An audit of intake screening and assessment tools used in the family and relationship services sector

SUMMARY REPORT
FRSA acknowledges Aboriginal and Torres Strait Islander peoples as the traditional custodians of this land. FRSA’s vision for reconciliation is that we recognise, respect and value Aboriginal and Islander people and communities in all our efforts to enhance the wellbeing, safety and resilience of Australian children, families and communities.

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Contents

Summary report 2

Background 2
  Why a survey? 2
  Methods 3
  FRSA member organisation survey respondents 3

Survey outcomes 4
  What intake screening and assessment tools and processes are used? 4
  Why conduct intake screening and assessment? 5
  Who conducts intake screening and assessment? 6
  Effectiveness of tools 7
  In conclusion 7

Next Steps 8
  A shared vision 8
  Future investment 8
  Building on existing achievements 8
  Recommendation 8

Case studies
  Case study 1: Centacare New England North West 10
  Case study 2: Anglicare Sydney 12
  Case study 3: Relationships Australia South Australia (RASA) 14
  Case study 4: Ishar Multicultural Women’s Health Centre 16
  Case study 5: drummond street services 18
  Case study 6: Logan Family Relationship Centre (FRC) 21

Attachments
  Attachment 1: Survey—An audit of intake screening and assessment tools used in the family and relationship services sector 24
  Attachment 2: List of survey respondents 26
  Attachment 3: Glossary of screening and assessment tools used by the sector 27
An audit of intake screening and assessment tools used in the family and relationship services sector

BACKGROUND

The development and dissemination of the FRSA members survey titled: An audit of intake screening and assessment tools used in the family and relationship services sector (see Attachment 1) is a significant step in the direction to enacting recommendations made in the FRSA research report: Strengthening prevention and early intervention for families into the future (2017).

The development of the report stems back to 2014, when FRSA invited expressions of interest from our membership to initiate and develop a new body of work with a prevention and early intervention focus. The successful tender applicant was internationally renowned Public Health and Prevention Science expert Professor John Toumbourou at Deakin University. The project is supported by FRSA’s Strategic Projects Fund.

As the lead author, Professor Toumbourou applied a public health lens in proposing the contents of this report and its recommendations for sector-wide and inter-sector discussion. The FRSA Board and particularly the FRSA Research Advisory Committee worked closely with Professor Toumbourou to co-author the report, in order to capture the specific progress and nuances of the family and relationship services sector.

The research report was completed and made publicly available in March 2017. In early 2018 FRSA designed a survey that was circulated to our 165+ member organisations.

A total of 49 member organisations completed the survey—23 in March and a further 26 following a second push-out in July.

Why a survey?

The Strengthening prevention and early intervention research report argues that there is ‘much (untapped) potential for the family sector to contribute to a public health approach incorporating universal and targeted prevention and early intervention strategies to address major health and social problems.’ The report subsequently recommends, as part of a systematic approach to prevention and early intervention, that a framework and tools for a common intake measure comprising valid indicators of health and social problems, as well as protective risks, be developed. Before such a framework could be considered, it was important for FRSA to identify what intake screening and assessment tools our members are already using.

It is generally acknowledged by our member organisations that it is essential to screen and assess clients at the onset of service delivery.
The research report identifies the importance of intervening early at times of vulnerable transitions, in order to prevent or reduce snowball risk trajectories. While family and relationship service providers use a large number and range of screening and assessment tools and processes, these have not been fully identified or quantified.

The report acknowledges that valid screening measures have been used in some health services to target early intervention programs for alcohol and drug use. Tools have also been developed specifically for the delivery of family law services, such as the Detection of Overall Risk Screen (DOORS). A valid and comprehensive assessment framework and tools for measuring priority health and social problems and their risk and protective factors are currently used in Australia for community planning for child and adolescent services, and a version of this instrument has been designed for adults.

There is also variation in how the family and relationship services sector decides on service allocations. For instance, Drummond Street in Victoria utilises information collected at intake to assess family risk factors, and this information is used to refer appropriate clients to family mental health support.

The family and relationship services sector in Australia has a number of areas of strength that are compatible with an expanded role in prevention and early intervention. One of our sector’s strengths is well-developed expertise and resources, including existing intake screening and assessment tools, that can be expanded into additional domains to achieve recruitment, engagement, alliance building and sustained therapeutic change working with a range of families.

The development and trial of a sector-wide, common assessment tool/s or framework are two of the four recommendations made in the research report—the four recommendations being:

1. develop a national action plan to increase family and relationship-based prevention and early intervention services;
2. develop a common intake screening and assessment framework and tools;
3. trial this framework and tools; and
4. obtain capacity building funding.

The report argues that a valid assessment framework and tools for monitoring indicators of risk and protective factors are required if the aim of intervening early to prevent health and social problems is to be achieved. The availability of an integrated intake screening and comprehensive assessment framework and tools would assist therapeutic efficacy by providing a framework for monitoring service systems. It would harness the public health potential of the family and relationship sector to make an increased contribution to the delivery of universal and targeted prevention and early intervention services. The report also acknowledges that improving intake screening in the sector would require a review of existing practices and the identification of valid frameworks and tools for identifying a more comprehensive range of priority health and social problems and the modifiable risk and protective factors listed above—toward delivering the right type and amount of services to meet clients’ needs.

Methods

In asking FRSA member organisations about the tool/s and approaches they use when conducting (1) intake screening and (2) assessment, the survey used the following two definitions that are provided in the research report:

- **Intake screening** refers to the process services use from first contact with the family to identify the type and intensity of interventions required.
- **Assessment** refers to the appraisal of a range of risk and protective factors at the individual, family and community level, in order to inform prevention and early intervention service allocation.

Whilst the survey had several open-ended questions, which provided respondents an opportunity to respond to some questions in a narrative form, it became very clear through this process that there was a high degree of diversity in the sector regarding intake and assessment processes. As such, several case studies were sought from the membership—post questionnaire phase—to demonstrate a number of applications in use across the sector. These are provided at the end of this report (and referenced throughout this report itself).

FRSA member organisation survey respondents

The survey was completed by 49 FRSA member organisations that deliver a range of federally funded family and relationship services. As well as several larger, multi-services organisations...
located in more than one state or territory, the survey was completed by a number of smaller, specialised organisations. See Attachment 2 for a list of participating organisations.

Thirteen of the 49 respondents indicated they only deliver one federally (DSS) funded service or program. The other 37 organisations indicated they deliver multiple, with ten indicating they deliver more than three (3) programs, 12 delivering more than five (5) and two (2) delivering more than ten. While Family Dispute Resolution (FDR) services, Regional FDR services and Family and Relationship Services (FARS) are delivered by a large number of our members, the full suite of DSS funded services include:

- Children and Parenting services
  - Children and Parenting Support
  - Intensive Family Support Services
  - Child Support Advocacy
  - Kids in Focus
  - Family and Relationship Services
  - Specialised Family Violence Services
  - Family and Relationship Support Services to support Intercountry Adoption Family Support

- Family Law services
  - Family Relationship Centres
  - Children’s Contact Services
  - Supporting Children after Separation Program
  - Parenting Orders Program
  - Family Dispute Resolution
  - Regional Family Dispute Resolution
  - Family Relationship Advice Line
  - Family Law Counselling (under FARS)

- Adult Specialist Support services
  - Find and Connect Support Services
  - Royal Commission community based support services
  - Forced Adoption Services

- Other
  - Communities for Children Facilitating Partners
  - Financial Counselling Services
  - Family and Domestic Violence Services
  - Men’s Services
  - Youth Services
  - Aged Services
  - Drug and Alcohol Services
  - Community Mental Health Services
  - Settlement Engagement and Transition Support (SETS)

A majority (35 of the 49) of member organisations who completed the survey indicated they also deliver state-funded programs, whereas 14 do not.

**SURVEY OUTCOMES**

**What intake screening and assessment tools and processes are used?**

All respondents indicated they use intake screening tool/s on initial contact with service users (for example, during the first inquiry phone call to an agency from a potential service user or the first meeting upon referral from another agency).

Numerous respondents specified they developed the intake screening tool they use in-house, which can comprise blending their own informal approaches with formal validated tools developed by other organisations (see for example, Case study 1: Centacare New England North West).

They indicated the intake screening tool/s they use for initial contact with a service user are (respondents could select more than one response):

- Tool/s developed in-house (43 respondents)
- Informal approach, such as telephone conversation, with contact or other details passed on to others in the organisation (26)
- Formal validated tool/s, e.g. Kessler Psychological Distress Scale (K10), Life Skills Profile (LSP-16), Parenting Scale, Social Conduct Scale etc. (14)
- Tool/s adapted from tool/s developed by another organisation (12).

Several respondents indicated they had selected more than one option, with one respondent explaining that they initially screen during the first phone call with the new client, and then later complete a full screen using DOORS during the face-to-face interview (see Case study 2: Anglicare Sydney).

When asked what tool/s they use to assess risk and to inform their service provision in the programs or services they offer (e.g. AEDC for early childhood services; Family DOORS for Family violence screening and risk assessment, etc.), respondents identified several different tools. More than one respondent identified they use the following tools: CRAFT related tools (9 respondents); DOORS (9);
Why conduct intake screening and assessment?

Identifying social and health problems

All respondents indicated they use their intake and assessment tools to identify at least a few social and health problems facing clients. The main problems screened, in descending order, are:

- Domestic/family violence (48 respondents)
- Mental illness (48)
- Substance abuse (45)
- Child neglect/abuse (43)
- Antisocial behaviour, including other forms of violence and crime (30)
- Social exclusion, e.g. lack of meaningful and constructive social and economic participation (27)
- Developmental injury, e.g. foetal alcohol problems, child neglect/abuse etc. (25)
- Chronic illness, including preventable Type 2 diabetes, cancer, cardiovascular disease, asthma, allergies (25)
- School failure, including leaving school and not participating in further education (18)
- Obesity (4).

Forty respondents think the intake screening and assessment tools they use are effective in identifying the above listed social and health problems facing service users, four (4) do not and five (5) are not sure.

Identifying protective factors

Tools used by family and relationship service providers are also used to identify protective factors. Respondents indicated their assessment tool/s attempted to measure the following protective measures: social connections (41 respondents); social and emotional skills (33); safe, stimulating and healthy environments (33); warm attachment and/or positive role models (30); and religiosity and civic engagement (15). Four (4) respondents indicated their assessment tool/s do not attempt to measure any protective factors, and several respondents elaborated on aspects of protective factors their tool/s attempt to identify, including that associated with mental wellness, resilience, and social supports (friends, family, etc). One respondent commented that the initial interview, and not the tool/s used, identifies protective factors, and another respondent said that the extent to which protective factors are identified depends on the tool/s used for each service or program delivered.
How information collected is used

There are various ways the information collected from the intake screening and assessment tool/s is used, including (from most to least prevalent):

- to identify risks facing service users (46 respondents);
- to make referrals to other services/programs in your organisation (45);
- to make referrals to external services/programs (44);
- to identify service required (42);
- to identify the strengths or protective factors professionals can build on in targeted programs or interventions (33);
- as a pre-program assessment/baseline tool for individual service users (31);
- for mandatory reporting (30);
- for continuous improvement (29);
- to identify the amount of service (the ‘dose’) required (28); and
- as a pre-program measurement for program evaluation (20).

Other purposes that were identified in respondents’ optional comments included ‘to design the mediation process’, ‘to combine with pre- and post-evaluation tools’ and ‘to assess suitability for service’.

Reporting to Government

FRSA member organisations were asked in the survey how useful the information gathered from intake screening and assessment tool/s is for DEX and SCORE reporting requirements. Half (24) of respondents selected ‘somewhat useful’, while 18 selected ‘very useful’ and seven (7) selected ‘not useful at all’. One respondent who selected ‘not useful at all’ commented ‘the issue is not our tool rather we do not find DEX useful and only fill in for reporting purposes … staff need to undertake our assessment and then we fill in DEX’. One made the comment that usefulness ‘varied in different program areas’. One respondent elaborated ‘The DOORS family of tools helps identify which SCORE Circumstance to address … the information can’t be used in outcomes in SCORE because the translation matrix doesn’t include the FL DOORS (for family law services) or MyDOORS (for counselling and case management services)’. Several respondents indicated they were unsure as to the usefulness of their tool/s for DEX and SCORE reporting requirements as they had not yet reported in DEX and SCORE.

Who conducts intake screening and assessment?

Respondents identified that the following staff conduct intake screening for the delivery of their service/s or program/s:

- designated professional staff, such as program managers and family support workers (33 respondents);
- all staff involved in direct service delivery (21); and
- general staff, for example, receptionist (15).

Respondents reported that the following staff conduct assessments of clients in the delivery of their service/s or program/s:

- designated professional staff such as program managers and family support workers (36 respondents); and
- all staff involved in direct service delivery (24).

One respondent commented that it is ‘registered and provisional psychologists’, one indicated ‘family relationship advisors’, one indicated IT IUS general staff (for example, receptionist) and one indicated they use self-assessment sheets that clients complete.

Intake screening and assessment: Minimum skills/qualifications

There was mixed response to the minimum skill or qualification required for staff to conduct intake screening and assessment. In regards to conducting intake screening, 18 respondents selected a minimum of ‘Degree or higher’ is required, 10 selected ‘on the job training’, ten selected ‘Certificate III or IV’, nine selected ‘Diploma’ and two selected ‘informal training’. Several respondents made the comment that it ‘depends on the program area’, one commented the minimum requirement is the member of staff being ‘registered or provisionally registered with the Australian Health Practitioners Regulation Agency (AHPRA) and one said ‘intake requires the base line of this skill, ongoing on the job coaching and support of a qualified practitioner who is within the Intake area’. One respondent said, ‘initial Intake screening (on the job training) otherwise a
diploma’ and another said, ‘all practitioners needs a Bachelor degree in a relevant discipline, there is also in-house training’.

**Conducting assessments: Minimum skills/qualifications**

In regard to qualifications for conducting assessment, ‘Degree or higher’ was the most prevalent response (28 respondents), followed by ‘Diploma’ (12), ‘Certificate III or IV’ four (4), ‘on the job training’ four (4) and ‘informal training’ one (1). Several respondents also made the comment that it depends on the program area, and again one respondent said staff being ‘registered or provisionally registered with AHPRA’ is what is required.

The majority of respondents (29) believe the level of training provided to their staff in the use of intake screening tool/s and assessment tools is ‘adequate’, while 14 believe it is ‘more than adequate’, four (4) believe it is ‘inadequate’ and two (2) selected ‘unsure’. One who selected ‘adequate’ made the comment ‘adequate, but with room for improvement’ and another respondent similarly reflected ‘further training is always important’. One respondent who selected ‘inadequate’ made the comment ‘we have invested in a specific project manager to improve our risk assessment staff training and resources so that this improves’.

**Effectiveness of tools**

Most respondents indicated that the tools they use are suitable for identifying risk factors facing the children and families they serve (see Case study 4: Ishar Multicultural Women’s Health Centre, which outlines tools used that are culturally sensitive to the children and families accessing Ishar services).

About 80 per cent of respondents think the intake screening and assessment tools they use are effective in identifying social and health problems facing clients; the other 20 per cent think they are not or are unsure. Over 90 per cent of respondents perceive the tools they use identify a range of protective factors for clients. Respondents also identified various ways of using information about risk and protective factors, with the most prevalent being to identify risks facing service users; make referrals to other services/programs within their own organisation; make referrals to external services/programs; and identify services required. However, the survey did not specifically ask whether identified needs would or could be met (whether that be through internal or externally referred prevention/early intervention or specialised support).

For an example of the use of intake screening and assessment tools to provide clients with a more integrated service see Case study 5: drummond street services.

**In conclusion**

All 49 respondents identified that they use some form of intake screening tool/s on initial contact with service users and assessment tools during subsequent contact. A large variety of tools were identified, including tools that are a blend of formal validated tools and the organisations’ own preferred approaches to working with clients. Respondents identified a total of 36 different tools, with this number not including tools developed in-house. However, some of the tools identified, including DEX and SCORE—which are platforms for outcomes reporting developed by the Australian Government Department of Social Services—are not intake screening and assessment tools.

The main social and health problems identified through intake and assessment tools are domestic/family violence, mental illness, substance abuse and child neglect/abuse. This indicates that family and relationship services have a key role to play in the early identification of, and early response to, at least some significant social and health risks facing families. This further suggests there is a case for family and relationship services, at both universal and targeted levels, to be more overtly integrated into a public health approach to address these, and other, serious health and social issues (see Case study 6: Logan Family Relationship Centre, which has extended its comprehensive screening and assessment tool to reflect the range of factors in FRSA’s *Strengthening prevention and early intervention services for families into the future* report applying a broader public health approach).
NEXT STEPS

The *Strengthening prevention and early intervention* research report recommended the development of a comprehensive framework and tools for family intake screening and assessment across eight priority health and social problems. The report asserts that a common approach would demonstrate that services are identifying early signs and risks of key social and health problems and would assist service evaluation.

The survey findings outlined in this report suggest that many services are indeed using evidence-informed tools to identify early signs and risks, but at varying levels of sophistication. The effectiveness with which screening and assessment tools identify problems and risks can at best be evaluated on an organisational or program level, not a whole-of-community level.

How then, would FRSA seek to enable sufficient commonality in the early identification of, and response to, priority health and social issues leading to the achievement of (measurable) whole-of-community outcomes?

A shared vision

Any systems change across our sector needs to be built on:

- a shared vision for improved outcomes for children and families; and
- shared responsibility for vulnerable children and families and shared accountability toward achieving improved outcomes.

When that vision is supported by a culture of collaboration and trust, sector-wide take-up of a common screening and assessment framework has a chance to occur.

Future investment

Development of a shared public health approach to family intake screening and assessment will require significant investment in stakeholder engagement, planning, data collection, resource development and sector capacity building.

Building on existing achievements

While the survey revealed an uneven approach to the use of intake screening and assessment tools, the case studies illustrate just some examples of good practice and innovative ways of managing intake and assessment across a range of services and with diverse client groups. Development of a comprehensive framework should build on (rather than replace) what is already working and ensure enough flexibility to meet the needs of different families and communities.

Recommendation

FRSA recommends that with our members and broader network, we further explore the opportunity for family and relationship services to take a more coordinated public health approach, with a prevention and early intervention focus, through:

- developing an action plan to deliver a more coordinated, public health approach to intake screening and assessment, including a common approach to intake, assessment, risk and protective factor identification; and
- identifying the potential for cross-sector collaborations, including the expansion of prevention and early intervention services.
Endnotes


CASE STUDY 1
Centacare New England North West

IN-HOUSE SCREENING TOOLS DEVELOPED TO RESPOND TO HOLISTIC NEEDS

Fallon Roberts
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Centacare New England North West

Centacare New England North West has developed in-house screening tools to respond holistically to clients engaged with its Legally Assisted and Culturally Appropriate Dispute Resolution program. This tool screens and assesses for a range of risk and protective factors across various domains including education, employment, mental health and suicidality, family violence, connectedness to family and culture, child protection, drug and alcohol, family relationships and communication, and previous engagement with other services and/or legal matters.

The tool is generally delivered through a narrative assessment based on the client telling their story and practitioners then putting the information they receive into the context of the tool and exploring further areas where clients may require supports. Through this process, initial screening can lead to further screening, with more specific tools. For example, if family violence is identified this is then assessed and monitored through the DVSAT which is an external tool used by local domestic violence services and police. Intake and assessment tools are delivered by practitioners with a wide skillset; many have tertiary qualifications in a range of fields, others have a wealth of experience in engaging with diverse communities. All staff are supported by management and teams to become proficient in using internally developed screening tools and are offered training to use externally developed tools, such as the DVSAT.
Client case study

A young mum, Jenny, approached Centacare seeking mediation. She had recently left a relationship and was having no contact with her two-year old daughter who had remained living with her father. Jenny was homeless and experiencing depression and anxiety, with recent thoughts of suicide.

While completing Centacare NENW’s Request for Service form we were able to identify various risk factors that would require a high level of support. Jenny was referred to support services and booked in for an urgent Intake and Assessment meeting with a Mediator.

By utilising our internally developed Mediation Intake and Assessment tool a number of reports/incidences of family violence in multiple forms during the relationship and post-separation were shared by Jenny with the mediator.

Staff worked closely with the local Women’s Refuge and domestic violence services to have Jenny referred to specialist support, as well as to support her to find accommodation. Given that we were preparing to bring Jenny and her former partner together for mediation, Centacare staff also monitored the escalation of risk to ensure family safety.

Engaging dad (Bob) was difficult. It took over a month to build rapport with him as he had a distrust of services. When we met with Bob for his Mediation Intake and Assessment, he informed us that he could not read or write. To overcome this barrier, we did not complete any paperwork at this session and instead conducted an initial assessment on a narrative basis. We identified that he was engaging in problematic drinking, experiencing financial hardship and struggling with anger and depression as he was adjusting to life as a single parent. Bob was reluctant to engage in any kind of counselling service, so his Mediator checked in with him via weekly phone calls, simply to have a chat. After several weeks Bob admitted to his Mediator that he was having a hard time and agreed to work with our Education Facilitator to strengthen his parenting skills and knowledge. He also started contacting our service regularly to update us on his progress or to simply talk if he was feeling frustrated or overwhelmed.

By this time, mum was also doing better. She had successfully secured a rental property and was feeling stronger.

As noted above, screening for safety was critical in considering whether Jenny and Bob would be suitable for mediation. Upon review, the mediators brought the two parents together for two legally assisted shuttle mediation sessions, where they were supported to develop interim parenting arrangements that would allow Jenny to have contact with her daughter safely.

Jenny’s ultimate goal was that their daughter lives with her. Unfortunately, this issue could not be resolved through mediation; however, Jenny and Bob who had now established rapport with their respective lawyers used during the legally assisted mediation process were able to continue to work with their lawyers through court.

Jenny reported feeling in a much stronger position after mediation and continued to engage with support through domestic violence services.

Dad returned to our service and completed all our parenting workshops over the next twelve months. He reported an improved relationship with his daughter along with better co-parenting skills. Dad has even referred people experiencing difficulties in their family relationships to our service.
Context

Anglicare Sydney, Community Services, delivers a range of programs across four broad practice areas (see chart below). This case study focuses on the Counselling, Mediation and Youth Services (CM&YS) practice area. Programs delivered in this practice area include Family Relationship Centres, Post Separation Cooperative Parenting Service, Family Law Counselling, Family and Relationship Services, Men’s Behaviour Change Program, Reconnect, and other state funded counselling programs.

Anglicare Sydney, community service practice areas

Intake and assessment

Drivers that have informed the design of CM&YS intake and assessment include person centred care, using a safety lens, geographic context and technology.

Person Centred Care

When a potential client contacts Anglicare CM&YS they usually start with a phone call to ask for a specific service. A typical request may be: “I’d like to make a counselling appointment please”.

Intake calls are managed by the client services team. Intake workers are trained to ask for a range of information before offering a specific appointment, so that callers can be offered the most appropriate services for meeting their needs. After obtaining the necessary consents and explaining privacy and confidentiality, the intake worker asks the caller about the concerns that led to them make contact with Anglicare. After clarifying this, the intake worker is well placed to help the caller access the most helpful service or services, whether within Anglicare or elsewhere. The intake worker continues to ‘hold’ the fact that the caller is enquiring about a particular service (such as counselling) but is also able to factor in other intervention or program types that might benefit the caller. For example, a client who has been referred to counselling may also require stabilisation of issues like housing or material wellbeing. The client services team staff are encouraged to keep a wide lens in the initial stages of the intake with a view to narrowing the lens to a specific service type.
or referral by the conclusion of the call. Anglicare’s processes ensure that clients can access multiple services through internal referrals and without needing to go through an Intake process more than once.

Using a safety lens

Questions on Anglicare’s intake form are designed to screen for major risks in relation to concerns for self and others. Specific questions are asked about suicidal ideation, family and domestic violence and, where children are involved, child protection. Significant concerns can then be addressed. All counselling and post separation program staff administer the Detection of Overall Risk Screening (DOORS) tool at the client’s initial face to face appointment with a clinician. This first session is an assessment session focussed on clarifying goals and considering safety concerns. The information that the DOORS tool generates greatly assists with this process.

Client case study: How use of the DOORS tool helps Anglicare keep clients safe

This example comes from a program that works primarily with adolescents. A parent had made contact in order to secure a counselling appointment for a teenage daughter. The first session was conducted with the mother who was invited to complete the DOORS tool. Through this process, the mother identified that she had suicidal ideation and there were also indicators of family violence. The mother clearly communicated: ‘I haven’t come to talk about myself, I just want you to work with my daughter’. However, the DOORS information gave the counsellor an opportunity to very quickly identify significant factors in the young person’s family system that impacted both parent and daughter. This enabled Anglicare to work with the parent to meet her needs for support and assistance through other referrals, and to ensure that support for the daughter was not undertaken in isolation from the family system. In Anglicare’s experience, it is not uncommon that a child’s problematic behaviour is perceived by parents as the primary issue to be addressed, when the actual underlying issues relate to a troubled family system. Context is critical to understanding—had the DOORS tool not been used this information may not have been revealed so early in the process, if at all. If you don’t ask you may never know!

Geographic context and technology

Anglicare Sydney’s CM&YS cover a relatively large geographic footprint with services from the lower south coast of NSW through to the Illawarra, Sydney & Suburbs and the Northern Inland region. Operating with a one size fits all model doesn’t work across regional, metro and city-based contexts. For this reason, the intake model is ‘regionalised’ with capacity for ‘centralised’. Client services teams are in four locations that represent the spread of service delivery. Athena Penelope is used as the client management system. The intake form is embedded in Penelope and functions as the guide for how an intake conversation is conducted. Conditional questions are used for the safety related queries which allows for follow up questions to be used but only when relevant. The regional teams have a solid knowledge of the internal Anglicare program types and the external referral options that are specific to a geographic context. The telephone system is designed so that wherever possible the client’s call is answered by the team closest to them and a complete intake undertaken in the first call. If for any reason the call can’t be taken in that location it will flow over to one of the other teams. In this way the call can still be attended to and the client supported to access the services they need with a quick follow up by the local team to ensure appointments are booked. There have been many conversations about whether a fully centralised model would work however the main deficiency identified in a centralised model is the capacity of a team of workers or systems to ‘hold’ the knowledge required to have a depth of understanding about good referral options for any one location.

Conclusion

Anglicare’s intake system is being continually reviewed and improved. It provides important consistency in service delivery, facilitating the organisation to provide a level of professional support and oversight based on a common language and set of understandings. The capacity to use our staffing resources across the whole practice area gives significant organisational efficiencies. Clinicians are receiving a standardised but flexible range of initial information with screening becoming ‘deeper’ at the first face to face session. Keeping the client at the ‘heart’ of what we do ensures that the technology is used as our servant and not our master, and that obtaining a holistic view of the client in their world is prioritised. Keeping a safety lens also ensures that issues that require prompt attention or support for the client are known at the earliest opportunity.
Overview of the Family DOORS

The ‘Detection Of Overall Risk Screen’ (DOORS) is a simple, practical, and flexible standardised frontline framework. DOORS supports practitioners to identify, evaluate and respond to safety and wellbeing risks and, uniquely, screens both violence victimisation and perpetration risks and appraises risks for infant and child development.

The DOORS is a three-part screening framework. DOOR 1 is a standardised Parent Self-Report Form, or questionnaire covering 10 domains of risk, including child and parent wellbeing, cultural and social risks, and safety risks. DOOR 2, Practitioner Aide Memoire, takes responses from DOOR 1 and identifies areas of risk endorsed by parents that require further enquiry. Prompts are provided to assist the practitioner effectively and thoroughly elaborate identified risks with the parent. DOOR 3, Resources for Responding to Risks, provides resources for understanding case aetiology and support for conducting further risk assessments, if required.

It originated as the Family Law DOORS, designed by Professor Jennifer McIntosh (currently Deakin University) in partnership with Relationships Australia South Australia (RASA) with funding from the Commonwealth Attorney General’s Department. More recently, DOORS has expanded its scope outside of family law and now Family DOORS has a counselling, case management and community services version called MyDOORS. It is also available as a free-to-use App that is being used across family services.

Evidence of the Family DOORS Effectiveness

DOORS is the first externally validated instrument of its kind. Recent and large-scale validation studies of DOORS have demonstrated that the DOORS provides a robust framework to screen, elaborate and assess for safety and wellbeing risks.3 4

There are 11 distinct and meaningful domains of risk. This highlights the importance of holistic screening and suggests that if practitioners only ask clients about one category of risk, they may not accurately identify (or recognise) presenting safety concerns.

The safety concerns that clients report in the DOORS reflect objective markers of safety. Client self-report predicted at least one professional’s decisions about risks in the case. For example, a police officer drafting an intervention order, or a practitioner making a child protection notification. This suggests that self-report reflects objective markers of safety.

Parents broadly corroborate each other’s story on DOORS risk domains. When one parent in a dispute reported feeling unsafe (i.e. a high risk of victimisation), the other parent was highly likely to report unsafe behaviour (i.e. a high risk of perpetration). This was another important finding, given some practitioners see only one parent presenting for a service, and may need to consider risk to the other parent and/or the children in the absence of corroborating material.
Brief DOORS risk domains linked strongly to longer, detailed ‘gold standard’ measures. These include measures of child distress, parental responsiveness, coping, negative emotions, drug use, and infant distress. This suggests that it was just as effective as other well-established measures, but more efficient.

Important findings about the Family DOORS

It is not long or complex

A full DOOR 1 contains 10 domains, totalling 109 questions, only takes around 15 minutes to complete, and facilitates synthesis of a large amount of complex information. Some domains mightn’t need to be completed, such as the infant domain for clients without infants.

Client attitudes to being screened

It is often reported that clients will not want to complete forms and will be ‘put off’ by structured questionnaires. For many people the opposite is true. RASA conducted an anonymous survey with 141 “just screened” clients, 68.3% of whom said, “it’s easier to disclose sensitive information on a form than face-to-face”, and 95.8% who said they were “completely honest when filling out the forms”. In addition, client satisfaction with RASA services did not decline during this time.5

Child and infant wellbeing

Children’s safety and wellbeing is often regarded as ‘out of scope’ for programs that are not about parenting or children. Parents of dependent children frequently use family services that are not directly focused on children or parenting. As with family violence, risks to infant and children’s safety can easily be missed if practitioners don’t ask appropriately,6 or don’t ask at all.7

Surprisingly, recent analysis of RASA client data from DOOR 1 revealed that parents who were not using our parenting/children’s services had more parenting stress than those who were using our parenting and children’s services (with ‘harshness’ being the most common stress). Importantly, there were no differences in the level of children’s distress (or, children were equally distressed)8 indicating that screening for risks to children’s wellbeing even when their parents are not using parenting or children’s services is an opportunity to prevent and reduce harm to children.

Conclusion about the Family DOORS

FRSA recommended ‘the development of a framework and tools for a common intake measure providing valid indicators of health and social problems and the modifiable risk and protective factors that influence their development’.9 The Family DOORS is an example of a framework being used by several family services. The Family DOORS enables practitioners to enquire about the constellation of wellbeing and safety risks that affect people seeking help from family services.

The Family DOORS, grounded in Australian and international evidence, provides a validated means for harvesting layers of complex information and reliably indicating wellbeing and safety risks for children and parents, together with a compass for coordinated responses to risk.

Endnotes


Ishar is a multicultural service working with women of varied faiths, sexual orientations, languages, refugee and permanent status, migrants and those born here experiencing the issues of dual cultures, and women experiencing family and domestic violence.

Ishar uses the ‘social model of health’ for intake, assessment and support. The model is based on the premise that health and wellbeing can only be fully understood by exploring the many interactions and influences that emerge out of the complexities of human experience and the various inter-relationships of the mind, body and society. Ishar believes that if the woman is healthy then she can better support the health and wellbeing of her whole family.

Ishar’s screening and assessment tools are developed in-house and tailored to funding body requirements. At the initial point of contact we collect standard client information via intake forms for personal details, English proficiency, arrival in Australia, income, birthplace etc.

Ishar’s specialists—psychologist, counsellor, social worker, midwife or dietician—have their own assessment forms, which screen for a range of health and social concerns such as substance abuse, family and domestic violence (FDV), mental illness, chronic illness (including preventable Type 2 diabetes, cancer, cardiovascular disease, asthma, allergies), obesity and social exclusion. In addition, funding bodies may require us to gather certain information from the clients, e.g. reason for seeing GP, source of referral, presenting problem for counselling etc, which identifies health trends over given timelines and could lead to health promotion toward achieving better outcomes in relation to existing and emerging issues.

Ishar’s approach is client-centred, confidential and culturally sensitive. We use interpreters, both on site and over the phone, provide informational and emotional support and advocacy and offer wrap-around service within the organisation. Our approach is fluid, building on relationships in order to identify the most appropriate supports for achieving positive health and wellbeing outcomes.

Following screening and assessment, assistance can be provided in a number of ways: Group sessions focusing on specific issues like FDV; therapeutic support groups (e.g. domestic violence support group, carers support group; individual sessions and individual casework); and groups and workshops for parenting capacity and skill building, assessment of children and provision of appropriate activities to enhance social development and language, reduce social isolation, information on health and welfare issues.

Tailoring intake and assessment according to a social model of health enables Ishar to support women with knowledge, encouragement, skills and goal setting that are sensitive to their social environment and result in a range of improved health and social outcomes:
1. Income and social status;
2. Employment and working conditions;
3. Social support networks;
4. Gender;
5. Culture;
6. Early childhood development;
7. Food security;
8. Housing and transport;
9. Education and literacy;
10. Health services;
11. Social exclusion/inclusion; and
12. Personal health practices and coping skills.

Our clients have complex problems and often need to see more than one specialist (e.g. Midwife, DV officer and Psychologist). We are sensitive to this and make sure they don’t need to repeat their story more than necessary. In particular, FDV is a big issue for our clients and requires sensitive handling. Clients need to feel comfortable with a staff member before they will reveal the full extent of their issues. As an organisation we develop simple and effective ways of helping women with relationship building and ongoing support until they can navigate their own way. Our reputation for good service provision is ever increasing because our staff are well trained in the social model of health and have a genuine interest in helping the client.

Client case study (Dawt)

Dawt (not her real name) is a 32-year-old client from Myanmar who had arrived in Australia in 2016. Dawt first presented to Ishar’s Neighbourhood Mother Program (NMP) in August 2017 as socially isolated. She had two children and had recently split with her husband, but did not mention family or domestic violence. After initial assessment of her needs, she was linked with conversational English classes and NMP group and referred to Settlement Grants Program (SGP) for help with housing issues and Centrelink payments. Dawt presented to the midwife in January 2018. She had reunited with husband and was pregnant with their 3rd child. She was suffering with hyperemesis gravidarum and was referred to the hospital for treatment.

While initial support focused on health and pregnancy education, ongoing contact and needs assessment revealed relationship problems and emotional and verbal abuse by Dawt’s husband. Counselling was offered but declined; but Dawt did agree it would be beneficial to have a plan should she need to leave the house if she felt she or her children were at risk, and agreed to referral to the Domestic Violence (DV) Support Officer. As part of Ishar’s wrap around service support, during the intake and assessment process the staff identified Dawt’s needs moving forward. Ishar arranged warm referrals and assisted access to the social worker at the hospital and the SGP providers in her area. This combination of support resulted in a plan for leaving the home in an emergency, securing of accommodation (post-separation) and assistance with Centrelink payments.

Dawt was really happy about the support she received and the changes she was able to make in her life because of this. She appreciated the collaboration within Ishar, as well as with external services, to ensure her needs were being met and she didn’t need to tell her story to multiple service providers at different agencies.

Dawt continued to access services at Ishar following the birth of her baby—accessing the doctor; Mums’ Group; Neighbourhood Mothers Group and Settlement Services Officer.

This case highlights that women need a place where their often-complex needs can be met within a social model, not just a medical model of care. Having continuity of care allows women to gain trust, develop relationships and feel able to disclose their problems and feelings. Having many services under one roof means the clients can meet the staff involved in their care. They can also feel more comfortable accessing services in a place they know and in which they feel safe.
An audit of intake screening and assessment tools used in the family and relationship services sector

Over a decade ago drummond street’s response to clients, like that of most organisations, was largely transactional in nature. Clients usually presented with an issue and we responded with a single intervention. If they returned, the same pattern of contact and response would be repeated. However, it became clear that by the time people asked for support, they were dealing with not one, but multiple and compounding issues.

For drummond street it was clear that our starting point for further exploration and support needed to be relationship issues that, by nature, are broad, complex and usually indicative of other issues within the family. To optimise our potential for responding to complex needs, we needed a more holistic lens.

Remaining relevant and true to our mission this meant reviewing, adapting and changing the way we offered relationship support services. By offering services in a more systematic, broader and structured way we were able to achieve more measurable, effective services. This involved critically reviewing how we were working as well as drawing on evidence, policy frameworks and, importantly, the feedback from our client, communities and partners.

The first, substantial step was to embed all practice, programs and stages of our work in a public health framework: development, design (including co-design and co-production), delivery and evaluation. The framework helped us conceptualise and map our programs and services across the spectrum of interventions: promotion, prevention, early intervention, treatment, and recovery. Adopting Mrazek & Haggarty’s Spectrum of Interventions mental health model (1994) helped us to organise and structure our programs and community and client data. This meant that our practice model prioritises:

- Using relationships as the opportunity and setting to actively respond, address risks and positively influence protective factors;
- Utilising the ‘family’ (broadest definition i.e. family of origin/family of choice) as the primary support environment that builds physical, mental and emotional, social, economic and cultural wellbeing (for both adults and children);
- Recognising the drivers of help-seeking behaviours and the willingness for people to access generalist/universal community-based non-stigmatising support rather than services people seek out when they are referred to after a ‘first instance’ or ‘crisis’;
- Building capacity to screen, assess and respond to ‘early in onset’, ‘early in life’ risks across a range of social health issues as part of genuine prevention and early intervention efforts at the individual, community and population levels; and
- Targeting resources to communities and cohorts with the greatest needs and benefit potential.

Practice and processes to improve wellbeing

In our aims to improve wellbeing outcomes for children and families we intentionally focused on parenting support, connections to communities and cultures, improved material wellbeing, safety and reduced exposure to violence, abuse, neglect and discrimination alongside our clinical support services.
The challenge, then, was to develop the practices and assessment tools and accountability and reporting measures to support our practitioners and reorient our delivery across our organisation.

**Whole-of-family intake tool and centralised intake**

With a focus on the social determinants of health, we designed a whole-of-family risk screening tool for use within a centralised intake system for every client who presented to us for support. The tool was based on evidence-based assessment and screening instruments and incorporated comprehensive, bio-psycho-social information:

- Client demographic data such as family type, culture, socioeconomic status, relationship status, family life cycle transition, carer status;
- Primary and mental health and wellbeing and risk alerts;
- Trauma and abuse histories i.e. family and intimate partner violence;
- Addictive behaviours, substance misuse and gambling;
- Child wellbeing or concerns;
- Parenting issues;
- Financial and housing issues;
- Social supports and connections to resources;
- Presenting issues and expectations/goals; and
- Family relationship and other health and wellbeing indicators.

Through our centralised intake service, now a visible and accessible entry point, all clients are screened through a standardised process and against established risk and protective factors. This enables early identification, program matching and a focused targeting of issues before they become more serious or entrenched. Through a structured information gathering process, identification of known, modifiable health and wellbeing risk factors that have a significant impact on individual and family functioning are recorded. This supports the next stage where practitioners conduct a comprehensive whole-of-family assessment and support plan with the clients. Importantly, screening for risk and protective factors determines the response, not the program itself.

**Risk factors: Service responses**

The number and severity of risk factors present determines the intensity, duration and priority of service response and informs the ‘dose,’ from brief (one-two risks) to intensive (three or more risks) support and the practice resources and program responses required. It includes both **Family level Risk factors** (e.g. family/couple conflict, current or recent family violence, social isolation, lack of family or community support, parental mental health, parenting styles, substance abuse, economic deprivation, insecure housing and recent stresses or traumatic events) and **Child level Risk Factors** (emotional, behavioural and mental health symptoms, physical health, interpersonal skills and relationships with peers and school disengagement).

Our service responses are matched and planned for each client or case:

- **Intensive Intake** (high risk assessment/response/management)—e.g. family violence, mental illness;
- **Intensive Support** (case work and/or counselling)—individuals, relationships or families where three or more risk factors are identified;
- **Brief Support** (case work and/or counselling)—individuals or families where only one or two risk factors are identified;
- **Groups and seminars, information, therapeutic models, recovery, connection; and**
- **Referrals as part of linking and co-care support.**

In addition, this process informs a connected, integrated and focused service response where finite resources are allocated to those who need it the most, and where service accountability and efficacy can be actively measured to assess the extent that protective factors have been strengthened and increased.

**Focus on outcomes: Designing data capture**

The next challenge was to implement a whole-of-organisation client records management (CRM) platform that would support our efforts to develop our client data capture reflecting our client and service processes, as well as meeting the myriad and ever-changing reporting requirements. It was also important that our recording and reporting processes supported the implementation of our practice model, and be accountable to staff, Management and the community through visibility of support processes and its reporting against validated client outcomes data and program fidelity and quality assurance markers.

We wanted to capture and report ‘in real time’ all activity and outcomes measures, aggregate client demographic data and support processes, i.e. case reviews, dynamic risk assessments,
quality assurance and performance management, across all of our programming, and across multiple domains from intake, assessment, support and case closure. We subsequently invested in a purpose-built system that aligned our evaluation processes and measures across all services and as an integrative, outcomes-oriented mechanism which support our whole-of-organisation approach to measurement, evaluation and reporting of individual and community outcomes.

Our practice and processes have been continually refined over the past five years. Our validated outcome measures are based on a synthesis of evidence, population-based social health data, local community profiling and common life-course risk and protective factors across multiple wellbeing domains known to work across family relationships, mental health and wellbeing, family violence and community programs and show effect and positive impact on a range of validated scales relating to:

- Relationships and family functioning;
- Parent-child relationships;
- Health and wellbeing; and
- Community connection and participation.

The sustained use of our data allows us to map community needs and address negative preventable outcomes for our clients, which changes their lives, and those of their children and families, not just to a presenting issue. The number of programs we deliver has grown substantially over this time. However, regardless of program type, funding source or client cohort, our practice and outcome measures are easily and readily incorporated into our services framework and our standardised intake and response practices.

### Endnotes


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### Client case study: Whole-of-family interventions—Belum Family*

The Belum family were referred to drummond street by their local school wellbeing officer who reported that both children (Cal 9 yrs. and Anna 11 yrs.) appeared sad and withdrawn and their interest in school had waned. Cal was prone to outbursts of rage and bullied other students, whilst Anna frequently cried in class.

The children lived with their mother Johanna (45 yrs.) and her partner (stepfather) of seven years Stephen (52 yrs.). Although the initial referral did not include any details about the children’s father, Joe, drummond street was able to connect with Joe and involve him in our whole-of-family practice, subject to safety and risk assessments that supported his inclusion in to support. Joe subsequently talked at length during his first session about his mental health concerns, compounded by difficulties in finding full-time, permanent work, and feeling inadequate as he was unable to financially support his children. Based on a whole-of-family assessment, each family member was offered a mix of individual and group supportive interventions over many months including:

- Parenting information and strategies to support the children’s emotional and developmental needs;
- Whole-of-Family counselling and parent coaching to strengthen family/relationship dynamics;
- Relationships work to improve communication and reduce conflicts, focusing on positive co-parenting and step-parenting;
- Active facilitation of mental health treatment for the father’s depression, improving self-esteem, and addressing issues impacting on his ability to positively parent;
- All parents attended a parenting group to build their skills and confidence and connect with other parents; and
- Individual Child mental health support to assist Cal and his parents with emotional and behavioural strategies.

Over eight months, all family members participated in individual and group sessions focused on child mental health information and support strategies, modelling of positive communication and parenting through individual and family goal setting. Throughout the delivery of support to all family members, the work done by several practitioners and programs was visible and co-ordinated both in practices and processes.

* Real names are not used
CASE STUDY 6

Logan Family Relationship Centre (FRC)

AN FDR PROCESS THAT RESPONDS TO NEEDS AND BUILDS ON STRENGTHS

Norma Williams
Local Services Manager (Family Law Services Logan and Redlands)
UnitingCare Community

In 2017, Deakin University and Family Relationship Services Australia (FRSA) released a research report on taking a public health approach to service provision. The report, *Strengthening prevention and early intervention services for families into the future,* takes a comprehensive look at the progress, achievements and diversities of the family relationship services sector and asserts that most of the health and social problems that bring high health and social costs to family and society are preventable. The report provides evidence for prevention and early intervention as the key to collective impact at a whole population level.

Persuaded by the findings of the FRSA report, Family Relationship Centre (FRC) Logan has taken a systemic, public health approach to identifying needs, determining interventions and achieving outcomes. Over time, Logan FRC has progressively refined its comprehensive screening and assessment tool in order to capture client information across key preventable health and social problems – substance abuse, anti-social behaviour including family violence, mental illness, obesity, developmental injury, chronic illness, school failure and social exclusion. This focus on health and wellbeing begins at first point of client contact and continues throughout every phase of clients’ engagement with the FRC.

What the stats tell us

The health and wellbeing of FDR clients and their children are significantly impacted by many factors, predominantly:

- Past and present family violence mostly in the form of psychological abuse;
- In adults, undisclosed and/or unrecognised/unresolved trauma due to childhood abuse, domestic violence or child sexual abuse;
- Ongoing risk to children and adults related to presence of relationship violence and family violence;
- Range of mental health issues, including depression, anxiety and PTSD;
- Entrapment in financial distress and social disadvantage;
- Disconnection from self-identity and self-determination;
- Low self-worth, self-esteem and shame;
- Disempowerment in decision making;
- Attachment distress;
- Risk of homelessness;
- Substance abuse; and
- Loss of hope for and the capacity to envision an alternative preferred life experience due to present overwhelming circumstances.

We know that parent resilience is depleted through trauma and on-going high conflict, and daily life is consumed with juggling the survival needs of the separated family. Undertaking a multiple complex needs assessment at intake for one intervention, such as family dispute resolution (FDR), will invariably shed light on other complex needs that require other kinds of intervention.
The likelihood of the most vulnerable clients making their own follow-up connections with on-referral contacts for health and other forms of intervention (whether provided through the FRC FDR practitioner or through other FRC or external services) is, understandably, low.

**The process: Recognising and responding to the range of issues that impact clients’ lives**

Conversations with clients post-intake and through the assessment and dispute resolution processes intentionally canvass issues across the eight social determinants of health identified above. Data is collected on a number of health and wellbeing indicators such as mental illness including depression, anxiety and self-harm, family and domestic violence, substance abuse, disability, obesity and chronic illness. Data is also collected on relationship history and separation information to get an idea of the nature of the relationship and living arrangements, whether a child safety order/plan is in place, and the existence of consent orders, parenting orders and DV protection orders. The information also informs future planning of the joint parent meetings in family dispute resolution.

Each parent’s reflective capacity and sensitivity of response to their child (qualities of secure attachment) are considered when thinking and talking about the best interests of their children and what needs to change; and parents are supported to take responsibility for the care and wellbeing of their children—in spite of intimate relationship breakdown and separation—across all relevant areas of social, emotional and physical health. Children are also supported to have a say in pre-joint-parenting FDR in order to enable their views and expectations to be taken into account when parents are making decisions that will affect them.

**The key: Case management across a range of health and wellbeing needs**

Since the introduction of the Family Advisor/ Counsellor referral role in 2018, the FRC team has been able to provide ‘soft social work’ to referred clients with complex support and recovery needs and to actively coordinate and support on-referral and connection with services. A previous gap in service delivery in relation to strengthening parenting capacity for sustained parenting and parenting planning after separation has been met. This has been acknowledged by practitioners and case management clients.

This role complements existing integrated case management activity at the (post-intake) assessment and family dispute resolution phases. Internal and external referrals are provided through hands-on connection and support for the most vulnerable clients. Even in cases of high conflict, a supportive and holistic approach has a positive impact on the willingness/capacity of the separated parents to shift to a child-focussed parenting relationship.

**The outcome**

Already-vulnerable parents need to be helped to cope with the stress and anxiety associated with the family dispute resolution process, especially when resolution of the matters looks improbable, and resorting to legal assistance and the courts seems likely. Our case-managed, informed approach to FDR links people to the help they need, and results in improved wellbeing and sustainable parenting arrangements, with positive outcomes for adults and children.

Activity data collected at Logan FRC shows a significant reduction in the number of parents returning to FDR over the following three-six month period, and records client perceptions about the impact of the holistic, case-managed approach on their lives:

> Many clients engaged in this FRC activity have said that never before, with a professional in the family law system, have they felt the opportunity to be safely emotionally and psychologically vulnerable... they are able to talk about their personal difficulties and the changes they want to make for themselves and children in a personally meaningful way... and then get practical hands-on assistance to help them make the first steps. Parents gain self-confidence to make informed choices and decisions and are motivated for ongoing personal development. They gain knowledge and understanding of the current and long-term impacts of domestic and family violence and get practical help for accessing the resources they need to address health and other day to day survival issues.
The case study illustrates the potential of the family and relationship services sector to meet families’ and individual’s core social and health needs early, before crises arise. Such potential can be realised by investing in the capacity of services to work within a public health framework that focuses on the social determinants of health and wellbeing. This is a debate for all stakeholders —the family and relationships sector, the health, mental health, housing, drug and alcohol, education and justice sectors, researchers and policy makers, governments and philanthropic bodies. What Logan FRC has achieved on a local level can, and should, be scaled up to a national public health model.

Endnote


SECTION 1: About you, your organisation and your program/s and service/s

1. Your name:

2. Your organisation:

3. Please indicate below the best description of your position within your organisation
   • CEO / Executive Director
   • Manager
   • Practitioner
   • Other

4. Your email address

5. Your telephone number

6. Please list the Commonwealth funded program/s you (and your C4C community partners if applicable) deliver (e.g. FARS, C4C, CCS, etc.)

7. Do you also deliver any State-funded programs?
   • Yes
   • No
   If Yes, please list them (please limit your list to the three largest funded services/programs you deliver)

SECTION 2: About the INTAKE SCREENING TOOL/S you use

8. Do you use intake screening tool/s on initial contact with service users (e.g. during the first inquiry phone call to an agency from a potential service user or the first meeting upon referral from another agency)?
   • Yes
   • No
   If No, please go to question 10

9. If Yes to question 8, please describe the intake screening tool/s you use upon initial contact with a service user: (Select all that apply)
   • Informal approach (such as telephone conversation, with contact or other details passed on to others in the organisation)
   • Tool/s developed in-house
   • Tool/s adapted from tool/s developed by another organisation
   • Formal validated tool/s (e.g. Kessler Psychological Distress Scale (K10), Life Skills Profile (LSP-16), Parenting Scale, Social Conduct Scale etc.)
   • Tool/s adapted from tool/s developed by another organisation
   • Other, Please specify:

10. Do you use the same intake and assessment tool/s in your State-funded services/programs as you use in your Federal-funded services/programs?
   • Yes
   • No
   • N/A
   Comment (e.g., if No, do you use any other tool/s in your delivery of State-funded services/programs?)

SECTION 3: About ASSESSMENT of risk and protective factors

11. Which (if any) of these social and health problems facing clients do your assessment tool/s attempt to identify: (Select all that apply)
   • Child neglect/abuse
   • Substance abuse
   • Domestic/family violence
   • Antisocial behaviour (including other forms of violence and crime)
   • Mental illness
   • Developmental injury (e.g. foetal alcohol problems, child neglect/abuse etc.)
   • Chronic illness (including preventable Type 2 diabetes, cancer, cardiovascular disease, asthma, allergies)
   • Obesity
   • School failure (including leaving school and not participating in further education)
   • Social exclusion (lack of meaningful and constructive social and economic participation.
   • None
   Comment (optional)

12. Do you think the intake screening and assessment tools you use are effective in identifying the social and health problems facing service users identified in question 11?
   • Yes
   • No
   • Unsure
   Please explain (optional):
13. Which (if any) of the following protective factors for clients do/does your assessment tool/s attempt to measure: (Select all that apply)
   • Warm attachment and/or positive role models
   • Safe, stimulating and healthy environments
   • Social connections
   • Religiosity and civic engagement
   • Social and emotional skills
   • None
Comment (optional)

14. Please state the tool/s you use to assess risk and to inform your service provision in the particular programs or services you offer (e.g. AEDC for early childhood services; Family DOORS for Family violence screening and risk assessment, etc.)

SECTION 4: About the use of intake screening and assessment tools

15. How does your organisation use the information that is gathered from using intake screening and assessment tool/s: (Select all that apply)
   • To identify service required
   • To identify the amount of service (dose) required
   • To make referrals to other services/programs in your organisation
   • To make referrals to external services/programs
   • To identify risks facing service users
   • To identify the strengths or protective factors professionals can build on in targeted programs or interventions
   • As a pre-program assessment/baseline tool for individual service users
   • As a pre-program measurement for program evaluation
   • For mandatory reporting
   • For continuous improvement
   • Other (please specify):

16. Who conducts intake screening for the delivery of your service/program (select all that apply)
   • General staff (e.g. receptionist)
   • Designated professional staff (e.g. program manager, family support worker etc.)
   • All staff involved in direct service delivery
   • Please specify:

17. Who conducts assessment of clients in the delivery of your service/program: (select all that apply)
   • General staff (e.g. receptionist)
   • Designated professional staff (e.g. program manager, family support worker etc.)
   • All staff involved in direct service delivery
   • N/A

18. What is the minimum skill/qualification your staff are required to hold to conduct intake screening?
   • On the job training
   • Informal training
   • Cert III or IV
   • Diploma
   • Degree or higher

19. What is the minimum skill/qualification your staff are required to hold to conduct assessment?
   • On the job training
   • Informal training
   • Cert III or IV
   • Diploma
   • Degree or higher

20. From your perspective, the level of training provided to your staff in the use of intake screening tool/s and assessment tools is:
   • Adequate
   • More than adequate
   • Inadequate
   • Unsure

21. How useful is the information gathered from your intake screening and assessment tool/s for DEX and SCORE reporting requirements?
   • Very useful
   • Somewhat useful
   • Not useful at all

22. Would you or a colleague be available for a follow up conversation regarding your survey responses?
   • Yes
   • No

23. Any other comment/s (optional):
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<tr>
<th>List of survey respondents</th>
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<tbody>
<tr>
<td>Anglicare SA</td>
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<td>Bethany Community Support</td>
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<td>CAFS</td>
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<td>Cairnmillar Institute</td>
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<td>CatholicCare Sandhurst</td>
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<td>CatholicCare Sydney/Uniting Parramatta</td>
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<td>CatholicCare Tas North West</td>
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<td>CatholicCare Tasmania</td>
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<td>CatholicCare Wilcannia-Forbes</td>
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<td>Centacare Adelaide</td>
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<td>Centacare Ballarat</td>
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<td>Centacare Far North Queensland</td>
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<td>Centacare Geraldton</td>
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<td>Centacare NENW</td>
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<td>Centrecare Inc</td>
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<td>Dickson</td>
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<td>Family Action Centre, University of Newcastle</td>
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<td>FamilyCare</td>
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<tr>
<td>Geelong Family Relationship Centre</td>
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<td>Goulburn Valley FamilyCare Inc</td>
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<tr>
<td>Halsmith Dispute Resolution</td>
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<tr>
<td>Interrelate</td>
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<td>Ishar Multicultural Women’s Health Centre</td>
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<td>Jacaranda Community Centre Inc</td>
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<tr>
<td>LifeWorks Relationship Counselling &amp; Education Services</td>
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<td>Marymead</td>
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<td>NT Legal Aid</td>
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<td>Odyssey House Victoria</td>
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<td>OzChild</td>
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<td>Positive Solutions</td>
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<td>PRONIA</td>
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<td>Queensland Program of Assistance to Survivors of Torture and Trauma</td>
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<td>Relationships Australia Canberra and Region</td>
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<td>Relationships Australia NSW</td>
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<td>Relationships Australia South Australia</td>
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<td>Uniting (Sydney region)</td>
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**AOD tools** – Alcohol and Other Drugs screening and assessment tools.

**ARM-R – The Adult Resilience Measure.** ARM-R is a self-report measure of social-ecological resilience.

**AUDIT – Alcohol Use Disorders Identification Test.** AUDIT is a 10-item screening tool developed by the World Health Organization.

**Best Interests Framework – Best Interests Framework for Vulnerable Children and Youth** is a Victorian Government framework for family services, child protection and placement services to achieve a consistent approach to service delivery and evaluation. Note: aspects of the framework have been adapted for use on an intake form.

**BRS – The Brief Resilience Scale.** The BRS assesses resilience as the ability to bounce back or recover from stress.

**CAGE** is a screening test for problem drinking.

**ChildFIRST (Child and family services information, referral and support teams) intake tool.** ChildFIRST is a Victorian Government central referral point to community-based family services and other supports within different catchments.

**CIMS – Client Incident Management System.**

**CRAF related tools – Common Risk Assessment Framework.** CRAF has been redeveloped into the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM). The framework is established under law under a new Part 11 of the Victorian Family Violence Protection Act 2008.

**CYRM-R – The Child and Youth Resilience Measure.** CYRM-R is a self-report measure of social-ecological resilience.

**DASS – Depression Anxiety Stress Scales.** The DASS is a set of three self-report scales designed to measure the negative emotional states of depression, anxiety and stress.

**DAST-10 – The Drug Abuse Screening Test.** DAST-10 is a 10-item brief screening tool, which assesses drug use (not including alcohol and tobacco) in the past 12 months.

**DOORS – Detection of Overall Risk Screen.** DOORS is an evidence-based universal screening framework to detect and respond to wellbeing and safety risks.

**DVSAT – Domestic Violence Safety Assessment Tool.** This tool was developed by NSW Government. It is mandated for use by the NSW Police Force. All other NSW government agencies and non-government service providers are encouraged to use the tool.

**e-SCARF – Supporting Children and Responding to Families (SCARF).** e-SCARF is a case management system that includes assessment and planning tools.

**GDS – The Geriatric Depression Scale.** The GDS is a depression assessment tool specifically designed for older people.

**Gottman Family Relationship Scales.** The Gottman scales measure a range of aspects of family histories and relationships.

**HITS – Hurt, Insulted, Threatened with Harm and Screamed.** HITS is a domestic violence Screening tool.

**K10 – Kessler Psychological Distress Scale.** K10 is a checklist used to measure whether a person has been affected by anxiety or depression during the past four weeks.
An audit of intake screening and assessment tools used in the family and relationship services sector

**MRG – Mandatory Reporter Guide.**
The MRG is a NSW government guide for mandatory reporters to help decide whether a child is expected to be at ‘Risk of Significant Harm’ and a report to the Child Protection helpline should be made.

**MSE – Mental State Examination.** The MSE is used to gain an understanding of a person’s psychological functioning at a particular point in time in order to direct care appropriately.

**MSSI – Modified Scale for Suicidal Ideation.** MSSI is a measure for suicidal ideation.

**NCFAS – North Carolina Family Assessment Scales.** The NCFAS measure family functioning from the perspective of the worker most involved with the family.

**ORS/SRS – Outcome Rating Scale and Session Rating Scale.** The ORS is a four-item session-by-session measure designed to assess areas of life functioning known to change as a result of therapeutic intervention. These include symptom distress, interpersonal well-being, social role, and overall well-being. SRS - The Session Rating Scale (SRS) is a four-item visual analogue scale designed to assess key dimensions of effective therapeutic relationships.

**PAFAS – Parenting and Family Adjustment Scales.** PAFAS is an outcome measure for assessing changes in parenting practices and parental adjustment.

**Paykel – the Paykel suicide scale** is used to measure suicidal ideation.

**PCL-5 – Posttraumatic Stress Disorder Checklist.** The PCL-5 is a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD.

**PEEM – Parent Empowerment and Efficacy Measure.** This tool is a validated strengths-based tool for understanding caregivers’ sense of confidence in their parenting role. It was developed by Griffith University and the Pathways Family Support Service.

**Risk Assess** is a clinical assessment of psychiatric risk and risk of harm (to self and others).

**RUDAS – Rowland Universal Dementia Assessment Scale.** The RUDAS is multicultural cognitive assessment scale.

**SafeCare** – evidence-based training program to help parents of young children at risk of neglect and abuse. Assessment tools in the program are used.

**SAK – Suicide Assessment Kit: Suicide Risk Screener.** The Suicide Assessment Kit (SAK) is a comprehensive assessment and policy development package, designed to assist alcohol and other drug services in the assessment and management of suicide risk.

**SASH – Screening Assessment for Stalking and Harassment.** The SASH is intended as a decision making aid for police, health professionals, security organizations and other professionals who are dealing with stalking situations but don’t have access to specialised risk assessments.

**SDQ – Strengths and Difficulties Questionnaire.** SDQ is a behavioural screening questionnaire for children and adolescents.

**SIMPLE STEPS** is a model for suicide risk assessment.

**WAST – Women Abuse Screen Tool.** WAST is a screening tool to identify and assess women experiencing emotional and/or physical abuse by their partner.