuse, the patterns of abuse have been found to vary as a function of whether abuse occurs in the context of family violence, consumer or social relationships (EAPU, 2018). This article will only cover elder abuse in the context of close or intimate relationships.

Within an international context, notions of elder abuse and its underlying causes have evolved over time. In the late 1970s and early 1980s, elder abuse was thought to be a consequence of caregiver stress (Roberto & Teaster, 2017). Subsequent ideas were shaped by family violence research, with elder abuse viewed as intimate partner violence that continued into old age (National Research Council, 2003). More recent conceptualisations have recognised that elder abuse is a multifaceted issue which stems from the complex interplay between factors at the individual, relationship, community and societal levels (Santos, Nunes, Kislaya, Gil & Ribeiro, 2019).

Australia has an ageing population and the proportion of Australians aged 65 years and over is expected to increase from 15 percent in 2017 to 22 percent in 2057 (Australian Institute of Health and Welfare, AIHW, 2018a). There is currently no data on the prevalence of elder abuse in Australia; however, estimates based on international studies suggest that the rate could be between 2-14 percent of people aged 65 years and older (Kaspiew et al., 2016). The number of elder abuse notifications reported to Queensland’s Elder Abuse Prevention Unit (EAPU) has increased by 170 percent in the past decade from 714 notifications in 2007-08 to 1,946 in the 2017-18 financial year (EAPU, 2018). Consistent with this, the number of applications for domestic violence orders where victims were aged 60 years or older almost doubled between 2005-06 and 2014-15 (Queensland Government Statistician’s Office, 2016). However, it is likely that these figures underestimate the extent of the problem as the abuse of older people is often described as a hidden issue (Dean, 2019), with recent analysis by WHO (2018) indicating that only 1 in 24 cases of elder abuse are reported. The reasons for this under-reporting are complex. The signs of elder abuse can be subtle and occur in relationships where wrongdoing can easily be hidden (Chesterman, 2016).

Furthermore, capacity impairments, financial constraints and a fear of losing relationships with perpetrators present as barriers to help-seeking for victims of elder abuse (Cross, Purser & Cockburn, 2017).

It is important that the seriousness of elder abuse is recognised, as increased longevity means that increasing numbers of older people may be at risk of abuse. Based on population projections and estimated prevalence rates, Blundell, Clare, Moir, Clare, and Webb (2017) have suggested that more than 500,000 people in Queensland (aged 65 years and older) could experience elder abuse by 2037. Elder abuse has been linked to an increased likelihood of hospitalisation and mortality (Dong & Simon, 2013). In 2014-15, 210 victims aged 65 years and over were hospitalised in Australia due to assault at the hands of family members (AIHW, 2018b). Despite the burgeoning interest and recognition of the pervasiveness of elder abuse and its impacts, there is a dearth of Australian research in this field (AIHW, 2018c; Kaspiew, Carson & Rhoades, 2016; Lacey, 2014).

One issue consistently flagged by researchers as a key risk factor is cognitive impairment, which has been associated with greater vulnerability to elder abuse (ALRC, 2017; Bedson et al., 2018; Dong, 2015; Dong et al., 2011; Johannesen & LoGiudice, 2013; Kaspiew et al., 2016). In a large-scale, population-based study in Chicago, Dong et al. (2011) found that cognitive impairment was associated with an increased risk of physical and emotional abuse, neglect and financial exploitation, noting that the risk was highest for those with larger cognitive deficits. Johannesen and LoGiudice (2013) evaluated existing studies that had identified risk factors for elder abuse and found that victim behavioural issues and caregiver stress varied as a function of whether victims had dementia or required assistance with activities of daily living. As part of a longitudinal, population-based study, Dong et al. (2009) found that the mortality risk following confirmed elder abuse was higher for victims with cognitive impairment. Due to difficulties related to a perceived lack of capacity to provide informed consent to participate in research, people with cognitive impairment are often excluded from studies of elder abuse (Bedson, 2017; Bedson et al., 2018; Johannesen & LoGiudice, 2013; Prusaczyk, Chenery, Carpenter & Dubois, 2017). Developing a better understanding of elder abuse and whether this differs in cases where victims have cognitive impairment is likely to be beneficial for practitioners working in primary, secondary and tertiary intervention areas.

Drawing on data collected by Queensland’s elder abuse Helpline, this study aimed to determine whether victim and perpetrator characteristics, relationships, experiences of abuse and barriers to change differed as a function of victim cognitive impairment.
Based on the existing literature, it was expected that the types of abuse, victim characteristics and relationship factors would differ between victims with and without cognitive impairment.

Method

Data collection

The Elder Abuse Prevention Unit (EAPU) is a statewide service within UnitingCare’s Older Persons Programs. The EAPU is funded by the Queensland Government Department of Communities, Disability Services and Seniors to respond to the abuse of older people in Queensland. This is accomplished through provision of an elder abuse Helpline, awareness raising activities, facilitation of network meetings and the analysis and dissemination of Helpline data. The EAPU does not provide case management services and callers to the Helpline remain anonymous. The focus of Helpline calls is on providing support to the caller rather than collecting data about the abuse situation. Consequently, callers are not asked unnecessary questions to elicit information solely to improve data collection. Callers to the Helpline include victims, perpetrators, other family members, workers from a wide array of professions, neighbours and other persons with concerns about an older person.

After a Helpline call, staff enter non-identifiable information into PEARL (Prevention of Elder Abuse Record List), the EAPU’s purpose-built database. PEARL captures data based on relationships between victims and perpetrators. In some cases, a victim may be experiencing abuse from multiple perpetrators and each abuse relationship is captured as a separate elder abuse case.

The majority of Helpline staff are social workers, with the remainder having qualifications in psychology or counselling. Staff have received training in data entry and utilise a data dictionary with definitions and examples of operationalised variables to guide data entry and support the consistency of data entry across the team. Staff also participate in regular meetings to discuss data entry decisions in complex cases.

Abuse definitions

Data entry related to abuse is based on the following definitions used by the EAPU:

- **Financial abuse** - The illegal or improper use and/or mismanagement of a person’s money, property or resources.
- **Neglect** - The refusal or failure of a carer or responsible person to ensure that the person receives life’s necessities.
- **Physical abuse** - The infliction of physical pain or injury, physical coercion or deprivation of liberty.
- **Psychological abuse** - The infliction of mental anguish, involving actions that cause fear of violence, isolation or deprivation, and feelings of shame, indignity and powerlessness.
- **Sexual abuse** - Any unwanted sexual behaviour, language or activity that makes an older person feel uncomfortable, frightened or threatened. This also includes situations where a person is coerced into unwanted sexual activity or is unable to give consent due to intoxication, being unconscious or asleep, or not having the cognitive capacity to consent.
- **Social abuse** - The intentional prevention of an older person from having social contact with family or friends or accessing social activities of choice.

Dataset

Data analysed for this study consisted of 1,727 cases of elder abuse entered into PEARL over a 12-month period from 2 July 2018 to 30 June 2019. The dataset includes information about victims, perpetrators, relationships between victims and perpetrators, and the nature and impacts of abuse. Before data were analysed, some basic data cleaning was undertaken. One case was removed as the victim age was less than 50 years and another was removed as the perpetrator was not a family member, informal carer or a close friend “acting as family”.

Sexual abuse data were excluded due to the small number of cases reported (n = 14).

Where multiple responses were recorded for a single variable (e.g. multiple types of abuse can be selected simultaneously) the data were dummy coded into binary variables (Yes or No). Cases were categorised based on victim’s cognitive impairment status, with cases where no cognitive impairment was identified assigned to the NCI Group (N = 1,225, 70.9%) and cases where victims were reported to have a cognitive impairment assigned to the CI Group (N = 502, 29.1%).

Statistical analyses

Data were analysed using Stata statistical software. The analyses included: simple descriptive analyses, logistic regression and cross tabulation.

Results

Victim factors

The age of victims was found to differ significantly between the NCI and CI groups, χ²(10) = 82.65, p = 000. Victims in the CI Group (Mdn = 80-84yrs) were generally older than victims in the NCI Group (Mdn = 75-79). Furthermore, 67.44% of victims in the CI Group were aged 80 years and older, compared to only 48.45% of victims in the NCI Group. The gender of victims was also found to differ between the
NCI Group (Female n = 877, 72.18%; Male n = 338, 27.82%) and the CI Group (Female n = 313, 62.60%; Male n = 187, 37.40%). A significantly higher proportion of male victims were in the CI Group χ²(1) = 15.31, p = .000.

The odds of victims having care needs were 4.53 times higher in the CI Group (n = 379, 75.50%) than in the NCI Group (n = 491, 40.08%), χ²(1) = 178.67, p = .000. Victims in the CI Group were 4.83 times as likely to need support across four or more care domains, χ²(1) = 162.91, p = .000.

In summary, victims in the CI Group were generally older and had greater care needs than victims in the NCI Group.

**Perpetrator factors**

Significant between-group differences were found in perpetrator age, χ²(16) = 74.05, p = .000, with perpetrators in the CI Group (Mdn = 55-59yrs) older than perpetrators in the NCI group (Mdn = 50-54yrs). There were no significant differences in the gender of perpetrators between the NCI Group (Female n = 610, 50.16%; Male n = 603, 49.59%; Other n = 3, 0.25%) and the CI Group (Female n = 276, 55.20%; Male n = 223, 44.60%; Other n = 1, 0.20%), χ²(2) = 3.61, p = .165, n.s.

As Table 1 shows, significant associations were found between victim cognitive impairment status and perpetrator characteristics. The odds of perpetrators being reported to have a criminal history, external locus of control, emotional dysregulation, history of aggression, history of conflictual relationships, impulsivity, substance misuse or mental illness were higher in the NCI Group. Perpetrators in the CI Group were more likely to be reported as displaying signs of inheritance impatience or taking responsibility for their abuse-related behaviours.

In summary, perpetrators in the NCI Group were generally younger than those in the CI Group and more likely to be identified as having a history of interpersonal issues, mental illness and substance misuse.

Inheritance impatience was more likely to be reported for perpetrators in the CI Group and these perpetrators were more likely to take responsibility for their actions.

**Relationship**

As Table 2 shows, daughters, sons and spouse/partners were most frequently reported as perpetrators. Some between-group differences were found, with spouse/partners significantly more likely to be perpetrators in cases where victims had cognitive impairment. Grandsons were significantly more likely to be perpetrators if victims did not have cognitive impairment.

<table>
<thead>
<tr>
<th>Relationship to victim</th>
<th>NCI</th>
<th>CI</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCI</td>
<td>CI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Daughter</td>
<td>472</td>
<td>176</td>
<td>648</td>
</tr>
<tr>
<td>Friend</td>
<td>31</td>
<td>20</td>
<td>51</td>
</tr>
<tr>
<td>Granddaughter</td>
<td>49</td>
<td>25</td>
<td>74</td>
</tr>
<tr>
<td>Grandson*</td>
<td>61</td>
<td>13</td>
<td>74</td>
</tr>
<tr>
<td>Informal Carer</td>
<td>13</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td>Nephew</td>
<td>11</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Niece</td>
<td>11</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Other family</td>
<td>7</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Sister</td>
<td>19</td>
<td>10</td>
<td>29</td>
</tr>
<tr>
<td>Son</td>
<td>437</td>
<td>158</td>
<td>595</td>
</tr>
<tr>
<td>Spouse/partner***</td>
<td>108</td>
<td>76</td>
<td>184</td>
</tr>
<tr>
<td>Total</td>
<td>1,225</td>
<td>502</td>
<td>1,727</td>
</tr>
</tbody>
</table>

Note. *p < .05, **p < .01, ***p < .001

**Cohabitation**

Perpetrators and victims lived together in 33.14 percent of cases in the NCI Group (n = 406) and 30.68 percent of cases in the CI Group (n = 154). No between-group difference was found in the
likelihood of victims and perpetrators living together, χ²(1) = 0.99, n.s. Where victims in the CI Group were not living with perpetrators, they were 3.70 times as likely to be living in an aged care facility than victims in the NCI Group, χ²(1) = 70.44, p = .000.

**Provision of care**

A significant association was found between care provision and victims’ cognitive impairment status. The odds of perpetrators providing care to victims were 2.54 times higher in the CI Group, χ²(1) = 57.46, p = .000. Issues related to the provision of care were also significantly more likely in the CI Group, χ²(1) = 41.68, p = .000. The odds of perpetrators struggling to meet victims’ care needs were 2.76 times higher in the CI Group, χ²(1) = 34.12, p = .000.

**Dependence**

A significant relationship was found between victim cognitive impairment status and victim dependence, χ²(1) = 41.68, p = .000. The odds of victims in the CI Group (n = 166, 33.07%) being dependent on perpetrators was 2.42 times higher than in the NCI Group (n = 207, 16.90%). Further to this, the odds of victims in the CI Group being dependent on perpetrators increased to 6.16 if victims had care needs. As can be seen in Figure 1, victims in the CI group were significantly more likely to be dependent on perpetrators across all domains.

**Precipitating factors**

Overall, the most commonly reported precipitating factors in the development of reported elder abuse were: victim ill-health (n = 188, 10.89%), perpetrator moved in with the victim (n = 94, 5.44%), and victim bereavement (n = 75, 4.34%).

Differences in precipitating factors were observed between the groups, with the odds of perpetrator spousal separation being identified as a precipitating factor 7.89 times higher in the NCI Group, χ²(1) = 7.81, p = .006. The odds of perpetrators moving home was also 1.91 times higher in the NCI Group, χ²(1) = 6.35, p = .003. In the CI Group, the odds of victim ill-health being identified as a precipitating factor was 2.39 times higher, χ²(1) = 29.85, p = .000.

In summary, adult sons and daughters were the most common perpetrators; however, spouses or partners were more likely to be perpetrators in the CI Group than in the NCI Group. Perpetrators in the CI Group were more likely to be providing care to victims and struggling to meet their care needs than perpetrators in the NCI Group. Furthermore, victims in the CI Group were more likely to be dependent on perpetrators. Between-group differences were also found with regard to precipitating factors, with perpetrator spousal separation and perpetrators moving home more likely in the NCI Group. Victim ill-health was more likely to be a precipitating factor for the abuse in the CI Group.

**Types of abuse**

As Figure 3 shows, the types of abuse experienced were found to differ as a function of victim cognitive impairment status. Victims in the NCI Group were more likely to experience physical and psychological abuse than victims in the CI Group. The odds of victims in the NCI Group experiencing physical abuse were 1.52 times higher than the CI Group, χ²(1) = 8.37, p = .004. Victims in the NCI Group were 2.59 times as likely to experience psychological abuse than victims in the CI Group, χ²(1) = 72.06, p = .000.
For both groups, the most commonly reported impact was psychological. However, a significant relationship was found between victim cognitive impairment status and the impact of abuse. The odds of victims in the NCI Group being impacted by abuse were 1.63 times higher than the CI Group, \( \chi^2(1) = 17.79, p = .000 \). The odds of victims in the NCI Group experiencing psychological symptoms as a result of abuse were 1.96 times higher than in the CI Group, \( \chi^2(1) = 40.49, p = .000 \). The odds of victims in the NCI Group being diagnosed with anxiety after abuse were 9.31 times higher than the CI Group, \( \chi^2(1) = 19.08, p = .000 \).

Barriers to change for victims

There can be a number of barriers that inhibit the likelihood of victims reporting abuse or taking action to change their situation. Some previously identified barriers include capacity impairment, financial constraints, fear of losing relationships with perpetrators (Cross, Purser & Cockburn, 2017), fear of making the situation worse, shame, dependence, lack of knowledge of what constitutes abuse and options for reporting (Aday, Wallace & Scott, 2017), fear of institutionalisation, concerns about the adult child’s limited resources (Ziminski Pickering & Rempusheski, 2014), stigma, cultural barriers, lack of options or access to services and language barriers (Bagshaw, Wendt & Zannettino, 2009). As Table 3 shows, the barriers were reported to differ between the CI and NCI Group, with the most common barriers being fear of further abuse for the NCI Group and lack of capacity for the CI Group.

Table 3. Most common barriers to change by cognitive impairment status

<table>
<thead>
<tr>
<th>No cognitive impairment</th>
<th>Cognitive impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of further abuse (21.06%)</td>
<td>Lack of capacity (26.29%)</td>
</tr>
<tr>
<td>Fear for own safety (14.78%)</td>
<td>Financial impact on perp (11.95%)</td>
</tr>
<tr>
<td>Impact on perp - Police (14.69%)</td>
<td>Impact on perp - Police (10.56%)</td>
</tr>
<tr>
<td>Fear - Lose relationship with perp (14.12%)</td>
<td>Fear - Lose relationship with perp (10.16%)</td>
</tr>
<tr>
<td>Financial impact on the perpetrator (11.18%)</td>
<td>Fear of further abuse (9.76%)</td>
</tr>
</tbody>
</table>

Discussion

This study sought to examine whether individual and relational factors and experiences of abuse differed as a function of whether victims did or did not have cognitive impairment. Differences were found in victim factors, with the CI Group being older and having higher care needs, which is consistent with Australian Bureau of Statistics (2016) data relating to dementia.
Previous research has found that having care needs not only increases the risk of experiencing elder abuse but also the likelihood of victims being dependent on perpetrators (Ziminski Pickering & Rempusheski, 2014) and this was also found in this study. Females were over-represented as victim in both groups; however, there were more male victims in the CI Group than the NCI Group. It is unclear why this is so. One possible explanation could be that males are less likely to self-report abuse and it may be that older males with cognitive impairment come into contact with more medical and/or support staff, thereby increasing the number of people who could potentially report abuse. Another potential explanation could be that bystanders are more likely to report abuse if the victim is female; however, having cognitive impairment may mean that males are seen as vulnerable and increase the likelihood of abuse being reported. Future research could investigate these propositions.

Some of the most interesting findings in this study related to between-group differences in perpetrator factors. Perpetrators in the NCI Group were more likely to have a history of aggression and conflictual relationships, emotional dysregulation, external locus of control, impulsivity, criminal history, mental illness and substance misuse. Many of these factors have been found to be associated with an increased risk of violent behaviour in other contexts (Krakowski & Czobor, 2014; National Collaborating Centre for Mental Health, 2015). Although research has primarily focused on victim vulnerability, perpetrator factors such as substance misuse and mental illness have previously been found to be risk factors for elder abuse (Blundell et al., 2017; Pillemer, Burns, Riffin & Lachs, 2016). It is of interest that these factors were found to be significantly more likely if the victim did not have a cognitive impairment. In contrast to this, inheritance impatience was significantly more likely for perpetrators in the CI Group. Perpetrators in the CI Group were also more likely to be reported to take responsibility for their behaviour. These differences in perpetrator factors suggest that the drivers of abuse may differ as a function of whether the victim has a cognitive impairment. This supposition is further supported by differences found in relational factors.

Perpetrators in the CI Group were more likely to be providing care to victims and struggling to meet their care needs. A United Kingdom study of family members providing care to people with dementia found that more than half of family carers reported behaving abusively towards their family member (Cooper et al., 2009). Although previous research has not found carer stress to be the primary cause of elder abuse, there is evidence that providing care can affect the health and mental health of caregivers (Bon, Bakx, Schut & van Doorslaer, 2018; Frederick, 2018) and feeling overwhelmed can influence relationships between caregivers and care recipients (Brandl & Raymond, 2012). Victims in the CI Group were also more likely to be dependent on perpetrators across all domains; whereas, perpetrators in the CI Group were significantly more likely to be dependent on victims for accommodation. These findings are consistent with previous studies where victim and/or perpetrator dependency have been associated with an increased risk of elder abuse (Horsford, Parra-Cardona, Post & Schiamberg, 2011; Pillemer et al., 2016; Roberto & Teaster, 2017).

Abuse types were also found to vary as a function of victim cognitive impairment status. Victims in the CI Group were more likely to experience neglect and social abuse, and less likely to experience psychological and physical abuse than victims in the NCI Group. These differences in abuse types do not fully align with the findings of Dong et al. (2011), who found an increased risk of neglect, emotional and physical abuse for older people with cognitive impairment. A key feature of the NCI Group in this study was the presence of factors associated with violence perpetration; consequently, the higher rate of physical and psychological abuse among victims in this group appears to align. Victims in the CI Group had higher care needs and were more likely to be dependent on perpetrators. Once again, these factors fit with the higher rates of neglect and social abuse experienced by victims in this group.

The impact of abuse and barriers to change also differed between the NCI Group and CI Group. Victims in the NCI Group were more frequently reported to be impacted by the abuse they experienced. However, this may be due to people with cognitive impairments being more likely to have communication difficulties (Jackson, 2018) as the impact of abuse may not be recognised by others if victims are unable to verbalise it. Lack of capacity was identified as the most commonly reported barrier to change for the CI Group. This may go beyond communication difficulties as many victims with a cognitive impairment have an appointed decision maker. If the decision maker is a perpetrator, this may mean that the victim does not even have the ability to choose where they live or who cares for them. Coupled with dependency and higher rates of social abuse in this group, this factor is likely to further limit the ability of victims with cognitive impairment to report abuse or extricate themselves from an abusive situation.

This study is not without limitations and these should be taken into account when interpreting the results. This study did not attempt to examine the prevalence of elder abuse or compare prevalence rates between people with or without cognitive impairment in the general population. Consequently, the first limitation relates to the use of a convenience sample as the data came from calls to the EAPU Helpline.
Santos et al. (2019) found differences between data from convenience samples and population-based samples, with victims more likely to report abuse if the abuse was physical, severe and/or there was polyvictimisation. The use of control groups consisting of random samples of people with and without cognitive impairment who have or have not experienced abuse would improve research such as this. Helpline callers are not asked set questions and data is only captured if disclosed during calls which results in missing data. The EAPU does not conduct investigations so the information is based on unverified allegations of abuse. The use of self-report data means that there may be cases where victims had cognitive impairments, but this was not known by the caller, or may not have been diagnosed, leading to these victims being inadvertently included in the NCI Group. Edersheim, Murray, Padmanabhan and Price (2017) found that even during the early stages, cognitive impairment was associated with diminished decision-making ability. This study looked at factors for victims and perpetrators separately so there was no examination of whether there were interactions and factors that may have mediated or moderated the relationships between factors. Further research using modelling to examine this would be beneficial for improving the understanding of the dynamics involved.

Despite these limitations, the findings highlight the importance of including people with cognitive impairment in studies of elder abuse. The between-group differences found in relation to perpetrator factors are particularly valuable. Research is often focused on victim risk factors rather than perpetrator factors; however, it is important to understand how perpetrator factors contribute to the development of abuse as this enables the development of more targeted interventions (Blundell et al., 2017). It is recommended that the potential differences in the dynamics and mechanisms underlying elder abuse be explored further using more rigorous research methods. Developing a better understanding of how victim and perpetrator factors interact and the types of abuse associated with different risk factors would also be beneficial for work in the detection and prevention of elder abuse. If these findings were replicated, this information could be used to improve policies and intervention methods in elder abuse.

References


Introduction

Samaritans’ kinship carers support program grew out of a need expressed by grandparents who had taken on the role of raising their grandchildren. Initial support was coordinated by the Grahamstown Anglican parish community and a unique model of kinship was subsequently developed by the Samaritans in partnership with parishes. The first part of this paper outlines the evidence base for the development of that model, including First Thousand Days research and best practice, and identifies the challenges of fulfilling caring responsibilities within a kinship setting. The demographic characteristics of Samaritans’ clients are then described and the impact of Samaritans’ kinship carers model on carers’ wellbeing and caring capacity is explored. We demonstrate that, with interconnected support, timely information and assistance to deal with practical concerns, kinship carers can play a vital role in paving the way to a healthy future for their young family members who have experienced trauma or estrangement from parents.

First Thousand Days

In September 2017, the Murdoch Children’s Research Institute published an evidence paper titled ‘The First Thousand Days’ (Moore, Arefadib, Deery & West, 2017). Their research details the factors that influence the development of a child into adulthood, with the period of life from conception until the end of the child’s second year of life (the first thousand days) being crucial in that development. Their paper “examines the impact of early experiences on all aspects of development and functioning, including physical health and wellbeing, mental health, social functioning and cognitive development” (Moore, Arefadib, Deery & West, 2017, p. 2).

The First Thousand Days informs the work of Samaritans kinship care in that it documents, through research, the impact and influences arising from that period in a young person’s life that Samaritans has identified as most affecting kinship carers in their program. These influences are drug and alcohol addictions, poverty, family violence, poor mental health, death and incarceration.

The evidence that human development is a result of interactions between genetic, epigenetic and environmental factors needs to inform community understanding and replace any notion, that as humans we have control over who and how we are. We now know that the experiences and environments children are born into can trigger biological changes in children’s bodily systems and there is evidence to assist us in appreciating how risks can escalate over time; and early adverse experiences and outcomes increase the risk for later adverse experiences and outcomes (Moore, Arefadib, Deery & West, 2017). The inter-generational trauma so often seen in so many kinship care families can be understood when taking this into consideration and is demonstrated in the case studies included in this paper.

Importantly, the time young people spend in the care of kin can offer a key opportunity to influence a young person’s developmental trajectory. As Moore explains, “the brain is capable of rewiring itself in response to significant changes in environments” (2014, p. 6). With appropriate support, kinship carers can create a positive environment in which a young person’s brain development can begin to rewire, with the potential to have incredibly positive outcomes for not only the emotional development of the child, but also for their overall physical wellbeing.
Background – Kinship Care

The UN defines kinship care as “family-based care within the child’s extended family or with close friends of the family known to the child, whether formal or informal in nature” (General Assembly resolution 64/142, 2009). In Australia, kinship care may include formal arrangements (made through court order) or informal (made in agreement with the child’s parents but without court order). According to NSW Family and Community Services (FACS), the circumstances of recognising kinship care as ‘formal’ rely on a care or parenting order being made by the Family Court of Australia, the Federal Magistrates Court or the NSW Children’s Court (NSW Family and Community Services, 2019).

In these circumstances, or where kin have been granted a guardianship order from the NSW Children’s Court, the kin may be entitled to various types of financial and other support through either the federal system and/or the state system. Some of these payments are similar to or the same as payments made to foster carers, some are means tested, some are only granted to grandparents, but in all cases, the support is only provided where a court order is in place. In NSW, this includes where the NSW Children’s Court has given the Minister parental responsibility, in which case FACS are responsible for authorising and monitoring the kinship carer in order for the financial supports to be granted.

The amounts and types of allowances for kinship carers vary depending on whether a state or federal order has been issued, or if the order was for guardianship. Where children have been living informally with a kinship carer, the process to formalise the arrangement can be costly. In these cases, in NSW, Community Services will not see the children as at risk of significant harm (ROSH) so they will not progress the case through the NSW Children’s Court. This would be a far less costly option and would grant formal custody and parental responsibility to the kinship carers. Instead, the kinship carer would need to apply through the Family Court of Australia at their own cost.

Aside from not being able to access financial support, there are significant impacts to kin who are caring for children without court orders which are borne from the inability to make decisions around the child’s health, wellbeing and life. This might include inability to apply for a Medicare card or sign off on decisions around education. Kiraly reports that kinship care is “enshrined in child protection legislation as the preferred placement option in all jurisdictions” and “the Aboriginal Child Placement Principle (ACPP) is enshrined in legislation in all jurisdictions” (2018, p. 6). However, kinship carers are not included in the Commonwealth definition of “carer” unless they are caring for a child with additional needs (such as disability), which prevents them from accessing Commonwealth funded services such as respite.

Kinship is defined differently in Aboriginal and Torres Strait Islander communities. According to Queensland Aboriginal and Torres Strait Islander Child Protection Peak (QATSICPP), “Aboriginal Kinship is a diverse and complex system... Aboriginal Kinship refers to the biological bloodlines that have been passed on from generation to generation... Consideration of who is kin to a child is also the decision and responsibility of family and those with cultural authority for the child, not the statutory agency” (Position Statement for Aboriginal Kinship Care, n.d., p. 4). The Australian Institute of Health and Welfare (AIHW) explains that a kinship carer for Aboriginal and Torres Strait Islander children might be “another Indigenous person who is a member of their community, a compatible community, or from the same language group” (AIHW, 2019a, p. 87).

While it is not the intention of this paper to explore in detail the implications of culture and heritage in kinship care arrangements, there are important distinctions that can be made in the kinship care of Aboriginal and Torres Strait Islander children which must be taken into account in policy making (Kiraly, 2018).

Table 1: Distribution of Court Orders for Kinship Care in Samaritans Programs shows Samaritans’ data on the distribution of carers with formal orders and those without. This data was collected at referral to case management from 2017 until present. Figures do not include the Kinship Carers attending the Peer Support Groups although there will be some overlap.

<table>
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<th></th>
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<td>3</td>
<td>7</td>
<td>9</td>
<td>7</td>
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</tr>
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<td>6</td>
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</tr>
</tbody>
</table>

Source: DSS Grants Program Report [Internal Data] (Samaritans, 2019)
Samaritans’ data shows that in the past 2.5 years, only 41.38% of clients had formal orders (58.62% either had no formal parental orders from a court or did not know).

There is little available reliable data to show the prevalence of informal kinship care in Australia, however studies conducted in the UK and USA suggest that around 95% of kinship care occurs informally in those countries (Kiraly, 2015).

**Why Kinship Care?**

It is recognised that the placement of a child with a kinship carer is likely to be a more secure placement. The child has a greater chance of staying with siblings, has a greater sense of family identity and connectedness and it is more likely they will remain in contact with extended family and their culture (Wellard, Meakings, Farmer & Hunt, 2017). Data from AIHW (2019) confirms a steady increase in the rate of placements from 45.5% in 2010 to 51.0% in 2018. The data for the five years to 30 June 2018 is provided in Table 2: % of children by type of placement at 30 June each year. There are other contributing factors which are increasing the rates of children in kinship care including recognition of the important of culture for Indigenous children in policy, an increase in the number of children in out-of-home-care (OOHC) and a shortage of foster carers (Boetto, 2010).

A placement with kin provides better outcomes for the child. Children have a greater sense of identity, as they often already have a relationship with carers. The initial trauma of living somewhere else is lessened as relationships with family are maintained, and cultural aspects of family and community are continued (Boetto, 2010).

**Supporting Kinship Carers at Samaritans**

In 2000, grandparents caring for their grandchildren in Port Stephens expressed their need for a structured support network and the Grahamstown Anglican Parish, with Samaritans support, established the first grandparent’s group in response to this need.

In March 2003, the then Minister for Children and Youth Affairs, the Honourable Larry Anthony MP facilitated a two-day Project Development and Training Workshop in Melbourne with The Council for the Aged (COTA) staff and grandparent representatives. Funds were made available for state government representatives to identify existing support groups and contacts and to host workshops around the country for grandparents to share their experiences and issues around raising their grandchildren. The resulting report, Grandparents Raising Grandchildren (Department of Social Services, 2003), made 21 recommendations to address the various findings of the consultation across areas including:

- Recognition of grandparents raising grandchildren in society, policy and law.
- Adequacy of financial and legal support for grandparents and funding for support services.
- Support for direct care of grandchildren such as respite care.
- Tailored support for social inclusion, activities and programs specific for grandparents and their grandchildren.

Many of the 21 recommendations have never been fulfilled.

In 2006, Samaritans secured seed funding to create a support service specific to kinship carers called Grandparents as Parents (GAPS). The primary aim was to build on the work of the group in Grahamstown to ensure support for grandparents and prevent placement breakdowns. The first official GAPS group was started in Gorokan on the NSW Central Coast in January 2007 with 10 groups established across Samaritans service regions shortly after.

In 2012 the responsibility for the GAPS funding was incorporated into Department of Families, Housing,

| Table 2: % of children by type of placement at 30 June each year |
|-----------------------------|-------------|-------------|-------------|-------------|-------------|
| **Relative/ Kinship care**   | 20847       | 20510       | 22592       | 22639       | 23341       |
| **Foster care**              | 17654       | 17516       | 17982       | 18098       | 18012       |
| **Other home based care**    | 1688        | 2497        | 2896        | 3932        | 1229        |
| **Total home based care**    | 40189       | 40523       | 43470       | 44669       | 42582       |
| **Other/ Unknown**           | 2820        | 2876        | 2978        | 3246        | 3174        |
| **Total out-of-home care**   | 43009       | 43399       | 46448       | 47915       | 45761       |

*Source: NFPAC Indicator 0.2 - Children aged 0–17 years who are in out-of-home care at 30 June, by Indigenous status, age, sex and placement type, 2010 to 2018 [Supplementary tables] (Australian Institute of Health and Welfare, 2019b)
Community Services and Indigenous Affairs’ (FaHCSIA) Family Support Program. From 2015, funding has been received through Department of Social Services (DSS) Child and Parenting Support Program. The DSS increased the funding amount allowing Samaritans to employ a Case Manager who provides support, resources and refers both formal and informal Kinship Carers to the program.

The GAPS program, now called the Kinship Care Support Groups, is staffed by a part time project worker who supports the volunteer group facilitators and has supported 205 clients since 2015. Samaritans employ staff with degrees in Social Work and/or Early Childhood and staff have been offered specialised training in grief and loss, trauma, cultural sensitivity, counselling and parenting.

The Kinship Care Support Groups rely heavily on volunteer support and partnerships with the Anglican Church and the NSW Department of Education which provide space for the groups to meet. The commitment of the volunteer facilitators, many of whom have been in the role since the beginning, should not be understated.

Samaritans’ unique model of Kinship Care includes links with parishes and investment from the organisation into part of the wages for the program.

The importance of the First Thousand Days

The First Thousand Days paper tells us that the detrimental factors to a child’s development mimic the same detrimental factors which can cause trauma (Moore, Arefadib, Deery & West, 2017, p. 2). Moore, Arefadib, Deery and West (2017) report the links between childhood trauma and increased rates of physical and mental health issues to include:

- Disruption of critical developmental processes such as stress response and brain development and the impact this can have on physical and mental health.
- Impact on a child’s ability to interpret and react to their environment and the people they are in contact with, for example their ability to process emotion and their experience of stress.
- Likely increase in risk taking behaviours such as high-risk sexual behaviours, using violence, and alcohol and drug abuse.

These outcomes can manifest during a child’s time in care with their kin, presenting significant challenges for the stability of the family and the ability of the carer to provide care for the child. Samaritans are particularly aware of the impacts of poor developmental conditions and trauma on children and the reality of this for kinship families.

Trauma is defined by the National Institute of Mental Health (USA) as “The experience of an event by a child that is emotionally painful or distressful, which often results in lasting mental and physical effects” (The Blue Knot Foundation, 2019). In their report on a 2016 survey of foster and relative/kinship carers, Qu, Lahausse and Carson found that 71.9% of relative/kinship carers reported that the child in their care had experiences of at least one of three abuses (physical/emotional/sexual) or neglect prior to coming into their care (2018).

While the child is experiencing their own grief and loss for the parent, as well as dealing with the complexity of their experiences, there is also trauma for kinship carers. This might include the disruption of what is familiar, grief resulting from changes to their lifestyle and possibly economic position, as well as grief surrounding the circumstances of the care. For example, they might feel deep shame or responsibility if they are related to the child’s parent and there is evidence that the child has been abused or neglected. Supporting kinship carers through this process by creating peer networks where people feel understood and offering access to or connections with important services can relieve some of the pressure felt by kinship carers and improve their ability to care for the children.

As Moore explains, the functions of the brain are complex and not purely cognitive, and brain development is heavily influenced by early experiences (2014). The interdependence and connectedness of the brain with other major functions of the body therefore have the potential to impact many more areas of the body than just the brain. While Moore acknowledges the importance of those early days on foundational brain development, he also recognises the ability of the brain to adapt, grow and change over time, continuing to be influenced by the environment (2014). By providing adequate support to kinship carers, it is intended that vulnerable young people experience an environment that supports their continuing development and begins to address and reshape some of the poor foundations that have been formed around trauma and neglect.

Their stories – Case studies of Kinship Carers attending Samaritans Program

“...framing brain development in terms of building neuronal connections and brain architecture fails to capture the fact that brain functioning is not purely cognitive, that ‘learning’ is not purely conscious, that the brain is not purely skull-based, and that the brain is closely linked with other key bodily systems” (Moore T., 2014, p. 6).

Mental health concerns, which have historically been poorly understood and addressed, are often evident in the stories of kinship carers as they recount their lives. Histories of mental illness have often been hidden from their own children and they’ve never sought help or
support for themselves. For many, becoming kinship carers and having children come into their full-time care brings up memories of their past which can trigger deeply buried emotions. A grandmother shared her own experiences with Samaritans:

- She described for the first time ever her own experience of being in and out of foster homes throughout her childhood.
- She talked about the trauma experienced by her mother who had a child with mental illness who was placed in a secure facility and was never allowed visitors.
- She explained that she never felt loved or cared for by her own mother and she felt this had flow on effects to her own children.
- She reflected on the domestic violence she had experienced, witnessed by her children, and how she felt this might have contributed to her daughter having her children removed.

The opportunity to talk and be cared for can support healing. It is an important function of kinship care case management and the peer support groups. The group discussions support carers in understanding and being kinder to themselves, their children and the children in their care, as well as being empathetic to the behaviours and reactions of the children.

**Case study 1**

After decades of working, one self-funded couple retired and sold their home to buy their ‘dream campervan’ to travel around Australia. The large campervan was their home with limited savings remaining in a bank account. They bought a small block of land in a country town to live on, in their campervan, when not travelling. After six weeks their travel was interrupted by a Family and Community Services (FACS) phone call requesting that they take on the care of their two grandchildren (under the age of five years).

They now live in the campervan on a block of land in a country town with the grandchildren. They are effectively homeless and frantically trying to access birth certificates and immunisation documents to access childcare and support services. They are trying to sell their campervan and look for housing again, with the little saving they have. As they do have a savings account there is no support from government with all their money going quickly to raise and support the children.

**Case study 2**

A grandmother in her late sixties had a call from a FACS worker informing her that she has a 6-month-old grandson and her daughter wanted her to take on the full-time caring role for him. The grandmother did not know she had a grandson until this phone call. She explained that she never felt loved or cared for by her own mother and she felt this had flow on effects to her own children.

The baby boy had been placed in temporary foster care since birth. Once she agreed to take on this role FACS ceased involvement as it was now a family arrangement. The grandmother receives no support - financially, emotionally or with basic items like a cot, pram, highchair or car seat. There were no medical or health records; the grandmother was informed the baby may have been premature with a difficult delivery and he had some physical and possibly intellectual delays with ongoing therapy required. The child’s birth had not been registered so there was no birth certificate, no Medicare card and no Centrelink Customer Reference Number (CRN). This created a great deal of stress for the grandmother.

Samaritans project worker first met this grandmother whilst visiting a group and passed on the referral to the case manager. The case manager’s initial phone call to the grandmother was to have ‘a listening ear’ while she told her story. The grandmother acknowledged she was in shock, overwhelmed and in desperate need of support on how to parent a baby after nearly 40 years. The case manager let her know first and foremost her role was to support her through this journey, to ensure her own health and wellbeing would be not compromised or forgotten along the way. Case management would be able to help her make referrals to relevant services, obtain resources and advocate for her.

Together they identified the immediate needs and set up appointments with Samaritans outreach services, Centrelink, emergency relief and legal aid and got in touch with Samaritans kinship care support group. The Case manager advocated with Centrelink social worker, Medicare, medical professionals and therapists. She met the grandmother in the community, doctors and therapist waiting rooms, hospital, Centrelink and local coffee shops. The role enabled her to be flexible to meet the demanding and varied needs of the grandmother. It has been a long slow journey. Though her grandson still has no birth certificate, his birth is now registered resulting in him obtaining a Medicare card, a CRN card and he is now able to attend family day-care.

Nearly one year later grandmother is working through the process for guardianship to ensure the best outcomes for her grandson. Grandmother is very proud as her grandson is now walking and saying his first words.

**Case study 3**

FACS were case managing an Aboriginal family of seven children. The father was affected by alcoholism and the mother had mental health issues. The family were referred to Brighter Futures for a two-year intervention program. Toward the end of this time the mother gave birth to their eighth child and left the Hunter region with the children. After ROSH reports were placed with the FACS office in that area, the grandmother applied to
the family court of Australia for custody of the children. The Family Court awarded custody to her. This is when she contacted Samaritans to say she had the eight children coming to live with her in a two-bedroom flat.

The grandmother contacted the kinship care case manager for support. It was identified that an aunt and uncle of the children could help house the children, by dividing the family according to their ages. Three of the children aged three months, two years and four years came to her with nothing; Samaritans were able to provide bedding and clothes. This grandmother reported the children were overwhelmed that they had a pillow each. Over time, the two eldest children (teenagers) returned to their mother and the other two primary school age also went to the grandmother as the aunt and uncle found their own children were unable to cope with having their cousins in the house. Samaritans wrote letters of support to Housing to arrange a larger home for them, which was successful.

Case study 4

A grandmother was taking a nine month old baby from Newcastle to Taree (a 345km round trip) once a week to see the mother. This was at her own expense, but she was required to do so as it was part of the court orders. It is noted that if that same nine month old baby had been placed in foster care the supervised access would have been provided at FACS expense.

Samaritans Model of Kinship Care Support

When supporting kin in their role as carers, Samaritans implements a Trauma Informed Model as best practice. As we can see from Moore, Arefadib, Deery and West’s report, children are directly impacted by their experiences in their early years (2017). They therefore come into care with their development and wellbeing compromised by past events and a host of barriers to overcome as they grow. Many factors they face in kinship care, and in life in general, can continue to negatively influence their development unless their carers are supported to recognise and, where possible, counteract these. Samaritans Kinship Care Program not only offers a supportive network for the benefit of the carers but aims to improve the lives of the children they care for.

The model adopted at Samaritans places importance on supporting the kinship carers to deliver the best possible care to the children, and the philosophies and approaches taken to do this are based on the First Thousand Days research and best practice approaches to dealing with trauma.

Kinship carers participating in the peer support groups have additional support through Samaritans, including:

- Referral can be made to the Case Manager through the groups to address an identified need.
- The Project Worker acts as a hub for all information and disseminates it out to groups through the Facilitators who in turn distribute information to carers. This central point allows for efficient information sharing across groups and suburbs.
- The Project Worker attends interagency meetings to stay abreast of changes in the sector and learn of any developments in services for carers which they can feed back to carers through the Facilitators.
- Parenting and attachment programs are run each term, for example Seasons of Growth (a grief and loss program), Circle of Security, Bringing Up Great Kids, legal issues and computer skills courses. All of these programs have been introduced to meet an identified need or gap for kinship carers.
- Samaritans have a range of other community programs that staff and volunteers are familiar with and can be offered to kinship carers as needed (such as emergency relief).

An important role of the Project Worker is to mentor and de-brief with the volunteers, to listen to their stories as they learn of the trauma, sadness and grief of the kinship carers and ensure they are supported. Volunteers have the opportunity to share understanding and knowledge as a group during school holidays where they meet to talk, discuss challenges and implement strategies with the support of the Project Worker and Case Manager.

Samaritans model of support (originally established 19 years ago for grandparents), has positively impacted kinship carers across the Hunter region with carers reporting an improvement in their mental health when attending support groups. Samaritans attribute the success of this model in part to the focus on creating local support groups where people can share their thoughts and concerns with others that can relate. This has been enhanced by the employment of the Case Manager who is also able to provide individual support to the carers.

Demographics of Samaritans clients supported in Kinship Care Programs

Samaritans Kinship Care Support Groups (formerly GAPS)

From the commencement of the program under DSS in 2016 until July 2019, there were 724 groups held with an average attendance of 27 by 203 clients. In brief:

- Client gender breakdown over this period was 43 males to 158 females.
- 7.8% of clients attending kinship peer support groups over this period identified as having a disability.
Although only 11.7% of clients identified as Aboriginal and/or Torres Strait Islander, through conversations with kinship carers Samaritans is aware that a large number prefer not to have their cultural identity included in government data.

Figures 1 – 3 provide further detail about kinship carers’ participation in support groups and case management.

![Figure 1. Number of clients attending Kinship Peer Support Groups by group – 2016 to 2019](source)

![Figure 2. Number of clients attending Kinship Peer Support Groups by age – 2016 to 2019](source)

*Samaritans Kinship Care case management*

The majority of clients receiving case management were aged 50-69 (68.5%); only 25.6% were less than 50 years old and 5.9% were aged 70 or over.

**Challenges and Future Directions**

Some of the challenges Samaritans hears of and witnesses from kinship carers are also demonstrated by the research to be widespread concerns and include:

- Carers need help to find and navigate services available to them - in particular, legal, housing, transport, educational and financial support.
- There is a need for children’s Medicare cards and birth certificates to be available before children come into care.
- Grandparent carers are eligible for up to 50 hours of childcare per child per week through an assessment from Centrelink. However as other kinship carers (not grandparents) are not eligible for this support, the arrangement is fundamentally inequitable.
- The NSW Department of Education have Out of Home Care (OOHC) Support Teachers whose responsibility is limited to supporting children in statutory care. This support needs to be extended to include children who are in informal care.
- Children who are in kinship care without statutory status have the same complex needs as those who are placed through the Children’s Court. There will often be a presentation of mental health issues, developmental delay and challenging behaviours. Kinship carers need to be able to access counselling for these children. The Mental Health Care Plan available through Medicare is limited to 10 visits per annum which is not sufficient to support children with complex trauma histories.
- Poverty has a compounding impact on the situation. Without an allowance, like the entitlement paid to foster carers, kinship families struggle to maintain the basic needs such as paying accommodation, transport, health needs, supervision for family contact visits, power and water, educational needs, and food. Family tax benefit was introduced to supplement working parents wage, to ensure
they could buy necessities, it was not meant to be money that was used to raise a child.

- Kinship carers who do not have court ordered responsibilities for the child experience even greater challenges accessing the services and financial support that they need.

Boetto details the complexity of challenges faced by kinship carers, explaining that their responsibilities as carers often come with conflicting loyalties, abuse and harassment from the parents, lengthy and costly legal processes, financial hardship, lack of information about support and services available and poorer health outcomes compared to foster carers (2010). Kiraly’s review of kinship carer surveys found similar issues with reports of expensive legal processes and lack of support and access to services, and one third of survey respondents reported financial hardship (2015).

Conclusion

Kinship carers take on vitally important roles in creating an environment for young children who have experienced trauma and their delivery of care is a key factor that can be highly influential on a child’s physical and mental wellbeing as they grow into adulthood, particularly in the first thousand days of a child’s life where brain development is more easily influenced. Providing them with adequate and targeted support can therefore have a direct impact on the life trajectory of a child with the potential to start to reverse the negative impacts of trauma.

It is unknown exactly how many children are living in kinship placements in Australia and how many kinship carers are unsupported (either because they do not have formal parental responsibilities or because they are unable to access or unaware of services in their area).

This paper has canvassed a range of factors which impact kinship care, including the different kinds of care and support involved, whether formal or informal; the fact that informal care does not attract state-based financial support; and the different understandings of, and influences on, Aboriginal kinship care — including intergenerational factors such as the fact that many carers are affected by their own trauma as children.

The Federal Department of Social Services has gone some way to acknowledge what is evidenced in literature by funding support for kinship carers. With growing reliance on kinship carers and increasing knowledge about the benefits of keeping children with kin, it is hoped that the future will see additional funds committed to develop programs across Australia and thereby fulfil a burgeoning need.

It is also important that further consideration be given to the potentially significant volume of kinship carers that do not have court ordered arrangements in place and how those kin can be adequately supported, whether they choose to pursue court orders or not. Most importantly, all services for children and young people in care need to be focused on the best interests and wellbeing of the child; where and with whom the child is living should not limit the resources available to support the placement. Children in kinship care arrangements, and their carers, require parity and access to the same level of financial, educational and community support from all States and Territories as in the foster care system.

References


Background

Program context

Violence against women, that is “any act of gender based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (United Nations, 1993, p. 2), is a significant yet ultimately preventable problem (Our Watch - Victorian Health Promotion Foundation and Australia’s National Research Organisation for Women’s Safety, 2015). One in three and one in five women respectively have experienced physical and sexual violence (Australian Bureau of Statistics, 2017) and each week, on average, one woman is murdered by her current or former partner (Bryant & Bricknell, 2017).

As a fundamental supporter of human rights, the Australian government has recently taken steps towards its obligation under international law to prevent violence against women (United Nations, 2017) by funding community organisations to undertake projects (Victoria State Government, 2018), from which projects such as ALL Come Out to Play! commenced.

ALL Come Out to Play! is an innovative gender equality project that targets parents and their children under 5, merging the powerful worlds of primary prevention, music and playgroup. The playgroup platform provides a unique early childhood experience for both children and their parents, playing and socialising with other children and their parents (ages 0 – 5 years).

After delivering the program to over 1,500 people in regional, CBD, Aboriginal and CALD early childhood settings, we present the story of the ALL Come Out to Play! program, including the results of this first evaluation and recommendations for moving forward.

Violence against women and gender equality

Cultural norms, that is the ideas, values or beliefs that are common in a society, are associated with higher levels of violence against women, and this includes those about gender (Kim Webster & Michael Flood, 2015). There are four gendered drivers of family violence – social norms and attitudes that condone violence against women, men’s control of decision making, rigid gender roles and stereotyped constructions of
masculinity and femininity, and male peer relations that emphasise disrespect and aggression toward women (Our Watch - Victorian Health Promotion Foundation and Australia’s National Research Organisation for Women’s Safety, 2015) and these should be considered along with other forms of entrenched disadvantage and systemic discrimination. With this in mind, programs to address gendered drivers of family violence best take an intersectionality-based approach that considers the various overlapping identities and systems of oppression and discrimination (Victorian State Government, 2016).

With a body of research illustrating that gender equality is a prerequisite for prevention of gender-based violence (Our Watch, 2018), we are seeing growing awareness of the need to embed system-wide gender equality initiatives.

**Primary prevention**

Health programs designed on a primary prevention model are those which aim to avoid the manifestation of a disease before illness or harm occur (WHO, 2019). In this paper we are referring to preventing not a disease, but violence, before it occurs (Krug, Mercy, Dahlberg & Zwi, 2002). The World Heath Report on Violence and Health indicates that primary prevention programs should prioritise culturally sensitive and participatory approaches to changing attitudes and behaviour, as well as emphasise the importance of child rearing (Krug et al., 2002). It is widely recognised that the first 1000 days of a child’s life will largely determine neuronal development (Fox, 2015), and that this has lifelong consequences (Guilfoyle, 2010). Also, from an economic standpoint, early childhood is an optimal time to deliver targeted programs. It has been suggested that high-quality early childhood programs can lead to up to eight-fold return on investment, as opposed to only three-fold returns if delivered later in childhood (Sims, 2008). To prevent children from developing inequitable ideas about gender, the ALL Come Out to Play! team has designed a primary prevention intervention with young children (birth – 5 years) and their parents/carers, who play a crucial role in the development of their child’s ideologies. As playgroups bring together parents and children, it is an ideal setting for multigenerational primary prevention approaches.

**An innovative response - ALL Come Out to Play!**

In response to growing awareness that gender inequality, including stereotyped constructions of masculinity and femininity, is a key driver of violence against women, the ALL Come Out to Play! program was funded under the Victorian Free from Violence strategy, as part of a suite of primary prevention initiatives. Taking a multigenerational approach, the program utilises the playgroup platform, informing and/or empowering parents to prevent unhelpful gendered behaviours and attitudes with the ambition of preventing violence against women amongst their children’s generation.

The ALL Come Out to Play! program actively challenges traditional views about the need for rigid gender roles and attempts to normalise the concept of gender equality. The program intends to spread key messages to families and early years workers that more equal gender roles can lead to more positive self-identities and equal and respectful relationships. With the understanding that children learn first through their parents and carers, this program aims to shift attitudes and cultural norms about gender during the early years of a child’s development. The program incorporates three separate program activities:

- Music sessions delivered to children and their parents/carers
- Community facilitator training to deliver ALL Come Out to Play!
- Professional development (Prevention of Violence Against Women workshops) for early childhood professionals/program coordinators.

**Development of ALL Come Out to Play!**

**Bringing the right people to the table**

ALL Come Out to Play! is a product of a strong, collaborative partnership of three organisations that each bring different experiences and areas of knowledge. Building upon the partnership between drummond street services and Playgroup Victoria, which jointly developed and delivered a unique and engaging gender education workshop to parents and children across the state, Hullaballoo Music for All was included to ensure the high quality of the musical show, including professional song recordings, and energetic audience engagement. All organisations are committed to harnessing the social structures and influencing the norms and attitudes of parents of young children through this evidence-based initiative to improve gender equality in the future. drummond street services are considered leaders in the area of prevention and have demonstrated expertise in primary prevention programs. They have been working with families experiencing family violence for over 120 years; this work includes the development and delivery of training for early childhood professionals in primary prevention. drummond street’s strategic plan identifies forming partnerships with ‘first to know’ organisations who deal with groups where violence prevention is needed (i.e. parents and families in the early years of children’s lives).
Playgroup Victoria is the peak body representing all playgroups in Victoria, and empowerment of parents is one of their key objectives. Around 11,000 families attend playgroups each week, and this universally accessible platform can be used to communicate essential public health messages (e.g. about nutrition, SunSmart and mental health). Through its digital communication arm, Playgroup Victoria also communicated positive messages to playgroup families through social media including Facebook posts, info-animations, and blog articles.

The third element in the partnership is well-known Melbourne musician Amanda Testro from Hullaballoo Music for All. Amanda’s involvement was key to the formula, as music and movement has proven an engaging way to deliver these messages to young audiences, and a fundamental mechanism of the program was to ensure the sessions were fun and empowering for children of all abilities and cultural backgrounds.

Development of the content

ALL Come Out to Play! was designed with a deliberate focus on respectful relationships and gender equality, rather than spotlighting family violence, which is not deemed the appropriate approach with parents for young children attending a child focused playgroup. The intention of the program reflects the pre-existing Playgroup Principles: creating an environment that is fun, developmentally focused, educational, nurturing and supportive, capacity building, relational, inclusive and safe.

During the first stage of the project, 35 sessions were run across metropolitan and regional areas of Victoria, engaging 531 parents and pre-school children. Additional funding was sought and received which permitted the team to expand the program's reach to more rural/regional playgroups. Although participant demographics were not recorded, it is estimated that approximately 66 Aboriginal families participated, as well as many other families of culturally and linguistically diverse backgrounds. Since the pilot, Community Partnerships for Primary Prevention Grant and Free from Violence funding (Victoria State Government, 2018) have permitted numerous program adaptations to occur. Firstly, the program and musical content has been refined to meet the preference for a broader and more culturally-sensitive focus on Respectful Relationship Skills, and it has been delivered in additional settings (preschool and early education and care settings) and more Aboriginal specific services and/or settings. To enhance the reach of the program the project team have trained a growing number of individuals who work in playgroups to run ALL Come Out to Play! In addition to learning how to run the ALL Come Out to Play! music session, it also included training about primary prevention.

An additional aspect of the project has been delivering primary prevention professional development sessions to teachers and other community group facilitators with lesson plans linking to the Victorian respectful relationship curriculum.

The ALL Come Out to Play! program

Program aims

The overall program actively challenges conservative views about the need for rigid gender roles and attempts to normalise the concept of gender equality. With the understanding that children learn first through their parents and carers, the music session aimed to shift attitudes and cultural norms about gender during the early years of a child’s development. Whilst spreading key messages to families and early childcare workers that more equal gender roles can lead to more positive self-identities and equal and respectful relationships, the songs and activities illustrated these messages directly to the children. Community facilitator training was incorporated into the program so that there were more people trained to deliver ALL Come Out to Play!, with the aim of ensuring program sustainability and greater reach of the music session/program messages across broader early childhood settings. The professional development workshops were included in the program with the aim of informing early childhood professionals/program coordinators about Prevention of Violence Against Women.

The music session

The program aim is to subtly challenge rigid gender roles and stereotypes and, given the necessity to do so in an age appropriate manner, attention was not explicitly placed on preventing family violence. Rather, the focus was on respectful relationships and gender equality. The session was designed to be fun and engaging for both children and adults, and comprised storytelling, singing, dancing and interactive activities applicable to the messaging. It also functioned as a practical demonstration to adults of how role modelling, structured playtime and early learning can be modified to challenge rather than simply reproduce certain stereotypes. The narrative followed the day of a father and his three children during their adventures of going to the beach and visiting mum who is a doctor at the hospital. Direct messaging was integrated within the story’s narrative and promoted open discussion within the audience. For example, whilst holding a gender-neutral toy, the facilitator asked the children whether it is a boy toy or a girl toy. The program content challenges biases with adults, and also with the children, who often already appear to demonstrate bias in their understanding of the world and of gendered roles.
The cross-generational approach provided opportunity to concurrently deliver messages to both the children and the adults. In addition to reaching a larger audience, a cross-generational approach was favourable given the intergenerational transmission of violence (Millett et al., 2013). Whilst the adult was most often the parent, the messaging was deemed beneficial for whoever attended playgroup with a child, for example, a grandparent. Although the presence of a parent/carer was, as a key change maker, a key consideration for developing the program to be delivered in playgroup settings, the team decided to adapt the session to also be delivered in early childhood education and care settings. The educators, who make an important contribution to primary prevention (Yager & O’Dea, 2005) and generally influence children’s life narrative in the early years, participated alongside the children. Adaptations of the program for early education settings included detailed classroom lesson plans (Figure 1) that were developed in collaboration with Victoria University to assist the educators to continue the messaging of the program after the music session, which support their mandated inclusion of a Respectful Relationships curriculum (Ollis & Joyce, 2016).

Following the pilot phase, the program and musical content were refined, guided by facilitator reflections and participant feedback. Modification resulted in a broader and more culturally-sensitive focus on respectful relationship skills. The session focussed on promoting positive personal identities that are not constrained by gender or cultural stereotypes, whilst maintaining the format of story, song, dance and lots of humour. The content highlights to adults that many songs, nursery rhymes and toys are unnecessarily gendered, which may be limiting children’s beliefs about themselves and about what others expect of them and/or how they interact with them (Coyle & Liben, 2018). The ALL Come Out to Play! session is fully scripted and is delivered within a 50-minute slot. It is imperative that during this time, the adults (be they parents or educators) remain present and participate alongside the children. Parents/carers were provided with a tip sheet containing practical ideas to embed the messages, to take away and share with their partner and extended family.

The ALL Come Out to Play! session elements

1. Acknowledgement of Country song designed for early childhood settings.
2. Intro song that incorporates greetings in various languages.
3. Initial set up of story using illustration cards, ensuring the message is still accessible to groups whose first language is not English. Numerous versions have been created to reflect different skin colours, and number of/gender of parents.
4. Frequent opportunities for children to stand up to sing and move with their parents/carers. There are empowering songs and dances that are loud and active, such as ‘I love being me’ and the ‘Kangaroo song’, as well as some fun Aboriginal history, facts and content developed by Aboriginal consultants to the program.
5. Play with finger puppets.
7. Copy rhythms using clapsticks.
8. Role-playing caring for a baby using dolls, stethoscopes and changing their nappies; with a message that everyone can be gentle and nurturing (not only females).
10. Tip sheets provided to adults.

Figure 1. Example lesson plan
Figure 2. Tip sheet for parents attending the playgroup music sessions

- Role modelling is important. If you and your partner respect each other as equals your children will copy. If you and your partner yell at each and call each other names, your children will copy that also. Speaking and behaving respectfully to each other at home will encourage your child to grow up with similar values and apply these values to their own relationships today and into the future.

- Teach your children to question conventional stereotypes. Why can’t boys like pink? It is okay for girls to like trucks and machinery. If they gradually develop a critical eye as they grow it will help them reject media stereotypes.

- Limit their exposure to movies, internet or TV that is discriminatory and doesn’t support your values as a family.

- Avoid assigning chores on the basis of gender - girls are just as good taking out the rubbish bins as boys are doing the dishes.

- Remember that the more equal a relationship is – the safer it is. Gender equality is closely linked to healthy, respectful relationships. Inequality is linked with our Australia-wide problem of women’s and children’s safety. Do your part to promote a safer society. Target made the decision to “eliminate boys and girls signs from their toys and bedding departments.” This is a helpful cultural shift, always try to encourage your child to choose their toys based on their interests.

- Ensure your child sees that mum still has financial rights and power at home, even if she is in a non-paying role of child rearing at the moment. Model shared decision making where possible.

- Actively defend your child and educate anyone who makes unhelpful comments like “You should cut your hair you look like a girl” or “You should be more lady like”. You don’t have to get angry, just saying something like “We don’t believe that stuff is usually effective.


- If you find yourself telling your girls to be careful when they take risks and your boys to be tough if they express vulnerability - consider what messages they are receiving. It’s important for boys and girls alike to take a few risks and express their feelings. It may not be obvious, but they often need some encouragement in these areas.

- Encourage the men in your child’s life to take an active, involved, hands on role in parenting/saving and do try not “gate keep” by insisting they do things just as you do, or criticise their efforts. It’s also for kids to experience different parenting styles as long as some basic rules are consistently in place.

- Don’t let people label your child. If the early years educator calls your daughter a tomboy or makes a negative comment about your son’s emotional needs, gently correct them. Labels aren’t helpful to anyone.

These are just ideas to consider. You are the expert regarding your child - your behaviour and actions have a major impact on how they grow up. Enjoy the journey!

If you enjoyed today’s session and would go to find out how to run this program yourself please call Back from Grunwick Street Services on 9661 6738.

Please feel free to contact us with any comments and/or questions. We would love to hear from you.

We recommend these books:

Figure 3. Example of illustration cards used in session narrative

Community facilitator training

To enhance reach of the program messaging and ensure sustainability, the team created and delivered a one-day professional development session training session to build awareness about primary prevention of violence in their local areas across Victoria. The first component of the professional development was evidence-based Prevention of Violence Against Women (PVAW) training (Drummond Street Services 2018), which explicitly highlighted key prevention messages, including that gender inequality is a key driver of family violence. The format of the session includes the delivery of information, as well as interactive components to encourage reflection and discussion among participants.

The second component of the professional development was specifically about ALL Come Out to Play! Beginning with a practical demonstration of the ALL Come Out to Play! session allowed the professional to participate and thus experience the session from the perspective of a parent or educator. Participants were taught the show content, and the rationale behind it; they were encouraged and supported to consider ways of implementing ALL Come Out to Play! among their own networks and early childhood settings, such as integrating cultural references so the children could
The evaluation of ALL Come Out to Play! was conducted by The Centre for Family Research and Evaluation and Playgroup Victoria.

**Program reach**

The music session has been performed by the ALL Come Out to Play! team to more than 1900 people at playgroups across Victoria, and an additional 600 people by offering the program to children and educators in early years education settings. This universal program has been delivered in both metropolitan and regional areas in Victoria, including at least 10 Aboriginal specific services and/or settings. Twenty community facilitators have participated in the ALL Come Out to Play! training and as they deliver the music session the communities that they reach will also be tracked. More than 300 professionals (including teachers and other community group facilitators) attended the professional development session. The attendees of both the professional development and the community facilitators training have been a culturally diverse group which means that the messages of the program can be communicated beyond the English-speaking population.

**Methodology**

A mixed method evaluation approach was utilised to determine how well the program achieved the objectives and provide recommendations for program improvements.

The evaluation of the music session at playgroup considered: the perspectives from playgroup parents via a brief anonymous survey completed after the music session; the observations of the program team facilitating the music sessions about how both the parents and children appeared to respond to the songs, activities and key messages of the program; and personal reflections from the facilitators after each session. The data presented below is from 19 sessions held during the pilot phase (featuring responses from 185 parents of 210 children). An additional 12 evaluations were obtained from parents from a separate session; however we deemed it appropriate to exclude them given that the families involved were not proficient in the English language and appeared likely to have selected the most socially desirable responses without necessarily being able to understand the questions. Feedback on the PVAW workshop was based upon a brief evaluation survey that 113 participants completed following the workshop.

Eleven surveys were completed by the early childhood educators and facilitators (generically referred to below as educators) who were present when ALL Come Out to Play! sessions were delivered in playgroups or early childcare classrooms.

**Evaluation findings**

**Professional development workshop**

The workshop was reported by all but one respondent to have been appropriate for their existing level of knowledge and understanding about preventing violence against women. When asked about the level at which content was pitched, the majority of respondents (97%) agreed or strongly agreed that their awareness/understanding had been enhanced. That is, they agreed that training enhanced their understanding of the drivers of family violence and allowed them to understand why gender equality is important. Respondents also reported greater confidence to have conversations with others about adapting learning and play activities with non-gendered resources. Responses to statements about the usefulness of the professional development content are presented in Figure 4.

**Parents/carers**

Almost all parents agreed or strongly agreed that they enjoyed the music (99%) and the activities (99%), and that their child enjoyed the music (96%) and the activities (96%). Similarly, almost all parents agreed or strongly agreed that they learnt something (84%) and that the session made them think about how they parent their son or daughter (81%).

To obtain insight into parents’ prior knowledge, we asked how surprised they were to hear our key messages. As can be seen in Figure 6 at least two in five parents who answered these items did indicate surprise.

We anticipated that the reach of this program would extend beyond the families who attended via parent participants talking with and influencing other parents. To examine the potential impact of this, we asked the attending parents how likely they were to tell others what they had learnt from the session. As can be seen in Figure 7 almost all parents who answered these items indicated that they were likely or very likely to share what they learnt in the session.
To examine the potential impact of the session on the parents who attended, and thus their children, we asked whether they planned to do things differently after attending the session. In hindsight the response options should have included: ‘yes,’ ‘no,’ ‘because I already do this,’ and ‘no I do not plan to do this,’ as some parents used the open-ended item at the end of the survey to indicate that they would not make changes because their practice aligned with the messages being delivered in the ALL Come Out to Play! session. Accordingly, the potential impact of the session on parents is, in fact, even higher than the following percentages suggest. Most parents who answered these items indicated that after attending the session they would do the following differently:

- Encourage girls to take risks (86%)
- Encourage boys to express emotions (87%)
- Buy toys that are not traditionally feminine or masculine toys (80%)
- Encourage their child to play with any toy, not only traditionally feminine or masculine toys (85%)

An open-ended question completed the survey, inviting respondents to share anything else. All comments were positive, addressing messaging, the interactive content, and the energy of the session. There were some comments about learning a lot, and others about the messages aligning with existing family practices. One respondent noted “These sessions should be promoted into schools, kinder and playgroups.” The following responses are from a participating parent and a facilitator:
“I don’t want him to have the same problems I had. Like you’re a wimp - boys don’t cry. It is alright to be upset sometimes and luckily he isn’t growing up in a remote kind of area like I did so I hope it’s a bit easier to ask for help. But being a male is just difficult, as much as the feminists would disagree. I liked seeing him with the baby dolls—he was tender and that is how I was with him.” A dad

A parent came up to us and said – “I am going to be more careful about how I speak to my partner now you have been talking about respectful relationships—I give him a hard time—but they [kids] really are sponges, aren’t they?” A facilitator

Educators

Educators indicated that the messaging was likely or very likely to influence their approach and pedagogies (Figure 8).

Educators were also asked to indicate any barriers that may prevent them or other educators from adapting teaching practices/classroom management to be more gender inclusive. Responses to the open-ended question were:

- A lack of understanding (4)
- Uncertainty of cultural appropriateness (1)
- Teacher bias (2)
- Influences outside of the classroom: parents (2); grandparents (1)

Figure 8. Educators perceived likelihood of the messages influencing their approach

Figure 7. Rate of parents intending to share their learnings from the session
Conclusion

The ALL Come Out To Play! program was developed as an innovative multi-generational approach to primary prevention of violence against women. The program was a result of a partnership characterised by collective experiences in primary prevention. The playgroup platform, music and movement, and interactive ways of working with young children and families were the key to the partners’ ability to create and deliver the program.

The professional development workshops were included in the program to inform early childhood professionals/program coordinators about Prevention of Violence Against Women, and reports suggest that the content was pitched at the appropriate level to enhance their awareness/understanding. Importantly there was enhanced understanding about why gender equality is important, and greater confidence to talk to other educators about utilising non-gendered learning and play resources.

The music sessions at the playgroup aimed to shift attitudes and cultural norms about gender during the early years of a child’s development. The high proportion of parents who were surprised to hear the key messages illustrates that the program informed parents of relevant information. Furthermore, the session made them think about how they parent their children, with most indicating intent to implement non-gendered parenting practices. Another positive report was that parents intended to share what they learnt from the session, potentially enhancing the reach of the program’s messages.

The educators who attended the music session also indicated that the messaging had an impact on them, reporting that it was likely to influence their pedagogy.

The ALL Come Out to Play! music session has shown to be enjoyable and thought provoking, prompting parents to reconsider gendered parenting, in addition to spreading the messages of the program. As community facilitators deliver ALL Come Out to Play!, the program messages will continue to be spread.

References


drummond street services (2018), ‘Prevention of Violence Against Women (PVAW) training’.


Thirteen years after their inception in 2006, Family Relationship Centres (FRC) remain key to supporting families experiencing relationship difficulties and helping them to deal constructively with separation-related disputes, not least those related to caring for children. However, research and feedback from clients themselves suggest that for many FRC clients, dispute resolution processes do not achieve desired outcomes. Through reflective practice and the guidance of a neurological model of child development, Interrelate Newcastle designed an additional family dispute resolution pathway to provide specialised emotional support for parents while promoting children’s best interests and enhancing their development and wellbeing. The resulting psychosocial support model empowers and equips parents, reduces risk to children and supports child development, paving the way for stronger parent-child engagement over the life course.

Re-shaping the FRC pathway to improve client outcomes

Family Relationship Centres (FRC) were developed in 2006 as a result of the widespread reforms to the Family Law Act 1975. The role of the FRC was to “provide families experiencing relationship difficulties with support to strengthen relationships and deal constructively with separation-related disputes, particularly pertaining to parenting arrangements” (Smyth et al., 2016). The reforms focused on expanding the role of Family Dispute Resolution Practitioners (FDRPs) with “mediation techniques to assist families attempting to resolve their disputes without resorting to court proceedings where possible” (Smyth et al., 2016).

A significant number of families restructure through family separation each year in Australia. In 2013, 82,000 adults divorced, resulting in 42,747 children under the age of 18 years of age experiencing their own unique journey of family separation (Australian Bureau of Statistics; ABS, 2017). Of those children, only 31% who had a natural parent elsewhere met with that parent on a daily or weekly basis whilst one in four children saw the parent they were not living with less than once per year (ABS, 2017). The number of adults and children impacted may be higher given this data only reflects the divorce of married couples with children and does not take into account the separation of unmarried couples with children. In 2013 at least 124,747 individuals were impacted in varying degrees by family separation and between 2011 and 2015, 10,848 clients accessed Family Dispute Resolution services at Interrelate Family Centres for assistance to resolve children’s matters (Smyth et al., 2016). Smyth and colleagues (2016) stated “the number of s60I certificates issued by Interrelate between 2011–12 and 2014–15 steadily increased, with a marked increase between 2011–12 to 2012–13 (from 1,716 to 1,986) certificates issued”.

Smyth et al. (2016) further noted that “(although) the overall purpose of the FRC is to promote children’s best interests... the majority of respondents indicated they did not achieve the outcomes they set out to achieve” within the FDR process, with 72% of clients receiving a s60I for varying reasons.
In 2015, Interrelate Newcastle reflected upon client feedback and the high number of cases that were issued a S601 certificate and, through reflective practice, embarked on designing an additional FDR pathway that aimed at providing specialised emotional support for parents whilst, at the same time, promoting the best interests of the child. The FDR pathway involved embedding a specialist Family Counsellor trained child consultant into the FRC who would work alongside parents individually whilst heading towards mediation. The overall goals of this additional FDR pathway was to enable parents to arrive at an emotionally available place where both parents were able to negotiate from a child focused platform and develop a workable co-parenting plan.

**What research was the Family Counsellor Pathway founded on?**

Developing a parenting plan requires both parents to be able to separate their own issues from their children's needs in order to create a plan that is in the best interests of the child. This is referred to as operating from a child focused perspective however, after family separation, this is easier said than done. Researchers like Vaughn (1990) have written extensively about the impact grief and adjustment have on separated parents, and the impact this has on a parent's capacity to consider their own needs from those of their children. Emery (2012) referred to this as ‘asymmetry’ due to both parties being at different stages within the grieving process: when parents are operating from different stages of grief, this can lead to ‘his’ and ‘her’ versions of the separation as well as ‘his’ and ‘her’ versions of how the children are coping, resulting in both parties becoming rigid and ending in an impasse. The best approach when this occurred was for the practitioner to halt the process until both parties were emotionally ready to co-operate and cope with negotiations with the ex-partner (Ewing, Hunter, Smithson, 2015). Ewing et al. (2015) outlined that when parents become polarised in their views, each parent can then strategically invoke the rights of the children for their own advantage.

Holsworth (2017) stated “the most important people when families separate are those who are most vulnerable”, that is, the children. Unfortunately, divorce and family separation significantly heighten risks for children. Children’s risk of negative mental health outcomes are twice those of nuclear families. Divorce and separation double the risk of behavioural and emotional problems from 12% in nuclear families to 25% in separated families (McIntosh, 2017; Holsworth, 2017).

Gottman and Gottman (2015) directly correlated conflict and illness, with their findings suggesting each time a person is involved in a conflict, this equates to one illness the following year. Is it any wonder that family members, including children whose family is entrenched in conflict, often suffer from illnesses around the time of separation?

At a Child Inclusive Practice Forum in Adelaide in 2017, Macintosh referred to child inclusive mediation as ‘the Rolls Royce of interventions’ for separated families (McIntosh, 2017). During this forum, McIntosh referred to child inclusive mediation as the ideal way moving forward for not only families but also, in acknowledgement of the United Nations Convention on the Rights of the Child (UNCROC), in putting children’s needs ahead of parents’ needs.

**A child inclusive approach: The most effective counselling framework for working with families and children (nuclear and separated families)**

It can be argued that child inclusive therapy is the most effective counselling framework when working with children so why would one change this approach once a family is separated and the most vulnerable become even more vulnerable?

Child inclusive family therapy places the child or children at the forefront of therapy through strong engagement, active participation, permission to have a voice and, above all, actively focuses on the International Rights of Children. Children are actively included and engaged and all family members are given equal opportunities to contribute, engage and participate (Fisher, 2012). Child inclusive therapy is moulded around the notion that each family member, including the child, has a direct voice rather than parents assuming what their children feel, need, want and are experiencing; this is referred to as a child focused approach (Fisher, 2012).

The word family is defined as ‘a group of people who are related to each other’ (Cambridge Dictionary, 2019). Sori (2006) referred to the family unit as an interdependent system. Whether that unit is behaving in a functional or dysfunctional way, the behaviour of one member affects the functioning of the entire family unit given the family unit, or interdependent system, is made up of subsystems. Child inclusive therapy includes the children where they are viewed as “vital members whose participation is essential to understand overall family functioning” (Sori, 2006, p. 141). Children are viewed as a part of the subsystem. Since subsystems ultimately work collaboratively to create the family system, it makes sense that children are central to the counselling process. It is important to understand children's contributions to the family and to recognise the reciprocal impact of the child/ren on the family, and the parents' behaviour on the child/ren (Sori, 2006, P. 141). Family members are
interconnected and, as such, when one member is functioning differently due to stressors, emotional hurt, development etc. other family members can be affected either directly or indirectly; this notion formed part of Sori’s research, which found that “children are affected by adult problems” (2006, p. 141).

Families are in a continuum of change and development known as ‘The Family Life Cycle’ (Carter & McGoldrick, 2005). With development comes growth and with growth comes change. Carter and McGoldrick (2005) outline that family conflict generally results when families experience difficulty moving between stages of the family life cycle. The family life cycle consists of developmental tasks/stages for children and, operating simultaneously, parents also experience developmental tasks/stages. Family separation could be referred to as a stage within the life cycle. When children and/or parents get stuck when moving between stages resistance can occur. This leads to friction, which then impacts other members of the family unit resulting in conflict (Carter & McGoldrick, 2005). Carter and McGoldrick describe the family life cycle as ‘a system moving through time’ where relationships with parents, siblings and other family members go through transitions as they move along the life cycle (2005, p. 112). At each stage throughout the life cycle, “boundaries shift, psychological distance among members change, and roles within and between subsystems are constantly being redefined” (Carter & McGoldrick, 2005, p. 112).

Goldenberg and Goldenberg’s (2013) research suggests that conflict can also occur in families when one or more party(ies) experience difficulty transitioning through developmental tasks and stages. If parents experience difficulty adjusting or adapting to the change in the stages of the life cycle or developmental tasks, such as family separation, this will impact the children and conversely, if children experience difficulty moving to the next stage, this can have an impact on the parents (Carter & McGoldrick, 2005). Carter and McGoldrick emphasise that “stress is often greatest at transition points from one stage to another in the developmental process as families rebalance, redefine and realign their relationships” (p. 118). Sori (2006) goes even further to say that children are affected by adult problems and should be included to determine how they are affected and how well they are coping. White and Chasini’s (1989) findings believe a family is better understood when all family members are involved.

Everyone has rights and children are no exception. The United Nations Convention on the Rights of the Child (UNCROC) outline the rights of the child in broad categories. Article 12 states:

“Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child” (United Nations Human Rights, 1990).

According to the UNCROC, children have a right to participate in matters that affect them. Children are linked to a family unit whether nuclear or separated and, within that unit, each person sits somewhere within the family lifecycle. One major consideration when assessing and supporting a family under stress is identifying the family’s stage of development alongside each individual’s capacity and how this may interact with the presenting problem.

The child inclusive approach is an approach that includes all family members in the process. A large part of the child inclusive approach is about connecting with each member of the family and enabling those family members to reconnect with each other in more adaptive and healthier ways.

Few would disagree that the child inclusive approach generates the most success for families in improving outcomes for children. However, child inclusive practice is resource heavy and many non-government organisations do not have the resources, nor the clients the money, to fund it. How can the FRC improve outcomes for separated families in a way that makes best use of finite resources and delivers the best possible outcomes for families?

Providing psychosocial support: Family Counsellor Pathway within the FRC

The aim of family dispute resolution (FDR) is to assist separating/separated parents to improve their overall functioning in caring for, and ensuring the welfare of, their children. Commonly, FDR services seek to empower parents; they are child-focused, facilitative and encourage self-determination. McIntosh (2017) referred to the FRC practitioner as an advocate and a resource for the best interests of the child when working towards a resolution with both parties. In a 2017 Child Inclusive Forum, McIntosh stated:

“... to make a difference to children, you need to target with parents:

- parental attunement and emotional availability;
- Management of parental conflict and acrimony;
- Developmental responsive parenting plans; and
- Promotion of on-going engagement with their children’s wellbeing and lives”.

With approximately 72% of cases within the FRC receiving a s601 certificate (Smyth et al., 2016), and demand outstripping supply, a Child Inclusive Mediation may be out of the realms of many or even most families who enter the FRC. Many family dispute resolution
practitioners (FDRPs) have reported pondering the issuance of a s60i certificate with considerations such as: Where does this leave the children? How can the children have a meaningful relationship with each parent if the parents are entrenched in conflict and unable to develop a parenting plan? If a s60i is issued, how are we fulfilling the rights of the child to have their voice heard? How can the parents give up the fight and provide their children with helpful support if they either don’t have or are unaware of the tools to use? (Smyth et al., 2016; Ewing et al., 2015). Through reflective practice arose the question, how can we re-shape the FDR service to improve outcomes for families in a way that is less resource heavy?

The approach that was developed involved the introduction of an additional pathway within the FRC known as ‘The Family Counsellor Pathway’. The Family Counsellor Pathway (FCP) began in 2016 and has been supporting many families who may otherwise have been issued with a s60i using the traditional child focused approach. The FCP has been producing positive outcomes for a significantly high proportion of parents and children who have been referred for support with few returning to the FRC within four years.

Figure 1. Where the FCP sits within the FRC

If the child focused and child inclusive approaches were on a spectrum, the Family Counsellor Pathway could be described as occurring where the child focused approach meets the child inclusive approach.

**What is the overall goal of the Family Counsellor Pathway?**

The overarching goal for all clients who enter the Family Counsellor Pathway is for parents to arrive at an emotionally available place where both parents are able to mediate from a child focused platform and develop a workable co-parenting plan.

**How does the Family Counsellor Pathway work within the FRC?**

The Family Counsellor Pathway has the capacity to provide support to clients throughout the entire FDR process – before, during and after mediation.

**Referral of FRC clients to the Family Counsellor Pathway**

Either one or both parties may be referred to the Family Counsellor Pathway however each client is seen individually with each parent having their own unique goals to explore, develop and refine. The majority of cases presenting to family counselling in relation to past and/or current domestic/family violence exists as a presenting issue. Most male clients who consent to engaging in support for their psychosocial needs are referred to a broader family support service that does not engage or interact with any legal or other dispute resolution services in which the parties are involved.
What approach and model does the Family Counsellor Pathway use?

The Family Counsellor operates using a trauma informed-bottom up approach (Seigal, 2012; van der Kolk, 2014). During each session the counsellor works with clients through a trauma informed lens – meeting clients where they are on their journey of grief and loss, hurt, pain, despair, shame, anger, resentment, relief, exhaustion, depletion, worry, sadness, fear and more. Many clients who enter this pathway enter with the belief they are coping and putting their child’s needs ahead of their own, however over the sessions a significantly high proportion of clients reach a point where they can self-reflect and come to a realisation that both they and their children have not or were not coping as well as they initially thought.

The trauma informed-bottom up approach guides how the Family Counsellor interacts and works alongside the clients as the majority who enter this pathway have been traumatised, in varying degrees, by either the couple relationship, the separation or their experiences post-separation. McIntosh (2002) stated that:

“to make a difference to children, you need to target with parents: parental attunement and emotional availability, management of parental conflict and acrimony, developmental responsive parenting plans (and) promotion of on-going engagement with their children’s well-being and lives.”

Parental attunement, parental awareness, parental insightfulness and emotional availability require parents neo-cortex to be fully engaged, their limbic system and amygdala to be in a calm and non-defensive mode and limited stress hormones secreted throughout the body (Siegel, 2012; Gottman & Gottman, 2015). Most of the parents referred to this pathway are very much the opposite; they are in defence mode, fight mode, flee mode, feel emotionally and sometimes physically unsafe and are operating from within their limbic and fight, flight, freeze centres resulting in their neocortex, the logical, rational, empathetic part, which guides hindsight and foresight, being temporarily closed (Siegel, 2012). To ask parents to think about their children’s needs when their neocortex is offline and they themselves are in reactive mode is neurologically challenging and could be likened to asking a five year old child to do HSC physics.

The Neurological Model that acts as a guide when nurturing the development of a child focused mindset

The model described below is drawn from a number of sources – Seigal (2012), Siegal & Hartzell (2014), Siegel & Paye Bryson (2012), Johnson (2005), van der Kolk (2014) – and is the basis for the Family Counsellor Pathway approach.

**Figure 2 outlines four different parts to the brain, referred to as:**

**Part 1.** Spinal Cord/Reptilian known as Fight, Flight and Freeze, protection mode. Clients may appear to be defensive, withdrawn, frozen.

**Part 2.** Cerebellum known as the movement centre. Clients may be fidgeting, moving in their seat, unable to sit still, flicking a pen in their hands.

**Part 3.** Limbic Centre where clients appear to be experiencing big emotions; sadness, despair, frustration, anger.

**Part 4.** Neo-Cortex known as the thinking and rational centre where experiences and foresight meet with wisdom to guide decision making.

**Figure 2. Four parts of the brain**

Figure 2 identifies what the Family Counsellor refers to as bottom-up approach. The counsellor works alongside clients to calm each part of their brain from 1 through to 4. When parts 1 to 3 are activated, cortisone and adrenaline are released throughout the body as the body perceives it to be in danger. A large number of clients present during their initial session with the Family Counsellor as operating from within parts 1, 2 or 3, however they are unaware their neurological capacity and abilities are temporarily compromised. Unfortunately clients can be in part 1 through to 3 and appear to be coping. With many clients wearing electronic devices (i.e. smart watches), the Family Counsellor will often utilise technology to check in with clients and ask them to measure their heart rates using their own devices. Clients often report feeling surprised...
and shocked when their heart rate is above 100-120 beats per minute. Devices that measure heart rate prove to be a wonderful tool for informing both client and the Family Counsellor whether the neo-cortex is engaged or temporarily off-line indicating the client, at that point, is neurologically incapable of empathising, having foresight or hindsight or effective decision making. Gottman and Gottman (2015) reported that a heart rate over 120 beats per minute is an indication of the inability of clients not being able to make decisions or communicate effectively due to the neo-cortex being offline.

Siegel (2012) reports that when parts 1 to 3 are calm, this enables the neo-cortex to engage and it is at this point that parents are neurologically able to enter discussions at a child-focused level. They are able to attune to their children’s needs, have parental awareness, and be insightful and emotionally available; however, this capacity can be off line again in six tenths of a second taking the client back to either brain 1, 2 or 3.

Figure 3 shows the techniques and strategies the Family Counsellor regularly utilises with clients to effectively move clients at their own pace, through the different stages to part 4 where the neo-cortex engages (Gibson, 2018).

![Figure 3. Working from the bottom-Up](image)

Within and during each session, the Family Counsellor gently ‘holds’ the client at the part of the brain from which they are operating and, when the neo-cortex returns online, this is when the Family Counsellor metaphorically brings the children back into the conversation. Gottman and Gottman (2015) report the neo-cortex takes at least 20 minutes before it can be back on line. Many clients during the initial sessions report they are unable to hold hope for a happy future with issues resolved. These clients present with behaviours that indicate as operating in parts 1 to 3. It appears at these times that the clients are experiencing pain that is too heavy from operating within parts 1 to 3; they are unable to focus on anything or anyone but themselves. It is at this time the Family Counsellor informs clients that she will hold hope for them and the children until they are ready to hold it for themselves.

It is during the times when clients are operating out of parts 1 to 3 that they are unable to step back and reflect on how their children perceive them as a parent. Nor are they able to process the impact that continually operating in parts 1 to 3 may have on their children. To enable clients to develop a new neurological pathway that could be named ‘the child focused neurological pathway’, when clients display their neocortex is semi-online, the Family Counsellor is mentally guided by a set of questions, each of which includes a range of carefully worded explorative questions which assist to build the child focused neurological pathway.

These questions form a large part of the counselling process and the Family Counsellor Pathway. This is where the Family Counsellor learns about the clients’ experiences, their belief systems, their values, their attitudes, their family of origin, their attachment system, what is driving their behaviour, responses and reactions. This is also the part where the Family Counsellor learns about the children within the family, how they are or aren’t coping, if there is triangulation, scapegoating, blame, up-side-down parenting and more. The Family Counsellor operates from a unique balance of individual counselling blended with a child focused approach that leans toward a child inclusive approach. This is achieved using information provided by the parents about the children to enable the child to have a metaphorical presence in the room throughout the pathway.

Regularly used explorative questions (asked while the counsellor ‘holds’ the relevant part of the brain – see left)

1. Does this parent realise the emotional parenting availability (the hands) they are sending to their child? (mean, abrupt, weak, gone)
   - What do you think your children may be feeling when they see/hear that (frustrated/angry/afraid etc.) part of you?
   - I wonder what happens for them when they see/hear that happening?

2. If so, then what is driving them to continue using these hands (mean, abrupt, weak, gone)?
   - Are there times in your life when you have experienced that?
   - What was that like for you?
   - What are you feeling when this is happening?
   - How do you manage when this happens?
   - What happened for you when you shared that with me just now?
3. Are they aware that these hands are impacting their children’s development & the relationship they have with their children?
   - Have you noticed what happens for the children at these times?
   - I wonder what that’s like for them during those times?
   - Have you noticed any times when you respond differently and the children do also?
   - What is it that you notice about your children during those times?
   - How was that for you to share with me just now?

4. How do they want their children to be as adults?
   - What memories do you want your children to have of their childhood?
   - What qualities, traits and values do you want them to grow up having?
   - How do you want your child to manage conflict?
   - How would that be helpful to them as an adult?

5. Will the hands they are using enable their children to develop those traits, tools, skills, values?
   - I wonder how your children will develop these qualities, traits, values, communication skills (etc.)?
   - What is it that you can do to ensure your hopes and wise for them come true?
   - How will you do that?
   - What would that be like for your relationship with your children?

How was client progress and the effectiveness of the Family Counsellor Pathway measured?

The primary tool for measuring effectiveness was the Parent Empowerment and Efficacy Measure (PEEM) from Griffith University. In addition, all clients were asked to include their level of coping emotionally and their child’s level of coping on a 1–10 scale. Clients could also provide anecdotal comments. Other information was also collected, and included the number of s601 certificates issued in relation to clients accessing the FCP, the number of clients continuing to engage, or re-engage, in post-mediation sessions, the FCP or family counselling and the level of client satisfaction with the FRC, sourced from the organisational client engagement survey.

Administering PEEM

The PEEM was administered to all 25 clients throughout a seven month period. Clients engaged in four to five sessions with the Family Counsellor over a timeframe of 12 weeks. All clients completed both pre and post PEEM at the end of session four. Clients were asked to complete both PEEMS at the end of session four to enable them to accurately self-reflect on their areas of development and accurately compare their pre and post development.

Administering the Emotional Scale 1–10

In addition to the PEEM all clients were asked to record on a scale of 1–10 how they believed:

1. They as a parent were coping emotionally upon entering the Family Counsellor Pathway
2. They as a parent were coping emotionally upon exiting the Family Counsellor Pathway
3. Their children were coping emotionally before parent session one
4. Their children were coping emotionally upon completion of parent session four

RESULTS upon exiting the Family Counsellor Pathway

Analysis of client responses through PEEM, the Emotional Scale 1–10 and the organisational client engagement survey, together with data collected about clients’ going engagement with services, consistently point to the effectiveness of the Family Counsellor Pathway in achieving positive outcomes for parents’ and children’s efficacy and emotional coping:

Measuring the effectiveness of the Family Counsellor Pathway

In 2017 a small sample of clients was studied to explore the effectiveness of the Family Counsellor Pathway. The study was conducted using a sample size of 25 clients being a mixture of males and females who engaged in at least four to five sessions over a period of seven months. Clients were selected by Family Dispute Resolution Practitioners who had deemed that:

- Without any changes to the case presentation the matter was likely to be issued a s601 certificate; or
- It was likely that mediation would not result in a parenting plan with one or more parties not being in an emotionally stable place to mediate.
PEEM results
100% of clients felt more empowered with:
- 68% of clients increasing their pre to post PEEM score by 20 points
- 45% of clients increasing their pre to post PEEM score by greater than 42 points
- The average increase of client pre to post PEEM score was 34 points

Efficacy to Parent:
- Average pre-test score 61 points (r=37–93) possible score ranging from 11-110
- Average post-test score 82 points (r=59–103) possible score ranging from 11-110
- Average total scores increased by 33% over a period of four sessions

Efficacy to Connect:
- Average pre-test 52 points (r=37-93) possible score ranging from 9-90
- average post-test 66 points (r=59-103) possible score ranging from 9-90
- Average total scores increased by 26% over four sessions

- 1 of the 27 clients have re-engaged with the FRC within four years post engaging in the Family Counsellor Pathway (3.7%)

Overall results of Family Counsellor Pathway:
- Efficacy to parent increased by 33%
- Efficacy to connect increased by 26%
- Parental emotional coping increased by 33%
- Child emotional coping increased by 39%

Emotional Scale 1–10 Results:
- Adults Emotional Coping scale;
  - Pre-test average 4.3
  - Post-test average 7.6
- Child's Emotional Coping scale;
  - Pre-test average 3.1
  - Post-test average 7

Clients issued with a s60i Certificate:
- 5 (20%)

Clients resulting in a parenting plan post mediation:
- 20 (80%)

Other results – sourced from Interrelate CRM and client engagement survey:
- Just over 50% of clients continued to engage in the free post mediation sessions
- Three of the 25 clients re-engaged at least twice with the Family Counsellor Pathway for a fee for service post FDR within four years (12%)

Anecdotal feedback
Client comments upon exiting the Family the Counsellor Pathway
- “Thank you for this service. I feel like I can support my kids so much better now”
- “Thankyou!!! I feel like I can cope now’
- “I've got lots of tools that I can use for myself and my kids now”
- “I didn’t know what I didn’t know”
- “I think everyone should do this”
- “I didn’t know that my children's behaviour is driven by their feelings”
- “Until now I thought they were coping but you helped me to look through a different ‘lens’. Thank you”

FDRP comments regarding the Family Counsellor Pathway
The mediation process benefits from a Family Counsellor in numerous ways. At the initial intake a client can be referred to the Family Counsellor to work on counselling, parenting issues or high conflict issues and other needs as assessed by the Family Counsellor. The mediator is thus kept in an impartial role and allows the client to do direct therapy alongside the mediation process. Mediator Newcastle

At the mediation session, the Family Counsellor assists the mediator by being a resource for child development generally and (providing) targeted information for the clients’ children. The mediator is able to manage the process. In a different way with child focused exercises being enhanced and facilitated by the Family Counsellor. The Family Counsellor can also act as a focal point for clients as the Family Counsellor has a view of the conflict and can bring the words, work of the affected children into the room in a way that traditional mediation cannot. Mediator Newcastle

Conclusion
The Family Counsellor Pathway is an intervention that continues to support many clients accessing the Family Relationship Centre in Newcastle by working alongside FDR clients from a trauma informed practice to arrive at an emotionally available place and to mediate
from a child focused platform to develop a workable co-parenting plan. This pathway has significantly improved outcomes and family function for all clients who have engaged with the Family Counsellor, in particular, the children. Throughout this pathway, the children were never seen. However throughout each session, the Family Counsellor always, metaphorically, brought the child into the room and entwined them in the counselling conversations to enable parents to view their children through a different lens and reflect upon their parenting ways and develop the skills and strategies to operate from a child focused platform before, during and after mediation. Although the children were never seen by the Family Counsellor, the research highlighted the family members who made the most improvement with regards to coping were the children. The Family Counsellor Pathway has resulted in a significant reduction in the number of s60I issuances alongside a significantly high increase in the number of parenting plans developed through mediation. This pathway is succeeding in working alongside separated parents throughout the FDR process to improve outcomes for children and parents and reduce the risk factors for children post separation. It strengthens parental relationships, equipping parents to develop tools to step out of entrenched conflict and operate from a child focused platform.

The Family Counsellor Pathway within the FDR process is targeting with parents:
- parental attunement and emotional availability;
- management of parental conflict and acrimony;
- developmental responsive parenting plans; and
- promotion of on-going engagement with their children’s well-being and lives.

The Family Counsellor Pathway is equipping parents with neurological, developmental and psychosocial navigation tools to be their children’s hero. The Pathway also reduces the degree of risk for children after family separation by repairing what can be repaired, preventing what can be prevented and apologising for what can’t be changed through a child focused developmental lens using a bottom up, trauma informed practice. The Family Counsellor Pathway is an intervention that sits neatly at the point where child focus meets with child inclusive practice and is both empowering and equipping parents to be the heroes their children require them to be.

References


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elationships bring love and contentment. But under strain, relationships can also bring risk of harm to self and others. When people want help for their relationships, relationship practitioners must identify if there are any such possible risks of harm when they are clarifying the presenting issue. This is essential because clients may identify the problem as simply being an inability to talk or communicate when in reality it may be dangerous for them to talk.

Relationships Australia SA (RASA) paves the way in facilitating safe conversations with all its clients using the Family DOORS framework. Based on the Family Law DOORS (McIntosh & Ralfs, 2012a), Family DOORS begins with DOOR 1 which is a fifteen-minute universal risk screen developed from the evidence-based and validated Family Law DOOR 1 (McIntosh, 2011a). Clients self-report their risks on DOOR 1 on paper or using the Family DOORS app which selects relevant domains and builds a screen for the client based on client characteristics (like relationships status or being a parent).

This paper presents and reviews the findings from the first 675 clients of family and relationship services (FARS) to complete DOOR 1 at RASA. We found high levels of gendered past abuse and current risks of violence. However, other less obvious risks were also revealed as a result of undertaking the screening process including risky alcohol or drug use; parenting stress; child protection notifications about their children; and current suicidal thoughts. We describe the risk screening experience from both the client and organisational perspectives, and for both low and high-risk matters. We show how the early identification of risks informs early intervention requirements in response to family safety and wellbeing.

We conclude that for many early intervention relationship counselling clients the risks are real, and that quick, efficient and respectful screening is just as essential as it is for post-separation services. We demonstrate the Family DOORS app and provide participants with the opportunity to access the app to try it themselves.

Loving relationships bring happiness, meaning and celebration. When those relationships become strained, people do not suffer in silence or struggle on without support or simply separate with seeking help. Over a third of people in peaceful, respectful relationships will try relationship counselling or Family Dispute Resolution (FDR) services before finally separating (Kaspiew, Carson, Dunstan, De Maio, et al., 2015, p. 64). People in violent relationships are twice as likely to seek these services as those in respectful relationships; they are also twice as likely to use those generic services rather than specialist domestic violence services (p. 64–65). In other words, Family and Relationship Services Australia (FSRA) members see more clients in risky relationships than they do clients in respectful relationships in relation to separation.2
FSRA members are encouraged, or required, to be sensitive to domestic violence and other known areas of risk beyond simple frequencies. The 2012 Family Law Act amendments show the importance for services to ask about key family safety risks and encourage clients to speak out about those risks (Kaspiew, Carson, Dunstan, et al., 2015). Competency standards for psychologists, social workers and FDR practitioners (FDRPs) require practitioners to be proficient in assessing, identifying and responding to risks, including violence, in everyday practice. Relationship Services Centres (FRSCs) have operational guidelines that set out how Commonwealth-funded services should incorporate screening for risk. Relationship counsellors and family therapists should also screen for risk including domestic violence, with O’Brien (2015) and Weiss (2015) stating that psychologists in relationship services should inquire about the risk of domestic violence when working with couples. Finally, from a sector wide perspective, FRSA has recognised and advocated for the widespread adoption of intake, screening for risk and assessment based on a public health perspective (Toumbourou et al., 2017).

Given the top-down expectations in addition to prevalence rates, practitioners should be purposefully exploring key areas of risk as part of their daily practice. However, there is much evidence showing this is not the case. Practitioners often report that they ask about key risks such as family violence or child abuse, though it is often not clear how they do this (Kaspiew, Carson, Coulson, Dunstan & Moore, 2015), meaning the general requirement to screen is contested (Cleak & Bickerdike, 2016; McIntosh, Lee & Ralfs, 2016). Other surveys of practice specific to relationships services indicate that only one third to one half of US practitioners routinely use structured screening tools and few follow best practice processes such as individual screening of couples (Schacht, Dimidjian, George & Berns, 2009; Todahl & Walters, 2011; Tower, 2006). Todahl, Linville, Chou & Maher-Cosenza (2008) suggest this practice of ‘screening to screen’ relies on the dubious belief that the signs of domestic violence will be obvious to the practitioner. In summary, we should be screening all the time, but we don’t.

The opportunity to intervene in risks

By not formally inquiring about risks, practitioners may be missing an opportunity for early intervention or even prevention of harm. Clients may – quite rightly – not tell a practitioner about risk because they don’t recognise the behaviour as being a risk or risk indicator or something that they should tell the practitioner. For example, Kaspiew, Carson, Dunstan, De Maio, et al. (2015) found clients provided credible reasons to not disclose risks such as ‘it wasn’t really happening at the time’, ‘it wasn’t serious enough at the time’, ‘It was happening but I wasn’t worried about it’, or ‘It wasn’t affecting the kids’. Importantly, clients may not report high violence risks unless practitioners proactively ask about risk (Ballard, Holtzworth-Munroe, Applegate & Beck, 2011; Rossi et al., 2015).

Though the focus so far has mostly been on domestic violence, practitioners may also be missing opportunities to intervene with other types of risks that co-occur with domestic violence. Firstly, there is a risk of developmental harm where children have witnessed domestic violence, which happens according to two-thirds of mothers and a half of fathers in families with domestic violence (Kaspiew, Carson, Dunstan, De Maio, et al., 2015). Research also indicates that both mental illness and drug and alcohol misuse are linked to both family violence and relationship separation (Ellis & Stuckless, 2006a; Kaspiew et al., 2009). Separation can also increase the risk of mental health problems and drug and alcohol misuse – particularly for men – that further elevates the risk of violence and lethality in the post-separation context. Indeed, mental health and separation have been shown to share a bidirectional relationship, whereby mental health problems are predictive of separation, and separation is predictive of mental health problems (Gibb, Fergusson & Horwood, 2011). Australian data confirm these wider risks, with divorced/separated individuals in Australia being nearly five times more likely to have a substance use disorder than married individuals, and nearly twice as likely to have an affective (emotional/mood) disorder (Australian Bureau of Statistics, 2011b). In short, risks ‘run in herds’ and so domestic violence is unlikely, for clients, to exist in isolation while everything else is going well in their lives and in their families. In other words, practitioners should also be purposeful about wider risks.

To summarise, practitioners who are not purposeful in their practice around risks may be missing significant opportunities to intervene in a range of potential harms which they might otherwise see on a daily basis. This is significant given that parents may under-report harmful and even potentially lethal dangers unless practitioners ask about risk (Ballard, Holtzworth-Munroe, Applegate & Beck, 2011; Rossi et al., 2015). More succinctly, Cleak and Bickerdike (2016) emphasise that: “simply being asked would have led to disclosure [of risks]” (p. 18). While most effort on researching screening has focussed on domestic violence in a post-separation context, it is possible that similar trends of co-occurring risks will also be found in FARS.

The Family DOORS framework

One way for relationship practitioners to be purposeful in risk practices is through clients self-reporting risk with holistic universal risk screens. In 2012, McIntosh and Ralfs (2012a) developed the Family Law DOORS (‘Detection of Overall Risk Screen’) framework in Australia.
Funded by the Australian Government Attorney-General’s Department, the framework and handbook (McIntosh & Ralfs, 2012b) provided an approach and a practical set of tools to assist a wide range of practitioners working on post-separation parenting and property disputes (McIntosh, 2011a; 2011b). In 2015, the framework was expanded outside of the family law context as the Family DOORS framework which covered areas such as gambling and current relationships; it also covered individual clients not in intimate relationships or in disputes. This extension was piloted as MyDOORS (McIntosh & Lee, 2016) in non-family law services across RASA and Relationships Australia Tasmania. In 2017, all the resources and paper-based tools in the Family DOORS framework were integrated into a single online platform called the Family DOORS app (Flint, Lee & McIntosh, 2017). The app creates a personalised risk screen for each client built by asking a few basic questions about the client’s current situation. Though hidden to clients and practitioners, the app is selecting from the best of 16 different possible permutations for the client.

The three parts to the framework have remained constant throughout the development and refinement of Family DOORS; namely it enables practitioners to identify, elaborate and assess risks in order to minimise and manage those risks in everyday practice. The three parts begin with DOOR 1, a simple self-report form for adults to complete before their initial appointment with their practitioner. At DOOR 2, the practitioner elaborates any possible risk areas that the client has indicated on the self-reporting tool, meaning that the practitioner gently explores what the client has meant by reporting the risk. If any risk appears to be significant, the practitioner would undertake a detailed risk assessment with the client at DOOR 3, before planning a suitable response or onwards referral. Importantly, the framework makes a clear distinction in the steps between risk screening and risk assessment: everyone is screened but only those clients with possibly significant risks are assessed.

By using the three-part framework, practitioners distinguish between clients presenting with normative stresses and those presenting with high risk indicators (McIntosh & Ralfs, 2012b). In practical terms, practitioners do this by having the opportunity to explore their clients’ answers to up to 100 evidence-based risk questions, which clients have typically completed immediately before meeting their practitioner, potentially in consultation with DOOR 3 resources. Doing this allows practitioners to explore any patterns of risk that might need further assessment before they meet with the client(s). Using client self-report rather than practitioner interview is highly efficient because clients can typically do this in fifteen minutes, whereas answering the questions through practitioner interview would typically take 90 minutes.

**Rationale and research question**

Several presentations and publications have described organisational, practitioner and client experiences of ‘doing DOORS’ at Relationships Australia Tasmania and RASA (Kelly, French & Lee, 2017; Kelly & Lee, 2018; Lee & Ralfs, 2015; 2016; 2017), with numbers of DOORS completed across the world now reaching over 30,000. However, published analyses of clients’ responses have so far focused on large samples of family law clients (McIntosh, Wells & Lee, 2016; Wells, Lee, Li, Tan & McIntosh, 2018). Importantly, over 10,000 clients have completed a Family DOORS tool for services other than post-separation services (namely outside mediation, children’s contact services and family law services which would have used FL-DOORS tools). This provides the rationale for exploring a non-family law population, namely, all clients who presented for Family and Relationship Services (FARS) at RASA.

The research question for the present study builds on several premises. Firstly, it’s likely that clients may have significant risks in addition to their presenting issues when they come to FARS appointments provided by FRSA members. Secondly, it’s likely that they are not being pro-actively screened for risks despite the high prevalence and the numerous top-down requirements to screen. Thirdly, the sector has a freely available risk management framework tool that has already been applied many thousands of times with counselling clients. Lastly, this will be the first published and presented study analysing DOORS in everyday practice in non-family law services. Therefore, our research questions are: what risks are reported by clients in everyday practice who are screened with DOORS as part of relationship counselling compared to the equivalent family law service? Will we see significant levels of risk that would otherwise be unreported or undetected, had practitioners not purposefully asked key risk questions?

**Method**

**Participants**

The participants in this analysis were the full population of adult RASA counselling clients who commenced as new adult clients between February 2017 to November 2018. The Family and Relationships Service (FARS) at RASA is a generic Commonwealth Department of Social Services (DSS) funded relationship counselling service for individuals, intimate partners and families to work on problems related to relationships. Clients received a face-to-face service at one of ten organisational outlets or as part of outreach at a smaller host venue. All clients completed the pilot paper version of MyDOORS which was later used in the electronic version of the Family DOORS (namely the Family DOORS app).
RASA's privacy policy allows for use of de-identified client information for service evaluation purposes. All participants were made aware of this policy and agreed to the use of data.

**Procedure**

Clients undertook DOOR 1 as part of their intake appointment at RASA FARS. Typically, clients were asked to arrive at their appointment 30 minutes early 'to complete registration forms' before their scheduled face-to-face appointment with their FARS practitioner. If the clients were a couple or intimate partners, they were asked to sit separately and to complete their DOOR 1 in private. Once DOOR 1 was completed, the practitioner was notified that the client(s) were ready to begin their face-to-face session with the practitioner. The practitioner reviewed the client’s DOOR 1 responses before meeting him/her/them or read the DOOR 2, which contains guidance on potentially risky responses and suggested strategies. The practitioner then took the DOOR 1 results into the room to begin engagement, elaboration and risk assessment if necessary.

**Population demographics**

Data from a total of 675 unique and individual clients were used in the research exercise, with 460 of these clients having dependent children and 211 not having any dependent children. Those clients with dependent children completed additional questions. The relationship(s) between parents/carers and dependent children were: 58.8% were mothers (only); 31.4% were fathers (only); 2.9% both fathers and stepfathers; 2.7% both mothers and stepmothers; and 4.2% were in another type of relationship(s). Genders of clients were 38.5% male, 61.3% female and 0.3% neither male nor female. In terms of culture, 3.8% of clients said they were Aboriginal or Torres Strait Islander or both. Exactly half (50.0%) of clients were married or in de facto relationships; 29.0% were separated or divorced; and 17.9% were single or not in a relationship. The three most common presenting issues named by clients were: relationships assistance (61.9%); mental health (28.9%); and child’s coping (26.1%).

**Results**

In family law matters, attention is often directed first at the potentially high-risk indicators of the ‘big five’ safety risks: familicide, suicide, family violence, child abuse or neglect, and child abduction (Mcintosh & Ralfs, 2012b, p.4). Therefore, examining these for FARS relationships counselling clients, Table 1 shows DOOR 1 items which need elaboration by the practitioner to explore possible indicators of these ‘big five’ risks.

The figures in Table 1 show significant levels of risk across many indicators in addition to domestic violence. The figures also confirm the gendered nature of domestic violence, with women 4.0 times more likely to be protected by an intervention order than men; and men were 5.7 times more likely than women to be the defendant in an intervention order.

Table 2 compares the levels of risk and potential harm with those in FDR at RASA on several key items.

### Table 1. Items to elaborate for possible ‘Big five’ risks in relationship counselling

<table>
<thead>
<tr>
<th>DOOR 1 items</th>
<th>N</th>
<th>Yes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Familicide:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Currently afraid for own safety because of partner, ex-partner or someone else</td>
<td>575</td>
<td>10.3%</td>
</tr>
<tr>
<td>• Partner, ex-partner or other parent thought of suicide</td>
<td>571</td>
<td>19.4%</td>
</tr>
<tr>
<td><strong>Suicide:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ever thought of suicide</td>
<td>604</td>
<td>34.1%</td>
</tr>
<tr>
<td>• Currently thinking of suicide</td>
<td>567</td>
<td>9.5%</td>
</tr>
<tr>
<td><strong>Family violence:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Police called, criminal charge laid or criminal justice involvement due to behavior of partner, ex-partner or other parent</td>
<td>604</td>
<td>11.4%</td>
</tr>
<tr>
<td>• Police called, criminal charge laid or criminal justice involvement due to own behaviour</td>
<td>568</td>
<td>4.6%</td>
</tr>
<tr>
<td>• Intervention order currently protecting from partner, ex-partner or other parent</td>
<td>598</td>
<td>2.8%</td>
</tr>
<tr>
<td>• Intervention order currently protecting someone else from self</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child abuse or neglect:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Child protection report made about child/ren</td>
<td>401</td>
<td>11.7%</td>
</tr>
<tr>
<td>• Current child protection investigation into child/ren</td>
<td>398</td>
<td>2.8%</td>
</tr>
<tr>
<td><strong>Child abduction (separated parents only):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other parent threatened or actually withheld child far beyond agreed time</td>
<td>283</td>
<td>22.3%</td>
</tr>
<tr>
<td>• Parent him/herself threatened or actually withheld child far beyond agreed time</td>
<td>281</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

Note: No single screening item alone can predict risk with certainty but endorsement of an item along with many others indicate a need for elaboration and possible risk assessment with professional to decide if the risk is a high risk indicator. FARS population is 675 clients depending on question asked.
Table 2. Comparison of relationship counselling and Family Dispute Resolution

<table>
<thead>
<tr>
<th>DOOR 1 items</th>
<th>FDR (%)</th>
<th>FARS (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Familicide:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently afraid for own safety because of partner, ex-partner or someone else</td>
<td>21.7%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Partner, ex-partner or other parent thought of suicide</td>
<td>24.8%</td>
<td>19.4%</td>
</tr>
<tr>
<td><strong>Suicide:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever thought of suicide</td>
<td>21.5%</td>
<td>34.1%</td>
</tr>
<tr>
<td>Currently thinking of suicide</td>
<td>3.5%</td>
<td>9.5%</td>
</tr>
<tr>
<td><strong>Family violence:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police called, criminal charge laid or criminal justice involvement due to behavior of partner, ex-partner or other parent</td>
<td>33.9%</td>
<td>18.0%</td>
</tr>
<tr>
<td>Police called, criminal charge laid or criminal justice involvement due to own behavior</td>
<td>12.8%</td>
<td>11.4%</td>
</tr>
<tr>
<td>Intervention order currently protecting from partner, ex-partner or other parent</td>
<td>6.9%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Intervention order currently protecting someone else from self</td>
<td>6.0%</td>
<td>2.8%</td>
</tr>
<tr>
<td><strong>Child abuse or neglect:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child protection report made about child/ren</td>
<td>13.1%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Current child protection investigation into child/ren</td>
<td>2.2%</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

Note: FDR population is 2,977-3,818 clients and FARS is 675 clients depending on question asked

Broadly, Table 2 shows that risk levels for FARS are comparable to FDR for the potential harm to children, lower for family violence, but higher for suicide risk.

DOOR 1 also includes many items which act as if they are ‘intensifiers’. These items are indicators of heightened risk. This means that other identified risks, which without the presence of the intensifier may appear ‘risky,’ are actually likely to be ‘very risky’. For example, a domestic violence risk becomes very risky if a client also reports their former partner is using alcohol or drugs in a worrying way and these behaviours are becoming worse or more frequent; or a suicide indicator risk becomes very risky if a client also says he/she is humiliated by the separation and has recently been behaving out of character. Further examples of ‘intensifiers’ are shown in Table 3.

Table 3. Intensifiers in relationship counselling

<table>
<thead>
<tr>
<th>DOOR 1 items</th>
<th>N</th>
<th>Yes (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Escalation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaving out of character in past six months (self)</td>
<td>586</td>
<td>39.6%</td>
</tr>
<tr>
<td>Behaving out of character in past six months (partner)</td>
<td>414</td>
<td>38.6%</td>
</tr>
<tr>
<td>Behaving out of character in past six months (ex-partner/other parent)</td>
<td>191</td>
<td>33.0%</td>
</tr>
<tr>
<td>Other person’s risky behaviours getting worse</td>
<td>507</td>
<td>9.7%</td>
</tr>
<tr>
<td>Alcohol and drug use:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drunk/used more than meant (self)</td>
<td>640</td>
<td>23.4%</td>
</tr>
<tr>
<td>Felt needed to cut down (self)</td>
<td>634</td>
<td>21.3%</td>
</tr>
<tr>
<td>Someone else worried about drinking/drug use (self)</td>
<td>626</td>
<td>11.3%</td>
</tr>
<tr>
<td>Worried about drinking/use of partner</td>
<td>448</td>
<td>17.2%</td>
</tr>
<tr>
<td>Worried about drinking/use of ex-partner/other parent</td>
<td>171</td>
<td>32.7%</td>
</tr>
<tr>
<td>Hostility and hatred in relationships:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often feel hostile/hatred towards partner</td>
<td>439</td>
<td>13.7%</td>
</tr>
<tr>
<td>Often feel hostile/hatred towards ex-partner/other parent</td>
<td>225</td>
<td>19.6%</td>
</tr>
<tr>
<td>Often hostile/hatred towards family members</td>
<td>562</td>
<td>7.8%</td>
</tr>
<tr>
<td>Often harsher towards children than meant to be</td>
<td>383</td>
<td>5.2%</td>
</tr>
<tr>
<td>Emotional flooding about problem:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hopeless/powerless</td>
<td>675</td>
<td>32.0%</td>
</tr>
<tr>
<td>Angry/furious</td>
<td>675</td>
<td>19.1%</td>
</tr>
<tr>
<td>Scared/afraid</td>
<td>675</td>
<td>17.3%</td>
</tr>
<tr>
<td>Embarrassed/humiliated</td>
<td>675</td>
<td>17.2%</td>
</tr>
<tr>
<td>Shocked/devastated</td>
<td>675</td>
<td>11.0%</td>
</tr>
<tr>
<td>Jealous/resentful</td>
<td>675</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

Note: FARS population is 675 clients depending on question asked

There are a number of factors in Table 3 which show many other risks that become more potent for the client or someone close to the client. Specifically, these intensifiers may mean people become more impulsive, reckless or callous in their behaviour towards themselves and others. Most obviously, a client reporting an escalation in behaviour or acting ‘out of character’ may indicate a worrying trajectory.
Alternatively, the emotional state of a client may intensify his/her feelings towards him/herself and anyone close to them or more generally to the likely reactivity or resolution of the problem.

Discussion

Our research question aimed to explore the levels of risk indicators reported in FARS at a mainstream agency where DOOR 1 is used universally with clients as the first step in a risk management process. Clients use FARS to work on intimate partner relationships and family relationship issues; yet many clients report highly significant levels of risk on items in Tables 1 and 3. To recap, we found one in six had police called to domestic disputes; one in seven had child protection notifications made about their children; over one in ten had highly risky AOD use; and one in ten were currently feeling suicidal. FARS clients are disclosing risks at similar levels – or even more often than FDR clients (where risk screening practice is more established typically).

Combining high prevalence with high throughput of clients means a typical relationship practitioner with a typical caseload will see at least one client per day with very worrying use of alcohol or other drugs; and every other day will see at least one currently suicidal client and at least another who is currently scared for his/her safety. Given ‘risks run in herds’, it’s likely that there are many other co-occurring risks in addition to these. Anonymous feedback from relationship counsellors at Relationships Australia Tasmania has shown that learning about these risks with clients in daily practice is very helpful without becoming overwhelming (Kelly, French & Lee, 2017; Kelly & Lee, 2018). This answers our research questions about the levels of risk reported by clients and the utility for practitioners in knowing these risks in advance of meeting their client.

Another aspect of clinical utility for practitioners is about seeing clusters of risk behaviours within a client or between clients (where a practitioner is working with a couple or more than one client from the same family or case). A single response of ‘yes’ to any single DOOR 1 item can never definitively confirm high risk of a lethal outcome, yet clusters of many ‘yes’ responses may raise suspicions for practitioners that they need to explore and possibly assess for high risk outcomes family violence, harm to children, suicidality, and possibly even familicide. In particular, FARS clients often present as couples which means DOORS enables discovery where one person discloses a risky set of behaviours and their partner doesn’t. Where two or more clients in the family have answered the same questions using DOOR 1 then a practitioner can compare, contrast and make sense of a client who is dismissing, denying or simply unaware of their partner’s distress or safety risk.

In this analysis, there were combinations of ‘yes’ responses that showed FARS clients may have potentially dangerous combinations of content domains, risk intensifiers and troubling emotional states, which would not be known to the practitioner without DOORS. For example, one non-parent client’s profile was: resentful about doing counselling; feels hostile towards a current partner; has had risky alcohol use; and has had the police called to disturbances at home because of their own behaviour. Another client profile was a parent who is scared of a previous partner with whom she shares children; is aware of or has made child protection notifications; has been kept from seeing the children by their father; thinks the father is acting out of character and it’s getting worse; however she feels powerless to do anything about the situation. These profiles are possible for a practitioner to ascertain by spending a few minutes reviewing what the client has said ‘on paper’, enabling the relationship practitioner to much more quickly tune into any possible essential elaborations for risk before getting to the heart of the matter. This further demonstrates the utility of ‘doing DOORS’ for the FARS practitioner and answers the research question about value in risk discovery before meeting the client.

From the client perspective, the Family DOORS process of finding out about these potentially risky clusters is efficient and respectful. This typically happens through a client’s self-report of risk (while they are in reception) using either a paper form or – more usually – an app on a tablet. It may include at times sitting separately from a current partner while completing the self-report. Nonetheless, client feedback on the process and experience of ‘being screened’ is nearly entirely positive. An anonymous survey of 97 ‘just screened’ FARS clients confirmed this when it found that 99.0% thought the process was helpful; 89.8% said they were honest in their answers; only 5.1% felt suspicious about the process; and, importantly, 98.8% preferred to disclose sensitive or personal risks on a form rather than tell the practitioner face-to-face. In other words, the process is acceptable to an overwhelming majority of FARS clients and possibly even preferable if clients have high risks. In short, clients are active participants who ‘do DOORS’ rather than passive subjects who are ‘done by DOORS’.

Conclusion

According to large Australian surveys of people who have used services of FRSA member agencies (Kaspiew, Carson, Dunstan, De Maio, et al., 2015), clients using relationship counselling face significant levels of risk to family safety and wellbeing. Those at greater risk are more likely to seek help when attending relationship counselling rather than in isolation through specialist services such as domestic violence services. We also
know that risks such as domestic violence are rarely found in isolation and are likely to co-occur with other risks including the potential to harm a child's development by them having witnessed domestic violence. Finally, a simple way to find out about these risks early in the client's engagement with a service is for the service to use a thorough evidence-based tool like DOORS, the universal risk screening tool that includes the Family DOORS app.

The analyses presented here are taken from the full population of clients presenting for relationship counselling at RASA—a significant strength of this study because it's not a voluntary sample of clients opting into a research project. These analyses have shown that clients typically have a number of risky factors currently affecting their lives. The holistic, whole-of-family approach of Family DOORS shows that both victimisation and perpetration risks are real factors in the lives of clients and their families. Regardless of what the presenting issue actually is that led to a client seeking relationship counselling, knowing about the presence of these other risks for large numbers of clients is essential for relationships practitioners to maximise the outcome of relationship counselling.

Practitioners are helped by knowing about the risks in advance of meeting their clients. Practitioners also benefit from clients being asked the risk questions in a time efficient yet respectful manner now through the Family DOORS app. Clients also benefit from being able to disclose risks without having to do so directly to their practitioner—something which can overcome the embarrassment or even shame that may come from looking someone in the eye and saying “I feel unsafe”.

Based on these results, we conclude that universal screening should be seen as essential in counselling services just as it is in post-separation FDR services.

Endnotes

1 Available at no charge via www.familydoors.com
2 As ratios, for every client who has no violence before separation and uses a relationship service, there are 1.47 reporting physical violence and 1.91 reporting emotional abuse also using services (based on Table 4.2 in Kaspiew, Carson, Dunstan, De Maio, et al., 2015).
3 Key branching questions include the service sought; the presence and ages of dependent children; current intimate relationship; recent separation from a partner; communication with former partners or other parents; disputes with other parties; and non-biological parenting relationships.
4 To illustrate an ‘elaboration’, one client self-reported on DOOR 1 that she had concerns for her children’s safety when they were with their father. When the practitioner met her and asked about this, doing a DOOR 2 elaboration, she said that the children nearly drowned recently when they were with their father. Further ‘elaboration’ revealed how their father had taken them to a duck pond and spent time on his phone rather than watching carefully. Given the children were nearly teenagers and the pond was knee height, the practitioner’s elaboration suggested no risk assessment was necessary due to no risk of supervisory neglect, with no need for child protection notification or referral.

References


