Innovations in Court Services

Edited by

Cori K. Erickson

Association of Family and Conciliation Courts
www.afccnet.org

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ASSOCIATION OF FAMILY AND CONCILIATION COURTS

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PREFACE

Since 1963, the Association of Family and Conciliation Courts (AFCC) has convened a wide range of professionals dedicated to improving the lives of children and families through the resolution of family conflict. AFCC members are bound by their strong commitment to education, innovation and collaboration in order to benefit communities, empower families and promote a healthy future for children. Through educational programs, publications and the Internet, members discuss how best to help families resolve conflict, especially those experiencing separation and divorce.

AFCC's interdisciplinary approach has contributed to it being a leader in the development of initiatives in areas including mediation, custody evaluation, parenting coordination, and parent education. Above all, AFCC members are innovators who are accustomed to sharing their expertise with colleagues. The Innovations Series is designed to enable AFCC members to share practical information about programs, processes and ideas that are emerging in the practice of family law.

Each book in the Innovation Series has been edited, and each chapter written, by thoughtful and experienced practitioners who have given generously of their time in order to contribute. We are deeply honored to have worked with all of them.

We hope that a chapter in this series will spark an idea for a new program in your community or help improve the functioning of an existing program. And, of

course, we hope that you will continue your connection with AFCC by finding ways to share your own innovative ideas with our community through future publications and educational programs. The better our work and the more we learn from one another, the greater our contribution will be to the communities, children and families we serve.

Wendy Bryans, LL.B and Linda Fieldstone, M.Ed.
AFCC Innovations Series Project

INTRODUCTION

It is a reality of our times that many families will restructure as parents separate or divorce. This can be a difficult time for everyone involved, but the new family structure that emerges can successfully rear strong and resilient children when the judicial system responds to the complex nature of family relationships.

A child's adjustment and development depends on their parents' behavior and level of conflict before and after a separation or divorce. Emery (1994) stated that when children are exposed to higher levels of parental conflict, the effects of family dissolution are much more negative. Traditional approaches with families in transition often exacerbate problems and increase the conflict. The challenge to the judicial system becomes one of providing quality services without escalating the conflict to a vituperative, intransigent level. Every family has its own unique set of characteristics that should be assessed independently of any other families in the system. Fundamental concerns for these families are the safety and well-being of all its members.

Family courts around the world are recognizing the need to shift the way families in transition experience their court process, rejecting the traditional model where family conflicts are settled in a courtroom under the rule of law. Experts and research point to the need for innovative, collaborative, holistic and interdisciplinary processes to resolve family disputes. Courts are increasingly aware that family discord and conflict primarily stem from social and emotional processes, rather than a legal event (Schepard & Bozzomo, 2003).

These same courts find themselves looking to provide therapeutic jurispru-

dence to address the families' underlying emotional needs and dysfunction. Therapeutic jurisprudence (Winick & Wexler, 2003) enriches the practice of law through the integration of interdisciplinary, non-adversarial, non-traditional, creative, collaborative, and psychologically beneficial legal experiences. The shift in this paradigm takes responsibility for these families' problems from the judicial system alone and places it on the shoulders of society. In this place, a multitude of interdisciplinary professionals can come together to solve these problems and address the families' needs.

In a time when budgets are being slashed, more help is required for families in conflict. Many courts and communities are finding ways to meet their needs. Creativity, collaboration and innovation are keys to the success of any endeavor that will provide effective and efficient services within constraints of a tight budget. The collaborative efforts described within this book address unique approaches to program creation and acquisition of non-traditional funding for the courts, with an extremely low overall cost-to-benefit ratio of service administration. The programs' primary goals are personal interaction; appropriate, in-depth problem identification and screening; collaboration; treatment and/or services; and prevention. The outcomes are systemic and have a positive impact across generations.

This volume in the AFCC Innovations Series is launched by Steve Baron, Sandra Clark and Lilly Grenz with a program that has successfully created an infrastructure that effectively provides multiple services for families in crisis. A cornerstone of the FIRST 5 Santa Clara County Family Court Initiative is to have personal interaction with potential litigants and collaboration with other public and private entities to provide the necessary services. This large, multifaceted program is specifically designed to help families with children age five and under. By identifying the needs of families early in the process, the program provides services that are tailored to meet that specific family's problems. The services and interventions fall into two broad categories: 1) helping parents resolve disputes in a manner that preserves the child's best interest and the safety of family members, and 2) providing services for self-represented clients that effectively help them navigate the system. The authors discuss the process for setting the stage for collaborative efforts they find crucial to success. Funding for this program multiplied exponentially as a result of vigorous collaboration with non-profit community-based agencies and large public systems.

In the second chapter, David Royko, Sharon Zingery, and Corinne Levitz dis-

cuss a program where mediation can be pursued appropriately even when there is a history of family violence. The Marriage and Family Counseling Service through the Circuit Court of Cook County developed a comprehensive protocol for effectively and ethically conducting mediation when there is a history of family violence. Development of the protocol and screening criteria occurred in collaboration with local domestic violence advocacy groups. When screening uncovers safety issues, a determination will be made for an appropriate course of service. Assessing the capacity and competence of parents to mediate is critical for the success of mediation and the well-being of the participants. The chapter describes the process by which screening is administered and subsequent services are provided. Screening protocol and other forms created by the program have been added as appendices.

In chapter three, collaboration is again a crucial element in the equation for success. The Family Assessment and Intervention Resources Program (F.A.I.R. Program) is a cutting edge collaboration between the Second Judicial Court in Albuquerque, New Mexico and the University of New Mexico Clinical Psychology Program. Melissa Gerstle, Alisha Wray, Kathryn Wiggins, Peggy Maclean, Kathleen Clapp and Timothy Reed describe this program that teaches skills to help parents reduce their destructive interpersonal behavior and create healthier parenting environments. The F.A.I.R. Program is built on a theoretical framework of research on domestic violence and abuse and identifies which type of service would be most beneficial to the client through an intensive idiographic approach. Utilizing a framework for typology of domestic violence provides the program with information to identify which type of services would be most beneficial to the clients. Treatment components were created to meet the specific identified needs. The authors underscore the importance of comprehensive assessments in domestic violence cases. A thorough assessment, by highly trained clinicians, is paramount in evaluation for potential risk of danger to clients. The chapter and appendices provide exceptional information to replicate the infrastructure of the program.

Chapter four describes an approach that evolved in response to requests from family court judges for assistance with specific family problems. Linda Cavallero describes a brief, focused assessment model, which responds to a circumscribed legal question that needs immediate judicial action. The brief, focused assessment can be completed in a limited time frame and enables judges to make informed

temporary orders. The written report is an important component of this model. The assessment provides current information on the family, which can be important for future legal proceedings. When the courts are informed in a timely manner, judicial decision-making can promote a reduction in conflict between the parents and provide for the well-being of children. The author includes a fictitious assessment in the appendices.

In chapter five, Paul Murphy and Lisbeth Pike take the reader to Australia and share an innovative approach to managing negotiations between separating parents in cases that involve children. Family law in Australia is undergoing its most radical change since the introduction of 'no fault' divorce in 1975, and the Family Court of Western Australia has piloted numerous projects over the years. The focus for this chapter is the Child-Related Proceedings Model, which manages all cases involving children. In complex matters the case can be directly referred to a judge and then that judge and the Family Consultant jointly manage the case to its conclusion. Court etiquette has been adapted to encourage direct participation with the presiding judicial officer and Family Consultant. The program required intensive interdisciplinary cross training that led to an understanding: there is a "better way." The authors describe the catalyst for the new services, the value of collaboration, an interdisciplinary approach to decrease client alienation from the courts, benefits to both clients and the courts and positive outcomes.

The final chapter in this publication provides a detailed description of an early screening system developed by the Connecticut Judicial Branch–Court Support Services Division, Family Services Unit (Salem, Kulak & Deutsch, 2007). Peter Salem, Debra Kulak and Robin M. Deutsch describe the ground-breaking approach developed and implemented by the consultants from the Association of Family and Conciliation Courts in partnership with the Connecticut Family Services Unit to screen family disputes and match individual cases with the most appropriate court services. This program has been evaluated by Marsha Kline Pruett, Ph.D., who recently completed an in-depth analysis of the triage screening tool and new services developed in the wake of the screening tool's implementation. The research looks at how well the screening tool works, how new services may have improved the court process for families and what can be learned from the intake screening about vulnerable populations. Publication of the research is forthcoming and an initial peek at the results provides support for an extremely positive impact on the services provided by Connecticut's judicial system.

Today, more than any other point in history, we have a chance to provide the support for the emerging pluralistic family system—a family system that is not better or worse, merely different. The authors of these six chapters and their colleagues invariably recognize the necessity for the paradigm shift. They are tirelessly passionate about creating a better world for families and children who face the challenges of the ever changing family structure. A round of applause and gratitude goes out to these authors for dedicating the time necessary to share these innovative programs.

Cori K. Erickson

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CHAPTER 1

THE FIRST 5 SANTA CLARA COUNTY FAMILY COURT SERVICE INITIATIVE

By Steve Baron, Sandra Clark, and Lilly Grenz

INTRODUCTION

Family Court Services (FCS) of the Superior Court in Santa Clara County, California, serves a population of 1.7 million people. Each year, 5,000 parents of 10,000 children are referred by the court to FCS (a unit of court-employed child custody mediators and investigators) because the parents have not been able to resolve child custody or visitation disputes. FCS initially provides parents with education and mediation. If these services are not successful in resolving the dispute, the court usually orders investigations, which result in custody and visitation recommendations to the court.

Over the years, the Family Court Division in Santa Clara County, California, its administration and FCS have participated in the development and implementation of collaborative projects aimed at actively helping families address problems

impacting the health, safety and welfare of their children and consequently, the safety of family members. These underlying problems (e.g., domestic violence, substance abuse, child maltreatment, mental health issues, poor parenting and poverty) often contribute to the difficulties already faced by families and children entering the Family Court system. Children in these families are at risk for significant emotional, behavioral, cognitive, health related, and/or relationship difficulties during their development.

Experience suggests that assistance can be provided most effectively when: (1) the exact nature of problems are identified; (2) families are educated and informed about the availability of resources early in the history of the family's involvement in the court system; (3) families are provided with personal assistance at entry portals into the Family Court system; (4) court staff are aware of available resources and connect families to relevant resources; and (5) the program encourages sharing of resources among court-related associates.

The service culture that has evolved over the years in Santa Clara County operates on the principle that regardless of the number of informational supports available (e.g. Web sites, computer access, documents, resource lists), there is no substitute for staff spending a minimal amount of time with a litigant or potential litigant in order to personally: (1) ask how the staff member can help; (2) accurately understand the needs of the litigant; (3) actively communicate that those needs are understood; and (4) offer practical help to address those needs and connect the litigant with appropriate services.

The FIRST 5 Santa Clara County Family Court Services Initiative (Initiative) has been the most comprehensive grant-related project in which the Family Court has engaged. The Initiative was a logical culmination of a long process reflecting the evolution of the philosophy within the Family Court and FCS. The Initiative was based on the principles above and is a model of the type of court and community collaboration that best serves those in the Family Court system. This chapter will explain: (1) the rationale for the existence of the Initiative; (2) the pre-existing court related programs that set the stage for the development of the Initiative; (3) related results, statistics and evaluative findings; and (4) subsequently developed programs.

RESEARCH AND FACT-BASED NEED FOR SERVICES

The California Administrative Office of the Courts (AOC) has collected detailed information on court-based child custody mediation through the Statewide Uniform Statistical Reporting System (SUSRS) since 1991. The most recent research from the California SUSRS 2003 Client Baseline Study revealed that: (1) parents reported the existence of relationship violence in at least 53% of all cases and that children witnessed the violence in at least 38% of all cases; (2) at least one parent reported concern for future violence in 39% of all cases, the existence of a restraining order in 42% of all cases, and the need for supervised visitation in 35% of all cases; and (3) that supervised visitation had actually been ordered prior to mediation in 19% of cases. Other safety issues raised by parents or identified by the mediator included: parent feeling children are unsafe with the other parent/person, 32%; mental health problem of other parent/person, 13%; child abduction by other parent/person, 5%; child neglect, 11%; child abuse, 8%; child sexual abuse, 3%; and drug or alcohol abuse, 36%.

The California AOC's July 2005 Research Update on Demographic Trends of Clients in Court-Based Child Custody Mediation, found that: (1) 54% of all parents did not have an attorney and were self represented; (2) 69% of all families entering mediation had at least one parent without legal representation, and parents without legal representation were rising across all income levels; (3) 33% of the parents in custody mediation were never married; (4) almost 25% of the mediation clients were not employed; (5) 13% lacked a high-school diploma; and (6) the majority had monthly incomes of less than $2,000.

Johnston, Lee, Olesen, & Walters (2005) found that a significant proportion (about one-half) of the concerns about neglect and abuse raised in custody-disputing families were likely to have some basis in fact and should not be dismissed merely as indicators of a highly conflicted divorce. They also found that in about one-fourth of these cases, abuse allegations were substantiated for both the mother and the father within the same family. These findings contradict the belief that allegations raised in custody cases are typically false and/or exaggerated, and substantiate need for thorough investigation with links to necessary services. Results of the research lend strong support and justification for implementation of programs such as the Initiative within family courts. Coordination of services both internally (within the court system) and between the court system and community

service providers is necessary. The article's authors state:

> In an already overburdened child protection system, child abuse and domestic violence allegations in child custody matters may be disposed of by referral to family courts with the belief that complaints are more likely to be exaggerated by ulterior motives or that there is a least one good parent that can protect the child....these assumptions are likely to be wrong in 35-50% of custody-disputing families who are not entitled to receive equitable intervention by family court and its services compared to those in the jurisdiction of juvenile courts and child protective services....
>
> The more intransigent conflict-ridden divorcing families are likely to be troubled by multiple indicators of domestic violence, child neglect, molestation and abuse, parental substance abuse, mental health problems and child abduction. The courts' interventions must also be closely orchestrated with each other and with services provided in the community - for psychological and parenting counseling, substance abuse monitoring and remediation, batterers' intervention programs and victims' advocacy, and mental health treatment....

Baron (2003) noted that the California Family Code recognizes the seriousness of social problems affecting children by assigning them special weight in its definition of the best interest of children and by authorizing the family court to order parents to participate in educational, counseling and supervision programs. Baron argues that the court system has a responsibility to: (1) understand the nature and complexity of these problems and their impact on children and families; (2) appropriately use its powers and authority to identify and effectively address these problems; (3) to assist families in obtaining needed services; and (4) to monitor and enforce the court-ordered conditions imposed by the need to preserve the health, safety and welfare of the children and the safety of other family members.

> Family court is not juvenile dependency court, but it must deal with similar issues in many of the cases before it. Family court, in serious cases, can help keep children safe and allow them to live

> with their families in the community, out of the juvenile dependency system. But reaching this goal requires that the family court develop a philosophical orientation and logistical infrastructure to acquire the resources to effectively confront the serious problems occurring in families....

Wiesz & McCormick (2003) discuss the disparities that exist between the California Juvenile Dependency and Probate Courts in servicing children and families experiencing similar problems related to child maltreatment. They argue that "Court-ordered services and benefits should be available for children based on need, not venue." Wiesz & McCormick (2003) go on to state that:

> A family involved in the justice system is often confronted with broader societal problems that exacerbate children and family legal issues. These difficulties may include issues such as poverty, inadequate housing, education, immigration, medical services, substance abuse, child care and more. The court cannot eradicate these problems by a single judicial order, but can affiliate itself with service providers to augment and facilitate the court's decision for children with identified needs. Appropriate solutions to complex problems require that the courts readily and accurately connect the families to the vital services they need....

That last line conveys the spirit behind the FIRST 5 Santa Clara County Family Court Services Initiative.

EVOLUTION AND DESCRIPTION OF THE PROGRAM

Family Court and FCS collaborated with public agencies and private community services in an ongoing process over the years. These collaborations are dedicated to: supporting responsible, safe and high quality parenting, appropriate parent-child access, healthy childhood development, and amelioration of trauma in children and parents resulting from family violence or child maltreatment. Experience within the court system indicates that these families often have difficulty accessing and utilizing needed services without personal assistance, support and

encouragement.

Services and interventions fall into two broad categories. First, there are legally mandated procedures and services aimed at: (1) helping parents resolve child custody and visitation disputes in a manner consistent with preserving the best interests of children and the safety of family members (e.g., orientation, mediation, investigation, settlement conferences and related procedures); and (2) providing additional services designed to assist self-represented clients in navigating the Family Court system. The second category of services and interventions were specifically authorized in the Family Code or developed under authority provided in the Code, to help clients obtain primarily community-based services designed to assist them with some of the serious problems previously discussed. The services evolved and expanded over time as awareness of the need for them developed, and enthusiasm and motivation of the leadership of the Family Court, its administration, and FCS gained momentum.

SETTING THE STAGE FOR THE INITIATIVE

FCS Orientation Program

The mandatory three-hour educational class is typically the first step provided to help parents resolve their litigated child custody and visitation disputes. The class introduces parents to the court process with respect to child custody and visitation, prepares them for mediation, and provides basic parenting information. Approximately 20% of all parents entering Orientation resolve their disputes on their own after completion of the class, without the need for mediation or custody investigation services.

FCS Mediation

A mediator assists parents in developing their own mutually agreeable parenting plan for their children. There is a separate protocol for handling cases in which there are domestic violence allegations. The mediation agreement may include parental participation in various services, with the mediator providing information regarding relevant court and community resources. An additional 40% of the cases originally entering Orientation fully resolve their custody disputes after com-

pleting mediation.

Judicial Custody Conferences

Judicial Custody Conferences are held in the event that parents still have unresolved disputes after completing mediation. During these informal settlement conferences, the judge attempts to help the parents resolve remaining custody and visitation issues, and may suggest involvement in community-based services. The cases that remain unresolved are typically court-ordered to undergo Assessments or Evaluations, and are described below.

FCS Assessments/Evaluations

Assessments and Evaluations are court-ordered comprehensive investigations resulting in formal and detailed recommendations to the court regarding custody and visitation. These investigations often include assessment of allegations, including those of child maltreatment, domestic violence, and/or substance abuse, as well as assessment of parenting capacity and the various developmental, health, safety and welfare needs of the children involved. Recommendations frequently include that parents participate in services designed to deal with identified problems impacting the safety of children or families.

Court Settlement Conferences and Hearings/Trials

In the event that the parents do not agree on the Assessment/Evaluation recommendations, the judge meets with parents and any attorneys in the case in an attempt to resolve those issues. Approximately 2% of the remaining cases originally entering Orientation go to trial.

Emergency Screenings

These are court-ordered, immediate, time limited and focused investigations which may occur at any time during the history of the case. They are designed to address urgent issues that require immediate recommendations for temporary custody and visitation orders. They often include recommendations that parents participate in services aimed at addressing problems associated with the emergency,

such as supervised visitation, domestic violence services, substance abuse treatment, and counseling for parents and/or children.

Court-Ordered Supervised Visitation

The California Family Code authorizes the Courts to order supervised visitation when necessary to protect the safety of children. Family Court has become involved in a number of public/private collaborations, including the Access and Visitation Grants, aimed at insuring that accessible supervised visitation services are available in the community. To ensure that services are operating in a manner appropriate for handling cases in which domestic violence has been an issue, the Court became involved in a multi-county collaborative Safe Haven grant project (sponsored by the United States Department of Justice, Office of Violence Against Women). Safe Haven's grant developed model standards for the operation of supervised visitation programs. Supervised visitation services are available to clients from a number of community service providers whose programs must operate consistent with the Uniform Standards of Practice for Providers of Supervised Visitation. The Family Court also collaborates with the City of San Jose Police Department to make available a number of their local community offices for supervised visitation exchanges, and with the local Office of Child Support Services to provide a site for supervised visitation.

Family Court Clinic

Advent of the Santa Clara Family Court Facilitator's Office ("Clinic") and Superior Court Self-Help Center signaled a major effort to improve access to justice for self-representing clients. The Clinic began as pilot project with legislative appropriations. The Clinic assists self-represented litigants to navigate the court system, primarily with regard to child support issues. Since then, the services have expanded to assisting parents with divorce and custody issues, obtaining domestic violence protective orders and all parts of the court system. The Clinic includes the operation of an award winning Web site (www.scselfservice.org) and a Mobile Service Van, which provides these support services in various locations throughout the community to improve access to justice. While the Clinic's services do not include legal representation for clients, the Clinic, the Court and FCS are involved

in the recently implemented Domestic Violence Limited Scope Representation collaborative (DVLSR). DVLSR is a grant-funded project harnessing the skills of domestic violence advocates, experienced Family Law attorneys, local volunteer attorneys and certified law students from Santa Clara University School of Law. DVLSR matches low-income litigants with attorneys for representation in their domestic violence restraining order hearings. DVLSR is unique among legal services programs because it aims to provide legal representation to both victim and abuser.

Counseling Funds for Children and Victims

The Don Sagatun Edwards Child Services Fund was established by FCS and the Family Law Bar to provide limited assistance to indigent parents in the payment of court-ordered counseling for their children. The Victim Witness Assistance Program is a statewide legislatively authorized program, funded by fines and fees collected from individuals convicted of certain crimes. This Program provides victims of violent crime, including victims of domestic violence and child abuse, with various forms of assistance, including payment for counseling necessary to deal with the traumatic impact of those crimes.

Family Drug Treatment Court Facilitator & The Family Court Resource Specialists

The Family Court Resource Specialist is a Family Court staff member who operates a resource center within the Family Court building where clients obtain personal assistance with identifying and connecting with community-based resources. The Resource Specialist maintains an up-to-date list of all relevant community-based resources. The Administrative Office of the Courts offered a small mini-grant to assist interested jurisdictions in developing a Family Drug Treatment Court, noting that only one county in California (Riverside County) operated such a Treatment Court at that time. The Family Court in Santa Clara County received a grant, hired a half-time Family Treatment Court Facilitator, and assigned the dual title of Family Court Resource Specialist and Family Treatment Court Facilitator. The Treatment Court is designed to assist parents who have limited contact with their children due to substance abuse problems. These parents vol-

unteer for participation with assistance in pursuing recovery. The Facilitator/Resource Specialist helps connect these clients with treatment resources, coordinates and monitors treatment progress and drug testing for Family Court judges. The Family Court judges volunteer to take on the added responsibility of Treatment Court.

The Mental Health Professional Service Directory

The Family Court Related Counseling and Evaluation Related Services Web site was the result of a collaboration between FCS, Family Court, the Santa Clara County Mental Health and Drug and Alcohol Services Departments, and provides the public with lists and contact information for private qualified mental health professionals and agencies who provide community-based mediation, evaluation, psychoeducational and counseling services that address the needs of Family Court clients.

THE FIRST 5 SANTA CLARA COUNTY FAMILY COURT SERVICES INITIATIVE

Most projects above predated the creation of the FIRST 5 Santa Clara County Family Court Services Initiative. The mandates and authorities provided by law, the research, and the responses generated by the services had already occurred. All functioned to further enhance court and community awareness of needs to expand assistance to the higher-risk Family Court litigants.

The Initiative is a four-partner public/private collaboration between: (1) Superior Court (Family Court and FCS in Santa Clara County); (2) FIRST 5 Santa Clara County (a publicly funded agency serving children under six years old and their families, designed to enhance early childhood development and school readiness); (3) Resources for Families and Children (RFC); and (4) The Center for Healthy Development (CHD). The latter two partners are community-based private not-for-profits. The purpose of the Initiative is to ensure that children less than six years of age, in families involved in the Family Court process, will have critical health, developmental and social underpinnings to support their success in life.

The Initiative's Vision:

- Creating a network of specialized quality programs, services and activities that support parents and children in the Family Court system;
- Coordinating services geared toward prevention and intensive intervention for higher risk children and their families;
- Securing access to services identified and requested by the families;
- Diverting families, where appropriate and possible, from entering Juvenile Dependency Court;
- Being a major catalyst for systemic change within the Family Court System in a way that supports the above objectives and goals.

The Initiative Components:

1. A team of seven bilingual/bi-cultural Care Managers, provided through a contract with RFC, and two Resource Specialists is located in the various courthouses and court-related locations to provide clients with direct assistance in locating and securing services and resources needed by families.
2. A Supplemental Fund provides qualifying indigent families with financial assistance to pay for services that the court has ordered the family to obtain. The Supplemental Fund was a part of the initial grant, allocated to help families in Family Court custody/visitation cases or Probate Court guardianship cases, determined by the court to be otherwise unable to access or afford court-ordered services. The Fund pays for services when one of the parties has at least one child or step-child under the age of six years living in his or her residence. Qualifying court-ordered services are those that are determined to: help insure that the children and families have the necessary health, developmental and social underpinnings for success in life; secure access to early care and education services, parenting and family support services, and/or health and social services; and/or divert families from entering the Juvenile Dependency Court system.

   Examples include, but are not limited to: domestic violence related

services for victims and children; parenting and parenting without violence classes; supervised visitation; therapeutic supervision; re-contact counseling; drug testing for Family Treatment Court; mental health counseling; divorce education classes/group counseling; treating high conflict classes/group counseling; children of divorce classes/group counseling; bus passes needed to attend court-ordered services; and fees for children's developmental enhancement activities.

3. A New Skills and Choices Parenting Program, provided in a contract with CHD, consists of four psycho-educational and therapeutic components designed for families in the Family Court system.

   a. Parents in Conflict: A court-ordered, eight-week, psycho-educational class for parents whose conflict is negatively impacting the children;

   b. Kids Connection: A six-week program providing separate sessions for children and for each parent designed to educate parents on the impact of divorce and separation on children. The program gives children a safe place to express and understand their responses to the divorce/separation and improves family relations and coping skills;

   c. Co-parenting, Parallel-Parenting and Individual Counseling;

      Co-Parenting Counseling is available to families who have custody/visitation court orders in place. Counseling sessions are held with both parents. Counseling goals manage visitation, parenting conflicts and maintain court-ordered schedules and improve communications.

      Parallel-Parenting Counseling is designed for parents who have a history of domestic violence and/or restraining orders. These parents attend separate sessions on separate days with the same counselor. The focus for counseling is a safe and secure environment for the family. The counselor assists the parents in creating a parallel parenting plan that minimizes any contact and communication between the parents, while maintaining boundaries for safety.

      Individual Counseling focuses on the personal issues of one parent in a traditional form of therapy.

d. Safe Families: Twelve-week group intervention classes for separated parents who have a history of domestic violence, no contact orders, restraining orders, supervised exchanges, and whose children are at risk due to family conflict and/or a history of domestic violence.

See Appendix A for course information and outlines.

MEETING THE SERVICE GAP

An important component of the Initiative was the requirement for a service gap analysis using questionnaires and focus groups with Family Court clients. The results of the service gap analysis supported the experience of Family Court staff by indicating that a significant number of families seeking voluntary or court-ordered services and interventions were, due to various obstacles, often unsuccessful in obtaining those services. Consequently, those parents often had difficulty complying with court orders aimed at ultimately protecting and serving the best interests of their children. Some of the primary obstacles to accessing those services were identified through a review of the research, the results of the gap analysis, and staff discussions, and include: (1) disruptive high levels of stress associated with the family factors contributing to, and/or resulting from, the divorce or separation (e.g. high conflict, diminished income and/or unemployment, residential changes, emotional difficulties, family violence, parenting problems, substance abuse) and the demands of participating in the court process itself; (2) diminished parenting capacity due to those same factors; (3) the inability to afford the cost of services; (4) language or cultural differences that may lead to feelings of intimidation and/or alienation from the court and community service provider systems; and (5) cultural and language barriers that make it difficult to navigate the system. Additionally, the gap analysis indicated there was a local community service void in providing specialized interventions for high conflict families.

The Initiative's interventions were designed to help clients with young children overcome the various barriers described above by providing a team of easily accessible, multi-cultural and multi-lingual Care Managers, strategically located throughout the court system, to provide clients with personal assistance to: (1) identify the nature of the client's need for services through careful culturally sensitive listening and structured interviewing techniques; (2) inform the client of

existing services available to address those needs; (3) actively support the client to make his or her own choice of service provider; (4) identify the existence of any barriers that might interfere with the client's ability to actually obtain the services and comply with the related court-ordered conditions, and then attempt to provide the concrete support needed to overcome those barriers; (5) determine whether the client needs and qualifies for the financial assistance from the FIRST 5 Supplemental Fund necessary to help pay for those services, and apply for that assistance when appropriate; (6) actually connect the client with the service provider; and (7) make follow-up contact at set times in order to determine if the services were actually obtained and if any new assistance was needed. The Initiative addressed the service gap identified for high conflict families by funding the development and implementation of the New Skills and Choices Program previously described.

PROGRAM IMPLEMENTATION

Prior to grant approval, the application process was led by the Supervising Court Judge and the Director of FCS. The Director and Assistant Director of FCS, in consultation with FIRST 5 management and staff, Court staff, and Court Administration, led the implementation of the grant components. The initial three months required intensive time commitments for the FCS Director and Assistant, including multiple meetings per week. Additionally, they provided rigorous cross training regarding budgetary issues for the participants, including: Bench Officers and their clerical staff, FCS mediator/investigators, interns and clerical staff, Care Managers funded by FIRST 5 to work in the Courts, staff at the facilities of Care Managers, and Court Administration staff. Once the initial training was complete, the FCS staff involvement was limited to program usage. Supervisory, maintenance, and reporting functions continued to be performed on an ongoing basis by the FCS Director and Assistant Director.

The collaboration of FCS and FIRST 5 expanded with the development of the Initiative. Contracts were made with community-based organizations, which were selected through open invitations for proposals to provide the Care Manager Program and the New Skills and Choices Program. The Director, supervising staff of FCS and FIRST 5 Program Specialists met on a regular basis with the program

providers of the two agencies, who became partners with the court and FIRST 5 under the Initiative. These meetings coordinated efforts to improve parent access to services and responsiveness of services to the needs of the families referred.

The following are some of the factors and principles that contributed to the evolution, implementation and success of the Initiative:

1. Communication, networking, collaboration, the willingness to entertain new and creative ideas, and judicial, Court and FCS leadership;

2. Awareness of gaps in services to high conflict families: Even with the availability of the various services that pre-existed the Initiative, Family Court and FCS were acutely aware of the need for both increased services for high-risk families, as well as more assistance for families in connecting with those services. The Supervising Family Court Judge and the Director of FCS, who frequently communicated about Family Court and FCS operations, agreed that this function could best be served through a social worker position. FCS in Placer County, California, had been successful in obtaining a small California Proposition 10 grant for a FCS parent education program. The Santa Clara County Supervising Judge and FCS Director explored pursuing this funding to staff a half-time social worker position to provide service connection and coordination for high-risk families. Contacts with County officials identified others who may be interested in exploring this possibility. It was the County Commission that administered the program which later became known as FIRST 5 Santa Clara County. FIRST 5 officials, who were identified and contacted, discussed the concept for services. FIRST 5 expressed some initial interest and scheduled a time to submit and present a position paper.

3. The relevant facts were persuasively presented in the proper forum to obtain funding. FCS prepared the position paper utilizing the California Administrative Office of the Courts - Center for Families, Children and the Courts research, along with local statistics and analysis. FCS was able to document that there were a significant number of high-risk children, age five years and younger, who passed through the Family Court system each year, who could benefit from enhanced service connection and coordination assistance. The FIRST 5 administrators and staff reacted favorably and indicated that they would consider the request for a part-time social work-

er position. Within a few weeks, they responded to the Judge with a visionary proposal far beyond the nature and scope of the court's initial request. The concept for a multi-year plan totaling several million dollars involved a team of Care Managers who would secure community-based services for families with young children. Further discussions were completed between the Court, FCS and FIRST 5. The program design was further refined to include: a team of Care Managers, a supplemental fund to help indigent parents pay for court-ordered services, funding for the development and implementation of programs designed to fill service gaps, and enhancement of the pre-existing Resource Specialist/Family Drug Treatment Court Facilitator position with the addition of a bilingual Spanish-speaking half-time position. The formal grant proposal was prepared through the close collaboration of FCS and FIRST 5 staff, submitted to the FIRST 5 Santa Clara County Commission for approval and funding.

4. Understanding the "big picture" including the Court, its authority and limitations, families and their needs related to the health, safety and welfare of children, the community and its resources, and how they all relate to one another:
    - Thinking things through, anticipating and preparing for potential problems, and incorporating safeguards;
    - Implementing programs systematically and in a timely manner;
    - Keeping the field services as simple as possible in application, emphasizing people-to-people "connections."

STRATEGIC PROGRAM DEVELOPMENT

FCS and FIRST 5 communicated regularly to organize the implementation of the various components of the Initiative, which occurred as follows:

- System-wide meetings were held to keep all stakeholders involving Family Court and FCS staff apprised of the status of the program and its implementation. All stakeholders were immediately informed about the planned implementation of new parts of the program and how to utilize them as they became available. Ongoing education occurred throughout the imple-

mentation phase. Program troubleshooting, modification, adjustment and maintenance continue to occur in order to optimize program efficiency and success.

- Hours were immediately added to the existing Family Court Resource Specialist/Family Drug Treatment Court Position, and a half-time bi-cultural, bilingual Spanish-speaking Specialist/Facilitator was hired, trained and put to work helping clients within approximately three months from the time grant monies were made available.
- FCS managers were trained by FIRST 5 on grant reporting requirements.
- Internal procedures, protocols, forms, and FCS recommendation and court order templates were created by FCS and the Court, using the Supplemental Fund to help indigent clients pay for services they were court-ordered to obtain. The Court could authorize use of the Fund at the request of FCS or the Care Managers or upon its own motion. This part of the program was put into operation within approximately 30 days from the time grant funds were made available.
- A Request for Proposal was issued for non-profit community agencies to apply to provide a Care Manager team. An agency was selected and their workers trained by FIRST 5 and FCS. FCS made the decision to locate the Care Managers at as many of the entry portals into the Family Court system as possible so that clients could access them early in their history of contact with the court. The Care Managers were placed in the areas of high client traffic and where the high-risk families were most likely to appear. Primary objectives expressed within this Initiative component were: (1) expedited connection of the Care Managers with the clients who could benefit from their services; and (2) a sharing of resources in a manner designed to benefit as many high-risk families entering the court system as possible. The Care Managers were providing service approximately seven months from the time the grant was activated.
- An Initiative introduction and celebratory function was organized by FIRST 5 in collaboration with FCS and held at a community center with numerous community agencies, officials and staff from the California Administrative Office of the Courts - Center for Family, Children and the

Courts in attendance.

- FCS and the Family Court Supervising Judge made presentations on the Initiative at both statewide FCS and FIRST 5 conferences to inform them that such collaborations were possible and to encourage them to explore similar collaborations.
- The final component, and the one that required the most development, training and supervision, was the New Skills and Choices program to be provided by the contract agency. In the Initiative's first year, FIRST 5 and FCS conducted a survey (Appendix B) and analysis to identify and confirm the gaps in services needed by families in the Family Court system. A Request for Proposal was developed for a program that would provide the identified missing services – group intervention programs and counseling for children and their separated parents. Specialized consultation and support was provided to the selected contract agency, The Center for Healthy Development (CHD), for the purpose of assisting with the development of these programs. The consultants worked with CHD to develop a range of specialized services for families referred by the Court, train staff counselors and educators within the contract agency and assist with ongoing supervision and program modifications as needed.

BENEFIT/IMPROVEMENTS NEEDED

Related Results, Statistics and Evaluation Findings

An evaluation of the Initiative conducted by Harper and Associates concluded the following:

1. Impact of Care Management on Court Outcomes: The study examined administrative data maintained by the courts to see if the Care Management program was making a difference for families involved in Family Court. Court case files were obtained for a group of families receiving Care Management (n=142) and were compared to families with children under five who went through the Court system before the programs were in place (n=182). Court case outcomes included case re-fil-

ings, restraining orders, emergency screenings and assessments. The evaluators determined that each outcome was due to continued court filings and appearances and was, therefore, an indicator of family conflict and possible risk factors, such as domestic violence and child custody battles. True to the study hypotheses, according to chi-square analysis of the two groups, Care-Managed families were less likely to have:

- Re-filing activity: 7.0% of families who received care management services compared to 41% of control group cases.
- Restraining orders: 31.0% of care-managed families compared to 69% of control group cases.
- Emergency screenings ordered: 11% of care-managed families compared to 39% of control group cases.
- Custody/Visitation Assessments (investigations) ordered: 12% of care-managed families compared to 20% of control group cases.

2. Since 2002, the FIRST 5 program has served 6,185 parents with care management services. Legal services in domestic violence cases were provided to 685 parents and 717 children of those parents; New Skills and Choices workshops served 1038 parents and 1250 children; Family Law Treatment Court served 384 parents and 702 children; supervised visitation services were provided to 875 families; Parenting Without Violence Workshops were provided to 75 parents and 79 children. Additionally, some families that benefited from the specific named programs also used care management services to be connected to community-based services such as developmental assessments for children, dental care, health care and child care.
3. The Initiative served families with multiple financial risk factors. Just over one-third of the families (38%) had an income of less than $10,000 per year, and nearly three-quarters (71%) earned less than $20,000 per year. In addition, 26% had not earned a high school diploma, of which 28% had not completed schooling beyond the sixth grade.
4. Similar to findings from previous programs, there was a greater representation of Latino, African-American and multi-ethnic families served by the Initiative compared to the population of Santa Clara County as a whole, and, conversely, a smaller percentage of White and Asian/Pacific Islanders

receiving Initiative services compared to their presence in the county.

5. As a result of care management and financial support, families had greater access to resources and services to fulfill court-ordered requirements and address self-identified needs.

6. The role of Care Managers helps the court system operate more efficiently. Care Managers personally meet with parents to assist them in identifying areas of need for their children age five years and younger. They then connect the parents not only with community based services aimed at addressing those needs (e.g. medical insurance, medical or dental care, food/shelter/clothing/child car seats, developmental assessment and related services, supervised visitation), but also with a broader and more comprehensive system of care made up of over 60 community agencies. Care Managers often help litigant parents review court orders and requirements, understand those requirements, and connect them with the services necessary for compliance (e.g. mental health, substance abuse, domestic violence intervention services), as well as court-based services they may need (the Superior Court Self-Help Center and Family Court Clinic). They also work with clients to identify and overcome barriers to obtaining services and provide follow-up contacts and encouragement.

7. Parenting classes have a limited yet positive impact on managing family conflict, particularly regarding the parents' views of their children's safety and stability. The information was gathered from surveys handed out to every parent prior to taking the classes and again at the completion of the program. Parents also provided personal comments on these sheets as well as regularly reporting changes in their lives to the facilitators conducting the group classes that were included in quarterly reports to the contractor.

8. The evaluators concluded that this study is a first look at the impact Care Management has on court-related outcomes, adding to the evidence that the Family Court Initiative is helping to promote stable, healthy families.

FUNDING

Primary funding for the Family Court Initiative was from the grant awarded by

FIRST 5 Santa Clara County. The monies distributed by FIRST 5 are obtained from a collection of taxes on tobacco products as established by California legislation. Approximately $700 million is collected by the State each year to serve children prenatal to five years old and their families. Eighty percent of the revenues go to County Commissions to fund local programs according to their annual birth populations; FIRST 5 Santa Clara County receives approximately $23 million each year. The Family Court Initiative received a two and a half year $2.5 million grant to specifically serve families in the Family Court system that have at least one child prenatal through five years old. All other funding for the Initiative (approximately $350,000 per year) were in-kind services provided by the Court, as itemized below, and by funded services provided by the two non-profit agencies, as well as in-kind services and consultation provided by the staff of FIRST 5.

The two and a half year contract that began in 2003 was administered by the Superior Court and by Resources for Families and Communities (RFC), who recruited and supervised the seven Care Managers serving the qualifying families in the court system. This agency was given $700,000 a year to support personnel and administrative costs, as well as a supplemental fund of $27,000 a year to assist families with basic needs.

Initially, the contract with the court included the following budget averages each year:

- Funding for part-time Family Court Resource/Treatment Coordinators' services: $93,000
- A Supplemental Fund to help pay for services for qualifying families who are indigent: $100,000
- Administrative Analyst and Accounting Services: $56,000
- Facilities Start-up FY 02/03 $35,000 and Office Expenses: $6,000
- A sub-contract with The Center for Healthy Development (CHD) to provide the New Skills and Choices programs: $42,000
- Consulting Services: $10,000
- Services provided by Superior Court included: court management of the project by FCS supervisors, judicial participation in the process of assessing client needs and eligibility, as well as conducting referrals and orders for FIRST 5 qualifying families; work space was provided for the Care

Managers: $256,000

Additionally, all four agencies in the collaboration contributed significant in-kind commitments on an on-going basis to provide cross-training and oversight of service development. Systemic changes and other adjustments were facilitated as necessary to improve service delivery to the families.

Since 2006, FIRST 5 has implemented a new strategic direction. In addition to county-wide community engagement and education, it now provides services to targeted impact programs that focus on high-risk children and families county-wide and in specific communities and/or geographic regions of the county. Over ten million dollars have been allocated to provide services to the court and social service agencies who will serve children with high cumulative risk factors in targeted communities, with the largest number of children prenatal through age five. FIRST 5 has approved continued support and funding of the Superior Court services provided by the Family Court Resource/Drug Treatment Coordinator ($88,000), by funding limited-scope legal services for domestic violence cases ($115,000), supervised visitation services and Parenting Without Violence workshops for indigent families ($142,000). Additionally, the Center for Healthy Development will continue their New Skills and Choices programs ($118,000). FIRST 5 has also placed FIRST 5 Family Partners (formerly called Care Managers) in the court to continue access to resources for families. The Partners not only connect families to services through a carefully constructed network called the "System of Care," they provide feedback to funders and to the court on unmet needs and on outcomes to the referring system. Services include access to health insurance, pre-school and special needs interventions. The System of Care is designed to connect high-risk children with an immediate referral path to the non-profit and county mental health system and to the early education system. This occurs when FIRST 5 Partners administer the ASQ–SE (*Ages and Stages Questionnaire: Social-Emotional, a Parent-Completed, Child-Monitoring System of Social-Emotional Behaviors*, an instrument designed to assess a child's social/emotional development) on the spot. This information is given to Kids Connection, an agency located in the community, which then links the family with the correct person in the community or in the Mental Health/Education System.

CHALLENGES TO PROGRAM DEVELOPMENT

While the positive approach to this collaboration has obviously offset obstacles, there were roadblocks in the beginning, particularly from the legal and service communities. They doubted that court-involved parents would be receptive to services and questioned whether the court should be involved in community service referrals:

Initially, some community agencies voiced concern that court clients were not sufficiently motivated to benefit from services and would compete with clients who were self-referred and more motivated to get help. The court clients may be self referred and/or they may be court ordered to access services. The Care Manager services are voluntary, while supervised visitation and parent workshops may be court ordered. A combination of in-courthouse access to Care Managers and court-ordered services designed specifically for these families created a dual approach to providing assistance to families who are often overwhelmed and underserved. In the Initiative, some clients do not follow through or drop out; however, many parents find themselves engaged in the collaboration, enabling them to willingly participate. Many parents express gratitude and agencies are recognized for the positive outcomes.

Initially, some judicial officers and mental health personnel wondered if this work was going beyond the legal mandate of the Family Court. The phrase, "we are not a social service agency" described this perspective. Evaluation outcomes, which indicated that families who used FIRST 5 services filed fewer motions and required less time from FCS, went a long way to reducing skepticism.

A final obstacle was the belief that these projects, as others, take too much administrative time and thus funding from the court. However, the court consistently obtained financial and in-kind support from FIRST 5 for administrative time, upon request. Currently, the court receives $46,000 in administrative overhead to offset the cost. The savings to the court in lower filings offsets costs, as documented in the Harper and Associates study.

The new funding direction of FIRST 5 has multiplied exponentially through the collaborative efforts of non-profit community-based agencies and large systems (Court, Mental Health and Social Services) throughout Santa Clara County to provide services to the young children, some in specific communities. The joint efforts of the courts, mental health and domestic violence agencies have resulted in

the coordination of services for families in the Family Court, Domestic Violence Criminal Court, Probate Court, Unified Family Court, Juvenile Delinquency and Dependency Courts, Drug Courts and Mental Health Courts. Additionally, the County Mental Health department has joined with FIRST 5 in providing Medi-Cal for the mental health needs of eligible children and their parents. The ongoing success of the collaborative efforts of FIRST 5, the Court, Court Administration, FCS and other project partners is directly related to the continuing open lines of communication to trouble shoot, make adjustments, sustain relationships and plan for the future. The constant maintenance of these collaborative relationships is essential to providing sustainable services and support to these families, which, in turn, also benefit the court.

CONCLUSION

Commencing in the early 1990's, California's Administrative Office of the Courts - Center for Families, Children and the Courts, began conducting research that confirmed what many Family Court practitioners had known for a long time. A significant portion of families entering the Family Court system with child custody and visitation disputes experience very serious problems impacting the health, safety and welfare of their children and other family members. Around that same time, the Family Court and FCS in Santa Clara County, with the assistance of the Court Administration and many other community participants, took the initiative to begin exploring ways of helping families address such underlying problems as child maltreatment, domestic violence, substance abuse, extreme conflict, child abduction and mental illness. These efforts included internal court collaborations as well as numerous court-community partnerships and grant-sponsored projects. Success of earlier projects, and increasing appreciation of the nature of the problems cited and their detrimental impact on children and families set the stage for the creation of the largest and most comprehensive of these efforts: the FIRST 5 Santa Clara County Family Court Services Initiative. This Initiative created a broad range of supportive services specifically aimed at helping families with young children, including enhancing early childhood development and readiness for school and helping them obtain a multitude of needed services.

Evaluative and statistical evidence validates that when a culture considers the

entry of a family into the Family Court system as an opportunity to identify and effectively address serious underlying problems, benefits accrue not only to the family and its children, but to the court system.

In summary, the following are suggested steps for other organizations looking to provide a similar approach:

- Gather data in your community on unmet needs of families and children of separated parents/caregivers.
- Convene leaders in the judiciary, mental health, social service and domestic violence organizations.
- Convene key organizations in the community to create a collaborative structure to serve the needs of high-risk families.
- Locate potential funders in your community. If funding is limited, sponsor legislation to create a funding stream for high-risk families.
- Develop grant writing and grant management skills.
- Collaborate, collaborate, collaborate.

APPENDICES

To access this chapter's Appendices, go to:
http://www.afccnet.org/resources/resources_professionals.asp

Appendix A: Course Information and Outlines

Appendix B: Survey Conducted by First Five and FCS

Appendix C: System of Care Flow Chart

Appendix D: Announcement and Letter to the Family Law Community and Service Providers

Appendix E: Letter of Invitation to a Focus Group

Appendix F: New Skills and Choices Intake Form

Appendix G: Client Information Sheet and Parent Survey

Appendix H: End of Program Parent Survey

Appendix I: Resources

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CHAPTER 2

SCREENING FOR DOMESTIC VIOLENCE IN FAMILY MEDIATION CASES

By David Royko, Sharon Zingery, and Corinne (Cookie) Levitz[1]

INTRODUCTION

Cook County, Illinois is among the largest urban centers in the United States, encompassing the city of Chicago and 77 suburban communities. The Cook County court system is the largest unified county court in the U.S., representing a population as diverse as it is massive. According to the 2000 census, approximately half of the county's 5,376,741 residents were Caucasian, a quarter were Black, a fifth Hispanic, with the remainder a mix of Asian and other ethnic groups. The economic profiles of Cook County residents are equally varied, ranging from abject poverty to extreme wealth. The Circuit Court of Cook County, through its Marriage and Family Counseling Service (MFCS), provides mediation to clients across this spectrum.

MFCS's primary task is to mediate custody and visitation disputes between parents[2] who are in court disputing custody and visitation arrangements. Virtually all of these cases are ordered by the Domestic Relations Division of the court,

which has approximately 44 judges. About 2,076 cases were mediated at MFCS in 2005.[3] These cases include parents who are in the process of divorcing (pre-decree or pre-judgment); are already divorced but are back in court and in conflict over custody or visitation (post-decree or post-judgment); and parents who have never been married to one another (parentage cases). MFCS does not mediate financial, child support, or property issues. Mediation services at MFCS are free.

Rules and Legislation

Mediation at MFCS operates according to the rules set forth by the Illinois Uniform Mediation Act (UMA),[4] Illinois Supreme Court Rule 905,[5] and Cook County Circuit Court Rule 13.4.[6] According to Rule 13.4, mediation is mandated for "…any prejudgment contested custody dispute" and *may* [emphasis added] be ordered "…on any post judgment contested custody dispute within the judge's discretion" and "…on any post judgment contested issue of visitation and/or removal of the minor children from the State of Illinois." Cases can use the free services at MFCS, or parties or attorneys can request that their case be ordered to private mediation where both child custody and visitation as well as financial issues can be handled.

Even though attendance at mediation is required, reaching agreement is not. No decision or solution is ever imposed upon the parents by the mediator. The mediator never provides the court with any recommendations or evaluations.

Court Rule 13.4 goes on to require that "Before mediation may begin, the mediator shall screen for impediments to mediation. An impediment to mediation may include, but is not limited to, family violence (child or spousal abuse has occurred in the past or is occurring on an ongoing basis)…" as well as substance abuse and mental illness. The rule also states that "In the event that the mediator finds an impediment to the mediation, the mediator may, at his or her discretion, institute such protocols [e.g., the precautionary measures delineated in this article and the accompanying appendices] to address the impediment during mediation."

Mediators at MFCS use the "Power and Control Wheel"[7] from the Domestic Violence Intervention Project as a way of identifying domestic violence. The "Wheel" includes abuse on all levels, including but not limited to, physical (biting, spitting, kicking, hitting, punching, slapping, pushing, shoving, restraining, pinch-

ing, throwing things, etc.), sexual, economic, intimidation, coercion and threats, isolation and emotional and verbal abuse.

Background

The Domestic Relations Division's Conciliation Service started in 1968 for the purpose of assisting divorcing and separating parties in coping with the emotional aspects of their conflict. After receiving mediation training from John Haynes and Steve Erickson in 1982, the Service changed its focus to providing mediation, as well as conciliation and reconciliation, to their clients. By 1985, the department had become the Marriage & Family Counseling Service as designated and defined by court rule. At that time, the MFCS mediation protocol was based on early theories and practices in family mediation which ascribed to the beliefs that (1) it is up to the parties to bring issues to the table, not the mediator; and (2) parents were not to be seen separately. This created situations where domestic and family violence might be unidentified or undisclosed. Furthermore, even if the mediator were made aware of domestic violence, no protocols then existed that directly addressed how to respond to domestic violence in a mediation setting. That mediation cases were not handled differently when a history of domestic violence existed did not go unnoticed by the domestic violence community in the Chicago area, which argued that victims of domestic violence should be excluded from court-mandated mediation at MFCS.

In 1988, Benjamin Mackoff, Presiding Judge of the Domestic Relations Division of the Circuit Court of Cook County, formed the MFCS Family Violence Committee. Under the chairmanship of Sharon Zingery, a former supervisory mediator at MFCS, and supervision of Joan Massaquoi, then Director of MFCS, research was conducted and a protocol was devised to effectively and ethically conduct custody and visitation mediation for parents with a history of domestic violence. The Family Violence Committee met with representatives of local domestic violence advocacy groups and studied their concerns, which included that mediation further victimizes the abused party. Taking their concerns into account, MFCS also recognized that (1) domestic violence cases would still be ordered to mediation; and (2) far more often than not, a spouse/partner abuser would still receive visitation rights from the court, supervised or unsupervised.

The challenge was to make MFCS a place where mediation would be done appropriately even when there is a history of domestic violence. Categorically denying domestic violence victims access to mediation services that are available to non-victims denies the victim the possibility of reaching a detailed, structured and safer parenting plan on their own and the possible empowerment resulting from the mediation process. Therefore, effective protocols and procedures needed to be developed.

Training mediators is a key part of the protocols. The 17 MFCS mediators do their own screening of cases, rather than using a specified intake worker, in order to provide continuous screening while building rapport with clients. In order to do effective screening, all MFCS mediators go through extensive domestic violence on-site training before screening and mediating their first case. This prepares them to respond appropriately to cases where domestic violence may and does exist. Domestic Violence training and education continues throughout their tenure at MFCS and includes readings, presentations and hands-on training in skill development in screening, basic dynamics of domestic violence, and safer termination. Supervisors observe screenings of clients by trainees. In addition, MFCS mediators all have advanced academic degrees, primarily in the mental health field.[8]

Mediators who deal with cases where domestic violence may be an issue must have the capacity to assess the combination of nuances they are hearing, seeing, feeling and experiencing from the parents seated before them. Therefore, individual in-person screening is necessary and required. Further, mediators continually filter and assess all this information through their totality of training and experiences in order to determine a case's initial and continuing appropriateness for mediation. This is based in large part on each party's ability to negotiate in their own best interest, free of coercion, fear and intimidation. It is important that the mediator not rely upon their first assessment but continually assess the dynamics of the couple throughout the entire mediation.

MFCS practices a facilitative model of mediation which is based upon party self-determination. The process is confidential; however, MFCS clearly reveals to clients that an exception to the promise of confidentiality is the reasonable suspicion or belief that there is harm or the possibility of harm to anyone inside or outside the mediation session (e.g., parents, children, mediator and others). This assessment may be based on the parents' and children's statements and actions

during mediation, including actual harm or threats of harm.

THE MEDIATION PROCESS AT MFCS

Referral to Mediation

The mediation process starts with a Domestic Relations Division judge ordering a case to MFCS for mediation pursuant to court rule. Parents must be in the court system and must be ordered by the judge in order to participate in mediation at MFCS. The Mediation Intake Order and the Mediation Referral Order used by the court (see Appendix A and Appendix B) specify the mediation intake and screening date as well as set a status date for the parents to return to court after mediation has been completed.

Though all parents are encouraged to have legal representation when they come to MFCS, many parents are unrepresented, or *pro se*, during the mediation process. If parties are represented by counsel and the mediator uncovers any violence or safety issues, the mediator will encourage them to disclose it to their respective attorneys immediately if they have not already done so. Unless mediators are witnesses to harm or threats of harm, they do not report alleged abuse to the parties' attorneys.

Mediation normally takes place after parties have attended the court-mandated Focus on Children program[9] and before the appointment of a legal representative for the child or orders for home studies, psychological evaluations or substance abuse evaluations. Generally, the court seeks the speediest and most efficacious resolution of a case, wanting to avoid extensive and costly litigation approaches. When mediation is successful, these further interventions may not be necessary. Some parents have reported increased willingness to set aside their marital differences for the sake of their children after attending the Focus on Children program, making their mediation a smoother process.

Mediation Screening and Intake

Each judge determines his or her individualized intake and screening procedures. The procedures are the same whether or not there has been a history of domestic

violence. Parties arrive at either the Judge's courtroom or at the MFCS Office on the scheduled mediation intake date for their "Mediation Screening and Intake." While separated from the other parent, parties complete a "Confidential Mediation Questionnaire" (see Appendix C) to maximize confidentiality by minimizing the ability of each parent to influence or observe each other's answers. The mediator will not share any information from the questionnaire with the other parent or with anyone outside of MFCS. It will be up to each parent to raise his or her own concerns and issues indicated on his or her questionnaire or during the individual screening, in the joint mediation sessions, if he or she so chooses. The Intake Mediator (preferably, but not necessarily, the assigned mediator) then gives an oral description of the mediation process to the parents. This description includes, but is not limited to, how mediation works, the benefits, what will and will not be discussed, and confidentiality and its exceptions.

During the screening, a sheriff is either in the same room or close by. The mediator is concerned with providing as safe an environment as possible, both during screening and during joint sessions. Mediating in a court setting with security measures in place adds increased safety for all concerned. Private mediators do not usually have the advantage of security personnel in their offices and usually avoid mediating cases where there is any domestic violence. All mediators should err on the side of caution.

The mediator then meets with each parent separately using the questionnaire as the basis for screening. A separate and direct face-to-face screening of each party, *prior* to the joint mediation session, is essential to making as accurate an assessment as possible of the case's appropriateness for mediation. Based upon a party's responses to the questions on the Confidential Interview Questionnaire, the MFCS mediator is prepared to question more extensively, using the questions in the "Domestic Violence Protocol Follow-up Questions." (See Appendix D.)

If the screening uncovers safety issues or other impediments to mediation (e.g., substance abuse or mental illness), the mediator then determines what actions to take using the "Mediation Screening Protocol Flow Chart" (see Appendix) as a guide. The mediator will choose one of the following routes:

1. **Yes, Mediate (both parties can mediate in own best interest).**

   If the mediator determines that mediation is appropriate, he or she and the parents will schedule two two-hour mediation appointments, or more,

if necessary. MFCS has several security arrangements that are always in place: (a) two sheriffs on the premises at all times, (b) metal detectors that all clients must pass through, (c) separate banks of elevators, and (d) separate waiting rooms for mothers and fathers.

2. Yes, Mediate (with precautions).

If the mediator determines that the mediation might be feasible for the parents with certain precautions, the mediator can set up one or more of the following; however, no precautionary measures can ever guarantee an absolutely safe mediation, only a safer mediation.

A. *Co-Mediation* – When possible, co-mediation at MFCS is done in pairs by mediators of different genders. Since there are more females than males at MFCS at this time, sometimes two women will mediate together.

There are a number of reasons to co-mediate in domestic violence cases. Co-mediation may provide a safer mediation environment. It enables the mediators to better and more easily manage the mediation process. For example, if either mediator observes signals or body language between the parties indicative of intimidation, the mediators, in consultation with each other, may decide to meet individually with the parties or terminate the mediation entirely. Also, mediators can model effective negotiation and communication skills with each other in the presence of the parties. The process is more efficient through both the increased awareness of the co-mediators in the session and their ability to interact differently with each client, perhaps based upon gender issues, especially if it is a male-female co-mediation team.

At times it is necessary for the mediators to each caucus with a separate parent. Normally, when caucus is used, the mediators caucus together with each parent. On occasion, co-mediators may determine that it will be more effective for the female mediator to meet with the female client and the male mediator to meet with the male client. Based upon rapport development, one mediator may be able to more pointedly reality test or address emotional issues with a particular parent. Together, two mediators may more easily strategize and assess what the mediation requires.

B. *Separate Arrival and Departure* – Parties are asked to travel separately to and from mediation appointments when there are allegations of abuse. They are instructed to arrive 15 minutes apart, use separate banks of elevators, and sit in separate waiting rooms. On departure, a sheriff can escort a party to the main lobby or to public transportation. At the end of the mediation session, the alleged batterer will remain at MFCS for 15 minutes while the abused parent is instructed to leave the building immediately. Despite mediator admonitions, some parents will still commute to and from mediation with each other.

The mediator emphasizes to the parties, when together, the importance and expectation that parties do not travel together so that they may increase their ability to negotiate with less tension, and minimize the possibility of repercussions after the session. Though MFCS cannot require parties to adhere to the transportation safety policy, when there are Orders of Protection or Restraining Orders, parties are generally more willing to comply. In caucus, the mediator emphasizes each party's self-interest (i.e., that the victim might feel more comfortable and be less vulnerable to retaliation, and that the abuser might avoid further accusations of improper behavior) in order to improve compliance with the policy that parties travel separately. This separate arrival and departure keeps the parties together as little as possible outside of the supervised space at MFCS.

It is not uncommon in Cook County for parents to still be residing in the same household when ordered to mediation. On these occasions, a mediator carefully questions the suitability and timing of mediation for these parents because of their proximity to each other after mediation, regardless of how they travel to and from the sessions.

C. *Shuttle Mediation* – Parties may only be able to discuss their children when not in direct contact with the other parent. Face-to-face mediation may result in an environment where negotiation is not safe, nor feasible. This could be due to fear of reprisals, accusations and physical or emotional harm. In shuttle mediation, the mediator will place the parties in separate rooms and the mediator is responsible for relaying information between the parents. On very rare occasions, mediation might be held with each party on the phone or with one party in the

mediator's office and one party on the phone. The information can be relayed by the mediator, or the session can be conducted via conference call. For some parents, just the sound of the other's voice or the use of even subtle visual or behavioral intimidation renders that parent unable to proceed in their own best interest. The fact that a parent may not be able to deal with the other parent face-to-face in mediation does not mean that they are incapable of devising effective parenting plans that limit their direct contact. Many parents find it more comfortable to communicate about their children after separation or divorce through e-mails, faxes, letters, text messages, and even willing third parties.

D. *Caucus* – Meeting separately with the parties at different points in the mediation is an effective way to check out how comfortable and safe each party is feeling, and is done more frequently in cases with a history of impediments. Before finalizing an agreement in a domestic violence situation, a caucus is imperative to offer each party an opportunity to reaffirm their voluntary agreement or report problems with the agreement. The mediator is expected to inquire of each parent if they want to proceed with the agreement.

E. *Support Person* (e.g., domestic violence advocate, attorney, family member, friend) – If a person feels more empowered to participate in a negotiation when there is someone nearby (e.g., in the waiting room or in the mediation room), and that person's presence does not escalate the conflict (e.g., new paramour), this can increase the viability of the mediation. Sometimes the support person can also act as a "quasi-mediator," acting as a voice of reason to the parent. A support person also provides additional security coming and going from the session. Each party can bring a support person to the mediation. The other party has the right to decline being in the same room as the support person, in which case the matter is shuttled, or terminated, if necessary. All support persons are advised of and expected to abide by the confidentiality rules set forth.

The Illinois Uniform Mediation Act (710 ILCS 35/10) Sec. 10 specifies that: "…An attorney or other individual designated by a party

may accompany the party to and participate in mediation. A waiver of participation given before the mediation may be rescinded." This means that an abused party can bring a domestic violence advocate or other support person into the mediation sessions. At MFCS this has happened very little since the passing of the UMA in Illinois. Whether this facilitates the mediation or increases safety is yet to be determined.

F. *Glass Room* - Another option that MFCS has used is to mediate certain high conflict cases in a conference room with glass windows/doors/walls that enables our security personnel to observe the mediation in progress, and minimizes the likelihood of extreme behavior during the mediation session since the security personnel are in plain view. It is only used when all parties are willing to proceed under these conditions. No party is ever forced or required to continue the mediation process by MFCS.

3. Delay Mediation (to address imbalances).

If the Mediator decides that mediation might be possible but not at this time, the mediator can delay mediation in order for the following to take place:

A. *Counseling* – Counseling can help increase each parent's capacity to mediate by aiding in the development of heightened self-awareness and self-esteem. The abuser can work with his or her therapist to develop safer, more effective and legally appropriate coping skills to deal with conflict. The victim can develop sources of support and learn when it is or is not safe to negotiate with the other parent, as well as how to adequately represent his or her own best self-interest and that of the children.

If the victim has not actually perceived himself or herself as a battered spouse/partner, counseling can provide education about the systemic process that has controlled his or her life, and what precautions exist to protect himself or herself and the children when they are at risk. The counseling may enable him or her to feel stronger and more emotionally prepared to discuss parenting issues with the abuser. Counseling also may assist the parent in developing the awareness and willingness to seek out the assistance and support of a domestic vio-

lence advocate. MFCS provides appropriate resource referrals and literature. Maintaining a list of therapists who are experienced in addressing the needs of domestic violence victims, as well as domestic violence support programs, is beneficial to clients.

B. *Physical Separation* – If the parents are still residing in the same home and the mediator believes that there is a likelihood of conflict after sessions, the mediator may delay mediation until such time that the parents no longer reside in the same household, and thus no longer have to face each other at home after a session.

C. *Substance Abuse Treatment* – As it pertains to domestic violence, substance abuse (alcohol and drug abuse) is often used as an excuse for, but it is not a cause of, violence. If, however, participants in mediation are currently abusing substances, self control is less likely, thereby elevating the risk of violence. Active substance abuse also brings into question a party's ability to negotiate in his or her own self interest, and to make and keep agreements.

D. *Obtain Attorney* – When an imbalance of power situation exists, having a legal advocate in one's corner is essential. If no Order of Protection (OP) is in place, an attorney may petition the court for an OP for their client. In some jurisdictions, an OP automatically excludes parents from mediation. This is not the case at MFCS. In assessing our clients, the ability to seek protection under an OP can indicate that the victim was able to seek help and advice to protect himself or herself. Consequently, mediation might be more feasible after an OP is in place. Also, an attorney's strength is paramount in strongly supporting and defending the client, which may help address an unlevel playing field more effectively than self-representation. Safeguards already described or covered elsewhere apply similarly to cases where there is an Order of Protection.

E. *Domestic Violence Support Programs* – When one or both parties participate in reputable domestic violence education and/or treatment/counseling, they are more likely to make agreements in their own and their children's best interests. It is possible that the victim and children may be safer if the perpetrator is in treatment; though many question the

effectiveness of batterer treatment programs.[10]

4. **No Mediation (one party unable to negotiate in own best interests).**

Although this is not a common occurrence at MFCS, the mediator may decide during the intake process, or at any other time, that mediation is not appropriate for a case because one or both parties are unable to negotiate in their own best interest. Parties must have an understanding of their options and the choices available to them, meaning they must each be free from coercion, intimidation or threats so that each may make his or her own choices in a free and voluntary manner. Before proceeding, a mediator must determine that both parties can say yes when they want to say yes, and can say no when they want to say no, without fear of consequences.

Parties who are not able to negotiate in their own best interest, who do not have the capacity to understand the effects of different options available to them, or who are not acting out of free will, may not be able to mediate. This may be a result of current domestic violence or threats of harm.

Parents who are unable or unwilling to adhere to the rules of the mediation process may also be unable to participate in mediation. Violations of a current OP, for example, may result in the termination of mediation. Termination may also be based on the inability of MFCS to provide a safe enough environment for a particular mediation to take place.

The existence of domestic violence, mental illness or substance abuse should not be the sole determining factor as to whether a case can be mediated. To terminate mediation, the level of domestic violence, mental illness or substance abuse must be such that (1) either the individual is rendered unable to negotiate competently for himself or herself in the mediation, (2) the mediator is not skilled nor experienced enough to mediate the case, (3) MFCS cannot provide a safe enough environment, and/or (4) consequences to the mediation are predictably unacceptable (e.g., subsequent retaliation towards the abused party). Whether or not mediation will proceed at MFCS is based on the mediator's individual assessment of each party's unique capacity or ability and on each party's willingness to participate. For each individual, capacity is uniquely defined by his or her

own circumstances and individual capacity to handle that specific situation. For example, a sole incident of slapping may incapacitate one individual while hospitalization of another may not. Skilled screening is imperative.

5. **Termination and Resource Referrals.**

   Termination in cases of domestic violence requires great finesse. Ill-conceived or ill-planned termination could result in greater risk to the abused party. The batterer may blame the abused party or use the termination as an excuse for further abuse. Therefore, the mediator uses neutral language to terminate the mediation that in no way blames the abused party. The mediator is more likely to reference the policies of the office as the reason. A termination that uses the batterer's own fears, concerns and statements may redirect his or her focus away from blaming the abused party. When there is an OP, for example, and the batterer has expressed concern that the abused party will use this against him or her in the mediation or accuse him or her of violating the OP while entering and exiting the mediation office, the mediator might terminate with the statement, "You've convinced me that this mediation may not be the best forum for resolving your issues." If the batterer insists on mediating, the mediator can fall back on office policies and state that no one should mediate when in fear that participation puts them at risk (e.g., a batterer who fears he or she may be accused of violating the OP). The abused party will usually understand and/or accept the reason given by the mediator. When terminating, the mediator gives appropriate referrals to both parties in caucus.

First Mediation Appointment

Checking In

Parents arrive at MFCS, which is located in a busy downtown location directly across from the courthouse. They check in first with the sheriffs at the front door. Everyone, including parents, children, support persons and attorneys, pass through a standing metal detector. If the sensors go off, a sheriff will then scan whoever set off the sensors with a hand-held metal detector (wand). The parties then check in with the receptionist who instructs parents to sit in separate waiting

rooms. Children are checked into an on-site supervised childcare room by the parent who brought them. They may only be checked out by that same parent. Even if parents indicate that they are okay sitting together in the same waiting room, it is not allowed because one parent may be too afraid to admit that he or she wants to sit separately.

Orientation

Prior to meeting with the mediator, all parties who are present for their first mediation session are gathered into a glass-walled room for orientation. The glass room is designed so that the sheriffs can observe all the parties and all the parties can see the sheriffs. The parties' awareness of the sheriffs' proximity is intended as a deterrent to inappropriate behavior on the part of any party.

The first session starts with a 45-minute group orientation for new mediation clients. A "Mediator's Opening Statement" is presented to the group that describes and explains the mediation process in detail. Emphasis is placed on (1) the process being confidential with certain exceptions (i.e., harm or threats of harm, and suspected child abuse or neglect), (2) the mediator being neutral and impartial, (3) the mediator not being a decision-maker, (4) understanding that there is no agreement in mediation unless both parties agree, and (5) acknowledging that the mediator will never provide the court with an assessment or evaluation. Parents also watch a videotape[11] that describes the impact on children of high conflict divorce or separation. The goal of the orientation is to explain mediation and its benefits, and to foster a future- and child-focused mediation process. After the group session, the parents meet with their assigned mediator.

Meeting with the Assigned Mediator

After the orientation and before the joint session, the assigned mediator will first screen the parents *separately* for any impediments, if for some reason intake has not already taken place (e.g., this may result when a judge wants to expedite the scheduling of a case). Mediation begins with the parents seated together unless shuttle mediation is being utilized.

Often, in high conflict cases, the mediator immediately starts with the least threatening topics, such as asking each parent to describe their children, encourag-

ing each parent to share how their children are doing, and eliciting each parent's dreams for their children. This approach enables parents, from the beginning, to focus on their children rather than on the conflict between the two of them. The mediator then tries to uncover common ground and areas of consensus between the parents relating to their children. The mediator works with the parents to create, when possible, a structured agreement, with clear boundaries.

The Second Mediation Appointment

Child Interview

The second mediation session includes the children's interview. It is an expectation of the judges, and part of the MFCS mediation model, that all children, ages four through seventeen, are interviewed by the mediator. Some advocates have urged that all mediators should see children in domestic violence cases to assess how children are affected by the violence.

The second session usually starts with the mediator bringing in both parents and all the children to explain why the children are present. The mediator might say: "Mom and Dad are working on a plan so that you [the children] will know when you spend time with Mom and when you spend time with Dad. I am helping them talk about things. Since you are such an important part of the family, I wanted to meet you. When you meet with me, you don't have to answer anything you don't want to answer. I won't share anything you tell me unless I think you are in some type of danger, or unless you give me permission to share something with your Mom and Dad." The mediator then will ask the parents in front of the children whether it is, in fact, okay for the children to speak with the mediator.

The mediator will meet with the children separately. During their individual meetings with the mediator, children may be asked questions about their school, friends, activities, interests and feelings. Mediators are not conducting a formal psychological assessment of the children but rather are interested in how the divorce or separation is affecting them both positively and negatively. Also, while an abused party (i.e., parent) may fail to reveal abuse, such abuse might be disclosed by the children. Such a revelation by a child would lead to reconsideration of the appropriate protocol for the case.

After the children's interviews are over, the mediator then meets with Mom and Dad together, unless it is a shuttle mediation. During this session, the following are discussed:

1. to review the children's interview when it is not confidential,
2. to give only general impressions about the children's emotional state (never detailed information), when it is confidential,
3. to see what has transpired in the family since the last session, and
4. to continue mediating an agreement when possible and appropriate.

Concluding the Mediation

When there is a full, partial, or temporary agreement, the mediator records it in the parties' words. Copies of the parties' agreement, together with the "Mediation Status Report" form (see Appendix 8),[12] are provided to each parent, sent to all attorneys (if any, including the children's attorney if one has been appointed), and sent to the judge. The mediator instructs the parties to review the agreement with their attorneys prior to the Mediation Status Date, which is assigned to the parties by the court prior to mediation. This date is intended to inform the judge of the results of the mediation. The parties and their attorneys report to the court whether or not the parties still want the mediation agreement or whether they have changed their minds. Either party can withdraw from the agreement with no repercussions from the court since agreements reached in mediation are not signed and are not binding until made part of a court order. If the parties are still in agreement, the judge reviews and approves the agreement and after the attorneys formalize the agreement, it is entered as a court order and incorporated into the divorce decree.

Unless the court orders parties back to mediation for some reason, MFCS is no longer involved. When no agreement is reached, or either party has changed his or her mind, the judge and attorneys determine the next step in the litigation process.

Mediator Competence and Readiness

A mediator who is not fully trained in assessing cases for potential and existing severe power imbalances between the parties puts themselves and the parties at risk. Even if a case is appropriate for mediation, the mediator still needs to ask whether he or she is the appropriate mediator for the case. Questions they should ask themselves include, but are not limited to:

1. With what I have learned about this mother and father, do I feel personally safe mediating this case?
2. Can I remain nonjudgmental and impartial given my personal reaction to the information that has been shared with me during the screening?
3. Do I have the mediation space/environment necessary to safely accommodate these parents?
4. Do I have a personal history that might result in my buttons being pushed more easily by one or both of these parties?
5. Do I understand adequately the impact these issues (of abuse) have on the balance of power between the parties, and how that affects their ability to competently participate and represent their own best interests in the mediation process?
6. Do I have adequate knowledge and skills regarding their dynamics to address these imbalances enough to continue the mediation?

CONCLUSION

Families with a history of domestic violence may reach parenting agreements through mediation at MFCS due to the comprehensive screening and mediation protocol used to address safety concerns. A successful process requires that all parties and the mediator share the capacity and competence to mediate. Effective mediators are well-schooled in mediation tools and techniques, are highly trained in domestic violence dynamics and its effects on families and children, and, most importantly, are aware of their own limitations and the limitations of their parties.

Highly conflictual domestic violence cases are best handled within agencies that are equipped with sufficient resources to provide safer mediation. A system with this type of protocol and resources means that families with a history of domestic violence, like those without domestic violence, are able to enjoy the benefits of mediation.

In order to have the safest mediation possible, mediators must have effective screening tools and mediation protocols.[13] Effective screening means that the mediator understands that meditation should not go forward when: (1) holding the mediation increases the possibility of harm to the parties, their families, or the mediator, (2) the pattern of violence is such that if the mediation were held, there would be a probability of harm (e.g., a person hearing certain information during the mediation might react in a violent or dangerous manner), or (3) holding the mediation increases the harm to someone after mediation. Although mediation can be a powerful and empowering process for parents in conflict about their children, it is never paramount to the safety of all concerned.

APPENDICES

To access this chapter's appendices, go to:
http://www.afccnet.org/resources/resources_professionals.asp

Appendix 1: Mediation Intake Order

Appendix 2: Mediation Referral Order (front page only)

Appendix 3: Confidential Interview Questionnaire

Appendix 4: Domestic Violence Protocol Follow-up Questions

Appendix 5: Mediation Screening Protocol Flow Chart

Appendix 6: One Mediator's View: Victim Spectrum

Appendix 7: One Mediator's View: Batterer Spectrum

Appendix 8: Mediation Status Report

Appendix 9: Readiness to Mediate Spectrum

NOTES

1. We would like to thank the following persons for their contribution to this chapter: All current and past members of MFCS' Family Violence and Emerging Issues Committee; Jan Lain, L.C.S.W.; and Michael Nathanson, Ph.D., M.S., M.B.A., C.P.A., C.E.P.
2. Parties will be referred to interchangeably as "parties" or "parents" even though parties may be grandparents, uncles, aunts, guardians, or other types of caretakers.
3. In 2005, there were 17,671 Domestic Relations case filings in the Cook County Circuit Court (3,650 pre-decree and 14,021 post-decree); 6,305 never-married Expedited Child Support cases filed; and 1,506 temporary Orders of Protection.
4. Illinois Uniform Mediation Act, 710 ILCS 35 (P.A. 93 399, effective January 1, 2004), http://www.ilga.gov/legislation/ilcs/ilcs2.asp?ChapterID=51.
5. Article IX, Child Custody Proceedings, Rule 905 (effective January 1, 2007), http://www.state.il.us/court/SupremeCourt/Rules/.
6. Article IX, Child Custody Proceedings, Rule 905 (effective January 1, 2007), http://www.state.il.us/court/SupremeCourt/Rules/.
7. The "Power and Control Wheel" comes from the Domestic Violence Intervention Project of the Minnesota Program Development, Inc., 202 East Superior Street, Duluth, MN 55802, (218) 722-2781.
8. MFCS mediators have had one or more of the following advanced degrees: Psy.D., J.D., M.S.W., M.A. in Counseling, M.A. in Family and Community Counseling, M.A. in Early Childhood Education, M.A. in Dispute Resolution, M.A. in Criminal Justice, M.A. in Divinity, and M.A. in Human Services Administration. Most have state licensure in their professions of origin.
9. The Focus on Children program is a parenting-after-divorce or -separation class that is designed to educate parents about (1) the effects of high conflict divorce and separation on their children, and (2) how to better communicate with the other parent about the children. This class is intended to be a prerequisite for attending mediation, and parents must be court-ordered to attend it. This 4-hour class is conducted through lecture, videotapes, exercises, and small and large group discussions. Parents do not attend the same class. New Illinois Supreme Court Rule 924 requires that "Except when excused by the court for good cause shown, all parties shall be required to attend and complete an approved parenting education program as soon as possible." (Article IX, Child Custody Proceedings, Rule 924 (effective July 1, 2006), http://www.state.il.us/court/SupremeCourt/Rules.)
10. Controversies and Recent Studies of Batterer Program Effectiveness, http://new.vawnet.org/Assoc_Files_VAWnet/AR_bip.pdf.
11. Film: "Don't Forget the Children," Dallas Association of Young Lawyers (edited, in part, for

use by the Marriage and Family Counseling Service, Chicago, IL).

12. The Mediation Status Report form specifies when and if the parties attended mediation, what type of agreement (e.g., full, temporary, partial, or none) if any, was reached, or whether the case was not appropriate for mediation.

13. For an excellent resource on screening for domestic violence in mediation cases, see: Domestic Violence and Child Abuse/Neglect Screening for Domestic Relations Mediation, provided by the Office of Dispute Resolution, State Court Administrative Office, Michigan Supreme Court, April 2005, at either http://courts.michigan.gov/mji/resources/dvbook/DV3_D_appendix.pdf or http://courts.michigan.gov/scao/resources/standards/odr/dvprotocol-abr.pdf.

CHAPTER 3

THE FAMILY ASSESSMENT AND INTERVENTION RESOURCES (F.A.I.R.) PROGRAM: A COLLABORATIVE, COURT-BASED INTERVENTION FOR HIGH CONFLICT PARENTS

By Melissa Gerstle, Alisha M. Wray, Kathyrn T. Wiggins, Peggy C. Maclean, Kathleen Clapp, and Timothy D. Reed

INTRODUCTION

Bernalillo County, located in central New Mexico, is home to nearly one-third of the state's population (i.e., nearly 600,000 residents). Served by the Second Judicial District Court, Bernalillo County encompasses approximately 1,200 square miles and contains the city of Albuquerque, one of the nation's oldest cities and the state's only metropolitan area. A state rich in history, Bernalillo County reflects New Mexico's unique intermingling of Hispanic and Native American cul-

tures, with 42% of the county's population being of Hispanic or Latino heritage (according to the 2000 census).

The Family Assessment and Intervention Resources Program ("F.A.I.R. Program") resides in the Second Judicial District Court in Albuquerque, New Mexico. It is a cutting edge collaborative effort between the Court and the University of New Mexico (UNM) Clinical Psychology Program. The F.A.I.R. Program has existed in two operational phases: 1991 through 1996 and 2004 to present. The impetus for its inception in 1991 was the frustration felt by the staff of the Court Clinic and the Domestic Violence Division. They were all too often witnesses to parents involved in domestic violence and/or high conflict relationships who were putting their children at great risk, psychologically and physically.

HISTORY OF THE F.A.I.R. PROGRAM

Originally, the F.A.I.R. Program was funded by a grant through the New Mexico Department of Public Safety with funds available to aid in protecting families. The Department of Psychology Clinic at UNM was asked to collaborate with the Court Clinic on the design of the program and to provide consultation services and supervision. Doctoral level psychology students were employed to provide assessment and treatment to families experiencing domestic violence. The focus of the F.A.I.R. Program is the family: to help parents, whether separated or divorced, learn skills to reduce their destructive interpersonal behaviors and to create healthier co-parenting environments. The F.A.I.R. Program, albeit successful, ended in 1996 when the five-year grant expired.

In 2004 the F.A.I.R. Program was resurrected when funds became available through the New Mexico legislature. It was evident that domestic violence had become an even larger public health problem. The need to protect children from domestic violence exposure remained imperative. The Court's willingness to house an evidenced-based treatment program and to collaborate with the local university was novel, and the F.A.I.R. Program continues to be an evolving vision.

Since 2006, the major aims of the F.A.I.R Program have been to continuously critique and improve the present curriculum, to serve a greater number of families, to create a curriculum for parents with below average cognitive functioning and/or low reading level, and to disseminate research findings. The F.A.I.R.

Program staff has presented at several international conferences and has participated in local community outreach. The staff is committed to creating the most effective interventions, informed by the current empirical research, for high conflict families.

THEORETICAL UNDERPINNINGS: NATURE OF DOMESTIC VIOLENCE

The F.A.I.R. Program is built upon a theoretical framework of research on domestic violence and abuse. Although conflict may be an inevitable aspect of family life (Camara and Resnick 1988; Straus and Smith 1992), aggression is not. Aggression represents intentional acts that inflict psychological or physical harm and is synonymous with abuse (Straus, Hamby, and Warren 2003). One of the most destructive types of aggression that occurs within families is interparental aggression. Often subsumed under the labels of domestic violence or intimate partner violence, interparental aggression can have extensive detrimental effects on child, parent, and family functioning. Johnson (1995; Johnson and Ferraro 2000; Kelly and Johnson 2008) proposed four distinct types of aggression within the intimate partner relationship: coercive controlling violence, violent resistance, situational couple violence, and separation-instigated violence.

Coercive controlling violence (CCV), formerly known as patriarchal/intimate terrorism, involves the systematic control of one's intimate partner through the use of violence, emotional abuse, economic control, coercion, and isolation; its counterpart, violent resistance, denotes an immediate reaction to a violent, coercively controlling partner that is intended to protect the individual from injury (Kelly and Johnson 2008). These two types of violence are compatible (though more gender neutral) with the feminist conceptualization of intimate partner violence. From a feminist approach, intimate partner violence denotes violence that is persistent and severe and is intended to dominate and control women through use of intimidation and coercion (R. E. Dobash and Dobash 1979; R. P. Dobash et al. 1992). The use of terms such as "male batterer" and "wife abuse" underscores the view of male dominance as central to intimate partner violence (Kurz 1989). Consistent with the feminist approach, Weston, Temple, and Marshall (2005) found that, even within the context of mutually violent intimate relationships,

more than half of the relationships involved men as the primary perpetrator of violence, engaging in more frequent and/or more severe violence. Notably, the authors interviewed only women, obtaining their individual perceptions of the violence dynamic in the intimate relationship.

Situational couple violence (SCV) is more consistent with the family violence approach, which postulates that intimate partner violence signifies a larger social problem, impelled by societal norms condoning violence and inherent family conflict (Straus and Smith 1992). SCV involves mutual aggression, most frequently at low levels, with little likelihood of escalation that arises from the context of a specific argument. It is not connected to a general pattern of control, and it is the most common type of physical aggression in the general population of married and cohabiting partners (Kelly and Johnson 2008). Although proponents of the family violence approach acknowledge that a culture of male dominance may engender violence (Straus and Smith 1992), they highlight that intimate partner violence is equally initiated by men and women, though women may suffer greater injury (Stets and Straus 1992).

The fourth type of violence, separation-instigated violence, is also seen symmetrically in men and women. It denotes the occurrence of violence when partners are in the midst of separation in which there have been no prior violent incidents, thereby representing an anomaly in the relationship. The broad distinction between coercive controlling violence and situational couple violence has received general empirical support in the literature (Graham-Kevan and Archer 2003; Simpson et al. 2007; Williams and Frieze 2005), with support for differentiation of the four types still in early phases. In similar support of this classification, Caetano, Ramisetty-Mikler, and Field (2005) found that different factors predicted the occurrence of unidirectional intimate partner violence, in which only one partner perpetrates violence, and bidirectional, or mutual, intimate partner violence. Importantly, this proposed distinction in intimate partner violence could extend to the interparental relationship and have implications for child outcomes.

Men who engage in intimate partner violence are *not homogeneous*, and treatments are likely to be ineffective if these differences are not taken into account. There are differences in the precipitating events that lead these men to engage in violence, thus altering the function of the violence. While it is premature at this point to determine what clinical interventions will be effective with these subtypes, data indicates that treatments that ignore differences among these men are

likely to be ineffective and may in fact be iatrogenic. Thus, treatment for intimately-violent men will need to be adapted in order to be effective.

In addition, intimate partner violence treatments have not been shown to be particularly effective in general (Babcock, Green, and Robie 2004; Rosenfeld 1992), and findings indicate that men who elevate on measures of antisocial, borderline, and avoidant personality characteristics have the worst treatment outcomes (Dutton et al. 1997). For example, Langhinrichsen-Rohling, Huss, and Ramsey (2000) found that men with antisocial traits are particularly likely to drop out of treatment and are viewed by therapists to be most likely to recidivate. Taken together these findings suggest that men in the two more severe subtypes will likely need treatment interventions that focus on additional clinical problems such as traumatic stress and substance abuse, in addition to intimate partner violence. However, because these two subtypes exhibit different clinical problems, they may benefit from differing treatments (Holtzworth-Monroe et al. 2000).

Although little is known about what interventions will be effective for generally violent/antisocial GV/A offenders, there is data suggesting that insight-oriented treatments (Bonta and Cormier 1999; Rice and Harris 1997, D. G. Saunders 1996) are less effective than cognitive-behavioral treatments. Additionally, evidence suggests that men who score high on psychopathy tend to recidivate more following therapeutic intervention (e.g., Rice, Harris, and Cormier 1992), indicating that therapy may have adverse effects resulting from treatment for this population. However, a recent study with youth elevating on measures of psychopathy suggests that a specialized behavioral treatment involving contingency management to engage clients in treatment may be helpful with this population (Caldwell et al. 2006). Taken together, evidence suggests that the tailoring of treatments is necessary to obtain positive treatment outcomes.

RELEVANCE OF TYPOLOGY TO F.A.I.R. PROGRAM FATHERS

Given the ethnically diverse composition of the F.A.I.R. Program clientele, it was unclear if the Holtzworth-Monroe and Stuart (1994) typology, which has been studied with predominantly Caucasian samples, would indeed characterize the men participating in the F.A.I.R. Program. Specifically, 77% of the individuals

served by the F.A.I.R. Program are ethnic minorities, with the largest proportion (62%) being of Hispanic/Mexican-American descent. The typology identifies three types of batterers: family only (FO), borderline/dysphoric (BD), and generally violent/antisocial (GV/A) offenders. The three types are based on levels of violence and level of psychopathology. Additionally, the F.A.I.R. Program clientele is court-ordered through civil court proceedings, which, to the authors' knowledge, is a sample that has not been studied to date. However, results from a recent study (Wray et al. 2008) suggest that this three-group typology does in fact characterize the F.A.I.R. Program population. Fathers referred to the F.A.I.R. Program were classified based on their scores on borderline and antisocial personality characteristics into either a Family Only (FO) group or a severe group (i.e., elevation on the borderline scale, antisocial scale, or both). Results indicated that men in the FO group had undergone significantly less traumatic experiences, as measured by the total number of traumatic events, than did the severe group (combined GV/A and borderline/dysphoric (BD) group). In addition, the FO group had significantly fewer occurrences of those traumatic events than did the severe group. FO men also reported significantly fewer symptoms of traumatic stress than did the more severe group. Furthermore, alcohol use as well as substance use-related consequences were significantly lower in the FO group than in the severe group. Based on these preliminary data, it appears that the Holtzworth-Monroe and Stuart (1994) typology may be a useful way to characterize the fathers referred to the F.A.I.R. Program.

The F.A.I.R. Program conducts a thorough assessment in order to determine the precipitating events and the function of intimately-violent behavior, thereby identifying which type of services would be most beneficial to the client. In particular, based on the existing literature, men who fit the FO profile are considered most likely to benefit from the F.A.I.R. Program's 12-week psycho-educational group treatment, which does not specifically address concerns related to substance use or trauma symptomatology.

Although the typology is a useful clinical tool when making treatment recommendations, it is noteworthy that the men referred to F.A.I.R. Program may not fit neatly into one of these three categories. For example, it is not uncommon for men accepted into the F.A.I.R. Program group treatment to have engaged in violence outside of the intimate relationship or to have engaged in severe violent acts. Similarly, men accepted into the F.A.I.R. Program often have mild to moderate

substance use problems. In fact, the F.A.I.R. Program has been relatively successful at referring individuals who do not presently seem likely to benefit from the group treatment to time-limited individual counseling, in order to address more urgent issues before returning to participate in the F.A.I.R. Program group treatment. For example, as B/D men tend to be extremely distressed (e.g., anxiety, depression), they may need additional individual therapy to address their current level of distress before entering a group setting. Likewise, men have also been referred to alcohol abuse treatment to reduce their level of use before returning to the program.

To summarize, the F.A.I.R. Program views assessment as the beginning of treatment. An essential part of the process, assessment engenders an idiographic approach, which ensures that the best possible recommendations are made for each client.

IMPACT ON CHILDREN

Studies of the impact of marital aggression on children conducted with community-based samples have found that children who have witnessed domestic violence are reported to exhibit increased levels of internalizing and externalizing behavior problems in comparison to normative samples (El-Sheikh et al. 2008; Jouriles et al. 1996). One hypothesis put forth to explain these associations between marital aggression and child behavior problems is the emotional security theory (Davies and Cummings 1994). This theory posits that children's responses are guided by implications of marital conflict for their emotional security and reflect the meaning of conflict for family relations. They evaluate marital conflict based on the appraised impact it has to contribute to or undermine their sense of emotional security within the family.

Much of the research supporting this theory has been conducted with parents engaging in general interparental conflict and has found that children react differently to parental use of constructive (e.g., compromise, support, affection) and destructive (e.g., threats, insults, hostility, defensiveness, withdrawal) conflict tactics (Cummings, Goeke-Morey, and Papp 2003; Cummings et al. 2002; Goeke-Morey, Cummings, and Papp 2007). In particular, exposure to destructive conflict tactics and negative parental emotionality increased the likelihood of chil-

dren's aggression, presumably because children perceive these methods as threats to their emotional security (Cummings, Goeke-Morey, and Papp 2004). Notably, when children were present, parents displayed increased negative emotion and greater levels of destructive tactics, with the subject of conflict more often centering on the children than for conflicts in which children are absent (Papp, Cummings, and Goeke-Morey 2002). Thus, by being present during interparental conflict, children were exposed to more potential threats to their emotional security and even may have altered the use of parental conflict tactics.

BUFFERING THE EFFECTS OF CONFLICT

Research has shown that interparental aggression and violence is detrimental to children; however, conflict in a co-parenting relationship is inevitable. The F.A.I.R. Program treatment was designed to focus on the *co-parenting relationship*, with the goal of reducing the destructive interpersonal behaviors used during conflicts that often lead to violence, as well as providing parents with the skills needed to buffer their children from conflicts that naturally arise. In service of this goal, the F.A.I.R. Program brings together elements from the marital and family theories and methods of researcher John Gottman to provide a therapeutic intervention that addresses three areas: (1) interpersonal skills to manage conflict effectively (Gottman, Driver, and Tabares 2002); (2) the significance of emotion in relationship interactions (Mirgain and Cordova 2007); and (3) the importance of emotion coaching as a way to buffer children's experience of their parents' conflict (Gottman 2001; Katz and Gottman 1997).

Most parents share the goal of providing the best possible life for their children, regardless of other diverging objectives. Thus, the F.A.I.R. Program examined existing couples or marital interventions that have shown lasting and favorable results when designing the treatment component. Successful interventions consistently target three objectives: (1) the increase of positive interactions outside of the conflict; (2) the decrease of negativity during conflict; and (3) the increase of positivity during conflict (Prince and Jacobson 1995; Snyder, Wills, and Grady-Fletcher 1991). It was hypothesized that the inclusion of techniques focused specifically on increasing positivity and decreasing negativity during the inevitable conflicts of co-parenting would be beneficial. Therefore, the F.A.I.R. Program

treatment includes educating parents about Gottman's concepts of helpful and damaging relationship behaviors. The treatment aims to encourage parents to have increased awareness of helpful behaviors and, through practice, to become knowledgeable of their utility in both increasing positivity and de-escalating conflict. In addition, the treatment promotes parents' increased awareness of the damaging nature of behaviors, such as contempt, belligerence, criticism, stonewalling, and defensiveness, in order to encourage them to avoid their use of these tactics, thus, decreasing negativity during conflict.

EMOTIONAL AWARENESS AND EMOTIONAL COACHING

An overarching theme of the F.A.I.R. Program treatment is that awareness leads to informed action, which is distinguished from reactive and often harmful behavior. In each aspect of treatment, the importance of awareness and informed choice are emphasized. Awareness of emotions and an understanding of how the parent "feels about their feelings" are also stressed in the F.A.I.R. Program treatment. This component of the treatment is drawn from Gottman's work on meta-emotion (Hooven, Gottman, and Katz 1995), which covers three aspects of emotions. It looks at the importance of parental awareness of and skill at regulating their own emotions, awareness and acceptance of emotions in their children, and their willingness and skill at interacting with their children around emotions. The emotional awareness and related skills used with children is known as emotion coaching (Gottman 2001). In addition, the F.A.I.R. Program treatment extends this focus on awareness and acceptance of emotions to the co-parent, hypothesizing that awareness and acceptance of the other parent's emotions will make it easier for parents to empathize and take the perspective of the other parent (Block-Lerner et al. 2007). Research has found that when parents are skilled at emotion coaching, their interactions with the other parent are less contemptuous, belligerent, and defensive than parents with less emotion coaching skill (Hooven et al. 1995).

Moreover, research has shown that children whose parents engage in emotion coaching benefit in several ways. In a three-year longitudinal study of preschool children whose parents varied widely in both marital satisfaction and emotion coaching tendency, it was found that when parents practiced emotion coaching

preschoolers showed less physiological stress, greater ability to focus attention, and less negative interactions with friends. At follow-up when school-aged, children who were emotion coached showed higher academic achievement in mathematics and reading, had fewer behavioral problems, and were physically more healthy (according to parent report) than children whose parents did not emotion coach (Hooven et al. 1995). Based on this research, the F.A.I.R. Program encourages parents to emotion coach their children not only so children can learn to regulate emotions, but also to mitigate the detrimental effects of witnessing interparental hostility and buffer children against upcoming conflicts (Gottman 2001).

F.A.I.R PROGRAM REFERRAL PROCESS

Parents are referred to the F.A.I.R. Program from within Family Court at the Second Judicial District Court. Although all referrals are made by a court order signed by a Family Court Judge, they may be initiated from any department that handles domestic matters or domestic violence cases. In order to be a suitable referral, parents must be having difficulty co-parenting due to high levels of conflict and hostility, and must have at least one child in common through biological, adoptive, or psychological ties.

Domestic matters (DM) case referrals are initiated by Court Clinicians, Hearing Officers in the Child Support Division, or Judges when it becomes apparent that a high level of conflict and hostility exists between the parents. (Court Clinicians are licensed psychologists, counselors, or social workers employed by the Court to evaluate and make recommendations concerning the well-being of the children when custody and time-sharing are in dispute.) Parents and/or lawyers who are aware of the F.A.I.R. Program may also request a referral. In the case of referrals made by Court Clinicians and Hearing Officers, referrals are made to the F.A.I.R. Program as part of their overall recommendations to the court. After the required time for review has passed with no objections, the recommendation to the F.A.I.R. Program becomes a court order, and a copy of the F.A.I.R. Program Referral Order (Appendix A) is forwarded to the F.A.I.R. Program clerk. In the case of Judges, once a minute order is signed referring the family to the F.A.I.R. Program, the referral becomes court ordered. In either

event, once the referral becomes an order, the F.A.I.R. Program clerk contacts each parent to schedule his or her intake assessment. An appointment letter and a blank intake questionnaire (see Appendix D) to be handed in, completed, at the time of the assessment, are then mailed to each of the referred parents. A copy of the appointment letter is retained for each parent's F.A.I.R. Program file. In situations where telephone numbers are unavailable or are no longer valid, an intake assessment appointment date is assigned, and an appointment letter and a blank intake questionnaire are mailed to the address on file. The intake questionnaire includes such information as educational history, employment history, prior military service, and overall relationship history and is intended to help expedite the intake assessment.

Domestic violence (DV) case referrals are initiated by DV Special Commissioners or by Family Court Judges during domestic violence hearings. Judges and Special Commissioners make referrals to the F.A.I.R. Program based on the documented history of high conflict/violence in the case. Prior to making the referral, Judges and Special Commissioners describe the F.A.I.R. Program and ask if both parents are willing to attend without discouraging the protected party from seeking protective orders in the future. A description of the F.A.I.R. Program and related brochures are provided to Judges and Special Commissioners, both to remind them of the availability of the F.A.I.R. Program and to assist in describing it appropriately. Once a Family Court Judge or Special Commissioner refers parents to the F.A.I.R. Program, a F.A.I.R. Program referral order is issued. Each parent is then directed to report immediately to the F.A.I.R. Program office to schedule an intake assessment. Every effort is made to keep the parties apart during the scheduling process, including staggering their exits from the courtroom and scheduling their intake assessments on separate days, in order to prevent incidental contact. Parents are then given an appointment letter (again, a copy is retained for their F.A.I.R. Program file) and a blank intake questionnaire at the time of scheduling their appointment.

Once the initial referral has been made, the parent begins the three-phase process of the F.A.I.R. Program: the intake assessment, treatment (individual and group sessions), and exit assessment. Although parents are referred to the F.A.I.R. Program as parties of a court case, once they begin the process, they are regarded as individuals; none of their appointments include the other parent. It should be noted that the initial contact with the referred parent, whether in per-

son or on the telephone, is seen as an opportunity to begin building rapport. The development of rapport with parents who have been referred is considered critical to increasing the likelihood that they will attend the intake assessment and feel comfortable to disclose private information, as well as to increase their motivation for treatment.

PHASE I: INTAKE ASSESSMENT

The importance of comprehensive assessment in domestic violence cases has been voiced by many in the Family Court community, including at the Wingspread Conference on Domestic Violence and Family Courts (Ver Steegh and Dalton 2008). The F.A.I.R. Program provides comprehensive assessment in order to appreciate more fully the unique difficulties faced by each parent. As a result of the in-depth understanding obtained from this assessment, the F.A.I.R Program is able to determine amenability to treatment and provide individualized treatment recommendations to each parent referred. In addition to developing treatment recommendations, the information obtained from the assessment measures is used to determine if the F.A.I.R. Program group treatment will be well-suited to the needs of the parent and to help tailor each group to fit the needs of its members. The intake assessment, particularly the interview portion, is also seen as an opportunity to continue building rapport with the parent. Many parents state that the assessment is the first time they have been given the opportunity to speak openly about the conflict and hostility that has resulted in court involvement. Lastly, the thoroughness of the assessment enables the clinician to evaluate the potential risk of danger.

Prior to beginning the intake assessment, the F.A.I.R. Program procedures are thoroughly explained to all parents. The F.A.I.R. Program's relationship to the Court is discussed along with confidentiality and its limits (e.g., suicidality, intent to harm, child abuse). As the parents are considered the "clients" of the F.A.I.R. Program, no information other than treatment compliance is reported to the Court. It is important that parents understand that no personal information will be shared with the Court, or anyone else, without their written consent, so that they feel comfortable in disclosing intimate material. Given the F.A.I.R. Program also collects data for research purposes, a research consent form is presented to

parents prior to the onset of the intake assessment. It is stressed that participation in the research component of the F.A.I.R. Program is not part of the court order and is completely voluntary, and that declining to participate in research will not affect access to treatment services.

Intake Assessment Components

The intake assessment consists of several elements, including a semi-structured clinical interview (see Appendix E); cognitive instruments; self-report measures that focus on personality characteristics, trauma history, substance abuse, parenting, relationship with the other parent; and a treatment goals questionnaire. Each element provides critical information used to inform the process of generating treatment recommendations. The assessment generally takes four to six hours to complete and can be concluded over multiple sessions.

The semi-structured clinical interview takes approximately 60 to 90 minutes to complete. It covers the following topics: sociodemographic information; family of origin history; childhood history of physical and/or sexual abuse; medical history (e.g., prior head injuries); psychiatric history (e.g., previous diagnoses, previous treatment); relationship history; information regarding the relationship with the other parent (e.g., presence of physical, emotional, and/or sexual abuse within their relationship); legal history; information about their children (e.g., their exposure to violence, the presence of behavioral/emotional difficulties, their need for treatment); information regarding the incident that prompted the protective order (if applicable); and treatment goals. Critical items, such as suicidality, intent to harm, and child abuse are also assessed during this interview.

Cognitive tests are also included in the intake assessment in order to determine each parent's level of cognitive functioning. This brief cognitive evaluation, which requires approximately 45 to 60 minutes to administer, includes measures of reading ability (i.e., *Wide Range Achievement Test - version 3: Reading subtest*; Wilkinson 1993) and IQ (i.e., *Wechsler Abbreviated Scale of Intelligence*; Weschler 1999) as well brief measures of verbal fluency (i.e., *Controlled Oral Word Association Test: FAS, Animals*; Benton 1968) and executive functioning (i.e., *Trail-Making Test: Parts A and B*; Reitan and Herring 1985). The information obtained from these tests allows us to determine whether the parent has the ability to read and comprehend

the curriculum materials and whether he or she will be able to communicate effectively in a group setting. Low scores on cognitive tests, particularly on reading ability and verbal IQ, indicate that a parent might benefit more from completing the curriculum in an individual setting or in a group specifically designed for individuals with lower reading ability and/or cognitive functioning.

Personality measures (i.e., *Personality Assessment Inventory*; Morey 1991; *Millon Clinical Multiaxial Inventory - Third Edition*; Millon, Davis, and Millon 1997) provide material useful in determining whether a parent is suitable for group treatment. In addition, some personality characteristics have been shown to be contraindicated for domestic violence treatment (Dutton et al. 1997; Langhinrichsen-Rohling et al. 2000; Rice, Hare, and Courmier 1992). For instance, clinically significant elevations on narcissism and/or antisocial scales are seen as potential indicators that the parent might not benefit from treatment (and may in fact become more skilled at manipulating others) or may be disruptive to the group process. Material obtained from personality measures is also used to supplement and/or support behavioral observations and information obtained in the semi-structured clinical interview. Brief measures (i.e., *Trait Meta-Mood Scale*; Salovey et al. 1995; *Mindful Attention and Awareness Scale*; Brown and Ryan 2003), which assess the parent's emotional awareness and strategies used to cope with emotions, are also included.

Trauma history measures (i.e., *Traumatic Life Events Questionnaire*; Kubany, Haynes, et al. 2000; *Posttraumatic Stress Disorder Screening and Diagnostic Scale*; Kubany et al. 2000) included in the intake assessment help to determine the amount of trauma the parent has experienced (e.g., type and frequency of traumatic event) and the associated level of distress. High levels of trauma may indicate the need for Posttraumatic Stress Disorder (PTSD) treatment. Similarly, substance use measures (i.e, *Alcohol Use Disorders Identification Test*; J. B. Saunders et al. 1993; *Inventory of Drug Use Consequences*; Tonigan and Miller 2002) provide information regarding the level of current and past alcohol and/or drug use. Each parent reports on their own alcohol and drug use and provides a proxy report of the other parent's alcohol and drug use, which is important in examining the contributing influence of substance use in the current relationship conflict as well as the potential need for substance abuse treatment.

Additionally, parenting and relationship measures are incorporated into the intake assessment. Parenting measures (i.e., *Parenting Alliance Measure*; Abidin and

Konold 1999; *Parenting Styles and Dimensions Questionnaire-Short Version*; Robinson et al. 2001) provide information regarding the quality of the existing co-parenting relationship and the type of parenting strategies employed by each parent. These measures aid in determining to what degree parents are capable of and desire to co-parent their children. Relationship measures (i.e., *Revised Conflict Tactics Scale*; Straus et al. 1996; *Inventory of Interpersonal Problems*; Horowitz et al. 1988), on the other hand, focus not only on the relationship that is the center of the given court case, but also on general interpersonal skills. These measures provide information about the frequency and severity of violence in the specified intimate relationship and the strategies used for coping with this aggression, as well as each parent's overall approach to interpersonal interactions.

Lastly, a treatment goals questionnaire (i.e., *What I Want from Treatment*; Miller and Brown 1994) offers information regarding what treatment areas the parent would like to target, affording a better understanding of what type of services would best meet the expressed needs of the parent. Altogether, the self-report measures take approximately 2.5 to 3.5 hours to complete.

STAFFING CASES

All cases are presented in a weekly staff meeting, and, when possible, intake assessments of both parties of the court case are presented in tandem. The information gathered in the intake assessment is presented by the clinician who conducted the assessment. Case presentations follow a concise and consistent format, including background material (e.g., family history; medical/psychiatric history, relationship overview), present functioning (e.g., current symptoms, cognitive results), and treatment goals, which facilitates a sound conceptualization of the parent's family system. After a case is presented, the F.A.I.R. Program staff reaches a collective decision regarding each parent's acceptance into the F.A.I.R. Program treatment. Possible reasons for not accepting a parent into the treatment component include the presence of extreme psychological distress (e.g., depression, anxiety, severe psychological problems), severe substance abuse, and/or limited proficiency in the English language, as these issues are likely to interfere with the ability to attend, participate in, and/or understand the curriculum. Additional reasons include clinically significant elevations on narcissistic and/or antisocial per-

sonality characteristics, as these signs often indicate that a parent may not benefit from group treatment and may harm the group process (Dutton et al. 1997; Langhinrichsen-Rohling et al. 2000; Rice, Hare, and Courmier 1992, D. G. Saunders 1996).

Parents with severe psychological distress, substance abuse difficulties, and/or antisocial personality characteristics are referred to reputable outside treatment agencies for more intensive therapy tailored to the parent's immediate needs. For some parents, however, it is determined that the psychological and/or substance abuse problems may be amenable to brief treatment, and parents can be re-evaluated and accepted into the F.A.I.R. Program group treatment at a later date. In these events, the referral specifies that, after a course of therapy targeting specific problems, the parent should return to the F.A.I.R. Program for additional assessment and potential inclusion into the group treatment. In situations where it is recommended that the parent attend treatment at an outside agency, a release of information is often requested to allow the F.A.I.R. Program staff to remain in contact with treatment providers in order to monitor progress and coordinate treatment services.

Final recommendations (i.e., acceptance into the F.A.I.R Program, referrals to outside agencies) are reported to the Court via the F.A.I.R. Program Referral Results disposition form (Appendix B). A copy of the docketed disposition form is placed in the court case file, and copies are mailed to both parents and their legal council. In addition, the parent is contacted by the clinician who conducted the assessment to discuss the final recommendations and to answer any outstanding questions.

PHASE II: TREATMENT

Individual Sessions

Once a parent is accepted into the F.A.I.R. Program, the treatment component begins with one or two individual sessions, each lasting 50 minutes. The purpose of these individual sessions is multi-fold: (1) to work on specific problems identified by the parent in the intake assessment; (2) to help the parent prepare for participation in the group treatment; (3) to maintain contact and parent involvement

from the intake assessment to the beginning of group treatment; and (4), as throughout the program, to continue building rapport with the parent and to address any treatment resistance. A safety plan is also formulated by each parent in this phase of treatment, which emphasizes ways to achieve and maintain physical and emotional safety (e.g., awareness of the early warning signs of conflict, steps to de-escalate or to escape potentially unsafe situations, potential indicators of dangerousness in current and/or future relationships). Throughout these individual sessions, clinicians utilize Motivational Interviewing techniques (Miller and Rollnick 2002) in order to increase and maintain the parent's motivation for attending sessions and participating in the treatment. If the parent expresses a desire to receive additional sessions, individual sessions are scheduled and may even continue concurrently with group treatment.

Group Treatment

Group treatment is at the core of the F.A.I.R. Program, and the majority of parents involved in the treatment component participate in a group setting. The F.A.I.R. Program provides 12-week psycho-educational treatment groups, separately to women and men, and offers only closed groups (i.e., no open enrollment) in order to increase the cohesiveness among members. Treatment groups are comprised of a maximum of 12 members, and each group session lasts 90 minutes with a 10-minute break. Sessions take place in the evening in an attempt to accommodate parents' work schedules. As services are often provided to parents with current protective orders, the men's group and the women's group are scheduled at different times to limit the risk of incidental contact. Each treatment group is run by two co-facilitators. Sessions are designed to include both process-oriented activities as well as psycho-educational activities, skills practice, and feedback.

Recently, the F.A.I.R. Program has added two daytime groups, which consist of fewer members, for parents who have additional challenges. Parents eligible to participate in these daytime groups may display a variety of different needs, including difficulty with reading, lower verbal abilities, prior educational challenges, or some other reason that necessitates inclusion in a smaller group (e.g., severe social anxiety). These groups are comprised of a maximum of five mem-

bers and are led by one facilitator. The same curriculum material is presented in these smaller groups as in the larger groups, but in a more streamlined manner. The smaller group size makes it possible to present the material more slowly, allow for more detailed discussion, provide more hands-on practice (e.g., role plays), and yet still complete in 12 weeks.

Occasionally, it is determined that a parent would benefit from the F.A.I.R. Program curriculum, but would not be a good candidate for the group setting (e.g., a parent with social phobia, a parent with significant rumination problems who might monopolize group time). In these situations, the parent would receive the curriculum in individual sessions, rather than in group sessions, to allow the curriculum to be tailored to the parent's needs. Although presenting the curriculum in an individual setting is possible, the group setting is preferred for its many advantages, including peer support, peer feedback, and the opportunity to normalize the experience (i.e., to interact with other parents experiencing DV and/or going through difficult separations or divorces).

F.A.I.R. Curriculum

The curriculum is made up of five flexible modules that include conceptual material, exercises, and homework that can be tailored to fit the group members' needs and the facilitators' teaching styles. In addition, throughout the curriculum, there are several themes interwoven into all modules, including: concern for emotional and physical safety, the importance of awareness in sound decision-making, and the impact of parents' choices on their children's well-being.

To aid in increasing awareness, mindfulness (i.e., the ability to non-judgmentally bring one's full attention to the internal and external experiences of the present moment (Baer 2003)) is practiced in every session. Through the use of short exercises called "breathing breaks" group facilitators instruct parents to attend to their own internal experiences in the present moment (e.g., their breathing, physical sensations in their bodies, emotions that they are experiencing) without evaluating or judging those experiences. This process of cultivating mindfulness has been shown to decrease problematic reactivity to distressing emotions and sensations in individuals experiencing high levels of anxiety (Linehan 1993). It is theorized that reduced reactivity will help group members tolerate and cope more

effectively with the conflict inherent in their current relationship, and these exercises serve to provide parents with a positive introduction to the practice of mindfulness. Moreover, breathing breaks provide a group ritual that helps members transition from their everyday worries and activities to the session at hand. They provide a moment to relax, an uncommon activity for many of our parents.

Another aspect of the curriculum that carries over from session to session is the check-in phase, conducted at the beginning of each session. This is designed to give parents the opportunity to talk about their experiences of the past week. It is often used to practice concepts learned in prior sessions.

Module 1

The first module, which is usually completed in one to two group sessions, includes a discussion of group rules and course objectives, activities to help group members become acquainted with one another, and a review of the safety plan that they formulated in the individual sessions. Group rules outline the expectations surrounding confidentiality, respect for members and facilitators, and compliance, including punctuality, attendance, and completion of homework assignments. Course objectives are linked to goals that are often expressed by parents in the intake assessment, such as learning how to express emotions in more appropriate ways, learning how to become a better parent, and learning how to have healthier relationships.

Course objectives are:

1. To identify and practice behaviors helpful to relationships.
2. To identify and reduce the use of behaviors harmful to relationships.
3. To promote a healthy and safe lifestyle.
4. To become familiar with our individual emotional history and the impact it may have on our emotional awareness and expression.
5. To increase awareness of a wider range of emotions and a broader spectrum of their expression.
6. To raise awareness of the importance of emotions in parenting.

An introductory exercise is presented in these initial sessions in order to acquaint parents with the level of participation that is expected and to underscore

the importance of safety. This exercise consists of a discussion of safety in new relationships in which parents are asked to list what they would like and what they do not want (i.e., "red flags," warning signs) in an intimate partner relationship. In order to expand the focus to include the co-parenting relationship, parents are also asked to describe the "ideal" co-parenting relationship. Participation by all group members is encouraged.

Module 2

The second module, typically comprised of three sessions, introduces the concept of damaging and helpful relationship behaviors. These behaviors comes from the research of Gottman and colleagues (Gottman, Ryan, Carrère, and Erley 2002) who have shown that couples using a higher ratio of helpful to damaging behaviors have healthier, more satisfying relationships than do couples using more of the damaging behaviors. In group sessions a brief review of this research is presented to parents, relating specifically to the co-parenting relationship. Then, each of these damaging and helpful behaviors is presented and discussed. Damaging behaviors include contempt, belligerence, criticism, defensiveness, and stonewalling, whereas helpful behaviors include validation, affection, interest seeking, surprise/joy, sadness and "pure anger" (to be differentiated from anger coupled with damaging behaviors). Activities include practicing helpful behaviors in-session, using prepared dialogue and discussing real-life situations in which a damaging or helpful behavior was used (and if a damaging behavior was identified, what helpful behavior could have been used instead).

It is emphasized that most people use a combination of damaging and helpful behaviors in their relationships, but it is a high ratio of helpful behaviors to damaging behaviors that is associated with more successful relationships. In addition, the ability to identify the types of behaviors and to be aware of the harmful or helpful nature of each kind of behavior encourages parents to reduce their use of damaging behaviors and to increase their use of helpful behaviors through more informed choices. Homework includes practicing the helpful behaviors and reporting subsequent outcomes to the group members and facilitators. Validation has been shown to be the most beneficial of the helpful behaviors (i.e., the ability to show acceptance and understanding of a partner's viewpoint without necessarily agreeing with it). Group activities and homework assignments that provide opportunities to

practice validation skills are continued throughout the duration of the group treatment.

Module 3

In the third module, covered over three sessions, the importance of emotions, emotional history, and emotional awareness are discussed. The crux of this dialogue details how emotions can impact actions and how emotion regulation difficulties can often lead to problems in relationships. Parents are asked to examine their own emotional history, including how their culture and family of origin influence their ways of thinking about emotions (i.e., meta-emotion) and how emotional history differences between partners can result in misunderstandings and conflict. Emotional awareness is also addressed, with an emphasis on how paying attention to emotions can inform behavior and lead to skilled actions. In-session activities include guiding parents to focus their attention on their feelings during the breathing break and discussing real-life situations in which emotions have impacted (positively or negatively) an interpersonal interaction. Homework assignments include completing emotional logs and emotional diaries in an effort to increase awareness of the experience of emotions.

Module 4

The fourth module, encompassing three sessions, marks the beginning of the curriculum dedicated to parenting with the introduction of emotion coaching. This concept also comes from the work of Gottman (Gottman 2001) and is described as the process of teaching children to recognize and respond to emotions in a healthy way. This module begins with identifying various parenting styles (i.e., disapproving, dismissing, hands-off, emotion coaching) and describing how each style differentially affects children. Emotion coaching parents are those who recognize their children's expressions of emotions as opportunities to share intimate moments and to teach their children about emotions. In the group setting, parents are taught steps of how to emotion coach (e.g., recognizing and validating emotions, labeling emotions, setting boundaries for appropriate actions). One parenting skill deficit commonly observed in this population, parents often become so uncomfortable when their children experience unpleasant emotions (e.g., sadness, anger, fear)

that they hasten to resolve the problem that resulted in the unpleasant emotion rather than acknowledge their children's emotions, thereby invalidating or neglecting their children's emotional experience. As evidence suggests that parents who validate their children's emotions raise more emotionally well-adjusted children (Hooven et al. 1995), the importance of parents helping their children work through unpleasant or difficult emotions instead of immediately engaging in problem solving is discussed. Exercises include examining parenting scenarios and discussing how an emotion coaching parent would respond in each situation. Homework assignments include practicing emotion coaching skills and reporting on the outcomes in the following group session.

Module 5

The last module, covered in one to two sessions, introduces discipline techniques derived from behavioral theories of learning. The concepts of positive and negative reinforcement (i.e., operant conditioning) are presented and the advantages and disadvantages of punishment are discussed. Parents are encouraged to talk about how they were disciplined in childhood and how that history influences how they discipline their children. The potential risks of using physical discipline techniques (e.g., spanking) with children who have been exposed to conflict and violence is emphasized. Exercises include having group members identify behaviors that their children exhibit that they would like to change and discussing strategies that parents can use to increase or decrease the frequency of these behaviors. The overall focus is on increasing desired behaviors through reinforcement rather than punishment. Homework assignments include practicing these strategies and reporting on the experience in session.

PHASE III: EXIT ASSESSMENT

The last phase of the F.A.I.R. Program, the exit assessment, serves three purposes: to assess parent satisfaction with treatment, to identify areas within the curriculum that could be enhanced or refined, and to collect outcome data. Upon conclusion of group treatment, an exit assessment is scheduled with each parent. During the interview component, parents are questioned about the nature of the current relationship with the other parent and whether the co-parenting relation-

ship has improved or worsened. They are asked if there have been any new incidents of domestic violence or significant conflict with the other parent since the intake assessment. They are also asked whether they are in a new relationship and if there has been any domestic violence in this new relationship. Additional inquiries are made about any recent legal involvement. Parents are then asked to describe how they felt about being ordered to treatment and to relay their initial expectations of the F.A.I.R. Program. They are also asked for feedback about the treatment and whether the F.A.I.R. Program has met their expectations and needs. Lastly, parents are asked about their children's current well-being and if they have any concerns regarding their children's emotional, behavioral, or adaptive function.

In addition to the interview portion, parents are asked to complete some of the same self-report questionnaires that they previously completed in the intake assessment in order to examine differences in pre- and post-treatment outcomes. These measures focus on emotions (i.e., *Trait Meta-Mood Scale*, *Mindful Attention and Awareness Scale*), parenting (i.e., *Parenting Alliance Measure*), and relationships (i.e., *Revised Conflict Tactics Scale*, *Inventory of Interpersonal Problems*). A self-report measure asking parents about what they received from treatment (i.e., *What I Got from Treatment Questionnaire*) is also completed.

ADDITIONAL TREATMENT CONSIDERATIONS

Supervision

Treatment services are provided by master's level clinicians who are typically concurrently enrolled in graduate programs in the fields of clinical psychology, counseling psychology, and/or social work. These student clinicians have completed multiple courses in mental health assessment and treatment (e.g., psychopathology, cognitive and personality assessment, adult psychotherapy, ethics) that have prepared them for working in a clinical setting. Given that the F.A.I.R. Program is staffed by student clinicians, the provision of supervision is critical. Supervision is provided by the director of the F.A.I.R. Program, a licensed psychologist. Treatment groups are supervised via a two-way mirror, with supervision provided during the mid-session break. In addition, each student clinician receives weekly

individual as well as group supervision. During supervision meetings, student clinicians receive feedback regarding their performance and are given suggestions of how to proceed in future sessions. Assessment and treatment issues are also discussed. Overall, this supervision ensures consistency and compliance with treatment protocol and ethical guidelines.

Treatment Compliance

As the F.A.I.R. Program is a court-ordered program, compliance with treatment is monitored closely. During the intake assessment phase, when a parent fails to attend a scheduled appointment, a second appointment is scheduled. If the parent fails to attend this second appointment, a Notice of Non-Compliance (Appendix C) is filed with the court, and a docketed copy is mailed to each parent in the court case. During the treatment phase, parents are allowed to miss one group session. Any further group absences result in a Notice of Non-Compliance. Parents must make up any group absence with one of the group co-facilitators prior to the next group session in order to cover the missed curriculum material. Due to Program policies regarding confidentiality, compliance information (i.e., attendance) is the only information about the parent that is reported to the Court.

Child Assessment and Therapy

In addition to providing clinical services to referred parents, the F.A.I.R. Program also provides child assessment and child therapy services upon parental request. Parents are informed in the intake assessment that, if they are concerned about their child's well-being and believe that their child would benefit from treatment, they can request a psychological assessment and/or therapy services. These child services are provided by doctoral-level student clinicians who have additional training and specialize in the assessment and treatment of children.

Treatment Outcomes

The domestic violence literature identifies two different gauges of program success for men participating in treatment: completion rates and recidivism rates. For the F.A.I.R. Program, the treatment completion rate for fathers over a 3-year period

was 86%. In contrast, recent completion rates for other domestic violence treatments were 77% for men displaying SCV and were between 9% and 38% for men exhibiting CCV (Kelly and Johnson 2008). In terms of recidivism, the F.A.I.R. Program recidivism rate for fathers over the same 3-year period was 9%. Events that qualified as offenses included violations of protective orders, new protective orders/extensions of current orders, and criminal convictions for violent crimes, such as assault or battery. Recent recidivism rates, based on partner report, for other treatments were 21% for men demonstrating SCV and between 42% and 44% for men employing CCV (Kelly and Johnson 2008).

ROLE OF THE F.A.I.R PROGRAM

Filling the Void

The F.A.I.R. Program attempts to fill a number of voids present in the DV/intimate partner violence field, namely in the areas of differentiation, treatment, and research. First, researchers are beginning to address the need to differentiate the types of domestic violence encountered not only in the judicial system, but also by researchers and practitioners (Kelly and Johnson 2008; Ver Steegh and Dalton 2008). The F.A.I.R. Program conducts a comprehensive psychological assessment in order to differentiate between two of the most prevalent types of intimate partner violence, CCV and SCV, with SCV being more common in the general population of married and cohabitating partners (Caetano et al. 2005; Kelly and Johnson 2008). By differentiating between these two types, the F.A.I.R. Program staff can determine the most appropriate treatment plan and referral sources.

In addition, the F.A.I.R. Program is specifically designed to address the intimate partner violence that occurs between parents, a topic often neglected in the treatment literature. In fact, the F.A.I.R. Program assesses both the mother and father in order to understand the nature of dynamics within the family. This method of assessment allows the staff to incorporate information from both parents in order to form a coherent conceptualization of the family system and to identify the needs of the family and its individual members. In turn, the thoroughness of the assessment allows for a more accurate matching of client need to resources and services within the F.A.I.R. Program, or in the community through

referrals to outside agencies. In contrast, the vast majority of other domestic violence programs address only one part of the family system.

Second, the F.A.I.R. Program addresses several weaknesses evident in the treatment and research literature. The F.A.I.R. Program aims to provide treatment to both the mother and the father (as well as to the children), because the risk of future violence among parents is elevated due to both the history of high conflict interactions and the continued need for contact (Brownridge 2006). The use of virtually the same treatment curriculum with both mothers and fathers, particularly those with a history of DV, has been debated in the literature and in clinical practice. The act of mandating or ordering the protected party (generally assumed to be the woman/mother) to treatment is also extremely controversial. However, as the F.A.I.R. Program assessment process differentiates among types of intimate partner violence, the parents who participate in the F.A.I.R. Program treatment are those that display the mutual aggression of SCV and, therefore, can both benefit from treatment. Even for women who are the protected parties in situations of CCV, they still stand to benefit from treatment because research has found that women who do not receive treatment are at a greater risk of re-victimization by current or future partners (Cardarelli 1997).

The ability to conduct such a comprehensive assessment is due to the collaboration between the Court and UNM, which permits skilled graduate students to conduct the comprehensive assessments and to provide treatment at greatly reduced personnel costs to the Court and at no-cost to the family, something that a free-standing agency is unlikely to be able to afford financially. One example of the success of the in-depth assessment process was the identification of a group of parents with low reading levels/below average verbal IQs who were not receiving appropriate services in the community. The F.A.I.R. Program was then able to design two new treatment groups in order to address the needs of these clients.

Third, the F.A.I.R. Program addresses limitations in research by incorporating the most recent research findings into its overall design, implementation of assessment and treatment, and program evaluation, with the overall aim of making unique contributions to the research literature in the field of domestic violence. One of the future research goals of the F.A.I.R. Program is to utilize control groups in order to improve upon and strengthen the research design.

Benefits

The F.A.I.R. Program offers many valuable benefits to families and to the Court. First, assessment and treatment are provided at no cost to the family, eliminating one critical barrier to clinical services for many families. Second, as the F.A.I.R. program is housed in the Second Judicial District Court, which is centrally located in downtown Albuquerque, it is easily accessible by public transportation and the highway system. Third, the emphasis on co-parenting gives parents new skills and strategies, which parents have indicated have been useful in resolving issues not only in their co-parenting relationship, but also in their court case. This added benefit has reduced their need for further court involvement in both DV and DM court cases. Fourth, in bettering the quality of the parents' relationship, the children's well-being is also improved. Lastly, the parents' perception of the Court and of therapeutic services is enhanced by participation in the F.A.I.R. Program.

In addition, the Court receives many direct benefits from the F.A.I.R. Program, including its unique collaboration with UNM. In particular, graduate students, bringing their extensive knowledge of research literature and experience with research methodology, are able to unite with court personnel who provide the practical, hands-on experience; the combination of skills is synergistic. Moreover, the court benefits from having an in-house program that offers assessment, treatment, and referral services: (1) the court gets immediate feedback on compliance and completion rates; (2) the court has greater accessibility to the F.A.I.R. Program staff in the event of questions or concerns about clinical services; (3) the court can be confident in the quality of services received by parents; (4) parents report that, after participating in the F.A.I.R. Program, they have been able to settle other issues in their DM cases, thereby freeing the Court's time for more protracted cases; and (5) the Court has also benefited from parents having a more positive perception of the court as a result of their participation in the F.A.I.R. Program.

COSTS AND REPLICATION

The annual budget for the F.A.I.R. Program has been approximately $200,000. This amount includes the cost of court personnel (i.e. a 20-hour program director,

a 30-hour support staff member, and a six-hour court clinician who helps to facilitate the men's group treatment), testing materials, and four graduate students funded part-time, at a rate of 20 hours each per week. Additional expenditures accounted for in the budget include facilities and administration costs paid to UNM, office supplies, and utilities in the building space.

The overall cost of running such a program has been vastly reduced by utilizing the time and expertise of graduate students. Without this opportunity, such a program would not be able to conduct as extensive an assessment or provide treatment at no-cost to families without substantial external funding. Program replication would require a commitment by the jurisdiction to collaborate with service providers, internally or externally, to conduct the comprehensive intake assessment and to provide individual and group treatment.

CONCLUSION

The F.A.I.R. Program is committed to intervening with families, particularly young families, in an effort to alter their trajectory of conflict, hostility, and violence. A major goal of the F.A.I.R. Program is to enable both mothers and fathers to co-parent their children in a peaceful and respectful manner, thereby protecting children from the harm of witnessing psychological and/or physical aggression between their parents. Feedback from parents who have completed the F.A.I.R. Program suggests that the treatment promotes healthier interactions, enhanced respect for the co-parent, and reduced conflict overall. Internal administrative reports are consistent with this anecdotal evidence and indicate that parents who participate in the F.A.I.R. Program treatment successfully close their current court cases and return to the system for additional litigation less often than parents who have not participated in the treatment component. Our recidivism data for fathers further support these findings.

Moreover, the F.A.I.R. Program signifies a unique collaboration between the New Mexico Second Judicial District Court and UNM. It represents pioneering efforts in the work of assessment and treatment of families at risk for continued high conflict. In addition to reduced court involvement and utilization, the F.A.I.R. Program provides many benefits to families, to the University, and to the Court. Beyond its no-cost service to families, the F.A.I.R. Program provides valu-

able hands-on experience for budding psychologists. This innovative collaboration also increases understanding between these two distinct entities, encouraging future partnership, and provides a fertile environment for ongoing research on the differentiation and treatment of domestic violence.

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APPENDICES

To access this chapter's appendices, go to:
http://www.afccnet.org/resources/resources_professionals.asp

Appendix A: Program Referral Order

Appendix B: Notice of F.A.I.R. Program Referral Results

Appendix C: F.A.I.R. Program Notice of Non-Compliance

Appendix D: F.A.I.R. Program Questionnaire

Appendix E: Structured Clinical Interview

Appendix F: Completion Times for Intake Assessment Measures

Appendix G: Appointment Letter

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CHAPTER 4

UMASS FAMILY COURT CLINIC BRIEF, FOCUSED ASSESSMENT MODEL

Linda M. Cavallero

BACKGROUND

Family courts today face many complex and litigious family cases that require judicial orders regarding custody and access to children. The pressures of providing courts with reliable information within limited time frames in light of increasing numbers of litigants, busy court dockets and scarce resources to fund assessment have led to the development of a variety of models, offered in settings ranging from court-based to private practice (Pearson 1999; Birnbaum & Radovanovic 1999).

The model described in this chapter evolved in response to requests from family court judges for assistance with specific family dilemmas presenting to their day to day practice. What began as a few consultations around specific aspects of family disputes developed into the formulation of this model of brief, focused assessment by the author, a child forensic evaluator in practice at the University of Massachusetts Medical School in Worcester, Massachusetts. Initially funded by the

Greater Worcester Community Foundation as a pilot program for six years with under $10,000 in funding per year, the model was refined, systematized and offered on a limited basis to family court judges in Worcester County. After positive feedback from judges and attorneys involved in assessment cases over a period of several years, a lobbying effort by attorneys and mental health colleagues, with support from the judiciary, was successful in persuading legislators to include funding in the state budget for a small court clinic employing this model, starting in 1998.

As a pilot project, the author was able to use foundation funding to offset some of her salary, essentially buying a few hours per week to fund two to three brief, focused assessments per month. There were no additional administrative services otherwise assigned, except support staff, who assisted with scheduling, recordkeeping and finalizing reports. Brief, focused assessments were one of the services provided by the author in addition to child custody evaluations (CCEs) and Parenting Coordination (PC), as well as teaching and supervision of trainees. Once state funding was granted, the UMass Family Court Clinic was established. In that process, a full-fledged, albeit simple, budget was calculated that included salary dollars for clinical staff, an administrative assistant, overhead and a small budget for equipment and supplies. When it was established as a court clinic, funding was channeled from the state budget to the Office of the Trial Court, which contracted with the State Medical School to provide assessment services. A simple organizational model was set up consisting of a total of three half-time clinical staff, a .75 administrative assistant and part-time director.

COURT CLINIC OPERATION

UMass Family Court Clinic is separate geographically from the courthouse. This has proven to be an asset in that the separation of the agencies means court clinic staff have access to the resources of the medical school for consultation as well as review of the psychological literature. Some judges have reported this physical separation facilitates maintaining the independent roles of the court and evaluator.

The court clinic operates within a larger administrative unit, the Child and Family Forensic Center in the Department of Psychiatry, which provides office space as well as administrative support. Currently, the UMass Family Court

Clinic supports four part-time clinicians (two full-time equivalents), a .75 FTE administrative assistant and .25 FTE for a court clinic director/administrator. The total annual budget is approximately $180,000 per year, with some variation from year to year depending on the vagaries of the state budget. Staff are all experienced and independently licensed psychologists and social workers, trained as forensic evaluators, although, at times, clinicians who need supervised experience in order to become licensed have been hired.

TRAINING AND EXPERIENCE OF CLINICIANS

A brief, focused assessment is akin to a consultation to the judge. It is important that clinicians performing brief, focused assessments have the appropriate skills to assess the questions asked. In addition, as time is quite limited, evaluators must quickly ascertain which information is relevant to the referral question. For these reasons, evaluators should be seasoned mental health clinicians with training in adult and child psychopathology, adult personality functioning, child development, family dynamics, interviewing and assessment. All staff are trained in specialty topics such as domestic violence, parenting and attachment, impact of parental separation, divorce, and conflict on children, relevant aspects of family law and forensic assessment. Less experienced evaluators should receive supervision to assist them in developing their skills. All new clinicians are trained in the brief, focused assessment model described in this chapter, by first observing senior staff conduct several family assessments and by assisting a senior staff member in a family assessment prior to conducting assessments independently but under close supervision of a senior clinician.

REFERRAL PROCEDURES

Referral procedures and practices have been developed with liaison staff in both the court and the court clinic to ensure the transfer of assessment requests from the court to the court clinic. Timely filing of reports makes them available to attorneys, *pro se* litigants and the judiciary for review. All assessments are completed at the order of family court judges by clinic staff. Court orders may specify that a report is sent to attorneys and the court. Reports are only disseminated by

court order and, unless ordered otherwise, are sent only to the court.

Initial contact with the parents is done by the court clinic administrative assistant by telephone, or by letter if telephone access is not possible, to establish the assessment date and time. Parents are generally aware of the court order for assessment but require an explanation of the process, including timing of the assessment and other logistical details. A follow-up confirmation letter includes a written explanation of the assessment process and information sheets for the client to fill out and bring to the assessment. (See Appendix A.)

INTRODUCTION TO THE MODEL

The present model describes a brief, focused assessment, which responds to a circumscribed legal question requiring immediate judicial action. The assessment model proposed here is designed for a subset of divorce or paternity cases presenting to family courts that involve disputes over parenting schedules or access to children. Cases appropriate for this model may raise issues of immediate child safety or questions regarding a child's needs. Urgent mental health issues in families presenting to the family court in crisis require a timely response. Brief, focused assessments average only 12 to 16 clinician hours and may complement more comprehensive child custody evaluations. The assessments can help to establish a safe access or parenting plan for the duration of temporary orders. Sometimes the brief, focused assessment is used to expedite an answer to a specific question during the process of a comprehensive psychosocial evaluation. In other cases, the brief, focused assessment may provide sufficient information in specific areas to allow the court to proceed with decision-making without further assessment.

DEFINITION OF A BRIEF, FOCUSED ASSESSMENT

A brief, focused assessment has a narrow scope and purpose. It generally consists of a single interview with each family member, although follow-up contact may be needed, observation of parent-child interaction and limited record and collateral review. Its purpose is to provide reliable information to assist a judge in a specific legal action. A written report is essential to provide a record of the assessment

process and results. These assessments are well suited to urgent family issues. They can be completed within a short time frame, and enable judges to make more informed temporary orders, which often have long-term consequences in family matters. An essential component of the assessment referral is the delineation of the issues of interest to the judge that defines the focus and shapes the process of the assessment.

REFINING THE QUESTION

In order to offer brief, focused assessments as a service to family court judges, clinicians must have a working relationship with the court to facilitate communication regarding referral questions. The assessment model, along with its advantages and disadvantages, must be understood by referring judges to ensure the appropriate selection of issues is addressed and an effective referral process is developed. Judges utilizing this model must understand the differences between comprehensive and focused assessments and must recognize the limitations of what each can provide the court in terms of reliable information relevant to the issues at hand. Instruction regarding the use of different models of assessment and types of questions that can be addressed is provided during a one-hour in-service training. Judges learn to identify the psychological components of information they need in applying the law to cases before them. A broad-based, long-term question such as child custody or post divorce relocation requires a comprehensive assessment of both parents' strengths and weaknesses as well as a child's needs. However, a decision to require supervised visitation for three months or whether to allow a long-absent parent access to a child under certain conditions or to allow a parent to engage in a specific activity with a child over the objections of the other parent, may benefit from a brief, focused assessment limited to psychological issues particular to the family situation. This could be an assessment of factors related to risk for children or of their developmental or psychological needs. The assessment may be of parent factors, such as psychiatric disorders that might impact parenting abilities in particular situations. The court clinic director is available to consult with court personnel to define appropriate referral questions or to determine if the issues at hand are amenable to brief, focused assessment.

This assessment model relies on a clear definition of the issue(s) of concern to

the court. The clinician must also understand the context in which the issue(s) arose, and the particular legal question before the court. This allows the clinician to tailor the assessment to the focused questions formulated in the referral from the judge. Contact with attorneys before the assessment begins, if the parties are represented, is important to ensure that the issues in dispute are accurately outlined. The clinician can then define questions to be addressed in a clinic model that includes individual interviews of all family members as well as observations of parents and children. In a brief, focused assessment, the evaluator moves directly to gathering information relevant to the referral question, rather than assessing the full spectrum of the family's functioning. (See Appendix B for an example of a judicial referral form.)

CLINIC MODEL OF ASSESSMENT

Although the brief assessment process can be altered to suit individual circumstances, a clinic model is generally an efficient format. Assessing the entire family in a back-to-back sequence of appointments provides maximal information in a minimal amount of time. Clinicians should be well versed in relevant legal issues, in addition to being trained and experienced in family assessments as it is important to grasp the crux of the case quickly.

SAMPLE ASSESSMENT SCHEDULE

9:00 Interview with custodial parent (child and sitter play separately)
9:50 Observation of custodial parent and child
10:20 Individual interview with child
11:00 Observation of noncustodial parent and child
11:30 Child and custodial parent leave; interview with noncustodial parent

INTERVIEWS WITH PARENTS

Depending on the circumstances, the clinician may interview the custodial parent for approximately 50-70 minutes, while the children play in an adjacent space with

a familiar caregiver who has accompanied them to the evaluation. The limits of confidentiality are discussed. (See General Information and Informed Consent Agreement, Appendix C.) Depending on the referral question of the court, the focus of the custodial parent interview is on a brief history of the parent's family of origin, the history of the relationship with the non-custodial parent, each child's developmental and parenting history, the parent's understanding of each child's needs, and the parent's concerns in the litigation. Behavioral measures, such as the *Child Behavior Checklist* (Achenbach and Edelbrock) can provide additional detail if there are issues related to the child's adjustment. For specific types of referral questions, individual psychological tests such as the *Personality Assessment Inventory* (PAI) can be used. Selected collaterals and relevant records should also be identified and appropriate releases signed by each parent. It may be appropriate to have follow-up telephone contact with either parent regarding issues that arise in the course of the assessment. Following this interview, the children and the custodial parent are observed in a play setting.

OBSERVATION OF CHILD - PARENT INTERACTION

The roles of judge and the evaluator are explained to the children while the parent is present. The children are also told that they do not have to discuss any topic or answer any questions that may make them feel uncomfortable. There is little opportunity for the interviewer to get to know each child, to be sensitive to the child's internal discomfort, or to help resolve emotions that may arise. Therefore, it is important to respect the child's limits in the assessment process. The quality of the interaction between parents and children and the level of functioning of the individuals is observed. A more structured task, such as playing a game or drawing a picture together, may be used to facilitate parent-child interaction.

If there has been regular or, at least, recent contact between the non-custodial parent and the children, an observation of their interaction is attempted subsequent to the individual interviews with each child. Clinicians must be cautious in interpreting both observations of parent-child interactions and child interview data, as children brought in by a particular parent may appear more comfortable with that parent. The children generally accompany the evaluator to a separate waiting area to greet the non-custodial parent, whose individual appointment time

is generally scheduled two or more hours after the appointment time for the custodial parent and children. The timing of the non-custodial parent's appointment is dependent upon the number and ages of the children. The interactions between the non-custodial parent and the children in tasks similar to those described above are observed and noted. The observation can be truncated or extended, depending on the court's referral question, the children's age and the time available. After this observation, the custodial parent and children are thanked for their participation and allowed to leave. The non-custodial parent's interview follows in a manner that parallels the interview with the custodial parent.

CHILD INTERVIEWS

When the clinician has enough observational data to respond to the evaluation questions, the parent leaves the room, and the children are interviewed individually, unless this is developmentally inappropriate. Generally, children over two and one-half years of age are seen in a play interview. This process generally begins as an open-ended play interview for younger children. With older children, or children who have more advanced verbal skills, the interviewer may use a discussion format. The evaluator tries to obtain a sense of any concerns each child may have, as well as of family relationships and his or her experience of the family disruption. After an open-ended inquiry phase, direct questions about the issues at hand are asked. Each child is also asked if there is anything they want the evaluator to tell the judge on their behalf. This particular question is used in an effort to convey to the children the judge's interest in their needs.

Special circumstances may make it impossible to complete the sequence as outlined above, especially if the non-custodial parent has not seen the child for an extended period, or if the child refuses to see this parent. Given the short-term nature of the assessment, the evaluator likely does not have a supportive relationship with the child. Therefore, great care must be taken not to exceed children's tolerance for stress in the assessment process. If a restraining order bars contact between the non-custodial parent and the children, no observation of their interaction can be conducted without further court order. In that circumstance, follow-up observation may be recommended by the evaluator in the assessment report.

PROTECTIVE CONCERNS

The clinic format makes it possible to keep parents separate from one another throughout the assessment. This is essential in cases of abuse prevention orders or allegations of domestic violence. Cases involving allegations of domestic violence require a careful review of issues and may not be appropriate to the model. When family situations exceed the capacity of the clinic model, further assessment can be recommended in the report.

FOLLOW-UP ACTIVITIES

Following the interviews, any psychological tests are scored and collateral contacts made. Selected records may also be reviewed, including any information provided by the attorneys or by the parents themselves. Collateral interviews and records reviewed should be screened for relevance to the issues being evaluated. In order to remain within the time frame of four to five hours of clinical time, plus an additional four to ten hours for collateral contacts, record review and report preparation, all activities must be sharply focused on the issues in the referral. If new information or allegations of concern come to light during the brief evaluation, the clinician must decide whether these issues need some type of immediate attention or can be simply noted in the report as possible areas for future investigation. (See Appendix D for Outline of Clinical Model of Assessment.) Further contacts with the parents, either brief follow-up interviews or telephone contacts, are possible to clarify information, fill in gaps or to request additional information, when needed. Both parents must be given an opportunity to comment on serious allegations made by the other parent. Efforts must be made to gather sufficient information on pertinent topics in an efficient manner. Due to the narrow time frame of a brief, focused assessment, at times, some collateral contacts or records cannot be obtained in time for inclusion in the written report. The clinician must list the missing data and consider whether to submit the report without it, noting the implications of its absence and possibly calling the report incomplete without the missing information. This might occur if the clinician is asked for an assessment of a parent's mental status in light of a psychiatric history, with a question of safety of young children with that parent. If the parent has hospital records that are not

readily available, this missing data might mean any recommendations about the child safety question would be lacking an important part of its foundation. In such a case, it may be preferable for the clinician to submit the clearly labeled incomplete report, followed by an addendum when the records are reviewed.

REPORT

A written report of the brief, focused assessment is an important component of this model. Documentation of the family's current situation is important for future legal proceedings, which are common in this population. Reports based on brief, focused assessments should clearly state the referral question and the legal matter before the court, as well as noting individual interviews, observations, and other assessment activity. The report will consist primarily of descriptions of the interviews, the clinician's observations of family members and their interactions. Conclusions will be limited, and recommendations will be primarily of a short-term nature. This is essential, given the limited data available to the clinician, and the most frequent context for the referral, i.e. temporary orders. Further assessment, including a comprehensive family psychosocial evaluation, can be recommended. In such cases, it is often possible to suggest important questions to be addressed in greater depth. (See Sample Report Outline, Appendix E.)

CLINICAL TESTIMONY

Court clinic staff testify in legal proceedings if subpoenaed by either party. It is essential that forensic assessments are subject to court review in the litigation process.

CASE EXAMPLE

A judge provided the following case facts, with the concern that her decision to place a two-year-old in foster care might not have been necessary, and could cause harm to the child due to separation from his mother:

In an *ex parte* motion, an unmarried father, released from jail the day before,

sought custody of his two-year-old son. His affidavit alleged that the child's mother lived in conditions unsuitable for a young child, with numerous drug abusers and boyfriends in and out of the home, which was in a dangerous area of a mid-sized city. The father further alleged that the mother had unconventional beliefs about illness and healing, and, as a result, medically neglected the child. The father's motion was denied because he had no relationship with the child and lacked resources to provide for him. The judge gave temporary custody of the child to the local child protective agency. A social worker removed the child from his home on the day of the order and placed him in foster care. A referral for a brief, focused evaluation was made, with the specific question of whether the child's safety required him to be in foster care while the family situation was clarified.

On the following day, the mother was interviewed in a brief, focused assessment to shed light on whether the foster care placement was necessary for the child's safety, given the potential negative effects of the abrupt separation from his mother. The mother's personal history, her current mental status, and a history of the inter-parental relationship were obtained. The child's prenatal and developmental histories were briefly reviewed with the mother. A *Child Behavior Checklist* and *Millon Clinical Multiaxial Inventory-III (Millon-III)* were administered to the mother and scored immediately. The child protection agency worker escorted the child to the assessment. The mother/child dyad was observed, and the child protection worker was briefly interviewed. Permission to speak with the child's pediatrician and the mother's obstetrician was granted by the mother, and the physicians were contacted. The evaluation uncovered no evidence of psychosis or thought disorder, showed maternal compliance with pre and post natal care and well baby visits, and demonstrated appropriate mother-child interaction. At the conclusion of the brief assessment, the clinician reported to the court that she found no evidence to support the father's allegations. It was noted that concerns about the living arrangement and the child's longer-term well being would require further assessment. The judge, after hearing the result, ordered the child returned to the mother's physical custody after less than 24 hours of foster care, although legal custody temporarily remained with the child protective agency. The judge also ordered follow-up monitoring of the child by the child protection agency, and a court review of the legal custody issue was scheduled for 60 days later.

EVALUATION OF THE MODEL

The brief, focused assessment model is based on crisis intervention theory (Parad & Parad 1990). The concept is simple: better informed and more timely judicial decision-making is important to the safety of children and can promote a reduction in conflict between parents. In addition to providing information for the judge's use in the decision-making process, the brief assessment is an intervention in which parents feel heard, as their concerns are assessed and clarified. Some parents benefit from the evaluator's feedback about the validity of their concerns and the appropriateness of their decision-making. In some situations, early interventions of this type may keep a case on track. A case may continue to move toward resolution, rather than become mired in repeated hearings and court delays that can cause disputes between parents to escalate.

TYPES OF CASES BEST SUITED TO BRIEF, FOCUSED ASSESSMENTS

Some examples of appropriate issues for brief, focused assessments include:

- In a case where one parent asserts that a child wishes to live with the non-custodial parent, a BFA of the circumstances of that request could be useful. The assessment might include: What is the context of and basis for the child's wish to change residence; is the child able to articulate his or her reasoning in a developmentally appropriate way; what is the parent's report of the history of this request as well as the parenting and attachment history; are there concerns about parental influences on the child's thinking/wish; does the child have any special needs; and what would be the impact on the child of such a change were it to be granted.

- In a case where one parent has been absent from a child's life for a lengthy time: Under what conditions might it benefit the child to establish a relationship with the parent and what might be the risks to the child and current caretakers?

- In a case where there are allegations of instability in a parent: In what ways

might the parent's alleged substance abuse or mental health condition impair the ability to provide a safe and nurturing environment for the child during their parenting time? Or, does the parent suffer from a mental illness or substance abuse problem, and, if yes, how might this impact the parent's ability to provide a consistent and safe environment during the parenting time?

- In a case where a child is very young or has special needs: Given a parental agreement or court ruling on legal and physical custody, what sort of parenting schedule would be developmentally appropriate?
- In the context of a larger matter, e.g., custody or relocation, a well-defined issue may be identified for BFA. For example: What would be a developmentally appropriate access plan if a post-divorce relocation is allowed or in light of a parent's mental illness?
- In the case of specific disputes of parents, e.g., should a young child be allowed to ride on the back of a motorcycle, travel to a third world country or attend an activity that the other parent opposes?

ADVANTAGES AND DISADVANTAGES

This model has several advantages. First, it is efficient and cost-effective. Second, it provides data quickly when urgent matters must be addressed, enhancing the judge's ability to make effective decisions for children. Third, timely, high quality assessments may save court time. Addressing issues early in the legal process may promote resolution and eliminate the need for some court hearings.

However, there are potential pitfalls and disadvantages to this model as well. The brief, focused evaluation cannot encompass all of the relevant concerns of some families. Clinicians must take great care not to exceed the available data in making conclusions. At times, the court may overvalue the written report, not recognizing its limited data base or may have unrealistic expectations of the brief, focused assessment process. Judges must fully understand the limited scope of the assessment and refrain from over-interpreting the results. The court must also appropriately select cases, and carefully frame the assessment questions as well.

The brief assessment is a snapshot of a family at a single point in time (Cavallero 2000). It is a useful, but limited, tool. The brief, focused assessment is best when used to assess immediate issues that require some urgency in decision-making, particularly questions of child safety. Custody recommendations cannot be based on a brief evaluation. More extensive comprehensive evaluations, with multiple interviews of family members, and observation of interaction, more extensive psychological testing, and the collection of collateral data remain the appropriate choice for complex questions regarding the best interest of the child.

As in all forensic evaluations, it is important that the evaluator maintain good boundaries and independence in his or her relationship with the court. The information provided by the evaluation is one data source for the judge to consider. It is not a ready-made solution to be adopted wholesale. In addition, when working within the brief, focused assessment model, it is especially important for the clinician to remain cognizant of the limitations of a single interview assessment. It is essential that the clinician not go beyond the limits of the data in forming conclusions and making recommendations based on a brief, focused assessment. A written caveat explaining the limitations should be prominently included, preferably in the conclusion section, in every written report.

USE AS A TRAINING MODEL

The brief, focused assessment model is also useful in training settings such as ours that includes psychiatry residents and fellows, forensic psychology and social work interns, as well as post-docs and other students. The model allows an overview of larger numbers of cases than would be possible with comprehensive evaluations early in the training period, and the potential to assess a greater number of families, providing the trainee with a greater breadth of experience. This experience does not replace the depth that is gained from participating in more comprehensive evaluations, but it is an effective teaching tool. Trainees learn to attend to the focused questions and the legal issues at hand, to think carefully in selecting the assessment measures most appropriate to the referral questions and to keep the limitations of these methods in mind. They learn to restrict data gathering to the focused questions. The written report involves less synthesis of data than a comprehensive evaluation, focuses on more descriptive information, the interpretation

of which is left to the court. Close supervision of trainees by experienced clinicians is essential, especially given the limited time and data available and the gravity of the issues presented. Only trainees who will be involved in the court clinic for at least six months and at least eight or more hours per week are able to participate in brief, focused assessments, in order to ensure that there is sufficient time to learn the model and to achieve a sufficient level of proficiency in the process. Trainees may be called upon to testify about the assessment at a later date, just as any other clinician, and they are made aware of this prior to conducting assessments.

CONCLUSION

The brief, focused assessment model is one of a number of tools which can be used to help inform judicial decision-making in the family court. This model is based on assessment of narrowly-defined family issues identified by judges and assessed by mental health professionals trained in forensic assessment. The brief, focused assessment model, as defined in this chapter, is cost-effective and efficient. When used appropriately, these assessments may help keep cases moving through the legal system toward resolution.

Delays common in divorce proceedings may prevent families from moving on with their lives and establishing new patterns or traditions that promote healing. Brief, focused assessments can screen for psychological difficulties in parents and/or children. An assessment can help anxious parents feel that their concerns have been heard and addressed. A variety of allegations can be explored early on in the litigation process via this model, before mutual suspicions become entrenched. Through the brief, focused assessment, parents can be helped to understand how the legal process might impact their children and themselves, and they can be encouraged to seek alternatives to costly litigation. Recommendations can be made for relevant mental health services and educative community programs. In some cases, a brief, focused assessment can precede or follow-up a comprehensive psychosocial family evaluation in a complementary way.

The brief, focused assessment functions as a consultation to the court. Clinicians must be well-trained in forensic assessment, child development, individual psychopathology, family dynamics, domestic violence, and substance abuse at a

minimum. Written reports must clearly state the assessment functions performed and the limits of the data available to the evaluator to avoid misinterpretation by readers and ensure the appropriate use of the assessment results. Only narrowly defined, focused issues can be addressed within this model. Broader questions with longer-term implications for the family, such as custody or relocation, require more comprehensive assessments. It is important that brief, focused assessments not be used as less expensive alternatives in family situations that require in-depth evaluation.

SAMPLE EVALUATION

CENTERVILLE COURT SERVICES

BRIEF PSYCHOLOGICAL EVALUATION

JONES FAMILY**

**Editor's Note: Please note that this report was created for educational purposes; case details as well as all names and geographic locations are fabrications. Any resemblance to real persons is purely coincidental. The reader is cautioned that each brief, focused assessment should be designed to answer the referral question identified by the Court or judicial officer and should reflect the issues specific to the case. No sample report such as this one should be regarded as ideal or used as a template to report on other families.

DOCKET NUMBER 99X9999-XX1

This report is confidential within the confines of the present legal matter. It cannot be released without the permission of the Court.

DATE OF REPORT

10/31/08

EVALUATOR

Jane Smith, M.A., Psychology Intern

FAMILY MEMBERS INTERVIEWED

John Jones, father, DOB: 7/16/80, Age: 28
Mary Jones, mother, DOB: 4/10/82, Age: 26
Jill Jones, child, DOB: 9/21/04, Age: 4 years, 1 month
Cody Jones, child, DOB: 11/30/06, Age: 1 year, 11 months

REASON FOR REFERRAL

The Jones family was referred for a Brief Psychological Evaluation by the Honorable David Parker, Judge of Family Court, Centerville Division in an order entered on July 22, 2008. The referral question from the Court indicated that the focus of the assessment is the safety of the Jones' children with their parents, specifically Ms. Jones, who is seeking unsupervised visitation.

The parents married in May 2004 and have two children, Jill (DOB 9/21/04) and Cody (DOB 11/30/06). Ms. Jones has a history of several psychiatric hospitalizations. The couple separated in September 2007 when Mr. Jones left the marital home. Custody of the children was transferred to Mr. Jones on an emergency basis in February 2008 when Ms. Jones was involuntarily psychiatrically hospitalized after making suicidal and homicidal threats.

DATE OF CONTACT: 10/1/08

John Jones: Individual interview, 1 hour 15 min
John Jones: Brief observation with Jill & Cody*, 30 min
Mary Jones: Individual interview, 1 hour 30 min
Mary Jones: Follow-up phone call (10/11/08), 1 hour
Mary Jones: Brief observation with Jill & Cody, 25 min
Jill Jones: Individual interview, 25 min
*Due to his young age, Cody was not interviewed alone

ATTORNEYS

Gary A. Fagan, Esquire, Ms. Jones' Attorney
Ken Sawyer, Esquire, Mr. Jones' Attorney

COLLATERAL CONTACTS

Interviews/Conversations with the following individuals:

- 10/8/08: Violet Brennan, MD, Ms. Jones' psychiatrist, Centerville Community Care, 15 min.
- 10/12/08: Jeremy and Deborah Duffy, Visitation Supervisors, 18 min.
- 10/16/08: Jane Harper, Program Specialist, Happy Days Daycare, 15 min.
- 10/9/08: Barbara Memory, LMHC, Ms. Jones' therapist, Centerville Community Care, 10 min.
- 10/11/08: G.H. Mercer, MD, Centerville Pediatric & Adolescent Care Center, Jill and Cody's pediatrician, 10 min.
- 10/10/08: Randy Post, MD, Ms. Jones' Primary Care Physician, 10 min.
- 10/16/08: Bob Wood, LICSW, Mr. Jones' therapist, 15 min.

RECORDS REVIEWED

- Discharge Summary for Mary Jones, Moonlight Hospital, dated 2/13/06
- Health records for Jill and Cody Jones from the Centerville Pediatric & Adolescent Care Center, dated 1/07 to 5/15/08
- Progress Reports for Jill Jones from the Centerville Head Start, dated 10/30/07 and 1/10/08
- Centerville Police Department Report and Narrative, Case #999999, dated 2/16/08

- Abuse Prevention Order Docket #999999, Central District Court, dated 2/17/08
- Psychiatric Discharge Summary for Mary Jones, Helpful Hospital, dated 3/03/08
- Letter from Gary A. Fagan, attorney for Mary Jones, to Ken Sawyer, Attorney for John Jones, dated 3/9/08
- Letter from Gary A. Fagan, attorney for Mary Jones, to Ken Sawyer, Attorney for John Jones, dated 4/28/08
- Letter from Ken Pierce, Assistant District Attorney, Central District, Centerville County Courthouse to John Jones, dated 5/24/08
- Order for Brief, Focused Assessment, signed by the Honorable David Parker, Justice, Family Court, Centerville Division, dated 7/22/08
- Letter from Deborah Duffy, Visitation Supervisor for Mary Jones, dated 8/03/08
- Letter from Peter Pane, Jill Jones' former preschool teacher, Centerville Head Start program, dated 9/14/08
- Letter from Frank Frost, Centerville Office of the Department of Children, Youth and Families, addressed "To Whom It May Concern" and provided by Mary Jones, dated 9/26/08

STATEMENT OF THE LIMITS OF CONFIDENTIALITY

At the beginning of the initial interviews with the parents and collaterals, the nature and purpose of the evaluation were discussed. The parents were given a written "General Information and Informed Consent Agreement," which details the mission of the Family Court Clinic and the limits of confidentiality in terms of information shared in interviews as well as the written report and protective concerns. Both parents signed the agreement, indicating that they understood the circumstances of the evaluation and agreed to participate. The limits of confidentiality were explained to Jill in language appropriate to her developmental status but not to Cody due to his young age.

HISTORY OF THE MARITAL RELATIONSHIP ACCORDING TO MR. JONES AND MS. JONES

Mr. and Ms. Jones reported that they began dating in the fall of 2003 and Ms. Jones became pregnant three months later. The couple married in May 2004 and Jill was born in September of 2004. Mr. Jones reported that he and Ms. Jones first began having problems in their relationship soon after Jill was born. He attributed this, in part, to Ms. Jones developing postpartum depression and purportedly becoming more "moody and angry" during the months after Jill was born. He stated that he found it difficult to please her and she became fragile, so that any perceived insult by himself or others resulted in prolonged tearfulness or rage. He stated that he learned of her history of suicide threats and psychiatric hospitalizations only after Cody was born. Ms. Jones acknowledged that they had relationship problems after Jill was born, but she attributed this to Mr. Jones purportedly being immature and distancing from her once she became a mother. She reported feeling very rejected by the alleged changes in his behavior toward her. In addition, both parents reported that when Mr. Jones' twin brother died in an accident in the winter of 2006, he became very withdrawn. She claimed he changed and "just shut down" and alleged he began to accuse her of being insensitive to him. Ms. Jones said that she begged him to go to couples' counseling but he refused, claiming there was nothing wrong with him, although later he enrolled in individual therapy with Bob Wood, LICSW. Ms. Jones reported that her husband started sleeping in Jill's room, while Jill slept in bed with her. She acknowledged that Jill had slept in bed with her since a very young age and that she never discouraged this behavior.

Ms. Jones reported that about a year and a half after Jill's birth, she had a "breakdown" and was briefly psychiatrically hospitalized in April 2006. Mr. Jones alleged that during this hospitalization, his wife had made threats to kill herself and kill him. He also claimed that in the three weeks prior to her hospitalization, he noticed changes in her behavior in that she slept very little, was argumentative with family members and friends and showed diminished interest in both Jill's needs and in care of the home. He claimed that during this time frame, he returned from work to find the home in disarray, Jill in dirty clothing and diapers and his wife often engaged in internet pursuits. At that time, the couple argued over responsibilities in the home and her alleged neglect of her responsibilities.

Ms. Jones reported that while she was in the hospital, she discovered that she was pregnant. She claimed that when she informed Mr. Jones, he accused her of being pregnant with someone else's child. It should be noted that Mr. Jones denied this allegation. She alleged that he did not attend any of her subsequent prenatal appointments with her and their relationship was further strained.

According to Ms. Jones, soon after her hospital discharge, Mr. Jones left her and moved out of the house, leaving Jill in her care. However, Mr. Jones said that in the context of a disagreement over finances, his wife unfavorably compared him to a friend of his, resulting in his leaving the household overnight. He said that he returned the next day. With regard to physical violence in the relationship, Ms. Jones reported that at one point during the summer of 2006, she and Mr. Jones had a significant disagreement and that he threw a cup of coffee at her and pushed her aside. Mr. Jones claimed that his wife was intermittently argumentative and irritable, as if she wanted to start arguments with him. He also stated that the pressures of childcare and strained finances exacerbated their disagreements. Both parents reported that their relationship remained tenuous after Cody was born on 11/30/06. Ms. Jones reported some exacerbation of her depression after his birth, but claimed she remained the primary caretaker for both children, noting that her husband frequently worked overtime.

After a period of escalating tensions, the couple separated in September 2007 when Mr. Jones left the marital home. He claimed she told him to leave in a purported tirade and claimed she threw things at him as Jill shrieked in fear. Ms. Jones denied both his account of their exchange and that Jill was upset, claiming that he threatened to take custody of the children, telling her she is "crazy." She acknowledged having had problems sleeping at that time, alleging that the day-to-day care of the two children was overwhelming and her husband was critical and unsympathetic.

POST SEPARATION HISTORY

Mr. Jones claimed that he was concerned about her ability to provide consistent care and a safe environment for the children after he left the household, also alleging that she often refused to let him see the children in the months following their separation. He said he worked extra hours in order to save money for his own

apartment and she was not flexible in allowing him to see the children when he was not working due to her stated anger over their separation. He reported that he was hopeful that she would "settle down" over time, but said that the opposite ultimately occurred. He said that Ms. Jones' father and step-mother were only intermittently helpful to her, and her relationship with them was generally distant. Ms. Jones claimed that he visited the children sporadically by mutual agreement, but acknowledged that he paid the rent and household expenses after he left. She described the holiday season of 2007 as especially difficult for her and reported increasing frustration with her day-to-day life as well as a reoccurrence of suicidal ideation after Thanksgiving 2007, which she spent alone with the children. She reported that she frequently did not get out of bed and fed the children cereal for dinner during this time frame.

Mr. Jones reported that due to escalating angry behaviors on the part of his wife, he had Ms. Jones served with divorce papers on February 13, 2008, alleging that she had threatened to kill herself and harm him, and that she destroyed furnishings in the home while Jill and Cody were in the house. Two days later, on February 15, Mr. Jones said he contacted Ms. Jones' father because of his concerns about his wife's potential suicidality and his children's safety in her care. He said that her father visited her and the children at her home and reportedly told Mr. Jones that she was upset but did not say she had intentions to harm herself or anyone else. However, the next day, Ms. Jones' neighbor reportedly told police that Ms. Jones was outside without sufficient clothing for the weather and appeared distraught. Mr. Jones reported that based on this additional information, the police brought his wife to the Emergency Room for evaluation and she was subsequently involuntarily hospitalized on February 16, 2008. He reported that the Department of Children, Youth and Families (DCYF) then accompanied him to the courthouse to obtain an order for temporary legal and physical custody of their children and a restraining order prohibiting Ms. Jones from contacting him or the children. The restraining order was vacated after a hearing on March 22, 2008. Mr. Jones stated that he took these actions because of his wife's refusal to cooperate with treatment and he was concerned about his children's safety while in her care.

Since February 16, 2008, Jill and Cody have lived with their father. They did not see their mother for three weeks while she was hospitalized and until the restraining order was vacated. Since that time, Ms. Jones has been permitted con-

tact with Jill and Cody twice a week, for 2 1/2 hours on Wednesday afternoons and from 11am to 7pm on Sundays, supervised by Ms. Jones' neighbors, Jeremy and Deborah Duffy. Ms. Jones stated that after the first five months, her neighbors stated they were no longer able to supervise the contact so she has not seen the children in about six weeks.

PARENTING HISTORY

When Jill was born, Mr. Jones and Ms. Jones had recently married. Mr. Jones took one to two weeks off from work after Jill was born and Ms. Jones remained at home to be her primary caretaker during the day. Both parents reported that they shared childcare responsibilities at night. Ms. Jones said that for about six months, she worked weekends at a department store while Mr. Jones took care of Jill. She reported she became too physically tired, so she eventually quit working. She said that Mr. Jones was initially reluctant to have her stay at home full time with Jill because it involved financial sacrifices. Both parents reported she was the primary physical caretaker for both children when Cody was born in November 2006.

Ms. Jones reported that when Mr. Jones moved out of the marital home in September 2007, he visited her and the children only sporadically. She said this was not best for the children because they never knew when their father was going to visit. She said that she was "hoping things would change" so she did not discuss the separation with friends or family members at that time.

Ms. Jones stated that she was the one that first brought Jill to Head Start last fall (October 2007) because she was concerned that she was aggressive with her brother, Cody. She stated that in addition to being enrolled three mornings a week, and seeing a counselor outside of the program, she and the children participated in a play group with other Head Start mothers. She also reported that when the children lived with her, she often took them to the park to play or to visit their cousins who lived nearby.

Mr. Jones stated that he enjoyed caring for Jill on weekends when his wife worked and said he was always an involved father with both children, although his wife was the primary caretaker. He reported that despite her hospitalization in April 2006 and their conflictual relationship, he was not concerned about the chil-

dren's safety when he left the children in her care in September 2007, describing her as generally a good mother when she is at her best. He alleged that she made visitation difficult for him from the time of the separation in September 2007 until he filed for divorce in January 2008 but he had hoped that her anger would diminish over time. He claimed that he only became concerned about Jill and Cody in late 2007 and early 2008 because Ms. Jones increasingly made suicidal threats, describing her as "crazy" and "out of control" at that time. He also alleged that she made references to moving to start a new life with the children elsewhere, but refused to discuss this with him, threatening that he might never see her or the children again.

JOHN JONES

BEHAVIORAL OBSERVATIONS

Mr. Jones arrived on time for his scheduled appointment, accompanied by his mother and the children. He was cooperative with the interview process and appeared eager to demonstrate to the evaluator that he was very concerned about his own safety and his children's safety, but not trying to deprive his wife of parenting the children. Mr. Jones presented with constricted affect, but did express concern that men are not believed when they seek help in family court. While he was open to answering all of the evaluator's questions, he demonstrated a somewhat limited capacity for abstract thinking as evidenced by very literal answers. He also appeared to have limited awareness of specifics regarding the symptoms, diagnoses and course of his wife's mental illnesses. He was able to report a logical and coherent family of origin history. There was no indication in the interview of serious cognitive deficit, thought disorder or acute mood disorder.

BACKGROUND HISTORY

Mr. Jones reported that he was born on 7/16/80 in Lisbon, (state) and was raised with his twin brother and younger sister by married parents in Centerville, (state). He described his family as very close with "a lot of love and support," and cited his twin brother's death in the winter of 2006 as a difficult time. He reported no his-

tory of abuse or neglect as a child.

Mr. Jones graduated in 1998 from Centerville High School. He described himself as "a C average" student who was on the school basketball team. He reported no attentional issues and was never held back a grade or suspended. He stated that he was very active in music and band in school. Following high school, Mr. Jones attended two years of college at Centerville Community College, receiving an Associate of Arts degree in criminal justice.

Mr. Jones reported that the only major medical illness in his family is diabetes on his mother's side. He said that he has no chronic illnesses and is generally healthy. He stated that he has a paternal cousin diagnosed with bipolar disorder but is not aware of any other mental illness in his family. He denied a history of any mental illness himself and has never been in counseling until recently and has not taken psychiatric medications. He reported that he does not smoke, has never used illegal substances and rarely drinks alcohol. Mr. Jones stated that he was never arrested as a juvenile or an adult.

Currently, Mr. Jones works as a manager for Sherry's Department Store in Centerville from 8:00 a.m. to 4:30 p.m. during the week. He has held this job for three years. Prior to that, he stated he worked at the Centerville Apartment Complex as a manager. He reported he was never fired from a job. He lives in an apartment with the two children in Centerville.

MR. JONES' CONCERNS AND WISHES

Mr. Jones reported that his primary concern is for the safety and well-being of his children and said he believes that Ms. Jones currently poses a significant threat to them. While he acknowledged that some of her behavior may be attributable to mental illness, he also maintained that she may have been abusing her prescription medications, especially those prescribed for neck pain. Mr. Jones stated that he is particularly concerned about Ms. Jones' purported threats to flee the state with both children which allegedly were made during a day pass during the February 2008 hospitalization. He stated that Ms. Jones blames him for their difficulties and also does not appear to be accepting of the end of their relationship. He is also concerned that her current rage, in the context of her purported history of being out of control when angry and making suicidal and homicidal threats in the past, places the children at risk of being harmed. He further stated that she

continues to be threatening when upset with him and he expressed concern that Ms. Jones speaks to Jill and Cody inappropriately, such as telling them that “Daddy has a new girlfriend” or “Daddy is mean.” Mr. Jones also stated that the supervised visitation was inadequate because he was not certain that the supervisors were actually present throughout the visit and he confirmed Ms. Jones’ report that they have been unavailable in recent weeks.

MARY JONES

BEHAVIORAL OBSERVATIONS

Ms. Jones arrived on time for her scheduled appointment and presented as neatly dressed and groomed. She was immediately very focused on seeing her children and made several comments to the interviewer during initial introductions that she wanted to spend as much time with them as possible that day. She demonstrated pressured speech, but was also cooperative during the initial part of the evaluation. As questioning proceeded during the individual interview, however, Ms. Jones became notably defensive and refused to provide information regarding her childhood or her history of mental illness. She refused to sign releases of information for mental health providers and records. She became agitated and left her seat to walk around the evaluator’s office, pacing in an angry manner. She appeared to perceive the evaluator as asking questions that she deemed irrelevant to her abilities to parent. Indeed, she pointedly denied that she had been psychiatrically hospitalized, despite later acknowledging she was, which was confirmed by her treaters as well. Ms. Jones’ mood appeared to become irritable and her tone became hostile, as she expressed the belief that the evaluator, who had previously met her husband, had already decided to believe him and not her. She was not receptive to attempts by this evaluator to clarify her neutrality. After being interviewed for just 35 minutes, she impulsively said she needed to leave to go to work and took her things to leave the office but subsequently she agreed to remain until the assessment was completed. Once the questioning about her mental health issues ended, she then appeared to become calmer and less defensive. She was able to remain seated and addressed the evaluator’s questions, although she frequently responded “I don’t remember” to questions of her history.

Following the assessment, this evaluator contacted Ms. Jones’ attorney to

inform her that Ms. Jones had refused to sign releases or discuss her psychiatric history. After conferring with her attorney, Ms. Jones signed releases for her treatment providers and engaged in a more open conversation in a phone conversation with the evaluator. During this call, she reported feeling that she was unfairly "under the microscope" in the legal process and that she feared she was being wrongly portrayed as a bad mother due to her mental illness. She expressed sadness at not having her children in her life, both for the children and for herself, and was crying through much of the phone call.

BACKGROUND HISTORY

Ms. Jones reported that she was born in 4/10/1982 in Centerville, (state). Her parents separated when she was four years old and her father obtained full custody of her and her younger brother. Ms. Jones reported that her mother abandoned the children and her father subsequently physically abused them. Her father remarried when she was 12 years old and the family moved in with their new step-mother and step-siblings. Ms. Jones reported that her home life was "really hard" and that at age 14, when she did not get along with her step-mother, her father placed her in foster care. Ms. Jones stated that she lived in several foster homes until her religious education teacher took her into her own home for the rest of high school. Currently, she said, the "the best thing" for her is to limit her contact with her father and step-mother. She acknowledged a suicide attempt by Tylenol overdose followed by a brief psychiatric hospitalization at age 18 when she was initially diagnosed with bipolar disorder.

Ms. Jones reported that prior to her marriage, she worked full time as a sales clerk. She reported she had also worked at a real estate agency. She worked part-time after Jill's birth for about six months. Ms. Jones stated that she has been on disability "on and off" for the past year due to neck injuries sustained in a car accident just after Cody's birth. She reported taking Oxycodone prn, as well as muscle relaxants for neck pain, and Ambien for sleep three to four nights per week. She is currently unemployed.

Ms. Jones' family history is notable for heart disease on her paternal side. She stated she is unaware of her biological mother's family history. She said she has no history of substance abuse, is a nonsmoker and drinks socially usually one to two drinks while out with friends on weekends and never combined with pain medica-

tions. Ms. Jones reported that she has had significant health problems since injuring her neck in a car accident including headaches and muscle spasms. She also reported having been psychiatrically hospitalized multiple times and has been diagnosed with bipolar disorder, treated with Lamictal (a mood stabilizer). Hospital records indicate that she refused to comply with the recommendation that she attend a partial hospitalization program following discharge in 2008. Currently, Ms. Jones sees her therapist weekly and her psychiatrist every two months. However, following her therapist's collateral contact with this evaluator, her psychiatrist reported that Ms. Jones may have terminated her treatment with her outpatient therapist.

With regard to her legal history, Ms. Jones reported that she was never arrested as a juvenile or an adult. Ms. Jones has been investigated by DCYF on two occasions, in April 2006, when she reportedly threatened to harm herself and her husband in the presence of her daughter and in February 2008, when a child abuse complaint was filed at the time of Ms. Jones' psychiatric hospitalization. Hospital records indicate that DCYF came to the hospital to investigate. Ms. Jones reported that there is no active involvement of DCYF in her life at this time and she produced a letter from DCYF indicating her case had been closed. Currently she lives with a friend in an apartment, supporting herself on disability payments.

MS. JONES' CONCERNS AND WISHES

Ms. Jones stated that she has been the primary caretaker of both children since they were born, and was the sole caretaker during the more than four-month period after her husband left the marital home to mid-February 2008, when Mr. Jones obtained custody of the children. Ms. Jones expressed special concern about the negative impact on both children of having been suddenly uprooted from their life with their mother and placed in a different home environment, a different school, daycare for up to 10 hours a day, and very little contact with their mother. She alleged that Mr. Jones does not spend much quality time with the children because he drops them off at daycare at between 7 and 8 am and often does not pick them up until almost 6 pm.

Ms. Jones reported that the supervised visitation is not happening as it is supposed to because her supervisors are no longer able to offer their time. In addition, she said that Mr. Jones is being excessively rigid and is not trying to accom-

modate any of these challenges, thereby depriving not only her of visits, but the children as well. She also expressed concern that Mr. Jones is alienating her from her children by not keeping her informed about events in their lives. In particular, she said that Mr. Jones did not notify her when Jill needed to go to the hospital for a head injury. She said that if he were truly concerned about her ability to be a good mother to the children, he would not have left the children with her when he left the marital home in September 2007.

Ms. Jones stated that although she is very upset about the current custody and visitation situation, she is stable and capable of safely taking care of her children. She claimed that there has been no negative impact on the children by her mental illness or past behavioral difficulties. Ultimately, she said she wants full legal and physical custody of the children. At present, she wants them returned to her physical custody or, at a minimum, more frequent, unsupervised visits with them. She also said she wants to be notified about all doctor visits so she can accompany them, as she has always done in the past. She denied any intention to remove the children from the state.

JILL JONES

DEVELOPMENTAL HISTORY

Jill Jones was born on September 21, 2004, two weeks early, and labor was 30 hours long, but according to Ms. Jones, she was born "perfectly healthy." She reported that all developmental milestones were achieved on schedule and that Jill has not suffered any unusual illnesses or accidents.

In September 2007, Ms. Jones enrolled Jill in a Head Start program where she reportedly adjusted over time and received therapy for some behavioral issues. In February 2008, following the change of custody, Mr. Jones transferred Jill to Happy Days Daycare. In both placements, Jill received counseling services. Jill was described by Head Start staff as very interested in her peers and "consistently demonstrating an ability to independently engage in activities." Mr. Jones reported that Jill is doing well in her current daycare and is increasingly verbal. He stated that Jill is at daycare between 8 am and 5:30 pm on most work days.

Staff at the Happy Days Daycare describe Jill as cooperative and as doing better socially. Jill was also described as a generally happy child, without any aggression toward peers.

INTERVIEW WITH JILL

Jill presented as a pretty, well-developed almost four-year-old child. In the presence of her father and brother the evaluator briefly explained the assessment process. Jill appeared hesitant at the prospect of meeting with the evaluator, which is not unusual for a child of her age. During the play interview with Jill, she appeared shy but smiled a lot. She was minimally verbal and generally replied with "I don't know" to some questions. She was able to initiate play by taking a bin of blocks from the bookcase and opening it up. She nonverbally engaged the evaluator by gesturing when she sought acknowledgement for having built a structure. As she played, she appeared to relax and smiled shyly at the evaluator, becoming more verbal as the interview progressed. When asked, she stated her age and reported she lives with her "Daddy" and brother, Cody. When asked who else is in her family, she answered "Gramma." When prompted about her mother, she said her mother does not live with her, but is in her family, spontaneously adding that she misses her mother. When asked what she likes to do with her mother, she replied "play." When asked if she sees her mother "too little, too much or just right," she replied "too little."

CODY JONES

DEVELOPMENTAL HISTORY

Cody Jones was born on November 30, 2006 at full term and in good health. All developmental milestones were reportedly achieved on schedule. Cody was in the primary care of his mother until her involuntary hospitalization when he was about 15 months old and custody was granted to Mr. Jones. He was described as healthy and easygoing. He presented as a smiling and outgoing almost two-year-old boy who enthusiastically played with toys in the waiting room and the evaluator's office when observed with his parents. Cody was not individually interviewed due to his young age.

DAYCARE STAFF REPORT

Cody attends Happy Days Daycare with his sister five days a week generally from

8am until about 5:30 pm. Staff describe him as an easy child who adapted easily to the daycare routine. There are no behavioral or developmental concerns about Cody and he reportedly gets along well with peers.

BRIEF OBSERVATION OF MR. JONES AND THE CHILDREN

Mr. Jones readily engaged the children in play and suggested various activities during the observation period. Cody leaned against his father while the three drew a picture together. Mr. Jones actively explained to the children what he was drawing and encouraged Cody to draw too. He provided the children with positive feedback, such as saying "Good job." Jill frequently asked her father to draw various objects. When Mr. Jones asked Jill a few questions, she responded by saying "I don't know," but she actively engaged with him in play with dollhouse figures who she pretended were going on a picnic. Jill appeared comfortable with her father and appeared to enjoy interacting with him. While Jill and her father played with the dollhouse, Cody explored other toys in the room. Mr. Jones was noted to monitor Cody's well-being while attending to Jill.

BRIEF OBSERVATION OF MS. JONES AND THE CHILDREN

Prior to seeing the children, Ms. Jones was told that they would be observed in play for a brief period of time, at which point Ms. Jones said she wanted to play with them all day. When she met with the children, she was very physically affectionate and gave them hugs and kisses and told them she loved him. Jill initially was hesitant, but then she embraced her mother as well and allowed her to hug and kiss her. Cody backed away from his mother but she scooped him up and tickled him, at which he laughed. When Jill was sniffling at one point, she told her, "Jill, did Daddy give you medicine." Ms. Jones presented as enthusiastic with the children and seemed to make a great effort to demonstrate how she facilitates their learning, for example, by asking Cody the color names of various objects. She asked Jill questions about daycare and whether she and Cody were getting along. Jill's answers were brief and mostly a shake of her head or "I don't know." She tried to hold Cody on her lap, but he wriggled away. When Jill sniffled again,

she obtained a box of tissues and offered her one. Jill appeared to become comfortable with her mother over time. Cody was more tentative with her, but smiled when she spoke to him. Ms. Jones was supportive and encouraging of both children's play and their choices for play activities during the observation. When the evaluator informed them that it was nearing the end of the observation period, Jill hesitated and did not begin to clean-up. She tried to initiate other play and appeared to try to prolong the visit. After a second prompt by the evaluator, Ms. Jones directed the children to begin to clean-up and reassured them that "We'll play again soon." Ms. Jones was very physically affectionate and held them for awhile when saying goodbye. She made efforts to hide her tearfulness from them. Jill hugged and kissed her mother goodbye and was able to separate from her easily and rejoin her father and grandmother. Cody allowed her to kiss him. Although Jill had initially appeared reluctant to end the visit with their mother, she was able to separate from her without apparent upset.

COLLATERAL CONTACTS

Dr. Violet Brennan, Ms. Jones' psychiatrist, Centerville Community Care (10/8/08, 15 min.)

Dr. Brennan reported that she has been Ms. Jones' psychiatrist since October 2004. She sees Ms. Jones approximately once every two months and reported her diagnosis as bipolar disorder. She described Ms. Jones as having a number of strengths, but that she "does not handle stress very well" and noted that the most difficult stressors for her historically have been relationship-related. She prescribes Lamictal (a mood stabilizer) for Ms. Jones, which reportedly has been generally effective.

Dr. Brennan stated that she was never concerned about the children being with Ms. Jones, although she was concerned that they were witnessing their parents' fighting after the marital separation when Mr. Jones would visit the children at the marital home. She said that Ms. Jones had reported to her that Mr. Jones was verbally abusive and demeaning to her during these visits as well.

Dr. Brennan reported that Ms. Jones' therapist, Barbara Memory, recently had informed her that Ms. Jones was very upset about some of the information her

therapist had shared with this evaluator. Ms. Jones reportedly was not receptive to her therapist's explanations and she left the session prematurely and angrily. Her therapist reportedly received a subsequent phone call from Ms. Jones stating that she would no longer continue to work with her. Dr. Brennan indicated that this was unfortunate in light of the good supportive relationship they had developed since May 2006 and hoped Ms. Jones would change her mind.

Deborah Duffy, Visitation Supervisor (10/12/08, 18 min.)

Mrs. Duffy reported that she and her husband, Jeremy Duffy, provided supervision for visits between Mary Jones and the children for approximately five months. She said they stopped doing so because it was too time-consuming for them. Ms. Duffy reported that she did not witness any clearly unsafe behaviors or inappropriate interactions by Ms. Jones during these visits, nor in her observations of Ms. Jones and the children prior to the change in custody. She said that the children were always glad to see their mother. However, she did offer the opinion that the children appeared to be upset by the manner in which Ms. Jones separated from them when their visits ended. She said she observed that Ms. Jones would excessively hug and kiss them, cry and tell them she loved them, which seemed to upset Jill. Ms. Duffy thought Ms. Jones should have instead reassured them that they would be going with their father and that she would be seeing them again in a few days. She also stated that Ms. Jones sometimes appeared distracted or "spacey" during some visits, was sometimes agitated when she arrived, but was generally able to focus on the children. Ms. Duffy stated that on several visits she overheard Ms. Jones make negative comments to the children about their father, such as telling Jill that her father would not let her take the children to the zoo.

Jane Harper, Program Specialist, Happy Days Daycare (10/16/08, 15 min.)

Ms. Harper reported that Jill Jones has been attending the Happy Days Daycare since March 2007. She described Jill as doing well socially. She noted that she seemed more timid when she first came to the daycare, but seems to have adjusted well. However, she noted that on the days when she visited her mother, and on the following day, she appeared "more emotional" and withdrawn.

Ms. Harper described Cody as "easygoing" and reported he adjusted easily to

the center's routine when he was enrolled in March 2007.

Barbara Memory, LMHC, Ms. Jones' therapist, Centerville Community Care (10/9/08, 10 min.)

Ms. Memory reported that she has been Mary Jones' therapist since May 2006 when Ms. Jones was referred to her following her first psychiatric hospitalization. She sees Ms. Jones for therapy every two weeks. Ms. Memory stated that Ms. Jones is diagnosed with bipolar disorder. She indicated that Ms. Jones has demonstrated excellent compliance with treatment and she believes Ms. Jones is doing well in spite of coping with multiple significant stressors. Ms. Memory reported that currently, she does not perceive Ms. Jones to be clinically depressed or suicidal, and instead describes her as situationally depressed in the context of multiple, cumulative stressors over the past year.

Ms. Memory reported that Ms. Jones has always spoken very positively about her children and she has never had any concerns about Ms. Jones' ability to care for them. Indeed, she further said that she remains confused about why Ms. Jones has been prohibited from having custody of her children for such an extended period of time. However, Ms. Memory did confirm that one of the precipitants to Ms. Jones' psychiatric hospitalization in February 2008 was a disclosure she made to an Urgent Care counselor that she wanted to kill herself and her husband. While Ms. Memory acknowledged that Ms. Jones may have argued with Mr. Jones in front of the children in the past, Ms. Memory minimized this behavior. She also reported that she observed Ms. Jones to be able to shift her attention from her own distress to the needs of her children. She noted that on several occasions when Ms. Jones was upset and crying on the phone with her, Ms. Jones was able to quickly switch her tone and respond appropriately to the children if necessary.

Dr. G.H. Mercer, Centerville Pediatric & Adolescent Care Center, Jill and Cody's pediatrician (10/11/08, 10 min.)

Dr. Mercer reported that both Mr. Jones and Ms. Jones have been actively involved in Jill and Cody's medical care since birth. Their records indicated that both parents were present at Jill and Cody's' "well checks" from birth to age one. At age one, Jill was brought in by her mother and at age two, by her father. Cody

was brought in by his mother at birth and his father at age one. Dr. Mercer reported that both parents have also brought Jill and Cody in for visits when they are sick. He reported that well visits are up to date and he has no concerns about the children or either of their parents. Dr. Mercer reported that the records indicated that the Department of Children, Youth and Families called the office to inquire about both children's health status in February 2008, but the records did not specify the reason for this call. No follow-up contact from DCYF was noted.

Dr. Randy Post, Ms. Jones' Primary Care Physician (10/10/08, 10 min.)

Dr. Post reported that he became Mary Jones' primary care physician approximately two years ago. He is aware that she is in therapy and sees Dr. Brennan for psychiatric medication. He reported that about two years ago, Ms. Jones was in a motor vehicle accident following which she saw an orthopedist for neck pain, which may be a reinjury. He reported that he prescribes Oxycodone prn, for neck pain, Flexeril, a muscle relaxant and Ambien for disrupted sleep. He stated she is otherwise in good health.

Bob Wood, LICSW, Mr. Jones' therapist (10/16/08, 15 min.)

Mr. Wood reported that he has seen Mr. Jones monthly in supportive therapy to assist him in working through issues around the divorce as well as his grief over the loss of his twin in 2006. Mr. Wood stated that Mr. Jones has been prompt for all sessions and motivated to use therapy well. His diagnosis is adjustment disorder with depressive features. Mr. Wood said he does not believe Mr. Jones needs psychotropic medication at this time and that he consistently presents himself as a concerned parent.

RECORDS REVIEWED

Centerville Police Department Narrative Report, 2/16/08

This report stated Ms. Jones' neighbor had called the police to say she was outside in skimpy clothing and had not responded to offers of help. Two officers went to Mary Jones' residence for a "well-being check" and when they explained to her the

reason for their visit, Ms. Jones reportedly denied needing assistance. However, the report also stated that she appeared agitated and fearful and appeared to be a danger to herself as she refused to return to her home. Police also found the children unattended in the home and contacted Mr. Jones who assumed their care.

Abuse Prevention Order Docket #99X9999-XX1, Central District Court, dated 2/17/08

This order of protection, issued on 2/17/08 was vacated on 3/22/08. It stated that Ms. Jones was ordered not to have contact with her children or Mr. Jones and remain at least 100 yards away from both of them, including staying away from the children's daycare center.

CONCLUSIONS

This has been a brief evaluation that leaves the evaluator with limited data upon which to form conclusions. Care must be taken in extrapolating from this report.

The Jones family was referred for a Brief Psychological Evaluation by the Honorable David Parker, Judge of Family Court, Centerville Division, in an order entered on July 22, 2008. The assessment was focused on a question of the children's safety with their parents and, in particular, issues related to Ms. Jones' contact with Jill and Cody.

Mr. and Ms. Jones married in 2004 and have a four-year-old daughter, Jill, and two-year-old son, Cody. During the marriage, Ms. Jones was the primary caretaker during the day for the children, although both parents reportedly shared caretaking in the evenings and weekends. Ms. Jones suffers from a mood disorder (i.e. bipolar disorder, with depressive symptoms) that worsened following the births of her children and at times she has exhibited dramatic and poorly contained emotional responses to stressors. She required psychiatric hospitalization in April 2006. While she has made threats to commit suicide on multiple occasions in the past, the only suicide attempt that has been reported was when Ms. Jones was an 18-year-old. In the context of these relational difficulties, the couple also suffered a significant loss when Mr. Jones' twin brother died in the winter of 2006. While Ms. Jones has a history of psychiatric illness for which she has been treated, she experienced a decompensation in the context of these stressors and she made sui-

cidal and homicidal threats prior to both psychiatric admissions in 2006 and 2008.

Following the April 2006 hospitalization, Mr. Jones briefly separated from his wife after a dispute but the couple reconciled. They separated for the final time in September 2007 due to ongoing tensions. While he visited the children after the separation several times a week, Mr. Jones reported that he was working close to 60 hours a week to support the two households and so Ms. Jones was the children's primary caretaker. Mr. Jones stated that he was not initially concerned about her parenting. Both parents reported that she became increasingly depressed and suicidal toward the end of 2007 and into the New Year. When Mr. Jones filed for divorce on February 13, 2008, Ms. Jones had a strong negative reaction, dramatically destroying property in the presence of the children and allegedly threatening to kill herself and Mr. Jones. On February 15, 2008, Ms. Jones was again involuntarily psychiatrically hospitalized and Mr. Jones obtained a restraining order prohibiting her from contacting him or their children. He also obtained temporary legal and physical custody of the children. The children did not see their mother for several weeks because of her hospitalization and the restraining order, until the restraining order was vacated on March 22, 2008, and supervised visitation was allowed. Visitation had reportedly occurred weekly, supervised by neighbors who now are no longer available to do so. Ms. Jones has remained focused on her children being returned to her physical custody and has expressed disbelief and anger that this has not occurred. Mr. Jones maintains that Ms. Jones continues to present a risk to the children and while he wants contact between the children and their mother to continue, he thinks that more reliable supervision needs to be established.

The Court's question in this assessment is focused on the appropriateness of Ms. Jones' parenting with the children. From the information available, it appears that while she has at times demonstrated responsible parenting, when she is overwhelmed with her emotions, her judgment becomes significantly impaired and she is unable to contain her reactions and behavior. While there is limited information upon which to offer opinions about the quality of Ms. Jones' parenting prior to February 2008, she clearly has a strong connection to her children and her children have also responded to their mother by evidencing a comfort and closeness with her and a desire to see her more. In addition, most of the data suggests that she has always valued her children and valued being a mother. Even when she has been distressed in the past (for example, prior to February 2008), she has been

able to attend to the children's basic needs, such as schooling and medical care. By the reports of her therapist and psychiatrist, she was usually able to shift her attention to the children and temporarily compose herself when in direct contact with them, even if she was crying and upset.

There have been, however, a number of very serious incidents since April 2006, to which the children have been exposed, and it is likely that there were additional incidents that have gone unreported or unobserved by others. Ms. Jones has had episodes of affective dyscontrol during which time the children were at risk emotionally and possibly physically. When served divorce papers by her husband in February, in her shock and anger, she destroyed multiple household furnishings. She became acutely suicidal as well as homicidal toward Mr. Jones at that time and it does not appear that she was able to appreciate the impact of her behaviors on her children. While on a day pass from the hospital, she admittedly argued with her husband and yelled at him in front of the children. Also, Ms. Jones' therapist reported that she has had phone calls with Ms. Jones, providing support to her while she was upset and crying at home and the therapist noted that the children were present with her. While Ms. Jones reportedly was able to compose herself and appropriately attend to the children when they elicited her attention during these phone calls, she nonetheless was exposing them to her substantial distress.

Although Ms. Jones was distraught that she temporarily lost custody of her children, and vehemently disagreed with any allegations that she was an unsafe mother, she nonetheless sought to be released from the hospital prematurely against the advice of her treatment providers in early March 2008. Ms. Jones reported she is committed to being a mother and extremely upset with the disintegration of her family. While she has acknowledged that she suffers from a mental illness, she minimized the degree to which, at times of stress, she can decompensate and become dysregulated, demonstrating poor judgment and explosive behavior. While she maintained that she has demonstrated her good parenting abilities as a primary caretaker for the children until February 2008, she may have underappreciated the degree to which the children may have been exposed to inappropriate emotional behaviors and inter-parental conflict. Unfortunately, Ms. Jones' distrust and anger have also led her, at times, to reject the recommendations of her doctors and treatment providers. Currently, she may have disrupted her long-term therapeutic relationship with Ms. Memory, which would place her at

increased risk for decompensation without the weekly support of her therapist.

Mr. Jones appears to have been involved in parenting when he lived with his wife and children. After separating from his wife in September 2007 and leaving the marital home, he saw the children less frequently, when he would visit them at the marital home. Currently, he has full physical custody and appears to be providing the children with adequate care. However, while he is providing for the children's basic needs, it should be noted that the children spend up to 10 hours a day in daycare. Mr. Jones does not appear to sufficiently appreciate the loss that the children have experienced in the interruption of contact with their mother. He is, however, fearful of and concerned about the degree of risk that he believes Ms. Jones may pose to his own safety and that of his children. He alleged that she has been very threatening, such as leaving irate and threatening voicemail messages for him. During the course of the evaluation, Mr. Jones reported that Ms. Jones again threatened to harm him if he did not allow her access to the children. However, Ms. Jones denies ever threatening to harm anyone, although she also tended to minimize both her symptoms and the impact of her mental illness on her judgment.

Jill is a four-year-old girl and Cody is an almost two-year old boy who are attached to both parents and who appear loving toward both their mother and father. Given their young ages, they may not have adequate ability to communicate their experiences or concerns. While it is unclear the extent to which they have been exposed to inter-parental conflict, there is evidence that, at a minimum, they have been exposed to symptoms of their mother's psychiatric illness including angry outbursts, depression, and, at times, impulsive, aggressive behavior that is activated when she is overwhelmed with her emotions in the context of stressors. Nonetheless, they miss her in their day-to-day lives.

In summary, Ms. Jones has a chronic and serious psychiatric disorder, bipolar disorder. Currently, she appears to be struggling to cope with the day-to-day stress in her life as well as the loss of custody of the children. Based upon the available data, it appears that Ms. Jones, while demonstrating certain strengths, continues to have inadequate control over her impulsive behavior and mood and demonstrates poor judgment. The evaluator could not document Mr. Jones' concern that she might be overusing medication for neck pain, although the visitation supervisor, Ms. Duffy, observed that she sometimes appeared "spacey" on visits. In light of the fact that she has so few supports in her life, and has recently possibly

severed one of the principal supportive relationships she does have, namely, her therapist, her ability to safely parent in an unsupervised setting at this point is questionable. While she can clearly be a caring and protective mother under certain circumstances, when she is emotionally overwhelmed, her behavior is far less controlled and appropriate. Given the ongoing divorce proceedings, Ms. Jones is likely to continue to be at risk for psychiatric instability, especially if she is not committed to psychiatric intervention. The potential risk to the children is increased by their young ages and consequent inability to protect themselves if a situation becomes unsafe.

RECOMMENDATIONS

The following recommendations are offered to the Court to assist Ms. Jones in developing adequate supports for herself and as a mother to her children and to help assure the safety of the Jones family during this transitional period.

Since the current visitation supervision is not functional and safety is a concern, a professional supervision center, such as New Beginning Visitation Center, could immediately facilitate ongoing contact between Ms. Jones and her children. Additional benefits of utilizing a supervised center include professional monitoring, intervention (if necessary), and documentation of parenting behavior.

The daycare in which the children are currently enrolled has also indicated that they have a policy of allowing parents to visit during the day. If the daycare center is amenable and a schedule with clear conditions about acceptable behavior can be agreed upon, Ms. Jones could also be permitted to have visits for a designated period of time during the day while they are at daycare.

While Ms. Jones has been working with a psychiatrist for several years, she sees her infrequently and was meeting with her therapist every other week, in the context of very little additional structure or supports in her life, multiple major stressors, and serious psychiatric disturbance. She has a history of suicidality and in the absence of her children in her life, Ms. Jones remains at risk for her own safety and would likely benefit from additional supportive mental health services. She may benefit from more frequent individual therapy and from participating in group therapy and/or a partial hospitalization program, as was recommended upon discharge from the psychiatric hospitalization in March 2008 to help her

develop skills to more effectively and safely cope with stressors and painful emotions. If Ms. Jones' well-being is enhanced, she is likely to be able to parent more effectively as well.

It is recommended that the Court allow Ms. Jones' therapist and psychiatrist to read this report. This can only occur if the Court specifically orders it.

Ms. Jones may also benefit from being supported as a mother to the children through a referral for services through The Family Project of Parenting Options Inc., in Centerville, (state), which provides services for parents with mental illness to enhance and support their ability to successfully parent and maintain contact with their children. These services include visitation support, home visits, parent support groups and advocacy. The contact number is 000-000-0000.

It is hoped that as Ms. Jones stabilizes and her functioning continues to improve, she could see the children in a less structured or unsupervised setting. If it would be helpful to the Court, the Centerville Court Clinic could re-assess the family in two to four months to assess Ms. Jones' functioning at that time to see if she has stabilized enough to allow her increased time or less supervision with the children.

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APPENDICES

To access this chapter's appendices, go to:
http://www.afccnet.org/resources/resources_professionals.asp

Appendix A: Client Information Forms and Confirmation Letter

Appendix B: Referral Form

Appendix C: General Information and Informed Consent Agreement

Appendix D: Outline of Clinical Model of Assessment

Appendix E: Sample Report Outline

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CHAPTER 5

CHILD-RELATED PROCEEDINGS IN THE FAMILY COURT OF WESTERN AUSTRALIA

By Paul T. Murphy and Lisbeth T. Pike

INTRODUCTION

The family law sector in Australia has recently commenced the most radical systemic reforms since the introduction of "no fault" divorce in the mid 1970s. The reforms include not only new legislation and revised court procedures, but also introduce the concept of Family Relationship Centres as a new common entry point to the family law system. In addition to providing information and referral services for parents seeking assistance with all manner of parenting issues, the Centres will offer specialised mediation and counselling services to assist separating parents. The Centres will be supported by an extensive suite of mediation, counselling, education, and support services that are to be implemented over the next three years.

While some of these reforms are outlined briefly in this chapter, the main

focus is on the Child-Related Proceedings model that has been developed in the Family Court of Western Australia to manage all cases involving children. Before explaining the development, implementation and challenges of this new practice model, it is necessary to provide a background contextualization of the Australian family law sector and system.

THE AUSTRALIAN CONTEXT

Legislative Frameworks

In colonial Australia, religion and the law (in the persona of the English Governor) combined to control marriage among the settlers, and it was not until 1841 (over 50 years after colonization) that the Governor was no longer involved in approving convict marriages. At that time, the law (Act George IV C31 S22) permitted a second marriage if seven years had elapsed without the couple having had intercourse (Smith 1988). It is perhaps coincidental that the usual sentence for convicts transported to Australia was for a seven-year period, but difficult to imagine how else the requirement for a seven-year separation became incorporated in subsequent Australian divorce legislation.

During the second half of the 19th century, the six independent States of Australia each made provision for the regulation of marriage. Although the States ceded these provisions to the newly-created Commonwealth government in 1901, they were not consolidated for almost 60 years in the *Marriage Act (1961)* (Fogarty 2001). The provisions for dissolution of marriage also evolved within the States and then were also deferred to the Commonwealth. From 1959, divorce legislation was enacted nationally through various forms of *Matrimonial Causes Act* and, eventually, in family law in the *Family Law Act 1975(Cth)* (Harrison 1993, 1999; Nicholson 2000).

The Family Law Act introduced the concept of "no fault" divorce, together with equity in the division of matrimonial property, and also established a specialist jurisdiction, the Family Court of Australia. The States were given the option of ceding their powers to the new court, and all but Western Australia did so. Western Australia established its own Family Court of Western Australia within a State-based legislative framework, the *Family Court Act 1997 (WA)* that generally

mirrors the provisions of the law that applies throughout the rest of the country.

Family Court Structures

The two Family Courts developed quite different structures. From their inception, both Courts included a Family Court Counseling Service as an integral element of the court structure to provide an emotional balance to the legal proceedings. The counselors were either psychologists or social workers with significant experience and expertise in working with distressed clients and their children.

The Family Court of Australia is comprised of approximately 80 specialist family law judges assisted by 45 judicial registrars operating from 25 registries in five States and the two territories (Australian Capital Territory and the Northern Territory). However, by 1999 the volume of work was such that a Federal Magistracy Service was created as a separate jurisdiction to supplement the Family Court of Australia and to provide a less intimidating avenue to determine interim matters. The net effect, however, was to provide another layer of complexity in an already complex and intimidating system (Nicholson 2000).

The Family Court of Western Australia has the distinct advantage of operating from one registry in the State capital of Perth. The Court consists of four judges and eight stipendiary magistrates who also act as judicial registrars. In the past year, two judicial registrars have also been appointed to manage financial conferences, divorce applications, and to assist judicial officers as required.

The vast size of Australia means that at any one time, a number of judicial officers and counselors are “on circuit” to more remote locations in the country. In Western Australia this can mean being over 3,000 kilometers [1,864 miles] from Perth.

Unmarried Parents

During the 1990s, all States gradually referred their powers over unmarried couples (known variously as co-habitating, convenantual, consensual, and more commonly as de facto relationships). De facto couples were not covered by the provisions (and protection) of family law except for issues relating to children of the relationship. Disputes over the division of property and assets were civil actions dealt with outside the Family Court system (Hardingham, Neave and Ford 1989).

Thus, this additional referral of power to the Commonwealth enabled Family Courts to adjudicate both children's and financial matters (Sandor 1998). In Western Australia, authority to determine property matters for de facto couples was not transferred to the Family Court until 2004.

There are still some institutional inconsistencies between de facto relationships and de jure marriages. For instance, some states require an unmarried couple to have lived together for five years before they are regarded as an "eligible applicant" in seeking to claim against an estate (Hardingham et al. 1989; Sandor 1998). Some superannuation funds require the couple to have lived together for up to four years before a surviving spouse is eligible for benefits. Other areas such as the implications for worker's compensation, family tort liability, the provisions within wills for fictive kin, the vicarious liability of parents for the torts of their children, and inheritance are gradually being clarified. As Robinson and Smith (1993) observe, in many aspects the law has failed to keep abreast of contemporary trends of family (re)formation.

Provisions for Children

Custody rights over children have evolved from effectively absolute paternal rights in the 19th century, through ideas of the "primacy of maternal instinct," the "nature or nurture" debate, and the "best interests of the child" philosophies (Gibson 1994; Phillips 1991; Thackray 1997). Between 1986 and 1990 all Australian states (again except Western Australia) referred their powers over exnuptual children to the Commonwealth. This referral meant that all disputes over parenting orders involving children are subject to the *Family Law Act* regardless of the marital status of the parents. Similar legislation was also enacted in Western Australia.

Under the *Family Law Act 1975*, both parents retained joint custody in all but the most exceptional cases, with one parent (normally the mother) retaining the responsibility for day-to-day "care and control" (Goodman 1983). This situation was reviewed in the *Family Law Reform Act 1995 (Cth)*, which replaced the terms "custody" and "access" with "residency" and "contact"; thus a "custodial parent" became a "resident parent," and a "non-custodial parent" became a "contact parent" (Harrison 1999; Thackray 1997).

One of the main aims of this change in terminology was an attempt to defuse

the emotional connotations and implications of "ownership" of children implicit in the previous legislation (Funder and Smyth 1996). However, as Dewar (1996) observed, case law was still based on the earlier terminology and, despite the shift in official attitudes implied in the revised terms, it would have been naive to imagine that merely changing language would change societal attitudes or practice in the short term. Dewar's prediction was realized with a three-fold increase in disputes over contact and residency in the following three years (Rhoades, Graycar and Harrison 1999; 2000).

Calls for Reform

Increasingly vociferous complaints about the family law system, its inability to protect mothers and children, and its perceived bias against fathers, coupled with the increased demand (and consequent delays) that resulted from the 1995 legislative changes, prompted the government to establish the Family Law Pathways Advisory Group (FLPAG) to investigate and report on the family law system and to recommend ways in which it might be improved. The Group's report (the "Pathways Report") was released in 2001 and identified a number of areas of concern. The report concluded, among many things, that the (then) family law system was neither a system and nor was it integrated with the services that had supposedly been developed to support it (FLPAG 2001). The government had only just responded formally to this report in mid-2003 when pressure from backbench members led to a full parliamentary inquiry being established to investigate "child custody arrangements in the event of parental separation" (Commonwealth of Australia 2003a).

The report of the parliamentary inquiry was released in late 2003 (Commonwealth of Australia 2003b) and was the catalyst for the radical reform agenda that was announced in August 2004 (Commonwealth of Australia 2004; Howard 2004; Ruddock 2004). Details of the new policy direction were developed during the following year (Commonwealth of Australia 2005), and implemented in July 2006. These changes included:

- New legislation – the *Family Law Amendment (Shared Parental Responsibility) Act, 2006*;

- Revised processes for managing children's matters in Family Courts – the Child-Related Proceedings in the Family Court of Western Australia and Children's Cases Program in the Family Court of Australia;
- New roles for social scientists (counselors and mediators) appointed to Family Courts so that their work is now more integrated with that of the judicial officers;
- A proposed national network of 65 Family Relationship Centres that, with some exemptions, became the new common entry point to the family law system; and
- Increased funding for the suite of counselling, mediation, education, and support services that support the work of the family law system.

The total cost of the reform agenda was in excess of $400 million over three years (2005-2008).

CHILD-RELATED PROCEEDINGS IN THE FAMILY COURT OF WESTERN AUSTRALIA

The evolution of the Child-Related Proceedings practice model in the Family Court of Western Australia was unique in terms of the transformation of a legal system. The change process was initiated in the late 1990s by the court counselors (social scientists), adapted by the judicial officers, and implemented jointly by both professions in mid-2001 as the Columbus Pilot project. The Columbus Pilot was evaluated by external social science academics, and the results informed the change process over the next five years that culminated in the Child-Related Proceedings that were introduced in 2006.

In order to understand the extent of the change process, it is necessary to establish the starting point.

The Change Process in Western Australia

Although originally conceptualised as an informal "helping court," the Family Court of Western Australia evolved within a formal, highly legalised framework

managed and controlled by members of the legal profession (Chisholm 2005; Fogarty 2001). The resulting system was often unable to address core hurts or underlying issues of the parents, children, and wider family members it sought to serve, and so frequently became increasingly alienating to the clients. While provision was made for a counselling service within the Family Court of Western Australia to assist with children's matters, the roles and responsibilities of both the counselors and the judicial officers (judges and registrars) were very clearly defined.

Figure 1 is a diagrammatic representation of the case management relationships between judicial officers and counselors that pertained at the time that the Columbus Pilot was implemented in mid-2001.

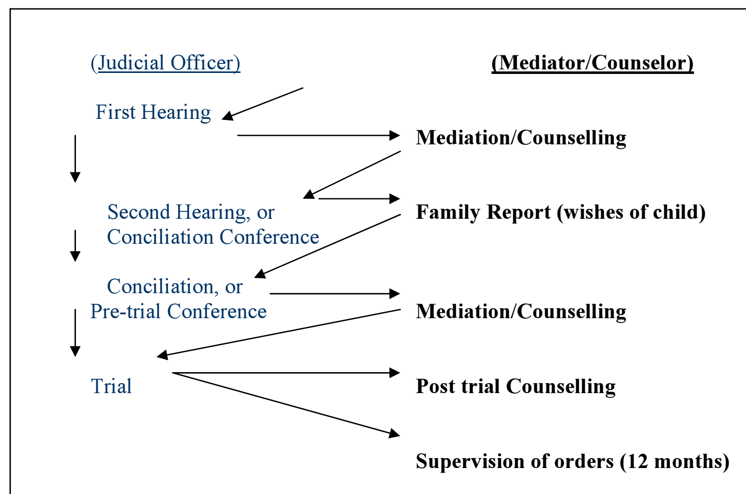

Figure 1: Representation of Relationship between Judicial Officers and Court Counselors in Children's Matters at time of Columbus Pilot Project Implementation

The relationships in this system were prescribed in legal convention and clients moved between two distinct court functions (judicial and social sciences) that had very limited capacity to either share information or jointly manage a case through the system (Murphy, Pike and Kerin 2005). Indeed, it was not unusual for judicial officers to serve in a court for many years without either entering the precinct of the counselling service or talking with a counselor other than in a formal legal setting. There was limited understanding of the different professions' capabilities and

this was manifest in increasingly disgruntled clients and adverse publicity.

At this time (mid-2001) many Family Court clients reported having to wait weeks for their initial court appearance while also submitting extensive affidavit material in support of their position. The common expectation was that their problem would be addressed (and solved) in court on that (first) day. However, the initial court appearance often resulted in an immediate referral to the counselling service (located somewhere else within the building). Many clients then had long waits to see a counselor, only to find that they then had to return to court after the counselling session. Depending on timing, there could well be another considerable delay such that it was not uncommon for people to spend up to six hours in the Court but less than five minutes in the presence of the magistrate. If there was no agreement between the parties, an interim decision would be imposed by the magistrate with a further hearing date set (normally in four weeks time). Information gained by the counselor was confidential and not available to the magistrate to inform their decision-making process.

For the typical Family Court client, little was resolved, issues were neither identified nor acknowledged, the parties were confused by the process, antagonisms became further entrenched (especially as affidavit material expanded and parties felt compelled to counter it), and the potential for prolonged litigation was heightened. It was clear that "*there has to be a better way*."

The Columbus Pilot

The Columbus Pilot evolved from an idea in 1997 by two of the counselling service staff who realised the potential to expand the approach of Project Magellan then being conducted in the Melbourne Registry of the Family Court of Australia (Brown, Sheehan, Frederico and Hewitt 2001). Project Magellan concentrated on matters involving allegations of child abuse and child sexual abuse while the Western Australian ideal sought to address other issues such as domestic violence, substance abuse, and potentially, mental illness. In 1999, an informal working party (a registrar and the two counselors) was established to develop the concept. Central to the project was the notion of interdisciplinary individualised case management (ICM) whereby a designated registrar and a counselor (usually a psychologist or a social worker) jointly managed the case through a series of privileged (confidential) conferences in an endeavour to address the abuse issues and to

achieve durable, safe outcomes for the parents and their children.

The Columbus Pilot was formally approved in early 2001. A group of three registrars and four counselors then jointly developed some operating frameworks for the conferencing process (Hill and Monaghan 2002) and the criteria for inclusion (Kerin 2002). The project was implemented in July 2001 (Holden 2001; Nicholson 2001).

The aims of the Columbus Pilot were not only to attempt to resolve the matter but also to identify and address the underlying issues with a view to achieving a more acceptable and more durable outcome for all members of the family. Once assigned to the Pilot, a case proceeded through a series of confidential family conferences that were jointly chaired by a designated registrar and a counselor until either the underlying issues were identified and addressed and a stable, safe contact regime was established, or the matter proved intractable and was referred back into the formal Court process (usually for a Pre-Trial Conference, and possible Trial).

Lessons from research

The multi-dimensional approach in the evaluation of the Columbus Pilot included feedback from magistrates, counselors, legal practitioners, agency personnel, clients, and some of their children as well as a cost/outcome analysis of the process (Murphy 2006). The participants confirmed the value of the conferencing process and the more acceptable outcomes that were being achieved (Murphy and Pike 2002; 2003; 2004; 2005). The evaluation also confirmed the value of the "social science" input into the legal process and the positive, and sometimes unconventional, outcomes that an interdisciplinary case management approach could achieve.

The Director of Court Counselling described the Columbus process as "the therapeutic use of (the Court's) authority" (K. Benham, personal communication, 29 July 2004). This view is consistent with the theoretical construct of "therapeutic jurisprudence" as described by Allen (2001). This theoretical framework, together with the lessons identified in the Columbus Pilot evaluation, underpinned the design of the Case Assessment Conferences that were introduced as the first court event in the Family Court of Western Australia in all but urgent children's matters in July 2004.

Case Assessment Conferences

The primary focus of the Case Assessment Conference model in the Family Court of Western Australia was risk screening, assessment, and case management. Although it is possible that couples might reach agreements, this was seen as a secondary benefit rather than the central purpose.

Case Assessment Conferences were chaired by a counselor (mediator) during the initial phases (risk assessment, issue clarification, and if possible, some negotiation) that lasted about an hour. The registrar then joined the conference to conduct a Procedural Hearing. If the parties agreed, the registrar could issue orders by consent. If there was no agreement, the registrar could give some indication of how the case might proceed (a "reality check") and issue directions for further proceedings. In matters where abuse was identified, the registrar could refer the case for individualised case management and issue instructions regarding notifications of child abuse or risk. In some circumstances, the parties could be rescheduled for a follow-up conference with the counselor.

The evaluation of the Case Assessment Conferences again included feedback from professional stakeholders, agency personnel, and clients who all identified even more encouraging outcomes than the Columbus Pilot (Murphy and Pike 2006). The results established that the conferencing process required a significant increase in the amount of time that both the counselor and registrar were involved with each matter before additional input (such as follow-up counselling conferences, writing case notes, or making and monitoring referrals to external agencies) is considered. However, the process demonstrated some very positive outcomes including:

- A 20% reduction in the time that a matter is in the system,
- A 30% reduction in the number of court events,
- A 17% reduction in the time taken before a matter has a Conciliation Conference,
- A 19% reduction in the number of matters requiring a Conciliation Conference,
- A 50% increase in settlement at an early stage (before a Conciliation Conference), and

- *An overall 70% settlement rate within a 23-week timeframe***.**

Feedback from the professional stakeholders (registrars, counselors, lawyers, and agency personnel) not only confirmed the positive outcomes indicated in the statistical data, but also endorsed the increased interdisciplinary collaboration that the Case Assessment Conference process promoted.

Preliminary feedback from the Case Assessment Conference evaluation coincided with the announcements of the proposed changes in the family law system in 2004. An interdisciplinary committee chaired jointly by the Principal Registrar and Director Court Counselling was formed to develop a practice model for the Family Court of Western Australia within the proposed new legislative framework.

CHILD-RELATED PROCEEDINGS

The *Family Law (Shared Parental Responsibility) Act 2006 (Cth)* enacted a range of procedural changes aimed at reducing litigation time-frames and providing better service to separating parents. The most significant changes in respect of managing children's matters were increased powers for magistrates such that they could now conduct trials of up to two days, and the withdrawal of the privileged status of the clients' discussions with counselors (now known as Family Consultants) employed within the Court. This meant that the "firewall" that existed between judicial officers and counselors in the process shown in Figure 1 earlier was removed thereby allowing the Family Consultants to have greater direct input into the legal processes.

In the Family Court of Western Australia, preliminary planning for these new provisions began almost immediately after the government's announcement of the family law reform agenda (Howard 2004). The legislative changes enabled a model for managing child-related proceedings to be developed that incorporated the lessons learned from the evaluations of both the Columbus Pilot and Case Assessment Conferences:

- Judicial officers and counselors jointly managing cases, interdisciplinary collaboration, and involving external service providers; and

- As much informality as possible, a more inquisitorial approach, greater participation by the parties, more expeditious decision-making.

The Western Australian Model for Child-Related Proceedings

Child-Related Proceedings in the Family Court of Western Australia begin with a Case Assessment Conference (risk assessment, issue clarification, and some negotiation) conducted by a Family Consultant about four weeks after the initial application being filed. The parties (and their lawyers) are advised that the proceedings are "reportable" and can be relayed to the Court *(Family Law (Shared Parental Responsibility) Act 2006 (Cth) Part III section 11A)*. At the conclusion of the assessment phase (about an hour), the parties and their lawyers move from the conference room into a court room for their case to be heard by a magistrate. In complex matters (such as the extreme Columbus Pilot cases involving domestic violence or child abuse issues, international relocation, or abduction) the matter can be referred directly to a judge and then that judge and the Family Consultant jointly manage the case to its conclusion.

The physical move into the formality of the court is producing some very creative outcomes, especially as the parties become aware that the consultant and magistrate (or judge) will manage their case to its conclusion.

Court etiquette has been adapted to encourage direct participation of the parties with the presiding judicial officer (magistrate or judge). One advantage of this is that the judicial officers report gaining a greater understanding of the dynamics of the cases they are being asked to determine. The parties sit at the bar table with their lawyers and the judicial officer advises them of the process that will now commence. The Family Consultant is sworn in as a witness and formally reports the outcome of the Case Assessment Conference. The Consultant may be cross-examined on their report so that, for all intents and purposes, a trial process is commenced – on the first court day.

If the matter cannot be resolved that (first) day, a further hearing is scheduled (usually in about four weeks' time). The judicial officer can determine the type of evidence required at such future hearings and limit the amount of affidavit material to be supplied to the Court. The parties may be referred to external services between the continuation hearings and a dedicated Case Coordinator is available to

provide direct liaison between the Court and the clients.

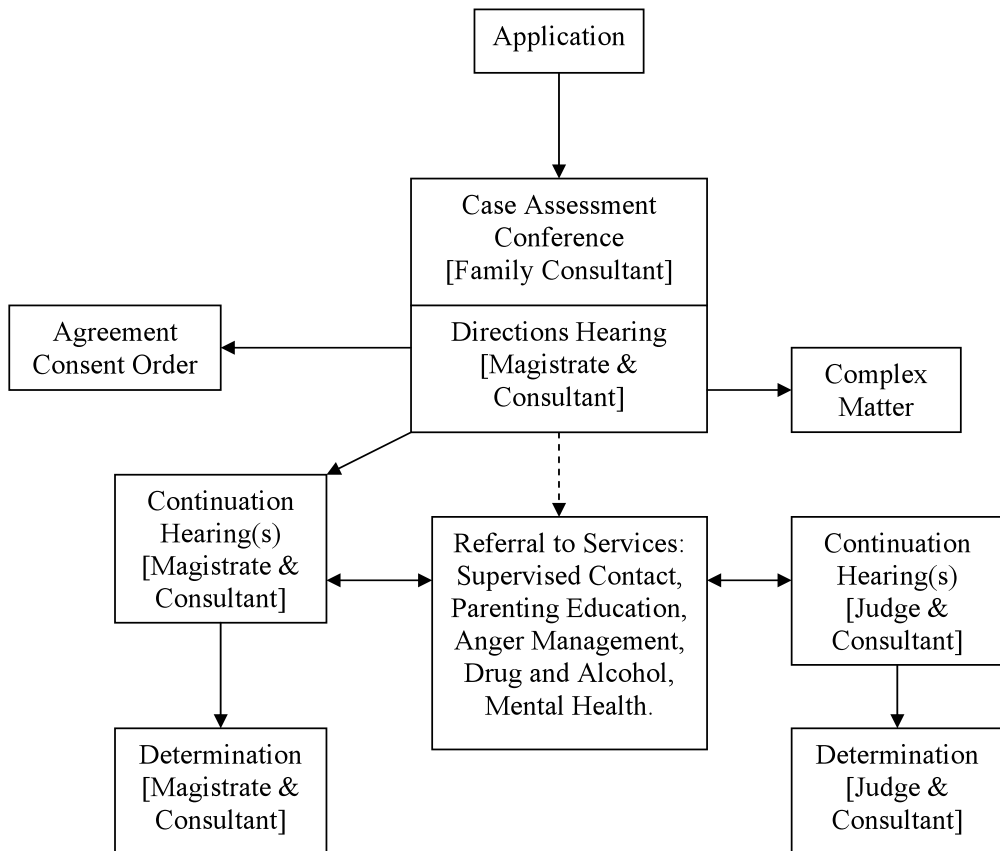

Figure 2: The Child-Related Proceedings Model in the Family Court of Western Australia

The timeframe for this process is potentially very short – as little as seven weeks between the first court event and determination of the matter. In complex cases, it is possible to hold the parties in the system while they attend the community-based services and courses designed to assist them in developing a cooperative post-separation parenting regime. The Family Consultant can obtain relevant reports from the service providers and keep the judicial officer fully informed of clients' progress. If assessed as appropriate in the circumstances, the Consultant

may also interview the children and, rather than preparing a lengthy written report, provide a summary of their findings (as evidence) at the next hearing. If necessary, additional continuation hearings may be scheduled to address new issues as they arise. In this respect, the Child-Related Proceedings process has been described informally as "Columbus with teeth."

Implementation

Once the implementation committee had established an agreed model and the Chief Judge had approved its introduction, a formal practice instruction was promulgated. Detailed briefings were prepared for legal practitioners and the various government and non-government agencies that support the court and its clients. Revised, simplified documentation (that negated the need for lengthy affidavits) was prepared and issued throughout the sector as well as being posted on the Court's internet site. A new client information session was prepared so that clients could be fully briefed on the new process, the documentation required, and what was expected of them in both the conference and then the formal hearing phases of the process.

An intensive interdisciplinary training program involving complex role plays of the proposed process was developed by the implementation committee. Each scenario was analysed and critiqued jointly by the judicial officers and consultants with input from the court administrative personnel. Areas of practice that were exclusive to the respective professionals were developed within their separate case practice meetings.

During the first weeks following its implementation, both judicial officers and consultants observed each others' practice to identify potential difficulties and to ensure consistency of practice. Weekly meetings of judicial officers, consultants, and administrative staff identified and debated difficulties (and successes) and revised the processes to maximise the advantages that were being demonstrated. Within a few weeks of implementation, the informal feedback from a range of practitioners in the family law sector was that the new process was a great improvement and, "*how the family law system should be – relatively informal and helpful in achieving very positive outcomes for a majority of clients*." Judicial officers and consultants also reported that, although the new process required intensive input from them, the preliminary results were indeed very promising.

Other Aspects of the Model

The collaboration with external agencies that commenced with the Columbus Pilot has expanded. The Columbus Pilot Reference Group that monitored the evaluation of that project was retained and now sits as the Family Court of Western Australia Reference Group under the chairmanship of a judge. This group provides a forum for discussion of issues to promote better integration of services and knowledge within the wider family law sector. The Family Law Pathways network (established in 2003 as a precursor to the subsequent reforms) provides another forum to promote inter-agency collaboration.

The Family Court has developed formal protocols detailing referral and reporting processes between the Court and a range of government and non-government agencies and service providers. These too are aimed at promoting better integration of services and better outcomes for clients. It is envisaged that this process will evolve further as the reform process expands the network of Family Relationship Centres across Western Australia.

In this context, the Columbus Pilot was a catalyst that promoted changes in both philosophy and practice within the Family Court of Western Australia (Murphy, Kerin and Pike 2003). This changed environment of interdisciplinary collaboration enabled the Court to react quickly and positively to the government's family law reform agenda when it was announced in 2004 (Benham 2004; Holden, Kerin, Pike and Murphy 2005). The empirical data obtained during the evaluation of the Columbus Pilot (Murphy and Pike 2002; 2003; 2004; 2005) and Case Assessment Conferences (Murphy and Pike 2006) informed the subsequent change processes such that the Court is regarded both nationally and internationally as being at the forefront of efforts to improve court processes and to achieve better outcomes for separating parents and their children.

Benefits

The Child-Related Proceedings model is the culmination of the change process that began with the Columbus Pilot in mid-2001 in response to the observation that *"there has to be a better way."* The lessons learned from the inter-disciplinary collaboration inherent in the Columbus Pilot and Case Assessment Conference models, coupled with the feedback from clients, were all incorporated into the

planning of the Child-Related Proceedings processes and administration. The new process is already demonstrating some benefits.

Benefits for Clients

The anticipated benefits for clients were seen as the simplified application documentation [a nine-page form (see Appendix A) as opposed to extensive formal affidavits that sometimes exceeded 50 pages of, often irrelevant, information]. An immediate observation from court staff at all levels about the new documentation is that clients now concentrate on the issues that they want assistance in resolving as opposed to making or countering allegations (and increasing the antagonism). This is seen as reducing the potential for the court process to exacerbate the tension between the parties and in so doing, reduce the stress on the clients (and vicariously on their children).

The risk assessment phase of the process allays concerns that issues of abuse or safety are taken seriously. The less formal, more inquisitorial approach in the court encourages clients to present their views in a situation where the decision-maker can also seek clarification of an issue with the parties and have immediate "expert" advice or input from the Family Consultant. It is anticipated that the length of time that most clients are in the system before a judicial determination is made (if one is required) will be significantly reduced (from about 15-18 months to less than six months). This will have a direct impact on the costs that clients incur in legal expenses.

Having a dedicated case management team (judicial officer, Family Consultant and Case Coordinator) for each matter means that clients will not appear before people who are unknown to them (a major criticism identified in the Columbus Pilot evaluation).

All of these aspects will not only reduce stress on litigating families, but also produce outcomes that are more acceptable and, potentially, more durable than the system that pertained before the Columbus Pilot in 2001 (see Figure 1).

Benefits for the Court

There are a number of perceived benefits for the Court. Conducting a risk assessment at the outset allows for complex, high conflict matters to be identified and

expeditiously placed before a judge. Having all conversations with the Family Consultants admissible in evidence has increased accountability in this aspect of the Court's work and enabled better decision-making as the judiciary are better informed about the nuances of a case from the first court event. With a dedicated Consultant working with the judicial officer it is possible for the children's views to be placed before the court at a very early stage in proceedings (often at the first continuation hearing). For those cases involving referrals to external agencies, the ability to obtain progress reports and place these before the judicial officer is another acknowledged benefit of this model.

In terms of court processes, the new model eliminates some of the stages in a matter proceeding to trial. The Conciliation Conference and Pre-Trial Conference (see Figure 1) are no longer required as the judicial officer who starts with the case will try the matter. Similarly, by having a dedicated judicial officer for an individual family, other court processes such as contravention of orders or variations in maintenance are no longer separate processes, but are managed and adjudicated by that family's designated team.

The capacity for the judiciary to control both the content and the process has resulted in better utilisation of judicial resources. The almost total integration of social science and legal practice in managing children's matters is continuing to produce better outcomes for clients and their children.

In the longer term, the reduced time-lines of the Child-Related Proceedings model will be reflected in reduced backlogs of matters awaiting determination.

Tensions

The Child-Related Proceedings model is still evolving as different judicial officer/consultant teams develop new approaches to individualised case management. This process has proven challenging for all staff as they are often operating outside of their professional "comfort zones." For consultants, this includes the increased accountability and pressure of quickly assessing risk factors and the issues of a case and then formally presenting these in evidence. For some judicial officers, there is still a tension about how much, and when, to discuss a matter with the consultant without the parties being aware of the discussions. These and similar issues are discussed and debated at fortnightly co-ordination meetings with all

staff. Where necessary, revised procedures are devised, trialled, and the results reported back to a following meeting.

Significant tensions are emerging in respect to the role of the Case Coordinators and how much they become involved in a case. The Family Consultants are managing increased workloads as many are now in court almost every day as part of their case management role. Magistrates are adjusting to controlling their own trial listings that include the case consultant, while also managing other duties such as writing judgements, conducting conciliation conferences for financial matters, and going on circuit. While there will be some compensatory savings over time in terms of other court processes that no longer exist, and more expeditious resolution of the majority of applications, the resource implications may not be fully evident for some time. This will require accurate and timely data as well as careful management in order to ameliorate the additional stress, fatigue, and potential loss of highly skilled and experienced personnel.

The new legislation prescribes a new role for legal practitioners who are appointed as the independent children's lawyer and for social science practitioners who are appointed as "single experts" (custody evaluators). How these roles might evolve is not yet clear.

The legislation also specifically acknowledges a child's right under the United Nations Convention on the Rights of the Child to be a party to the proceedings. How this might evolve in practice is also yet to be determined.

Similarly, the legislation provides for "other people who are significant to [the children's] care, welfare and development" to be included in the decision-making processes. How to accommodate these additional parties such as grandparents and, more particularly, stepparents, may be the next great challenge for family courts in Australia.

Underpinning all of these tensions is the fact that the Family Court of Western Australia is funded by the Commonwealth of Australia but administered through the Western Australian (State) Department of the Attorney-General.

CONCLUSIONS

Early indications concerning both the process and outcomes of the Child-Related Proceedings model are extremely positive. Both judicial officers and Family

Consultants report that the interdisciplinary collaborative relationships have strengthened as each becomes more aware of the others' expertise. Many magistrates report enjoying the control that they now have over both the listing of matters before them, and the (reduced amount of) written material that is produced in support of the arguments. They also report that, in having dedicated teams managing a case from initiation until determination, they gain a better understanding of the issues for all of the parties; thus, they can make better-informed decisions that are (hopefully) more acceptable to the parties, and potentially more durable.

Informal feedback from the legal profession is also extremely positive with almost unanimous support for the simplified forms, informal procedures, and more expeditious resolution of matters. Lawyers report that most of their clients are less inclined to challenge the outcomes even if they do not meet their expectations. The views of clients will be a central component of the evaluation that is currently being developed.

APPENDIX

To access this chapter's appendix, go to:
http://www.afccnet.org/resources/resources_professionals.asp

Appendix A: Application for Final Orders

Other Forms: Available at www.familycourt.wa.gov.au

CONTACTS

Further information on the progress of the Child-Related Proceedings model can be obtained from either:

The Director Court Counselling *or* The Principal Registrar
Family Court of Western Australia
150 Terrace Road
Perth, 6000
Western Australia

NOTE

The opinions, findings, and proposals contained in this chapter represent the views of the authors and do not necessarily represent the attitudes or opinions of either the Family Court of Australia, the Western Australian Department of Justice, or Edith Cowan University.

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CHAPTER 6

TRIAGING FAMILY COURT SERVICES: THE CONNECTICUT JUDICIAL BRANCH'S FAMILY CIVIL INTAKE SCREEN[1]

By Peter Salem, Debra Kulak and Robin M. Deutsch

INTRODUCTION

A system of early screening and appropriate provision of services has been discussed in many venues as a critical component of family court services of the future. The implementation of such a triage system by the Connecticut Judicial Branch-Court Support Services Division (CSSD) is a pioneering effort that can help inform courts seeking to efficiently match the specific characteristics of families with suitable court services.

The concept of triaging dispute resolution services is said to have originated with Professor Frank Sander's proposal for a Multi-Door Courthouse at the Pound Conference (the National Conference on the Causes of Popular Dissatisfaction with the Administration of Justice) in 1976. However, for the last thirty years,

mediation and, to a lesser extent, custody evaluations have dominated the family dispute resolution landscape, with many other processes taking a back seat (Salem 2004). Only recently have a very few court services agencies begun to explore a triage process to identify the most appropriate service from a menu of options, rather than a more traditional tiered services model.

For years, family court service agencies have faced the challenge of a growing number of referrals of increasing complexity, while staffing and other resources have remained level or, in some cases, been cut. Many agencies have attempted to address these challenges, sometimes with a full-scale overhaul of services but more often on a piecemeal basis.

This article presents an overview of how Connecticut's Judicial Branch-CSSD Family Services Unit responded when faced with these challenges. Over a three-year period, the agency, working in collaboration with consultants from the Association of Family and Conciliation Courts (AFCC), revised its menu of services and its service delivery model and developed a unique research-based screening instrument designed to match the characteristics of families in dispute with the most appropriate service.

This article begins with an overview of the development of family dispute resolution services in the courts and identifies the challenges facing today's family court service agencies. Connecticut's response to these challenges is then examined, including the decision to implement a triage process and add services. The development of the screening instrument, along with its empirical, clinical and social policy basis, is explored, as are the implementation and administration of the new services and screening instrument.

This article presents a relatively detailed description of the process as well as related information and the research, policy and theoretical underpinnings of the Family Civil Intake Screen (see Appendix A). However, it is important to note that *this article is not intended to provide a prescription for implementation of the screen in jurisdictions outside Connecticut*. Effective implementation of the screen requires a carefully coordinated effort between management, consultants and staff and includes significant training. Simply stated, the screen is not intended to be implemented independent of the process and considerable efforts that accompanied its development.

THE DEVELOPMENT OF FAMILY DISPUTE RESOLUTION SERVICES IN THE COURTS

Family court service agencies of the 1970s and 1980s traditionally offered a limited menu of services for separating and divorcing families. Some agencies provided counseling, conciliation services or divorce adjustment programs; however, since the 1970s, most court service agencies in North America have focused on providing child custody evaluation (or investigation) and mediation services to assist parents in resolving disputes over child custody, visitation and other parenting issues. Over the past four decades, these court-connected services have experienced a significant evolutionary process in order to meet the needs of families while frequently addressing ongoing staff shortages and budgetary constraints.

The early provision of custody evaluations placed a "heavy emphasis on cause, fault and extensive historical compilation" (Salius and Maruzo 1988, p. 164). During the 1970s, spurred in part by the nation's first no-fault divorce statute in California, the focus shifted from fault to the best interests of the child. This in turn led to custody evaluations that increasingly emphasized the identification of parenting abilities and examination of the primary parent-child relationships rather than discussion of unrelated and extraneous behavior. While a significant improvement over the fault-seeking approach, custody evaluations continued to take responsibility for family decisions without any meaningful attempt to evaluate the ability of the parents to make such decisions (Salius and Maruzo 1988).

As mediation became more popular, family court service agencies throughout North America began to review their child custody evaluation processes in an effort to better meet the needs of families and court systems. A number of evaluation models emerged. The Family Services Unit of Connecticut developed family-focused custody/visitation evaluation procedures, a participatory process in which parents identify their needs and those of their children, establish evaluation criteria and attempt to negotiate a settlement. Family Court Services in Los Angeles developed "Fast Track Evaluations" (Little 1997), and settlement-based evaluation models were implemented in numerous courts including Pima County, Arizona, and Harford County, Maryland (Milne and Salem 2000).

At the same time, an increasing number of jurisdictions began delivering mediation services in an effort to systematically integrate opportunities for parental decision making into the process. Mediation better allowed parents, rather than

custody evaluators and judges, to make decisions regarding the future of their family. Mediation services grew dramatically during the late 1970s and throughout the 1980s, both in the public and private sectors. In 1981, California became the first state to mandate mediation of custody disputes (Ricci 2004), and by the early 1990s court-based mediation of custody and visitation disputes had spread to thirty-eight states and Washington, DC (Thoennes, Salem and Pearson 1995).

Mediation became the preferred alternative for many court counselors, attorneys and judges. Indeed, research directly comparing the mediation and custody evaluation processes found that clients reported that mediation was fairer, involved less pressure to make unwanted agreements, produced more satisfying agreements and gave them more control over decisions than those in custody evaluations (Keilitz, Daley and Hanson 1992).

Mediation also underwent an evolutionary process, and a variety of practice models emerged. In 1996, Kelly reported, "[i]t is clear that different mediation models have developed but are rarely acknowledged or described" (p. 383). Notable exceptions at the time included California's "recommending" mediation model Impasse-Directed Mediation (Johnston and Campbell 1988), and Transformative Mediation (Bush and Folger 1994). However, just over a decade later, numerous mediation (and evaluation) models can be identified that have been designed and promulgated in response to the changing and growing needs of separating and divorcing families (Folberg, Milne and Salem 2004).

Along with the evolution of the mediation and child custody evaluation processes, additional dispute resolution processes have emerged. These include parenting coordination (Coates, Deutsch, Starnes, Sullivan and Sydlik 2004), high-conflict couples counseling (Thayer and Zimmerman 2001), mediation-evaluation hybrid processes (Shienvold 2004), collaborative divorce (Tesler and Thompson 2006) and cooperative law (Herman and Lande 2004). While many of these processes were developed for delivery in the private sector, court-connected programs also generated a significant number of creative and effective new dispute resolution processes (Association of Family and Conciliation Courts Court Services Task Force 2005).

This proliferation of dispute resolution processes has resulted in an exciting range of opportunities for service providers and users alike. What has not developed alongside these services, however, is a clear set of criteria to help determine the optimal fit between clients and the services that best meet their needs.

CHALLENGES FOR TODAY'S FAMILY COURT SERVICE AGENCIES

Family court service agencies have a particular need to determine the best fit between clients and services. Despite successful adaptations of the mediation and custody evaluation processes and the availability of new processes, court service agencies face the ongoing challenge of doing more work with fewer resources. While research indicates that a majority of couples succeed in moving beyond the anger, conflict and depression associated with divorce within two to three years following separation, as many as one-third of divorcing couples report experiencing significant conflict over their children many years after separation (Johnston and Roseby 1997). This conflict has significant long-term implications for children, families and court systems. Johnston and Roseby report on the characteristics of what they label "failed divorces":

> For about one tenth of all divorcing couples, the unremitting animosity will shadow the entire growing-up years of the children. . . . Frequently, although not always, these parents take their disputes with each other to family court. . . . Outside the court, highly conflictual divorced parents engage in frequent arguments, and undermine and sabotage each other's role as parents . . . high conflict parents are identified by multiple, overlapping criteria: high rates of litigation and relitigation, high degrees of anger and distrust, incidents of verbal abuse, intermittent physical aggression, and ongoing difficult communication about and cooperating over the care of their children. . . . The most serious threat, however, is . . . that these children bear an acutely heightened risk of repeating the cycle of conflicted and abusive relationships as they grow up and try to form families of their own. (1997, pp. 4–5)

Judges, lawyers, mediators and custody evaluators anecdotally report a dramatic increase in the number of seemingly intractable disputes in the last decade. This situation may be attributable to any combination of a variety of factors.

- In recent years married and cohabitating fathers have played a more active role in parenting, and the importance of fathers in child rearing has been more widely recognized and supported by society in general.

Consequently, following separation, many of these fathers naturally want more parenting time and responsibilities than desired by divorcing fathers in prior generations.

- Increased levels of reporting and incidence of domestic violence, child abuse and neglect and chemical dependency add significant complications to the dispute resolution process.
- An increased emphasis on the establishment of paternity, parental responsibility and child support payments impacts disputes over parenting time.
- Disputes over new issues, such as grandparent visitation or gay and lesbian parenting issues, arise with little or no case law to provide guidance for decision making.
- Dramatically increasing numbers of unrepresented parents create an enormous burden for the court since most parents possess a limited understanding of the process and little context for their decision making.
- Political interests, often gender related, surface during the process. These are sometimes prompted by organizations or books that provide guidance to separating and divorcing couples that may produce rather than help resolve conflict. These include groups representing fathers' rights organizations, victim advocates and mothers without custody.
- Today's increasingly mobile society has led to a greater number of relocation cases. Relocation disputes are challenging since they tend to present as an "all or nothing" situation.

Because family court service agencies often serve as either the point of entry or the initial point of services for most parents with custody, access and parenting disputes, agency staff must be equipped to deal with a wide range of issues and varying levels of conflict. The demand on family court service agencies to address the challenges cited above has resulted in an increasing number of more difficult cases. While the situations described above may represent a minority of cases, it is on many of these matters that court counselors, judges, lawyers and administrative staff spend a disproportionate amount of their time. These are the most frustrating cases for both professionals and clients and often lead to burnout and stress among court counselors.

THE CONNECTICUT RESPONSE

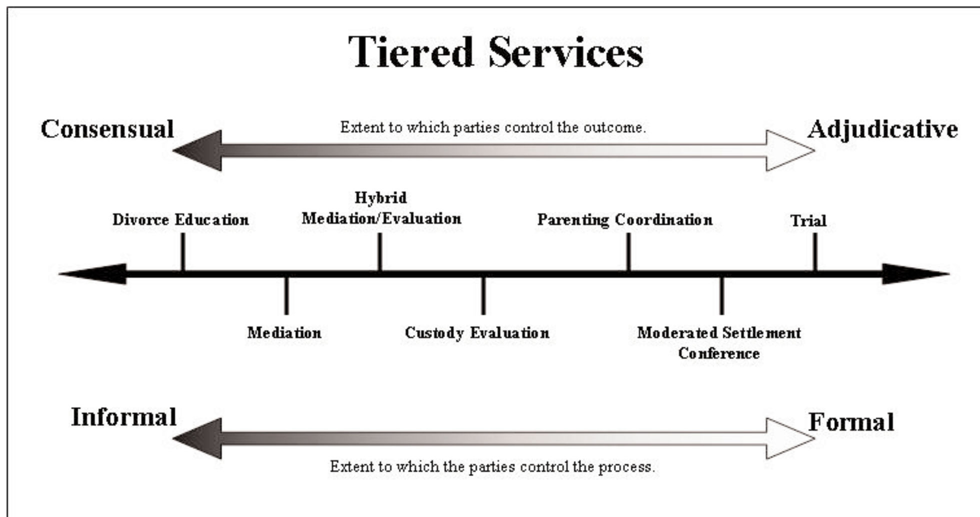
Connecticut's family court service agencies have long been acknowledged as innovators and leaders in dispute resolution processes and in addressing the complex challenges of families involved in parenting disputes. CSSD-Family Services Unit is a Judicial Branch agency that oversees thirteen primary offices and five satellite offices statewide and has a professional staff of approximately 100 family relations counselors. The creation of CSSD, in July 1999, marked the completion of the merger of six independent agencies within the Judicial Branch (the Office of the Bail Commissioner, Family Services Division, Juvenile Detention Services, Office of Juvenile Probation, Office of Adult Probation and Office of Alternative Sanctions) into one centrally administered division.

The original vision statement of the Court Support Services Division states that it is "[t]o provide Judges with effective services that improve public safety, enhance . . . the general welfare of communities, and contribute . . . to the quality of justice for all citizens." Critical to the achievement of these goals was the provision of scientific assessment tools to all the disciplines within CSSD. This objective is rooted in CSSD's movement toward evidence-based practices fueled by research and outcome measurements.

Shortly after its creation, the CSSD-Family Services Unit, contracted with the AFCC in its quest to develop and implement the most effective and efficient services possible. AFCC consultants conducted a comprehensive review of the existing practice models, caseloads and time standards for the family civil aspect of CSSD's work (primarily mediation and child custody evaluation services) and compared them with national benchmarks. The consultants found that Connecticut met or exceeded national standards in the vast majority of areas (Milne and Salem 2000). They also recommended enhanced case management strategies and expanded service delivery. The cornerstone of these recommendations was the development and implementation of an intake and assessment instrument to identify the level of conflict and complexity of issues in cases and correspondingly match the family to the most appropriate intervention.

THE CASE FOR TRIAGING SERVICES

Prior to the implementation of the Family Civil Intake Screen, CSSD-Family Services Unit, like most family court service agencies, had provided services in a linear service delivery model (also referred to as tiered services). Under this system, a continuum of services is identified and made available in a linear fashion. Families begin with the service that is least intrusive and time consuming, and, if the dispute is not resolved, the family then moves to the next available process. Under this approach, each service tier is typically more intrusive and directive than the one preceding it. The services offered and number of processes available can vary dramatically from one jurisdiction to another; however, a typical progression might include a divorce education program, mediation, child custody evaluation or investigation, moderated settlement conference and, finally, a trial.



Adapted from the Matrimonial Commission Report to the Chief Judge of the State of New York, February 2006.

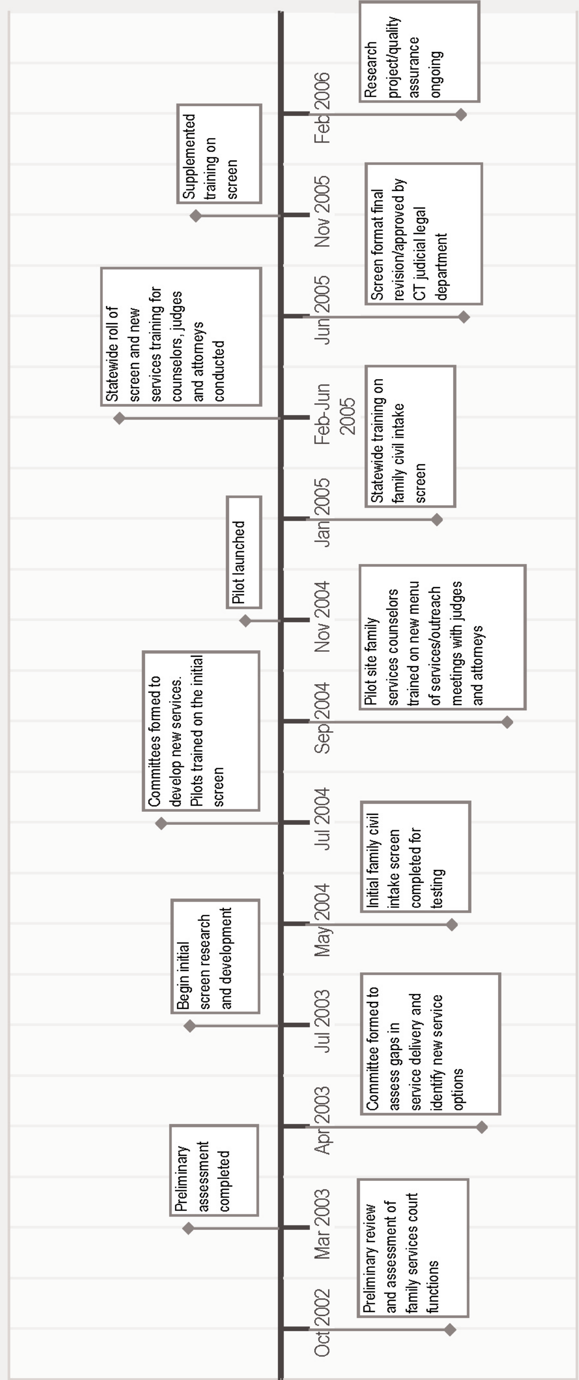
The tiered services model is based on the belief that it is preferable for separated and divorcing parents to make plans for their children and resolve their disputes with as little intervention as possible. In fact, mandatory parent education and

mediation statutes and court rules in many jurisdictions require these interventions prior to more invasive and evaluative interventions (Geasler and Blaisure 1999; Tondo, Coronel and Drucker 2001; Tondo 2002). Therefore, with limited exceptions (including some cases involving domestic violence), many courts have summarily referred even the seemingly most intractable cases to parent education and mediation, essentially claiming that there is no harm in trying. Indeed, many court-based mediators can provide anecdotes of ostensibly miraculous breakthroughs in mediation with high-conflict parents. This approach enables the parents not only to reach an agreement but also to develop a better understanding of each other's needs and interests and perhaps to do a better job of co-parenting in the future. More often, however, high-conflict families fail in mediation and are referred to the next process.

As family court service agencies experience increasing caseloads and static or diminishing staff time, providing confidential mediation services that offer multiple sessions and encourage self-determination to every family has became more challenging in a court-connected context (Welsh 2004). Not only are valuable staff time and resources used, but as families move through the system they spend an increasing amount of their own time (perhaps missing work, paying for child care and dealing with myriad expenses and inconveniences), their attorney's time (if they are represented) and their money, while often becoming increasingly polarized through repeated failed attempts to resolve their disputes. All the while, and most importantly, children must endure protracted conflict between their parents.

In many jurisdictions with mandatory mediation, court programs use hybrid mediation-evaluation processes or limit parties to a single mediation session (Sanchez 2005; Chavez-Fallon 2003; Dennis 1994), thereby potentially significantly altering the nature of the mediation process.

Unconstrained by a mandatory mediation statute, CSSD opted to implement a system that would still include mediation but would allow disputants to bypass it rather than change its nature. Mediation would be augmented with additional services, and a formal assessment tool would be developed to create more consistent and uniform referrals and provide guidance to family relations counselors in an effort to reduce the amount of time families spend in services and increase agreement rates. The chart below provides information on the project timeline.


Family Services Timeline
Oct 2002
Preliminary review and assessment of family services court functions
Mar 2003
Preliminary assessment completed
Apr 2003
Committee formed to assess gaps in service delivery and identify new service options
Jul 2003
Begin initial screen research and development
May 2004
Initial family civil intake screen completed for testing
Jul 2004
Committees formed to develop new services. Pilots trained on the initial screen
Sep 2004
Pilot site family services counselors trained on new menu of services/outreach meetings with judges and attorneys
Nov 2004
Pilot launched
Jan 2005
Statewide training on family civil intake screen
Feb-Jun 2005
Statewide roll of screen and new services training for counselors, judges and attorneys conducted
Jun 2005
Screen format final revision/approved by CT judicial legal department
Nov 2005
Supplemented training on screen
Feb 2006
Research project/quality assurance ongoing

A MULTIFACETED APPROACH TO FAMILY DISPUTE RESOLUTION

The decision to develop an intake and assessment instrument required CSSD to examine its menu of services. When the project began, court referrals were generally limited to mediation and a relatively comprehensive child custody evaluation that consumed about forty-five hours of staff time. CSSD has historically outsourced its parent education programs to community providers. Some of the more experienced and highly qualified family relations counselors conducted a specialized short-calendar negotiation dispute resolution process (Salem, Schepard, Deutsch and Milne 2003), an on-site prehearing facilitated settlement conference that is described more fully below.

It was clear, however, that this approach was not sufficient to manage the growing and increasingly complex caseloads of Family Services staff. Court service agencies elsewhere were beginning to offer a range of service options, from educational programs for all separated and divorcing parents to specialized and intensive services for members of high-conflict and violent families. Some agencies adapted their existing structure and offered specialized services on a case-by-case basis. Such services included: (1) educational programs and group mediation processes for high-conflict families; (2) therapeutic mediation; (3) mediation-evaluation hybrid processes; (4) issue-focused, settlement-focused or fast-track evaluations; and (5) parenting coordination. Numerous other family dispute resolution interventions have been implemented in family court service agencies (AFCC Court Services Task Force 2005). Often, these are hybrid processes combining some elements of education, counseling, mediation and evaluation in an effort to tailor the process to the specific needs of each family.

As the Family Civil Intake Screen developed, CSSD staff began to evaluate the efficiency and effectiveness of the service menu offered by the Family Services Unit. Since the early 1990s, the Unit's staffing has remained relatively level, but during this time the number of referrals to the agency increased significantly. These referrals often included self-represented litigants, litigants who were never married and an increasing number of litigants involved in postjudgment matters. These types of cases exacerbate the challenge of increased referrals since the individuals and families involved are often less prepared to participate in services or the legal system and have different (often limited) parental relationships than in a

typical divorce. Postjudgment matters are also more likely to involve high-conflict relationships.

As the demand for services began to outpace existing resources, the Family Services Unit recognized the need for a new service delivery model. Indeed, counselors in the field were driving the change as different offices were adapting their services in order to meet the demands being placed on their resources. The traditional mediation and evaluation services were being transformed, often on a case-by-case basis, to provide families with services more tailored to their needs. For example, when counselors determined that comprehensive custody evaluations were not needed, the scope of the process was modified and a process more closely resembling an issue-focused custody evaluation resulted. At times, mediators altered the process to incorporate an information-gathering function, including children's lawyers, information from other sources or the mediator's own expertise. These modifications enabled counselors to use their clinical judgment to help parties reach agreement on issues without a referral to a more comprehensive and time- and resource-consuming custody evaluation.

The success of these creative and often ad hoc interventions helped inform the more strategic development of a broader array of services to better meet the needs of the families and the court. Advisory committees of administrators, supervisors and counselors were formed to structure the new services and the policies governing them. The committees developed two additional processes, the conflict resolution conference and the issue-focused evaluation, which, on the continuum of services, lie between mediation and comprehensive evaluation (see Appendix B for case flow). These processes were formalized and implemented in Family Services Unit offices throughout Connecticut.

The conflict resolution conference is an eight-week confidential service that blends the negotiation and mediation processes. In most cases, the parties meet with the counselor for two or three sessions. The counselor spends additional time gathering information and writing agreements when applicable. Although parents are offered the opportunity and encouraged to reach their own agreements, the counselor can be more directive than a mediator, can independently obtain collateral information and can make recommendations to the parents in an attempt to resolve the disputed issues. Parents are the primary participants; however, attorneys and guardians ad litem also participate and may be instrumental in the process. At the conclusion of the process, a report is sent to the court outlin-

ing any agreement. If no agreement is reached, neither the details of the conference nor the recommendations of the counselors are divulged. The conflict resolution conference involves approximately ten hours of the counselor's time and three to five hours of the parents' time.

The second additional service implemented was the issue-focused evaluation. This service is also eight weeks in length, averaging four meetings and a home visit (if deemed necessary by the counselor). The evaluation is limited in scope, counselor involvement and duration. The issue-focused evaluation allows the counselor to assess a single issue causing conflict in a family rather than completing a comprehensive evaluation. It consumes approximately fifteen hours of staff time and is not confidential. The referral for an issue-focused evaluation comes from the court with a specific order defining the limits of the referral. The process concludes with the counselor sharing his or her assessment and recommendations orally to the parents and their attorneys and submitting a written report to the court.

THE DEVELOPMENT OF THE FAMILY CIVIL INTAKE SCREEN

As new services were being implemented, the Family Civil Intake Screen was developed to facilitate early identification of parenting conflicts and assist counselors in better matching the needs of the families to the services (both new and previously existing). The intent was to both guide and supplement the professional judgment of counselors, leading to more efficient and effective decisions regarding the most appropriate services. The screen was designed to strengthen the consistency of the intake process within each office and across the state and move away from more discretionary decision making that fluctuated between individual counselors.

The first step in the screen's development was a review of the Family Services Unit's civil intake practices service array in an effort to identify the strengths of the process and areas in which changes might benefit the Family Services Unit, the clients and the court. Project consultants conducted a three-day site visit to meet with the Unit staff, conducted focus groups and observed the short-calendar negotiation process. Separate focus groups were conducted with family lawyers, family

court judges, counselors and supervisory and management personnel. During the focus groups it became evident that the long history of cooperation between the bench and the bar and the high regard for the Family Services Unit staff would be key factors in the success of the project.

Observation of short-calendar negotiations took place in judicial districts in Hartford, Milford, New Haven and Rockville. This process is a unique on-site prehearing facilitated settlement conference. Experienced family relations counselors facilitate negotiations and provide information on child development, child custody, access and parenting matters, child support, property division and other financial matters, all in the face of a heavy caseload and significant limitations of time and space. It is within this forum that Family Services screens and accepts referrals for office-based services.

The short-calendar process, by definition, is tailored to the needs of each family and the resources and needs of each district. Lawyers generally participate if the parties are represented. Because the short-calendar negotiation process is typically the entry point for clients, it presents the ideal forum for a more systematic face-to-face intake.

The project team's second task was to review and analyze existing intake assessment tools and screening protocols in court services and related agencies (Deutsch, Schepard and Salem 2003) in an effort to determine how Connecticut practices compared with those in other jurisdictions. This effort included (1) a review of existing literature related to intake assessment, (2) a request for information posted on the AFCC Court Services listserv, (3) consultations with court service agencies throughout the United States and Canada about their screening protocols, (4) interviews with leading researchers to identify best practices of intake and screening, and (5) a review of the most widely used instruments that measure the critical variables of concern affecting the safety and protection of children. The search revealed no published reports, articles or papers that described court-based intake assessment or screening processes that were designed to differentiate court services.

The review led to the identification of several existing intake and screening practices that fall into three categories of practices:

(1) *Tiered services* (referred to above as a linear service delivery model) graduate a family through levels of services appropriate to its particular level of

functioning and conflict. Families participate in each level of service (e.g., parent education, mediation, judicial settlement conference, evaluation, hearing or trial), stopping only if and when they reach an agreement. The emergence of critical issues—such as allegations of child maltreatment or neglect, domestic violence or substance abuse—may trigger an emergency screening process.

Several examples of tiered systems were identified. In one Oregon jurisdiction, all parents must attend a parent education program, after which they attempt to develop a parenting plan (or modification). If no agreement is reached, they participate in mediation. If mediation does not result in an agreement, the parties move to a settlement conference and finally a hearing before the judge.

(2) *Emergency screening services* are offered in some jurisdictions. In Santa Clara County, California, parties can file a motion for an emergency screening when there is concern about the short-term safety and protection of the children, an investigation of child abuse, a severe incident of domestic violence, an incarcerated parent or a threat of abduction. The judge then issues an ex parte order for a brief emergency evaluation to take place within one day. A family court counselor meets with all family members, talks to Child Protective Services, the school, attorneys, police and other professionals and makes a rapid recommendation for temporary orders.

(3) *Triage* is used to determine the referral to the most appropriate service and was found on a limited basis and in very few jurisdictions. The most comprehensive form was used by the Office of the Children's Lawyer (OCL) in Toronto. The OCL provides evaluation, representation and intervention services on behalf of the children and uses an intake form to systematically gather information for screening from any parties claiming custody or access to the children. Information is collected about violence and the presence of protective orders, criminal charges, mental health and substance abuse issues, as well as information about legal proceedings and the kinds of court services previously used. Information about ability to communicate and concerns about custody and access are also solicited.

Review of Specific-Issue Assessment Tools

A review of specific-issue assessment tools helped identify key variables that may predict appropriateness for mediation, education or evaluation, as well as adjustment problems for children. Instruments that assess domestic violence, conflict, psychological distress and substance abuse were reviewed with an eye toward specific questions that could be used or modified as a brief comprehensive screening tool.

- Connecticut's domestic violence screening instrument, DVSI-R, has been in use since 2003. DVSI-R includes fourteen items that lead to a rating from low to high of imminent risk of violence toward partner and imminent risk of violence toward others.
- The Divorce Mediation Assessment Instrument (Tiong Tan 1988) was developed in conjunction with Hennepin County Minnesota Family Court Services to determine the appropriateness of mediation for a divorcing couple. The instrument was designed to highlight potential issues and problems in the mediation process and provide feedback to clients about areas for change. The subdimensions with the subscales identify useful domains of information including substance abuse, child or spouse abuse, intensity of conflict and conflict about children.
- Some standardized self-report inventories, including the Conflict Tactics Scale (CTS; Straus 1979) and the Brief Symptom Inventory (BSI; Derogatis 1975), were reviewed for potential areas of screening and categories of information.
- Also reviewed were the three most widely used screening instruments for substance abuse: the Alcohol Dependence Scale (ADS), the Drug Abuse Screening Test (DAST), and the Michigan Alcoholism Screening Test (MAST).

EMPIRICAL, CLINICAL AND SOCIAL POLICY BASIS FOR THE FAMILY CIVIL INTAKE SCREEN

Overview

Having gathered the relevant materials and information, the project team began the task of identifying key questions, based on empirical and clinical findings and social policy. The clear tension was to identify a series of questions that would provide enough information for counselors to make effective judgments but that could also be administered in a relatively efficient manner.

The Family Civil Intake Screen contains questions in six domains: (1) General Information; (2) Level of Conflict; (3) Ability to Cooperate and Communicate; (4) Complexity of Issues; (5) Level of Dangerousness; and (6) Disparity of Facts/Need for Corroborating Information. Questions were generally ordered to begin with those requiring factual and verifiable information and questions that were least likely to cause a defensive reaction from the parents. Essentially, the questions that are easier to answer come at the beginning and those that raise more sensitive issues come toward the end. No single question is intended to determine specific services; however, there are key questions about violence and safety that may trigger specific interventions. (See Appendix A for the screening instrument.)

General Information

The instrument's General Information section gathers basic information about the clients, existing court orders and previous participation in the Parent Education Program. Parents filing for divorce in Connecticut are automatically ordered to attend the six-hour program and are strongly encouraged to complete the program prior to referral for services by the Family Services Unit, although they do not always do so. Research indicates that, generally, attendance at parent education programs is related to lower relitigation rates and more well-informed parents, but that such programs do not necessarily ensure that settlements are more easily reached (Arbuthnot and Gordon 1996; Arbuthnot, Kramer and Gordon 1997; Gray, Verdieck, Smith and Freed 1997; Kramer 1998; Kramer and Kowal 1998).

The General Information section collects information on the age, gender and residence of each child, as well as family size, current legal and physical custody and parenting or access plans. Age, gender and family size have been found to be predictors of high-conflict divorce (Maccoby and Mnookin 1992), and current arrangements are the strongest determinant of custody outcome (Johnston, Klein and Tschann 1989; Maccoby and Mnookin 1992). This section also includes two preliminary questions related to family violence. These questions supplement a separate initial screening for domestic violence or other safety concerns. Inquiring about prior arrests and a current restraining or protective order allows the interviewer to further prescreen the case for domestic violence and the possibility that one party fears the other.

Level of Conflict

The second section of the screen helps counselors assess the parties' level of conflict, not by asking questions about their perception of the conflict, but by asking questions whose answers should be factual and verifiable. Clients are asked about the status of their relationship with the other parent (i.e., divorced, separated, never-married, cohabitating, etc.), the number of times they have utilized court interventions, their stage in the court process (e.g., no prior services, prejudgment, postjudgment) and what service usually resolved prior disputes.

This section relies on research findings and clinical experience that (1) mediation is especially effective if offered early in the divorce process (Zuberbuhler 2001); (2) never-married parents may need special services, and those with no history of cohabitation have little basis for cooperation and trust (Johnston 1999, 2000; Raisner 1997, 2004); (3) postjudgment disputes are likely to be more severe and intractable (Ash and Guyer 1986a, 1986b); (4) repeated litigation is a hallmark of high-conflict couples who are resistant to stable settlement through negotiation or mediation (Cohen 1998; Depner, Cannata and Ricci 1994; Duryee 1992; Hauser 1985); and (5) repeated litigation suggests the need for third-party decision-based models of dispute resolution (Coates, Deutsch, Starnes, Sullivan and Sydlik 2004; T. Johnston 1994; Zibbell 1995).

Ability to Cooperate and Communicate

The third domain of the screen assesses the parties' ability to cooperate and communicate with each other. This section includes general questions on parents' perceptions about how well they communicate and cooperate and the importance of the other parent to the children's well-being, as well as a specific question about whether current access/visitation arrangements were made. These questions are based on research findings that self-reported inability to communicate and cooperate is strongly related to resistance to settlement in mediation and a need for more directive services (Ahrons 1981; Johnston and Campbell 1988; Johnston 1999; Pearson and Thoennes 1984) and that those who make unilateral decisions without reference to the other parent and those who do not see the value of the other parent to the children are less likely to settle in mediation (Johnston 1999).

Complexity of Issues

The Complexity of Issues section is intended to identify families that require more complex assessment and are likely to require more directive and involved service interventions. This section focuses on the issues in dispute as identified by the parties, as well as the presence (or allegations) of substance abuse, child abuse or neglect, mental illness and domestic violence.

Conflicts over issues such as relocation; major medical, educational and religious decisions; and threatening or violent behaviors are more difficult to resolve (Stahl 1999). In such cases, mediation is likely to be contra-indicated, whereas issues related to access, decision making, child care and discipline are likely to be resolved in mediation, where the individual needs of the child and family can be more fully considered (Johnston 2000; Kelly 2004; Mayer 2004).

When there are reports of substance abuse and mental health concerns, a child custody evaluation may be needed since these factors may significantly compromise parenting capacities (Bow and Quinnell 2002; Gould 1999; Johnston and Roseby 1997). Current allegations of child abuse and neglect that are denied are shown to have some basis in fact in one-quarter to one-half of cases (Brown 2003; Shaffer and Bala 2003; Thoennes and Tjaden 1990) and also suggest the need for

careful consideration of further investigation and evaluation, although not necessarily a comprehensive custody evaluation (Birnbaum and Radovanovic 1999; Halon 2000).

Reports of ongoing domestic violence, especially those accompanied by denial or minimization, require careful screening, implementation of protective measures for victims and children and careful consideration of appropriate services (Dalton 1999; Jaffe, Johnston, Crooks and Bala 2008; Jaffe, Lemon and Poisson 2003; McGill, Deutsch and Zibbell 1999; Milne 2004). Such reports indicate a need to distinguish between abusive relationships and conflict-instigated violence, to assess the impact of domestic violence on parenting and the effects on the child of witnessing parental violence and to assess the degree of fear and dangerousness. While a more directive process is needed for abusers, others may be able to use a hybrid mediation or conflict resolution service (Dalton, Carbon and Olesen 2003; Gelles 1997; Johnson and Bunge 2001; Johnson and Ferraro 2000; Johnston and Campbell 1993).

Level of Dangerousness

The fifth section of the instrument is designed to help determine what, if any, level of dangerousness exists or previously existed by asking about specific incidents that occurred prior to the last year and within the previous year and about the frequency of the events. The questions in the screen address whether the parents fear each other, specific abusive behaviors and legal responses to family violence (e.g., police calls or restraining orders).

Disparity of Facts/Need for Corroborating Information

The final domain in the screen occurs immediately prior to the determination of services. This section is a single item incorporated into the Service Options/Determinations page, which is the final page of the screen. It calls on the counselor to review the parties' responses (both recorded and unrecorded) and assess the level of disparity in information presented. If parents have generally agreed on their answers and reported relatively low to moderate levels of conflict, they are more likely to be referred to mediation. Conversely, if the answers show

a significant disparity and indicate a need to gather additional and corroborating information, the selected service will likely be more directive and intrusive.

ADMINISTERING THE FAMILY CIVIL INTAKE SCREEN

During the development of the Family Civil Intake Screen, the project team thoroughly discussed and debated the method of administration. The appeal of a self-administered paper-and-pencil questionnaire was clear: it could be mailed to parties or their attorneys in advance and posted on the Internet. It would save staff time and create additional flexibility for clients since it could be completed off-site, in advance or while waiting for an appointment.

It was determined, however, that while self-administration may be more efficient, it would likely be less effective. The potential drawbacks identified included language barriers, low levels of reading comprehension and the possibility of outside influences on responses. Moreover, the opportunity for the counselors to screen in a face-to-face setting would enable them to observe nonverbal communication, clarify and probe using follow-up questions and employ their considerable clinical experience and judgment. Therefore, it was determined that the screen would be conducted through an interview process, and it was ultimately designed for that purpose.

The screens are completed at the conclusion of the short-calendar negotiation process when it has been determined that additional services are necessary. As the counselors have become more familiar with the screen, they have been able to incorporate many of the questions into the information-gathering stage of the negotiation, thereby reducing the amount of time needed to complete the screen.

Screening may be conducted conjointly or in separate meetings with each parent, depending on the case. Prior to the meeting, the counselor meets privately with each party to conduct a preliminary domestic violence screening to identify any immediate safety concerns or other issues that would preclude a joint meeting. Attorneys are invited to attend the session; however, they are informed that clients are expected to answer questions. Information collected for the screen is considered confidential and used only for assessment purposes.

The counselor conducting the intake completes a single screen for each family and records one answer per question. If parents provide conflicting answers to a

question, such as how well they cooperate, the lowest functioning answer (i.e., that which typically correlates with the higher level of conflict) is the one recorded. This practice is based on the premise that higher-functioning and lower-conflict parties will be more likely to agree on answers. The practice of accepting the lowest functioning answer becomes more important when addressing the complexity of issues and dangerousness, when one parent might indicate a trouble-free relationship while the other notes that there has been a history of violence or threatening behaviors. Accepting the answer that indicates the lowest functioning and highest conflict ensures that any allegations will be seriously considered and that safety concerns remain first and foremost. The counselor may ask follow-up questions to help parties refine their response; however, the answer recorded on the screen is that provided by the parent(s), not the interviewer's assessment of the parents' functioning.

The screen is divided into six distinct sections, as outlined above. Four of the sections conclude with a summary and overall determination rating for that section. While the answers on the screen are provided by the parties, the determination sections are completed by the counselor. For most sections, the determination rating is based on a rough average of responses given in that section. Including determination ratings for each section allows the counselor to make an assessment of that section's responses without being influenced by impressions from other sections of the screen; each section is intended to stand alone. It is not until the screen is completed that all sections are assimilated into an overall determination of service selection. As such, no single answer or section should determine the service selection.

Importantly, however, the rating for the Level of Dangerousness section is not determined by averaging the answers, as in the previous sections. Rather, because the issue is safety, the counselor accepts the single answer correlated to the highest conflict and greatest level of danger and enters it into the determination point.

The final page of the screen replicates the determination ratings selected for the sections on Level of Conflict, Ability to Cooperate/Communicate, Complexity of Issues and Level of Dangerousness. The counselors transfer the determination point from each section to form a snapshot of the screening results. Before the service selection is identified, however, the interviewer completes the final section on the disparity of facts presented and the need for corroborating evidence. Here, the counselor makes an overall assessment, taking into consideration

the answers provided, how greatly the parents' answers differed and how much collateral information the counselor believes will be necessary to satisfy the clients' concerns and help them move toward resolution.

The counselor then reviews the determination for each section of the screen and identifies the most appropriate service. If families have used mediation successfully in the past, or it has been determined that the parties have the capacity to discuss issues with each other and compromise, and if the level of conflict between the parties is low to moderate, mediation is generally the appropriate referral.

Alternatively, a conflict resolution conference would be the most appropriate referral if (1) the parties have limited ability to communicate and cooperate; (2) the level of conflict is moderate and either acute or mildly chronic; (3) the parties have some ability to consider alternatives proposed by each other or a neutral party; (4) limited collateral information is necessary; and (5) there is no denial of any issues of domestic violence, mental health, substance abuse or child abuse or neglect.

When conflict is moderate or high, an evaluation is likely to be recommended. Issue-focused evaluations are appropriate if the presenting issue is a crisis situation needing a rapid response, if the issue is limited or postjudgment (i.e., the family has already participated in an evaluation) or if the court has ordered an update of an evaluation prior to trial. A comprehensive evaluation is appropriate when the presenting issues require a thorough and in-depth evaluation to determine their impact on the family; when the case is complicated and requires multiple meetings with the parties; when relocation is an issue; or when the parties disagree on issues of mental health, substance abuse, domestic violence and child abuse or neglect. If the results of the screen fall between two different services, the least intrusive service is generally selected unless there are safety concerns.

PROGRAM IMPLEMENTATION

Upon completion of the screen and the development of new services, attention was focused on implementing the new practices in the field. The decision was made to pilot the intake process and services in four offices (Hartford, New Britain, Litchfield and Stamford) to attempt to identify and address the challenges that would be encountered when the program was rolled out statewide. The pilot

sites were selected to ensure a mix of small and large staff, rural and urban populations and varying levels of community support.

Training on how to use the screen as well as the empirical, clinical and social policy basis for the instrument was provided to supervisors and counselors at the pilot sites. Counselors were provided the opportunity to practice administering the screen both during training sessions and in the field prior to initiation of the pilot. During this phase, feedback on the screen was encouraged, which led to revisions prior to the statewide rollout.

Training on the policies and protocols of the two new services—conflict resolution conference and issue-focused custody evaluation—was conducted at all local offices. The training was held locally to account for the nuances of each court and office culture and allow for smaller group discussions on how the changes in practices would impact the office and staff. The opportunity for the staff to participate and raise practical, day-to-day issues was instrumental to the successful implementation of the program.

Once the staff members were trained, attention turned to further incorporating the stakeholders in the process. Informational meetings were held with the family judges and members of the local bar at each pilot site. Information about the project was provided, and feedback was actively sought.

The screen and new services were implemented at the pilot sites with the expectation of a minimum of a six-month pilot period. However, judges across the state quickly recognized the positive impact of the new protocols and services and, in order to respond to the judges' requests, the pilot period was reduced to three months. The program was implemented statewide over the next six months, and training on the screen and new services was provided for all supervisors and family relations counselors in Connecticut.

PRELIMINARY OUTCOMES

The screening process and additional services have been in place at the pilot sites since November 2004, and the statewide rollout was completed in June 2005. In the summer of 2005, CSSD began a formal evaluation, researching the efficiency and effectiveness of the screen and the new services.

The qualitative analysis includes a review of the actual screens to determine if

they are being completed fully and accurately, to assess divergences and to assure that the recommended services flow directly from the determinations made throughout the screen. Since the initiation of the pilot program, data from all screens have been collected and reviewed to ensure effective implementation. Central Administration Regional Managers formally reviewed 200 screens in October 2005 and identified common errors and misinterpretations. This evaluation led to the development and distribution of a more thorough guide to administering the screen. In addition, supplemental training was provided to supervisors who, in turn, provided training to their counselors.

A subsequent review of another 200 completed screens was conducted in February 2006 and found significant improvement in the quality of the screens. It was determined that additional training was not needed at that time. Office supervisors not only conduct formal reviews but also review each screen at the time of case assignment and address any questions or concerns with the counselors on an ongoing basis.

The continuing research also includes long-term analysis, looking at the efficacy of the Family Civil Intake Screen. A controlled study is examining the timeliness of case completion, settlement rates, length of time families are in the system and rates of return to court for refilings or relitigation. The outcome data collected since the beginning of the pilot phase show increasing rates of agreement in mediation and comprehensive custody evaluations, the two processes that existed prior to the project. Mediation agreements have increased by 13 percent, and agreements reached at the conclusion of the comprehensive evaluation have increased by 16 percent, thereby reducing the amount of time both counselors and clients spend on these cases.

The increased rates of agreement appear to support the overall effectiveness of the screen and the practice of matching families to the most appropriate services. Furthermore, a preliminary referral and workload analysis indicate that even though referral rates increased from the year prior to the initiative, the actual amount of counselor time needed to provide the services has decreased.

CONCLUSION

The challenges facing family court services show no signs of subsiding. In an era of

increasing demand and diminishing resources, effective implementation of projects such as the Family Civil Intake Screen will be critical to service delivery in the future. CSSD is but one of many court service agencies working to address these challenges. Preliminary data suggest that Connecticut's initiative has been successful in achieving early resolution of custody, parenting and access disputes while providing a more efficient and effective service delivery system. While these results are encouraging, the long-term benefits of the process will be not be assessed until the research project concludes at the end of 2007.

APPENDICES

To access this chapter's appendices, go to:
http://www.afccnet.org/resources/resources_professionals.asp

Appendix A: Family Civil Intake Screen

Appendix B: Case Flow Graph

NOTES

1. This project would not have been possible without the extraordinary efforts of the Association of Family and Conciliation Courts' (AFCC) consultants and Judicial Branch's Court Support Services Division (CSSD) management and staff. The authors would like to acknowledge the other members of the Civil Family Intake Screen project: Stephen Grant, Kathryn Ceruti, Joseph DiTunno from CSSD and Andrew Schepard and Janet Johnston from AFCC. Thanks also to the many Family Services Unit supervisors and counselors, too numerous to list, for providing their expertise throughout the process of developing and implementing the screen and new services. We thank Erica Salem and Andrew Schepard for their insightful comments on earlier drafts of this chapter. Finally, none of this would have been possible without the vision and leadership of the Judicial Branch, in particular Appellate Court Judge and former Chief Administrative Judge for Family F. Herbert Gruendel, Chief Administrative Judge for Family Julia Dewey and CSSD Executive Director William Carbone. For their support we are truly grateful.

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Sharon Zingery, M.A. was a custody/visitation mediator for 15 years and was a supervisor at Marriage and Family Counseling Service (MFCS), Cook County's Circuit Court family mediation program. For 15 years prior, she investigated child custody. In 1988, she founded the Family Violence Committee of MFCS, which developed the protocols for mediation when domestic violence is a concern. She serves on the Board of Directors of the Mediation Council of Illinois and was its President for several years. She was invited to serve on the Toronto Spouse Abuse Forum and was honored to participate in Janet Reno's research on mediation and domestic violence. She has trained hundreds of mediators in screening for domestic violence in mediation at numerous conferences.

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Appendix A

CO AND PARALLEL PARENTING COUNSELING
The Center for Healthy Development
New Skills and Choices Parenting Program

Parents must have custody/visitation orders in place prior to referral to **Co-Parenting and Parallel Parenting Counseling.** Families suitable for this court ordered referral:

- Chronic litigators who use the court system to resolve their continuing issues;
- Parents who have difficulty making mutual and timely decisions (particularly those with young children or who have children with special needs);
- Parents with an alienated child;
- Potentially abusive situations that need structure and monitoring;
- Parents with intermittent mental illness;
- Not appropriate for families with histories of significant family violence, child abuse, or active substance abuse;
- Both parents must participate.

All families referred should have a court order to Co-parenting and Parallel Parenting Counseling. Court ordered referrals should include goals of service intervention, who is allowed to be seen, and timely procedures for resolving issues that are pertinent to safety of child. This service is a Parent Monitoring intervention and not meant to be therapy or mediation of a custody dispute.

Counseling structure:

- The counselor functions as a manager of conflict and assists the parents in carrying out their court orders.
- A legal contract is set up with the counselor and parents that reflects the court ordered referral, includes what is required and the goals of the service.
- Other family members may participate as directed by the court and when considered appropriate by the counselor;
- Collateral contacts may be made with the child's therapist and other professionals involved with the family;
- Parents will be seen in sessions together, and, when appropriate, in separate sessions.

Objectives of service: The counselor functions as a parent coordinator to manage chronic, recurring disputes such as visitation conflicts and help parents to adhere to court orders in highly conflicted separating and divorcing families. Interventions generally include helping the parents understand the affects of their conflict on the children, to help them improve and protect good relationships with their children, provide advise and assistance in implementing their visitation and custody plans, help improve communication, coordinate the safe care of their children and help children cope with the stress and fears about the visiting plan.

Fees:

Families who are FIRST 5 qualified (they have at least one child under the age of six years old) will pay a co-pay fee of $15 per parent per session. All other parents will pay the CHD sliding scale fee according to gross income.

SAFE FAMILIES:
A Group Intervention for Parents with Children at Risk

The Center for Healthy Development
New Skills and Choices Parenting Program

SAFE FAMILIES is for families in the Family Court system that has one or more of the following: a history of domestic violence; no contact orders/restraining orders; supervised exchanges for visitation.

Class Structure:

- Classes are two hour sessions held on two different days of the week for sixteen weeks;
- The parents attend separate classes on different days;
- Both parents must attend the program.

Program objectives:

- Help parents build a safe environment for their children;
- Reduce conflict and increase child protection;
- Learn new skills in using a structured parenting plan;
- Understand the effects of conflict on their children;
- Increase accountability for parents who have been violent so that they take responsibility for the abuse, avoid using the child as a weapon in conflict and learn to appropriately support the other parent in the care of the child;
- Support the parents who have been victims of violence and provide them with skills in maintaining appropriate boundaries for protection of themselves and their children from abuse.

CLASS TOPICS

SECTION I: Introduce program objectives; Identify unsafe family practices and the effects on children; Explore choices in parenting behaviors.

Class 1 Introduction to Program: Provide an orientation and introduction to the group and its goals, begin to learn about the effects of violence on children, and begin skill building for safe parenting and protecting children from conflict.

* Provide an orientation to the group
* Learn about the effects of violence on children from a child's perspective
* Build emotional self-awareness
* Discuss Safe Families program goals
* Learn a skill-building tool to improve safety in the home

Class 2 Defining Conflict and Violence: Identify unsafe family practices and learn the importance of maintaining appropriate boundaries for a safe environment for self and children.

* Learn dynamics of control and dominance
* Assess personal accountability
* Build awareness of personal responses to control and dominance

Class 3 Children in the Middle: Focus on the difference between placing children in the middle and positive parenting and continue to build self-awareness.

* Learn ways in which children get placed in the middle
* Identify the price children pay for being placed in the middle
* Develop an understanding of positive parenting practices
* Use the Experience Log to continue to build self-awareness

Class 4 Defining Parenting: To help parents identify the parenting styles and learn skills to improve interactions with their children and others

* Introduce basic parenting styles
* Learn to communicate assertively
* Begin to make change through self-focus and use of new skills

SECTION II: Recognize personal coping skills and stresses; Identify expectations and control issues; Develop new skills in changing behavior.

Class 5 Stress, Anger, and Anxiety: To help parents build self-awareness around the anger and stress in their lives, learn about the impact on their children, and improve coping skills in order to provide a more secure environment for themselves and their children

* Increase self-awareness of anger and stress
* Analyze stress management and coping skills
* Learn why we turn to substances and how they affect us
* Make changes for the sake of the children and ourselves

Class 6 Revealing Expectations: To examine and understand the expectations we have of ourselves as parents and of our children as well as the effects of parental expectations on children

* Examine the roots of our expectations
* Identify our expectations of ourselves and our child
* Normalize childish behavior and understand our own behavior
* Explore what it means to be a mother/father

Class 7 Managing Self-Talk: Identify sources of stress in self-talk and examine how stress escalates into anger, how to manage self-talk, and how to cope and change behavior

* Introduce self-talk and its relationship to stress and anger
* Identify types of self-talk
* Examine self-talk and its relationship to expectations
* Relate self-talk to the experience cycle

Class 8 Stress Management and Coping Skills: To catch up on concepts and tools from previous classes, review anger and stress, and work on coping skills

* Introduce material from Classes 1-7 not previously introduced
* Review anger, stress, and coping skills worksheets
* Make changes for the sake of the children and ourselves

<u>SECTION III: Develop empathy for positive and responsive parenting; Learn constructive relationship choices; Build skills in listening and communication; Build a practice of safe parenting</u>

Class 9 Through My Child's Eyes: Learn to be more attuned to our child, increase awareness of our child, and experience empathy for our child's experience

* Examine child's perspective
* Review expectations

Class 10 Understanding Self Esteem: Examine the roots and meaning of self-esteem as well as how to build self-esteem in children

* Introduce self-esteem
* Identify obstacles to building a child's self-esteem
* Identify ways to build a child's self-esteem

Class 11 The Art of the Genuine Encounter and Listening: Build awareness of genuine engagement with child and promote child's unique expression of self through active listening and creating psychological safety.

* Identify types of interactions between parent and child that promote genuine encounters.
* Practice active listening and observation
* Learn how to create psychological safety for child

Class 12 Building Boundaries for Safe Parenting: Learn how to build boundaries for Parallel Parenting and develop a protocol of best practices for Safe Parenting.

* Develop structured methods of communication and rules for parallel parenting
* Set priorities of rules of safety and commit to them
* Make a list of the most important Best Practices for Safe Parenting

NEW SKILLS AND CHOICES PARENTING PROGRAMS
The Center for Healthy Development (CHD)

Terry McLarnan, Executive Director of The Center for Healthy Development (CHD)

Three new programs are now available for families who are in the process of separation and divorce. The **NEW SKILLS AND CHOICES PARENTING PROGRAMS** are:

- **Parents in Conflict** – eight weeks of group intervention for both parents;
- **Safe Families** – a twelve week group intervention for both parents
- **Co-parenting and Parallel- parenting Counseling**

The **New Skills and Choices Parenting Programs** are part of a Family Court Initiative public/private collaboration. The purpose of the **Family Court Initiative** is to ensure that children and families within the Family Court System will have the necessary health, developmental and social underpinnings to assist their success in life. The programs are a comprehensive and integrated continuum of care consisting of three levels: prevention, intervention, and intensive intervention. These multiple levels of services are provided by The Center of Healthy Development, a non-profit agency of mental health professionals, with twenty years of experience.

The following is a description of each of three new programs provided by The Center for Healthy Development:

1. PARENTS IN CONFLICT: Families referred by the Superior Court to the Parents in Conflict Group Intervention include:

- Parents in conflict over their children;
- Children in family are in stress due to parental conflict and separation;
- Parents are entrenched in litigation;
- Both parents must participate in the classes.

Classes are not appropriate for families with a history of domestic violence, active substance abuse or serious mental disorders. Parents are referred at any time during the court process.

Class structure:

- Classes are two hour sessions held once a week over an eight week period;
- Both parents must attend and are separated two different classes on different days;
- The two groups are a mix of fathers/mothers and custodial/non-custodial parents.

Program objectives: To help parents build new skills in communication and parenting and to make constructive choices for their family. Group interventions include role plays, videos, peer learning and didactic information to assist them in learning the ability to:

- Develop empathy for children and the other parent;
- Learn constructive ways to solve problems;
- Learn new communication techniques, especially clarifying and listening;
- Learn value of parallel parenting when appropriate;
- Understand effects of conflict on children and on each other;

- Recognize ways that stress, anger, violence, substance use, and emotions cause problems.

2. SAFE FAMILIES is a twelve-week skill-building group intervention program for families in the Family Court system whose children are at risk due to domestic violence and/or who have one or more of the following: a history of domestic violence allegations; no contact orders/restraining orders; supervised exchanges for visitation. Both parents must attend the program. The two hour classes are held on two different days of the week and the parents attend separate classes on different days.

Program Objectives:

1. **Help parents build a safe environment for their children:** Parents are asked to commit themselves to protecting their children from any exposure to violence or abuse by either parent or anyone else in their home.

2. **Reduce conflict and increase child protection:** Both parents will:
   - Follow their court orders exactly as written;
   - Keep to the written schedule and support the child's time with the other parent;
   - Not allow any harassment or bad mouthing of the other parent;
   - Not allow any discussion of the court case by anyone in the presence of their children;
   - Not use their child to send messages or to report on the other parent.

3. **Learn new skills in using a structured parenting plan:** Parents will learn how and when to communicate specific information about their child in a way that is safe for the whole family.

4. **Understand the effects of conflict on their children**: Parents will learn about the problems children have developed after living with conflict and violence in their families. Some of these problems are: delinquency, substance abuse, depression, physical/medical complaints,

5. **Increase accountability for parents who have been violent so that they take responsibility for the abuse, avoid using the child as a weapon in conflict and learn to appropriately support the other parent in the care of the child:**
   - Parents who have been abusive will identify specific incidents that have occurred in their family and will hold themselves responsible for their own actions;
   - They will learn appropriate behavior that supports protecting their child from violence and conflict;
   - Parents will model for their child the importance of respect and support of the other parent.

6. Support the parents who have been victims of violence and provide them with skills in maintaining appropriate boundaries for protection of themselves and their children from abuse:

- Parents who have been victims of violence will learn about setting up a structured plan and keeping rules of communication that protect the safety of the family;
- Parents will help their children feel secure by maintaining a consistent, predictable environment.

3. CO-PARENTING AND PARALLEL PARENTING COUNSELING: Parents suitable for this counseling intervention:

- Chronic litigators who use the court system to resolve their continuing issues;
- Parents who have difficulty making mutual and timely decisions (particularly those with young children or who have children with special needs);
- Parents with an alienated child or potentially abusive situations that need structure and monitoring
- Not appropriate for families with histories of significant family violence, child abuse, or active substance abuse;
- Both parents must participate.

Referrals to Co or Parallel Parenting Counseling are only be made after a court order for custody and a visitation plan is in place. Court ordered referrals include goals of service intervention, who is allowed to be seen, and timely procedures for resolving issues that are pertinent to safety of child.

Counseling structure:

- The counselor functions as a manager of conflict and assists the parents in carrying out their court orders. Other family members may participate as directed by the court and when considered appropriate by the counselor; Collateral contacts may be made with the child's therapist and other professionals involved with the family;
- Parents will be seen in sessions together, or in separate sessions.

Service goals: The counselor functions as a parent coordinator to manage chronic, recurring disputes such as visitation conflicts and help parents to adhere to court orders in highly conflicted separating and divorcing families. Interventions generally include helping the parents understand the affects of their conflict on the children, to help them improve and protect good relationships with their children, provide advise and assistance in implementing their visitation and custody plans, help improve communication, coordinate the safe care of their children and help children cope with the stress and fears.

Fees: New Skills and Choices Parenting Programs are funded in part by **FIRST 5 Santa Clara County**. There is a co pay of $10 per class for parents in the Family Court system with at least one child under six years old attending the Parents in Conflict program and Safe Families. FIRST 5 families in the co/parallel parent counseling program pay a co-pay fee of $15 per parent per session and for intake interviews. All other parents pay the CHD sliding scale fee according to gross income.

All services and classes of the **New Skills and Choices Programs** are treatment focused, confidential and not subject to assessments, reports or testifying.

PARENTS IN CONFLICT
The Center for Healthy Development
New Skills and Choices Parenting Program

Families to be referred to **Parents in Conflict** group intervention program include:
- Parents in conflict over their children;
- Children in family are in stress due to parental conflict and separation;
- Parents are entrenched in litigation;
- Both parents must participate in the classes.

Classes are not appropriate for families with a history of domestic violence, active substance abuse or serious mental disorders. Parents are referred at any time during the court process.

Class structure:
- Classes are two hour sessions held once a week over an eight week period;
- Parents meet in separate classes on separate days;
- The two groups are a mix of fathers/mothers and custodial/non-custodial parents.

Program objectives: To help parents build new skills in communication and parenting and to make constructive choices for their family. Group interventions include role plays, videos, peer learning and didactic information to assist them in learning the ability to:

- Develop empathy for children and the other parent;
- Learn constructive ways to solve problems;
- Learn new communication techniques, especially clarifying and listening;
- Learn value of parallel parenting when appropriate;
- Understand effects of conflict on children and on each other;
- Recognize ways that stress, anger, violence, substance use, and emotions cause problems.

CLASS TOPICS:
1. Introduction to Program and Program Rules
2. Communication
3. Children in the Middle
4. Stress, Anger, & Impulse Control
5. Stress Management
6. Negotiating and Advanced Conflict Management
7. Parallel Parenting
8. Summary and Empathy

Appendix B

FIRST 5 Santa Clara County is developing programs and services for families like yours with a child 0-5 years old. We need your help to define what kind of services would be helpful to you and your family during this time of change. We want to commend you in getting this far and asking for help. It indicates your strength as a parent and love for your child(ren).

Please give some thought to the questions and give your honest answer to each question.

1. What is your relationship to the child(ren)? } Mother } Father } Other ______

   Are you the primary caretaker of your children? ______________

2. How many children do you have in your household? _________

3. What are their ages? (*Please put the number of children in the box*)

   ☐ 0-2 ☐ 3-5 ☐ 6-9 ☐ 10-13 ☐ 14-18

4. Please check if any of the following issues is present in your case?
   ☐ Family violence ☐ Alcohol or drug abuse ☐ Child endangerment
   ☐ Not Applicable

5. What is the greatest strength of your family? ______________________
   ____

6. Do you have family or good friends living near-by who can offer you support or help?
   ☐ Yes ☐ No

7. Have you gone to a parent support group or class before? (This can be either with a community group, within your church, court ordered etc)
   ☐ Yes ☐ No
   If yes, where did you go? ____

   If yes, was this class or group helpful to you? ☐ Yes ☐ Somewhat ☐ Not really

8. What is the highest grade of school you have finished? __________________

Please check the response that indicates your family's need for the following services. Check all that apply.

	You need:			Your child needs:		
Services	Yes	No	Maybe	Yes	No	Maybe
9.Health services						
10.Counseling services						
11.Dental services						
12.Health insurance						
13.Supervised Visitation services						
Classes						
14.Parenting classes						
15.Adult Education (ESL, GED, etc)						
16.Anger management						
17.Children of divorce support group						
18.Substance abuse treatment programs						

19. What other kinds of services do you think would be helpful to you and your family?

____

____

20. Please circle any of the responses that reflect some of the reasons that you felt you could not get the services you thought you needed. (*Please check all that apply*)

☐ Can't afford the services
☐ Don't have transportation
☐ Don't know where the services are
☐ I work during the day
☐ I do not speak English
☐ I don't have childcare available
☐ I don't have the time to go
☐ There is a waiting list
☐ Other 1 ____________________________
☐ Other 2 ____________________________

20. Your home Zip Code: ______________

21. Your Ethnicity: (*You may check more than one)*

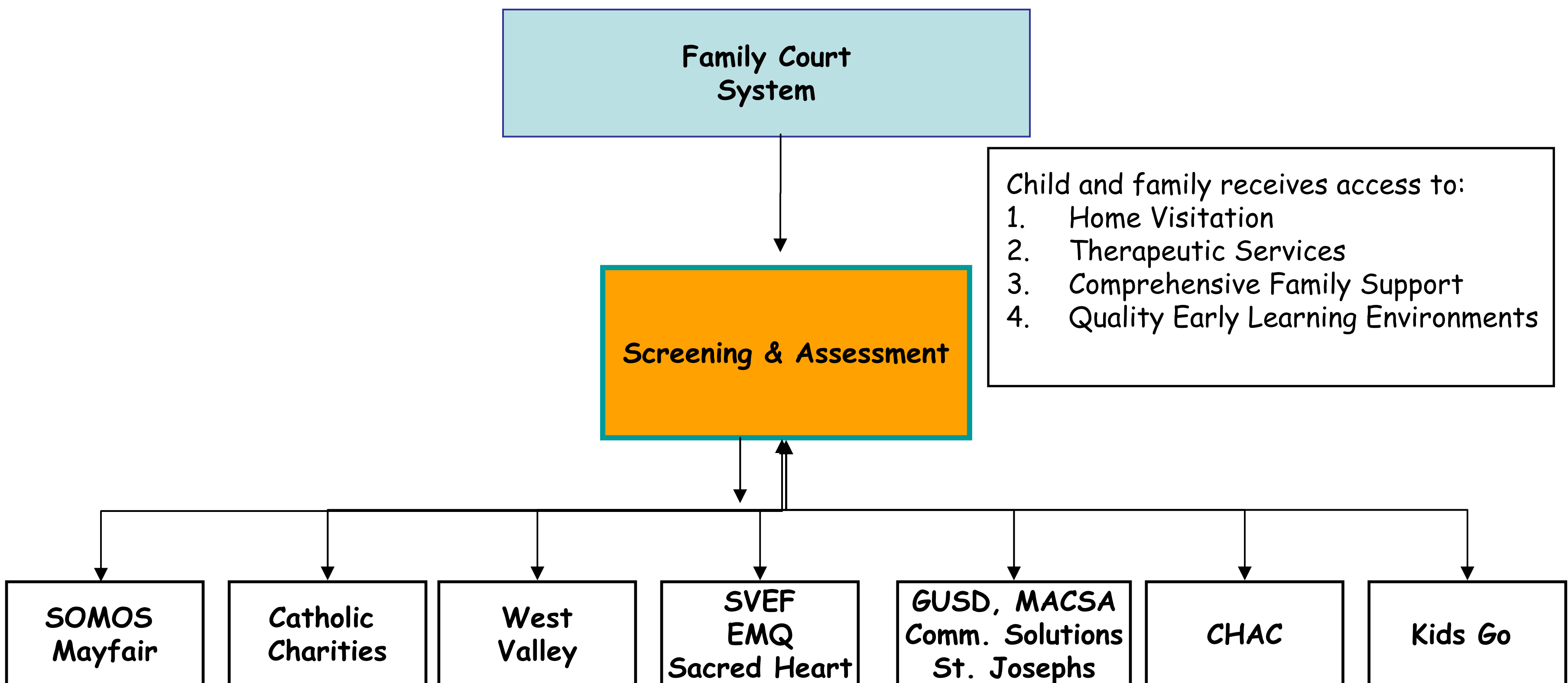
☐ Caucasian
☐ Latino/Hispanic
☐ *Mexican* ☐ *Other Hispanic*
☐ African American
☐ Asian/PI
☐ *Vietnamese* ☐ *Cambodian*
☐ *Chinese* ☐ *Korean* ☐ *Other*

☐ Other ethnicity not listed Please specify _____________________________________

22. What is the primary language used in your home? ____________________

Appendix C

The *System of Care* includes a collaboration with more than 68 partners who provide a continuum of services for children prenatal through age 5.



Appendix D

Dolores Carr, Supervising Family Court Judge
Karen Blinstrub, Executive Director of FIRST 5 Santa Clara County

Announcement and Letter to the Family Law Community and Service Providers

CARE MANAGEMENT INITIATIVE – FAMILY COURT SERVICES

The Superior Court and FIRST 5 Santa Clara County have entered into a new and innovative partnership under a two and a half year grant awarded by the FIRST 5 Commission of Santa Clara County. This opens unprecedented opportunities to provide prevention and early intervention services to children, five years and younger, and their families who are involved in the Family Court system. Our collaboration envisions that these children and families who are often in crisis, will be offered the health, developmental and social services necessary to weather their families' breakup and to assist them to succeed in life.

This vision is the foundation on which Care Management Initiative – Family Court Services (FCS) is built. Our objective is to support the healthy development of children. Our Initiative will:

- **Create a network** of quality programs, services and activities;
- **Coordinate** prevention, intervention, and intensive intervention services to children, prenatal through five-years-old, and their families;
- **Secure access** through coordination of multiple programs, services, and activities identified by the families in the **5 focus areas** of 1) early care and education services, 2) parenting and family support; 3) health and social services; 4) neighborhood initiatives, and 5) program infrastructure and administration through the Care Management Program;

- **Identify and address gaps** in needed services and the over- and under-utilization of existing services;
- **Prevent** families with children prenatal to five-years-old from entering Dependency Court;
- **Foster community collaboration** to enable the coordination and integration of existing services and infrastructures; and
- **Be a major catalyst** for systemic change within the Family Court System.

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The target population for this grant project is children prenatal through five years of age, whose families represent a wide range of families across Santa Clara County. All of these families are separated or divorced, many of whom are frequently in crisis as a result of instability, lack of income, conflict, and disruption in their home life. These families and their children are potentially high risk due to serious problems including child abuse/neglect, domestic violence, substance abuse, and extreme conflict and they have difficulty accessing the needed services and interventions.

The Initiative will staff the courthouse with Care Managers who will provide personal support and assistance to families in securing resources and services in the community aimed at protecting the safety and welfare of their children, enhancing their development, and improving family functioning.

An assessment will be conducted to determine the services needed by these families, as well as obstacles to access. The survey below is a first step in looking at developing programs and strategies to increase the percentage of families who will provide safe, stable and loving homes for their children.

Your experience with these families and your knowledge of services that they need as well as the obstacles they face in obtaining services is important information for this assessment. Please complete the survey below and add any other services or obstacles that we have overlooked.

Name: ____________________________________ Title: _____________________

Name of Organization: _____________________________ Phone#______________

Address: ____Email:_______________

Years of experience working with Family Court parents and children: ______________

Please circle your opinion on the following statements using this scale:

1	2	3	4	5
strongly disagree				strongly agree

The children of the families I see need this service:

Service					
Health care	1	2	3	4	5
Dental care	1	2	3	4	5
Counseling	1	2	3	4	5
Child abuse prevention	1	2	3	4	5
Health insurance	1	2	3	4	5
Learning assessment services	1	2	3	4	5
Supervised visitation services	1	2	3	4	5
Group sessions for children of divorce	1	2	3	4	5

The parents or caretakers that I see request or are ordered to the following services but have difficulty obtaining them:

Service					
Counseling	1	2	3	4	5
Parenting classes	1	2	3	4	5
Co-parenting and parallel-parenting services	1	2	3	4	5
Domestic violence intervention program	1	2	3	4	5
Anger management classes/counseling	1	2	3	4	5
Substance abuse treatment program	1	2	3	4	5
Group interventions for high conflict families	1	2	3	4	5
Victim witness counseling and services	1	2	3	4	5

The services are not utilized by the families because of the following reasons: (*Please circle all that apply*)

a) Cannot afford the costs of the services
b) Do not have transportation
f) Do not have child care available
g) Do not have the time to go

c) Do not know where these services are
d) Work during the day
e) Do not speak English
h) There is a long waiting list
i) Live too far away from the services
j) Other ______________________________

The following special services listed below are needed for families with young children in our system: (*Please circle all that apply*)

a) Home based parenting services
b) Re-connection counseling for children with a long absent parent
c) Therapeutic supervision for parents and emotionally traumatized children
d) High Conflict Family Programs for families of children who may be emotionally traumatized due to high conflict in the family.
e) Divorce education/Co-parenting groups designed to protect children from family conflict and promote healthy development.

f) Other (*Please describe*) ____

Other comments: ____

____

Your opinion is very valuable. Thank you for completing this survey.

Please mail this survey to:

Family Court Services, 170 Park Center Plaza, San Jose, CA 95113

3/21/03

Appendix E

April 2, 2003

Dear Parent,

FIRST 5 Santa Clara County and Family Court Services have entered into a partnership to improve services to families like yours who have experienced the difficulties that separation and divorce bring to parents and children. In order to identify what services would be most helpful, we are contacting parents who have gone through Family Court in the past two years. We are seeking your suggestions and ideas about services that would be most helpful to families during this challenging time.

In order to gather your ideas, we have scheduled focus group meetings to be conducted by FIRST 5 Santa Clara County, a public service commission supported by Proposition 10 tobacco tax funds. A focus group is a friendly place where parents can talk about their children and the best ways to help them grow into stable, loving adults. During the focus group session, we will discuss what services worked best for you and which ones were hard to get to or unavailable and why. Your participation in the focus group meeting is critical in that your suggestions for improving services will be used to develop and fund programs in the community that will increase support to families and children in Family Court.

We want to make this focus group a worthwhile experience and easy for you to attend. Child care will be provided and each family who attends will be given a $25.00 Wal-Mart gift certificate as well as passes to the Children's Discovery Museum.

Our next focus group sessions are scheduled for April ________________. Please call 534-5330 to sign-up for one of these sessions or to ask questions and find out more information. Please respond in advance so that we can make appropriate arrangements for child care, if needed.

Your participation in this group is confidential and all information will be kept anonymous. Thank you for considering our request and we hope to hear from you soon.

CLIENT NAME: ________________________________OTHER PARENT'S NAME: __________________________

CHD #______________________FCS #___________________CASE #____________________________________

Intake Therapist: ____

Intake #1 Date:____________________ Intake #2 Date (if needed)__________________

The Center for Healthy Development

1. Keep in mind that the Safe Families class is NOT appropriate for any family where there has been severe domestic violence (use of/or threats to use weapon, threats of death, injury), recent domestic violence (within the last 6 months), ongoing threat of violence or ongoing significant risk of violence, ongoing alcohol/drug abuse, or any indicator of untreated mental illness (thought disorder, bipolar disorder, impulse control problems, etc.).

2. Keep in mind as you conduct this interview that in addition to the situations mentioned above, you will be assessing for: ability to benefit from the group intervention; violence to self and others; and any other concurrent treatment needs.

3. Please make sure before starting the interview that you have the Client Information sheet completed.

4. Please explain confidentiality and its limits as well as mandated reporting of abuse before conducting this interview. **This is repeated in the Structured Intake for the Safe Families: A Group Intervention for Parents with Children at Risk.**

5. Please have the client sign the two (2) attached copies of the policy statement; one is for their files and the other is for our files.

6. Explain the Oath of Confidentiality for the class and have the parent sign the document.

CLIENT NAME: ______________________________ OTHER PARENT'S NAME: _________________________

CHD #_____________________ FCS #__________________ CASE #___________________________________

NEW SKILLS & CHOICES PARENTING PROGRAM INTAKE

Class Enrollment Requirements and Policies

(Please read to parent and ask for questions)

The Center for Healthy Development
100 N. Winchester Blvd., Suite 260
Santa Clara, CA 95050

1. Both parents must have an intake interview and be enrolled in the same class series; otherwise enrollment will be delayed**.** If both parents cannot start at the same time, we will ask you to take the matter back to court or work it out between yourselves and then contact CHD staff.

2. Each parent will be responsible for their own fee based on their household income. If the parent qualifies for First 5 funding (there is a child in either household under the age of 6 years), and at least one parent lives in a FIRST 5 qualifying zip code area, there will be a co-pay of $_______ per parent for each intake session and each group session**.** The total program fee will be determined when a specific program has been assigned. Each parent will pay for the intake interview and at least six (6) group sessions in advance. The remainder must be paid in full by the halfway point of the program.

3. We are asking you not to initiate any new litigation to modify custody or visitation during the New Skills and Choices Program unless there is an emergency; however, you do have a right to do so.

4. There will be no passing of court papers, support payments, subpoenas, mail, or personal items in the CHD building or parking lot. This policy is designed to maintain a safe environment for both parents. The only exception to this policy is if it has been previously agreed upon in a co-parent session held at The Center for Healthy Development (CHD) and both parents have agreed.

5. CHD staff will not appear in court to testify and will not subject CHD, its records or staff to subpoena and we will not talk to court mediators, assessors, or evaluators. This is your understanding as a condition of your enrollment in the New Skills and Choices Program.

6. Attendance at the first class of any New Skills and Choices Program is mandatory. You will be terminated from the New Skills and Choices Program for any of the reasons listed below; if you are terminated, Family Court Services and the other parent in your case will be notified.

a. Absences: You will be allowed one (1) absence from the Parents in Conflict Program and will be terminated if a second (2nd) absence occurs. You will be allowed two (2) absences from the Safe Families Program and will be terminated if a third (3rd) absence occurs. Please arrive on time for class. You will be denied entry to class if you are more than 10 minutes late; this will be considered an absence and can result in termination. If you are terminated, it is your responsibility to re-enroll by the end of your originally assigned class. There are no refunds.

a. Disruptive Behavior: You are expected to participate in the classes in a respectful manner and not be disruptive to the other members of the class. If the class facilitators feel that your behavior is disruptive or disrespectful, you will be asked to leave that class and it will count as an absence. At the facilitator's discretion, you may also be terminated from the New Skills and Choices Program.

b. Fees: We ask for the cost of the intake appointment and the entire class series at the time of the intake. If you are not able to do this, the minimum that we can accept is the cost of the intake appointment and six (6) classes. The remaining balance is due by the halfway point in the program. If the fees are not paid in full by the fourth (4th) class of the Parents in Conflict Program, you will be terminated. If the fees are not paid in full by the sixth (6th) class of the Safe Families Program, you will be terminated. There are no refunds.

c. Substance Use: Alcohol and/or drug use will not be tolerated. Individuals who appear to CHD staff to be under the influence of alcohol or other substances will be asked to leave immediately and will be terminated from the class.

7. At the completion of a New Skills and Choices Program, you will be given a certificate noting each class session that you attended. You are responsible for providing a copy of the certificate to Family Court Services.

8. This intake will not be considered complete until all requested documents are provided to CHD. These include, but may not be limited to, a copy of the court order requiring attendance in this program, a copy of each parent's photo identification, a copy of any current restraining orders, and a copy of any criminal convictions.

9. Sessions may be video taped exclusively for consultation with our New Skills and Choices Programs consultation group, staff training purposes and facilitator education. These tapes will be erased or recorded over.

10. The clinicians working at CHD are mandated reporters by the State of California and are required to report any disclosures or suspicions of child abuse, elder abuse, or dependent adult abuse. Further, if either parent says anything that leads the intake therapist or group facilitator to suspect that he/she intends to harm herself/himself or another person, then those disclosures or suspicions would also be reported to the proper authorities.

11. Please arrive on time for class. You will be denied entry to class if you are more than 10 minutes late.

12. For safety reasons, we ask you to come to these sessions alone except for a neutral support person who may accompany you to and from the CHD offices, and who may wait for you in areas adjacent to CHD or in the parking area but not on the premises. Do not bring any individual who has ever been abusive or violent, or who you have reason to believe is at risk for being abusive or violent, to you, your children, or any other person.

13. Your signature signifies your understanding of, and agreement with, the policies of the New Skills and Choices Program at the Center for Healthy Development.

Parent (Please print):_______________________________ Date: ________________________

Parent Signature: ____

Intake Therapist (Please print):________________________Date: ________________________

Intake Therapist Signature: ____

CLIENT NAME: ________________________________OTHER PARENT'S NAME: __________________________

CHD #______________________FCS #___________________CASE #____________________________________

OATH OF CONFIDENTIALITY

I,____, agree with the Center For Healthy Development's Oath of Confidentiality. This means that I will share no knowledge regarding the identity of group members nor discuss any information disclosed by group members when I am outside of CHD sessions. This includes, but is not limited to, the halls and parking lots at CHD. However, I understand there may be some exceptions to the rules of confidentiality (such as in court ordered cases, or situations of danger wherein an individual expresses intent to cause serious harm to oneself or another).

____
Group Member's Name (Please print legibly)

____
Group Member's Signature Date

____
Witness/Group Facilitator's Name (Please print legibly)

____
Witness' Signature Date

CLIENT NAME: ________________________________**OTHER PARENT'S NAME:** ___________________________

CHD #______________________**FCS #**___________________**CASE #**____________________________________

RECENT FAMILY HISTORY:

1. Who has legal custody of your child/children? ____________________________
2. Did you bring a copy of the court order? _________________________________
3. **How long were you and the other parent together?** _____________________
4. How recent was the separation? _________________________________
5. ***Do you have a current parenting and visitation plan?** __________________
   a.) **Is it completed? ______ Yes _______ No ________ Temporary __________**
   b.) Please describe: ____
6. **c.) Where do the exchanges take place?** ________________________________
7. Are you and the other parent on speaking terms? __________________________
8. Are you able to be in the same room as the other parent and be respectful? ______
9. ***How recent was the separation?** ______________________________________
10. ***How many court filings have there been over custody and visitation?** ______
    How many have you initiated?________________________________
11. ***Is there a pending case in Family Court**? ______ If yes, what is the issue? ___
    ____

    ***Status**: _____ Mediation ______ Assessment ______ Evaluation

12. ***Have there ever been any recent incidences of domestic violence**? ________
    If yes, please describe: ____
    ____
    ____

13. ***Is there any history of stalking**? _______________________________________
14. ***Are you presently or have you ever had to live in the shelter**? ____________
15. ***Do you have a confidential address**? ______ If yes, why? ________________
    ____
    ____

16. ***Do you have any felony criminal charges against you**? _____If yes, what are they? ____

17. ***Do you have any past or pending DV felony criminal charges against you?** ____ If yes, what are they? ____

18. Do you have any criminal convictions? _____ If yes, what are they? __________
    ____

19. Have you been enrolled in a 52 week Batterer's Intervention program, Parenting without Violence or Anger Management program? ________
    If yes, where? ____

20. ***Are there restraining orders in place**? ________ (If yes, please attach a copy to the file.)
21. ***Have the police been called to enforce the order**? ________________________
22. When was the most recent incident? ______________________________________
23. ***Number of times the police have been called?** ___________________________
24. Please give us a brief history of any incident that resulted in a restraining order?
____
____
____

25. ***Please describe in as much detail as possible the kind of conflict or violence your child (ren) has witnessed between you and the other parent.**
____
____

26. ***Have there been allegations of either physical or sexual child abuse**? ______
27. ***Has there been a Child Protective Services report**? _____________________
28. Who made the report and describe the complaint? __________________________
____
____
29. How many reports to CPS have there been and who made them? _____________
____
30. Date of most recent report? ____
31. ***Does the child have supervised visits or exchanges with either parent**? _____
If yes, please state where, with whom, why (DV related?) and for how long has this happened? ____
____

RELATIONSHIP HISTORY:

32. Are you presently married or living with someone?__________________________
If yes, what is their name?____
33. Do they have any children living with you?__________________________________
If yes, please provide name(s) and age(s):________________________________
____

34. How many times have you been married or lived with someone else?__________
35. Do you have any children from other relationships? _________________________
If yes, please provide name(s) and age(s):________________________________
____

36. Are there any children with special needs? (This would be a child that is not developing as the parent would like or has any concerns about cognitive/physical

development including ADD or ADHD-like symptoms)?____________________
____
(If so and family qualifies for FIRST 5 free assessment: Provide parent with the phone number for the Center for Achievement & Learning: 408-793-5959.

37. ***How do you coordinate (how successful/problematic) with the other parent a consistent schedule for the youngest child about feeding, sleeping, medical care and changes in the child's daily needs**? ____________________________
____

38. Who is your primary support person in parenting your child (ren)? _____________
____

39. What do you think is the reason for the separation from the other parent? ________
____
____
____

40. ***If you were able to identify it, what would you indicate is the primary reason you and the other parent cannot resolve your disputes**? (*Watch for "other" focus and follow up).*____
____

41. ***In what ways has the behavior of your child (ren) changed since your divorce or separation?** ____
____
____

42. Do any of your children have behavior problems at home? ___________________
____
____.

43. ***How do you discipline your children?** __________________________________
____
____

44. Is your discipline working? Why/why not? _________________________________
____
____

45. How were you disciplined as a child? _____________________________________
____
____.

46. How does your child (ren) perform at school? Do they have academic or behavioral troubles? If yes, what interventions have been tried?_______________
____
____

47. Has counseling been recommended? If yes, is your child(ren) currently in therapy and has it been helpful? ____
____

48. ***Do you believe your child could benefit from a support group for children for children with separated parents**? _____

49. Is your child's teacher aware of the ongoing conflict between you as parents?
____

50. How does your child (ren) handle conflict with peers?_______________________
____
____

51. How do you respond to your child (ren)'s conflict with siblings or peers?
____
____

52. ***Were the police ever called because of your behavior towards your former partner or children?** If yes, please describe (How many times?) _____________
____

53. What are your worries for your child (ren)? _______________________________
____
____

FAMILY OF ORIGIN HISTORY:

(Intaker: Be aware these questions will lead the client away from the current life situation, so do not let them ramble. The point is to gather information on how they learned to interact in spousal/parental relationships.)

54. How long were your parents married or together? __________________________
55. If divorced, how old were you? ____________________________________
56. Do you have any brothers and sisters? ______________________________
57. What reason were you given for your parent's separation? _____________
____
____

58. What do you remember feeling about their divorce/separation?_______________
____
____

59. What were the custody arrangements? Were you able to see both parents? ______
____
____

60. Was there drug or alcohol abuse by either parent? ___________________________
If yes, what substances did they abuse? ______________________________
____

61. Was there domestic violence in your parents' relationship? ___________________
____
____

62. Were you physically or sexually abused as a child? If yes, by whom? ________
If yes, please describe ____

***DANGEROUSNESS RISKS**:

63. What was the most violent episode you recall from your childhood? __________
____
____

64. ***What was the most violent thing you did in your youth?** ________________
____
____

65. How were you disciplined/ arrested for that violence?
____
____

66. Have you ever physically abused or mistreated an animal? YES NO
If yes, please describe the incident(s):_____________________________________
____
____

67. Have you ever been arrested for anything else? _____________________________
____
____

68. ***What, if any, weapons do you own (guns, knives, etc.)? Check court orders – most DV convictions are not allowed to own weapons. If not a probation referral, surrendering weapons to a third party should be a condition of participation in the contract**.____
____

69. What access to others' weapons do you have? ______________________________
____

70. If yes, please describe your experience with weapons.______________________
____
____.

71. Have you ever served in the military? YES, Number of years:______ NO
If yes, did you receive special training? YES, What?________________ NO
If yes, please describe your combat experience.___________________________
____
____.

72. Have you had any police training or experience?
YES, Number of years: _______ NO
If yes, please describe where and what kind.______________________________
____
____.

73. Have you had any experience as a security officer of any kind (including as a bar bouncer)? YES, Number of years:______________ NO
If yes, please describe what kind of experience and for how long.______________
____
____

74. Were you or a sibling ever sexually molested or abused by a family member or anyone outside your family? YES NO
If yes, please describe.____
____
____

EMOTIONAL HEALTH:

75. Have you ever attended a domestic violence or parenting without violence program in the past? YES NO
If yes, how many weeks did you participate and what was the outcome?
____
____
____

76. Have you ever participated in a support group for victims? __________________
Where? ________________________ Are you still in the group? _____________

77. Are you presently in counseling and/or have you ever received counseling or psychotherapy in the past? YES NO

If yes, please describe when and for what reason(s).________________________
____
____

78. What pressures or stresses do you currently experience? ___________________
____
____

79. Describe any extremely distressing experiences you have had in your life: ______
____
____

(Intaker: Watch for signs of dissociation or other difficulty with the next questions. If client is unable to complete the PTSD assessment, or if the number of symptoms is high, the client may be inappropriate for the group. Check with a supervisor to determine if individual therapy should be recommended to resolve some of the trauma before group is attempted.)

80. Do you currently experience any of the following?

_____Nightmares

_____Flashbacks to distressing events

_____Intrusive thoughts of distressing events

_____Re-experiencing distressing events

_____Distress or anxiety related to cues from distressing events

_____Going out of your way to avoid reminders of distressing events

_____Loss of memory for aspects of distressing events

_____Feeling detached or estranged from other people

_____Difficulty falling or staying asleep

_____Irritability or outbursts of anger

_____Difficulty concentrating

_____Easily startled

81. Have you ever been in or would you consider being in counseling to get help for the number of the experiences we just talked about? _____________________
____

82. What would it be like for you to be in a group of people who shared their stories about violence?

____

---

83. How would you rate your self-esteem currently on a scale of 1 – 10, with 10 being highest? ____

84. How would you rate each of your children's self-esteem currently on a scale of 1 – 10, with 10 being highest? ____
____

85. How would you rate your happiness currently on a scale of 1 – 10, with 10 being highest? ____

86. ***How often do you drink alcohol and how much do you drink**? ___________
____
____

87. ***How often do you use other drugs, and in what amount**? ________________
____
____

88. ***Do you believe that you currently have or *ever* had an alcohol or drug *problem***? YES NO
If yes, please describe: ____
____
____

89. ***Have you ever been arrested or convicted due substance related offenses?**
YES NO If yes, please describe: ______________________________________
____

90. What are your hopes and/or expectations of participation in this class? ________
____
____
____

THE CENTER FOR HEALTHY DEVELOPMENT (CHD)
Client Information Sheet

Dear Parents: The Center for Healthy Development needs your help to ensure that the best possible services are provided. Your responses to this survey will be confidential.

Date: _______________ **CASE #** ______________________ **FCS #** _______________

Parent's Name: _______________________ **Other Parent's Name:** ___________________

Address: ____

City: _______________________________ **State:** _________ **Zip Code:** _____________

Phone: HOME _____________________ → *Messages okay?* ☐ Yes ☐ No
WORK _____________________ → *Messages okay?* ☐ Yes ☐ No

Emergency Contact Person:

____

Name *Phone* *Relationship*

CHILDREN IN FAMILY COURT CASE

Name(s) of Child(ren)	Date of Birth	Gender	Lives with?

CURRENT FAMILY SITUATION

Are you currently living with a partner? ☐ Yes → *Name?* _____________________ ☐ No

Do you or your partner have children? ☐ Yes ☐ No

Name(s) of Other Child(ren)	Date of Birth	Gender	Lives with?

EDUCATION AND JOB BACKGROUND

How well did you do in school? ____

What learning problems, if any, did you have while in school? ____________________

Has anyone ever told you that you might have a learning disability or Attention Deficit/Hyperactivity Disorder (ADD or ADHD)? ☐ Yes ☐ No

Are you currently employed? ☐ No ☐ Yes → Where do you work? ________________
What is your job title? ________________

How many jobs have you held in the past three years? # ____________

How satisfied are you with your job? (Circle your rating)

1 2 3 4 5

not at all satisfied……………………………………………….very satisfied

PHYSICAL AND PSYCHOLOGICAL HEALTH

What, if any, ongoing physical health problems do you have? _____________________

____

What medications are you currently taking and what are they for? _________________

____

Have you ever received psychotherapy or counseling services in the past? __________

____

Have any of your children ever received counseling services in the past __________

____

Have there been any incidences of domestic violence in the past 6 months? _______

Please explain____

Are there or have there ever been Restraining Orders? _______ When? _______

Please explain____

Do you have any history of alcohol or drug abuse? _______ When? _______

Please describe ____

THE CENTER FOR HEALTHY DEVELOPMENT (CHD)
Parent Survey - Intake

Dear Parents: The Center for Healthy Development needs your help to ensure that the best possible services are provided. Your responses to this survey will be confidential.

1. What is your race / ethnicity? (Please mark one only)

- ☐ American Indian
- ☐ Alaska Indian

Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other ____________

☐ Hispanic/Latino

Pacific Islander
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian or Chamorro
- ☐ Other Pacific Islander

☐ Black/African-American
☐ White

☐ Multiracial / multiethnic
☐ Unknown / Declined
☐ Other → Specify: _________________

2. What is the highest level of education you have COMPLETED?

- ☐ None
- ☐ High school diploma or GED
- ☐ Associate's or technical school degree
- ☐ Master's, Doctorate or Professional degree
- ☐ Nursery to 6th grade
- ☐ Some college or technical school
- ☐ Bachelor's degree
- ☐ Other / Unknown / Declined

2. What is your zip code? _______________________

3. What is the primary language used in your home? (Please mark one only)

- ☐ English
- ☐ Spanish
- ☐ Cantonese
- ☐ Mandarin
- ☐ Vietnamese
- ☐ Other → Specify: ___________________
- ☐ Unknown

4. What is your gender? ☐ Male ☐ Female

5. How many children do you have? #__________

6. What are their ages? (Please indicate the # of children you have for each age group.)

______ 0 to 2 year olds ______ 3 to 5 year olds ______ 6 to 9 year olds
______ 10 to 13 year olds ______ 14 to 18 year olds

7. Are you the primary caretaker of your children? ☐ Yes ☐ No ☐ Shared

8. What is the present parenting schedule for your children?

- ☐ Equal time with each parent
- ☐ Every weekend with a parent
- ☐ Flexible schedule
- ☐ Alternate weekends with a parent
- ☐ Weekly visits
- ☐ Other → Specify: ________________________

9. Please check if any of the following issues are present in your case.

☐ Domestic violence ☐ Alcohol or drug use ☐ Child Safety
☐ Family conflict ☐ Other → Specify: ___________________________

10. How many times have you and/or the other parent filed for a custody/visitation issue in Family Court? #________

11. Do you and/or the other parent have an issue with following court orders regarding custody and visitation? ☐ Yes ☐ No

12. Have the police ever been called due to a conflict between you and the other parent?
☐ Yes → How often? ____________ ☐ No

13. Is there or has there ever been a Domestic Violence Restraining Order? ☐ Yes ☐ No

14. Has anyone ever been reported to CPS regarding your children's safety?
☐ Yes → How many times? ____________ ☐ No

15. Are you on speaking terms with the other parent? ☐ Yes ☐ No

16. Please rate how strongly you agree or disagree with each of the following statements.

	Strongly disagree	**Disagree**	**Neutral**	**Agree**	**Strongly agree**	**N/A**
I have very few disputes with the other parent.	☐	☐	☐	☐	☐	☐
Our conflict is harmful to our children.	☐	☐	☐	☐	☐	☐
Our family can learn new skills and choices.	☐	☐	☐	☐	☐	☐
I am concerned that our children are not safe.	☐	☐	☐	☐	☐	☐
Both parents want to reduce conflict.	☐	☐	☐	☐	☐	☐
Our family situation is not stable for the children.	☐	☐	☐	☐	☐	☐
I am concerned about my child's behavior.	☐	☐	☐	☐	☐	☐
My child is doing well in school / day care.	☐	☐	☐	☐	☐	☐

FAMILY COURT CARE MANAGER SERVICES

18. Have you been referred to a Family Partner? ☐ Yes ☐ No

19. Are you currently seeing a Family Partner? ☐ Yes ☐ No

20. If NO, do you plan to see a Family Partner? ☐ Yes ☐ No

21. What other kinds of services do you think would be helpful to you and your family?

____

____

THE CENTER FOR HEALTHY DEVELOPMENT (CHD)
Parent Survey – End of Program

Dear Parents: The Center for Healthy Development needs your help to ensure that the best possible services are provided. Your responses to this survey will be confidential.

CASE # ________________________________ **FCS #** ______________________________

1. Which of the Center for Healthy Development's services did you participate in?

- ☐ Parents in Conflict Program
- ☐ Safe Families
- ☐ Counseling Services
- ☐ Co/Parallel Parent Counseling
- ☐ Therapeutic and Supportive Visitation

2. Please rate how strongly you agree or disagree with each of the following statements.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	N/A
I have very few disputes with the other parent.	☐	☐	☐	☐	☐	☐
Our conflict is harmful to our children.	☐	☐	☐	☐	☐	☐
Our family can learn new skills and choices.	☐	☐	☐	☐	☐	☐
I am concerned that our children are not safe.	☐	☐	☐	☐	☐	☐
Both parents want to reduce conflict.	☐	☐	☐	☐	☐	☐
Our family situation is not stable for the children.	☐	☐	☐	☐	☐	☐
I am concerned about my child's behavior.	☐	☐	☐	☐	☐	☐
My child is doing well in school / day care.	☐	☐	☐	☐	☐	☐
Staff of this program were respectful of my family's culture.	☐	☐	☐	☐	☐	☐
This program has helped me learn how to deal with conflicts within my family.	☐	☐	☐	☐	☐	☐
This program has taught me new parenting skills.	☐	☐	☐	☐	☐	☐
I plan to use some of the things I have learned from this program in my own life.	☐	☐	☐	☐	☐	☐
I have learned about services and resources that can help me and my family.	☐	☐	☐	☐	☐	☐
Overall, I am satisfied with this program.	☐	☐	☐	☐	☐	☐

3. Please rate your experiences with each of the following.

	Poor	Fair	Good	Very Good	Excellent	N/A
Timeliness of CHD staff in answering your calls	☐	☐	☐	☐	☐	☐
Courtesy shown to you by CHD staff	☐	☐	☐	☐	☐	☐
Knowledge and helpfulness of CHD staff	☐	☐	☐	☐	☐	☐

4. IF YOU HAD A COUNSELOR, please rate your experiences with each of the following.

	Poor	Fair	Good	Very Good	Excellent	N/A
Ease with which you were able to reach a counselor by phone	☐	☐	☐	☐	☐	☐
Convenience of your counselor's location from your home or workplace	☐	☐	☐	☐	☐	☐
Convenience of your counselor's office hours	☐	☐	☐	☐	☐	☐
How well you counselor listened to and understood your concerns	☐	☐	☐	☐	☐	☐
Amount of time you had to wait to see a counselor	☐	☐	☐	☐	☐	☐

5 What is your race / ethnicity? (Please mark one only)

a. American Indian
b. Alaska Indian

Asian

c. Asian Indian
d. Chinese
e. Filipino
f. Japanese
g. Korean
h. Vietnamese
i. Other ______________

☐ Hispanic/Latino

Pacific Islander

☐ Native Hawaiian
☐ Samoan
☐ Guamanian or Chamorro
☐ Other Pacific Islander

☐ Black/African-American
☐ White

☐ Multiracial / multiethnic
☐ Unknown / Declined
☐ Other → Specify: ___________________

6. What is your gender? ☐ Male ☐ Female

7. How many children do you have? #___________

8. What are their ages? (Please indicate the # of children you have for each age group.)

_______ 0 to 2 year olds ________ 3 to 5 year olds ________ 6 to 9 year olds
_______ 10 to 13 year olds ________ 14 to 18 year olds

9. Are you the primary caretaker of your children? ☐ Yes ☐ No ☐ Shared

10. Are you on speaking terms with the other parent? ☐ Yes ☐ No

11. Have you been receiving services from a Family Partner? ☐ Yes ☐ No

12. Do you have any recommendations for how we can improve this program?

____

____

Appendix I

Superior Court of California, County of Santa Clara, Local Family Court Rules, 2. Custody and Visitation:
http://www.sccsuperiorcourt.org/family/rule3toc.htm

Center for Families, Children & the Courts, Judicial Council of California, Administrative Office of the Courts. *Statewide Uniform Statistical Reporting System, The 1996 Client Baseline Study, Report 12, Executive Summary, Preparing Court-Based Child Custody Mediation Services for the Future,* September 2000:
www.courtinfo.ca.gov/programs/cfcc

Superior Court of California, County of Santa Clara, Family Court Facilitator's Office(Family Court Clinic): http://www.scselfservice.org/fam/clinic.htm

Superior Court of California, County of Santa Clara, Self Service Center:
http://www.scselfservice.org/default.htm
http://www.scselfservice.org/fam/services.htm

Victim Witness Assistance Center, Santa Clara County, California:
http://www.victim.org/

First Five Santa Clara County, http://www.first5kids.com/

MEDIATION INTAKE ORDER

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, DOMESTIC RELATIONS DIVISION

	)	
	)	
	)	
	)	
Petitioner,	)	No. ______________
and	)	
	)	
	)	
	)	
Respondent.	)	

ORDER

The issue of Custody and / or Visitation having been joined in these proceedings, this cause is continued until Wednesday ______________, ______ at 2:00 p.m. at Marriage and Family Counseling Service, 69 W. Washington, Suite 1000, Chicago, IL 60602, for Custody Mediation Intake. Both parties are required to be present. Failure to appear may result in sanctions. Attorneys are excused from Mediation Intake.

This cause is further set on the Custody / Mediation Status Call for Wednesday ______________, ________at 10:30 a.m. in room 1603, of the Richard J. Daley Center.

Date: ____________ , _____

Atty. No.: ________________
Name: ___________________
Atty. For: _______________
Address: ________________
City/State/Zip: ___________
Telephone: ______________

ENTER:

____
Judge Judge's No.

MEDIATION REFERRAL ORDER (FRONT PAGE ONLY)

7288, 7289 - Order Referred to FOCUS 4578 - Order Referred to MFCS 4572 - Order Referred to DSS
4616 - Order Referred to FCSD 4574 - Order Referred for Report to Court (Rev. 6/30/05) CCDR 0009 A

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, DOMESTIC RELATIONS DIVISION

IN RE THE: ☐ MARRIAGE ☐ CUSTODY
☐ VISITATION ☐ PARENTAGE OF

NO: ____________________

CALENDAR: ____________________

____________________ PETITIONER

AND

☐ PREJUDGMENT

____________________ RESPONDENT

☐ POST JUDGMENT

CIRCUIT COURT RULE 13.4(f) CONSOLIDATED REFERRAL ORDER: CONTESTED CUSTODY/VISITATION EDUCATIONAL PROGRAM, ILLINOIS MARRIAGE AND DISSOLUTION OF MARRIAGE ACT

THIS MATTER having been represented as involving custody and/or visitation of the child(ren) of the parties IT IS HEREBY ORDERED that the matter is referred as follows:

A. TYPE OF REFERRAL AND AGENCY

☐ FOCUS ON CHILDREN parent education program (FOCUS); Cook County Administration Building, Suite 1000, 69 W. Washington, 10th Floor, Chicago, IL 60602; Telephone: (312) 603-1550 FAX: (312) 603-1588 or
Suburban Municipal District ________ located at ____________________
For ☐ Petitioner (7288) ☐ Respondent (7289) ☐ Focus Class in Spanish

Focus on Children fee assessed for attendance, to be collected by the Clerk of the Circuit Court of Cook County is:

☐ $25.00 ☐ $ Set at ________ ☐ Waived To be paid by ☐ Petitioner ☐ Respondent

☐ Marriage and Family Counseling Service (MFCS): Cook County Administration Bldg., Suite 1000,
4578 69 W. Washington, Chicago, IL 60602; Telephone: (312) 603-1540 FAX: (312) 603-9842 or
Suburban Municipal District ________ located at ____________________
For ☐ Mediation ☐ Conciliation ☐ Reconciliation ☐ Emergency Intervention
Nature of Emergency: ____________________
ISSUE(S): ____________________
____

Please check if applicable: ☐ FOCUS ON CHILDREN IS A PRECONDITION TO MEDIATION.
The parties and their attorneys are ordered to contact MFCS immediately when Emergency Intervention has been ordered.

☐ Department of Supportive Services (DSS); Cook County Administration Bldg., Suite 1630,
4572 69 W. Washington, Chicago, IL 60602; Telephone: (312) 603-0550 (contact Social Services Coordinator)
For ☐ General Study ☐ Specific Study ☐ Other
ISSUE(S): ____________________
____

CONFIDENTIAL INTERVIEW QUESTIONNAIRE

Circuit Court of Cook County - Marriage and Family Counseling Service
69 West Washington St., Suite 1000, Chicago, IL 60602
Telephone (312) 603-1540 FAX (312) 603-9842 TDD (312) 603-1547

FULL NAME OF PARENTS: ____

____

FULL NAME OF CHILDREN, AGES/DOB: ____

____

____

____

Date Parents' Relationship Began_______/____ _/______

Date Parents' Relationship Ended______/______/______

Parents' Relationship Status: Married?________Divorced?________Never-Married?__________Ever lived together? (When?) __________

YOUR NAME____AGE__________________

YOUR RELATIONSHIP TO CHILD(REN): Father______Mother_______Other________________________

YOUR ADDRESS____________________ ____

Street Apt. # City/State Zip Code

____

YOUR HOME TELEPHONE (   )_____________________WORK NUMBER(   )___________________________

CELL PHONE/PAGER (   )__________________________OTHER CONTACT NO.(   )_____________________

DISTANCE BETWEEN PARENTS' HOMES (time/miles)____

YOUR OCCUPATION______________________________EDUCATION COMPLETED_________________________

OTHER PEOPLE WHO LIVE WITH YOU (Names, Relationships, Ages)____

OTHER MARRIAGES/RE-MARRIAGES (Spouses' Names/Dates)_____________________________________

YOUR CHILDREN FROM OTHER RELATIONSHIPS (Names, Ages, Live with)________________________

Are you comfortable speaking English?____________Reading English?______________Writing English?_______

If not, what is your primary language?____

Previously had mediation/emergency intervention at MFCS?______When?___________With Whom?___________

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OVER —>

CONFIDENTIAL INTERVIEW QUESTIONNAIRE

(DO NOT LET THE OTHER PARTY SEE YOUR ANSWERS ON THIS QUESTIONNAIRE)

		YES	NO
1.	Do you have any concerns about the child(ren)'s emotional and/or physical safety with the other parent?	____	_____
2.	Has the Illinois Department of Children and Family Services been involved with the family regarding allegations of abuse and/or neglect of the children?	____	_____
3.	Has an attorney/Guardian ad Litem been appointed to represent the child(ren)?	____	_____
4.	Have you ever feared that you would not have access to your child(ren)?	_____	_____
5.	Do you have any questions or concerns about your child(ren) speaking with the mediator?	_____	_____
6.	Has there ever been medical treatment or hospitalization for psychiatric disorders in the immediate family?	_____	_____
7.	Do you have any concerns regarding the use of alcohol and/or drugs in the immediate family?	_____	_____
8.	Has there ever been any physical confrontation between you and the other parent?	_____	_____
9.	Do you have any other concerns about your own emotional and/or physical safety with the other parent?	_____	_____
10.	Are there now, or have there previously been, Orders of Protection? If yes, what is the expiration date?____	_____	_____
11.	Are you in any way afraid to meet with the other partner in your relationship?	_____	_____
12.	Do you feel you were an equal partner in your relationship?	_____	_____
13.	Do you feel you are ready to begin working with the other parent to develop a parenting plan? If no, briefly state why not:__________________________ ____	_____	_____
14.	Do you have any fear about answering these questions? If yes, briefly explain why: ____	_____	______

SCREENED BY: Intake/Screening Mediator_______ Resource Person_____Assigned Mediator_______

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DOMESTIC VIOLENCE PROTOCOL FOLLOW-UP QUESTIONS

The Family Violence Committee prepared these questions as follow-up to the Confidential Interview Questionnaire, the domestic violence screening tool of Marriage and Family Counseling Service. Each numbered question matches a question on the Confidential Interview Questionnaire form. The additional questions are suggested as ways to elicit more information from the clients in order to make your assessment of a) client ability to negotiate in their own best interests and b) safety issues pertinent to the mediation. [MFCS has changed their questionnaire slightly since this list was created.]

1. Do you have any concerns about the child(ren)'s emotional and/or physical safety with the other parent?

Have there ever been direct or indirect threats of physical harm to the child(ren)?

What types of emotional and/or physical abuse has the child(ren) experienced?

Have there ever been bruises or marks left on the child(ren) due to either parent's disciplining the child(ren)?

Do you have concerns about the way the other parent takes care of the child(ren)?

Has the child(ren) expressed fear of either parent?

What does the child(ren) do when either parent is angry?

Are there behavior problems at home or at school? Examples: aggressive behavior, sleepwalking, bedwetting, poor school performance, teeth-grinding, nightmares, headaches and other somatic complaints?

Have any of the children run away from home, been truant or suspended from school, or in trouble with the police?

Have you ever had any concerns about the other parent sleeping with your child(ren) or touching them in a way you think is inappropriate?

2. Has the Illinois Department of Children and Family Services been involved with the family regarding allegations of abuse and/or neglect to the child(ren)?

When? What happened? Was the case indicated/founded?

Was any child ever removed from the home?

Has any child been involved in treatment as a result of an allegation or court order?

Marriage and Family Counseling Service, Circuit Court of Cook County, Chicago, IL © 1992

Have investigations or formal charges by a law enforcement agency occurred regarding the above? Please explain.

Have you, relatives, neighbors, or others called the police because they thought any of your children were in danger?

3. **Has any attorney/Guardian ad Litem/Child's Representative been appointed to represent the children?** Please explain.

What is this person's name, address, and phone number?

For what reason have they been appointed?

Have both the children and the parents been interviewed yet?

Has this person made any reports or recommendations to the court?

If so, what do these reports or recommendations state?

Were the reports or recommendations accepted by the court?

4. **Have you ever feared that you would not have access to your child(ren)?**

Has visitation ever extended beyond scheduled times without the mutual consent of both parents?

Has access with the child(ren) been restricted by: the other parent, the court, other? Please explain.

Has the other parent ever threatened to take the child(ren) where you could not find them? Have they actually taken them? Please explain.

Have the police ever been involved because of difficulties in exchange of a child?

Has the other parent done anything to discourage your visits with the child(ren)?

5. **Do you have any questions or concerns about your child(ren) speaking with the mediator?** If yes, please explain.

6. **Has there ever been medical treatment or hospitalization for psychiatric disorders in the immediate family?** Please explain.

Who? When? Where?

Duration of treatment?

Type of treatment?

Diagnosis?

Medications?

Aftercare?

Have you or the other parent ever contemplated or attempted suicide?

7. Do you have any concerns regarding the use of alcohol and/or drugs in the immediate family?

Describe your/the other parent's use of alcohol. What do you/the other parent drink? How much? How often?

When drinking, do you/the other parent get rough or violent?

Describe your/the other parent's use of drugs. What do you/the other parent use? How much? How often?

When using, do you/the other parent get rough or violent?

Have you or the other parent been in treatment for alcohol or substance abuse?

Inpatient? Where? When?

Aftercare?

Have you or the other parent's use of alcohol or drugs resulted in involvement with the law, i.e., DUI?

How has your or the other parent's use of alcohol or drugs affected the child(ren)?

8. Has there ever been any physical confrontation between you and the other parent?

Has the other parent ever hit, punched, slapped, pushed, or kicked you, pulled your hair?

Have you ever hit, punched, slapped, pushed or kicked, or pulled the hair of the other parent?

Marriage and Family Counseling Service, Circuit Court of Cook County, Chicago, IL © 1992

Have you ever needed medical attention as a result of abuse?

When was the most recent incident? The worst? Please describe.

Has the other parent used or threatened to use a weapon to harm you?

Are there weapons in the home? What kind? How many?

Has the other parent ever damaged or destroyed any of your belongings, property, or hurt any of your pets?

Have any of these events involved the child(ren)? How?

Have you contacted any social service agency because of the abuse to seek help or support?

Do you have a safety plan?

Have you petitioned for an Order of Protection or Restraining Order?

[PROVIDE PARTIES WITH REFERRALS AND SAFETY PLAN AS NEEDED.]

9. **Do you have any other concerns about your own emotional and/or physical safety with the other parent?** Please explain.

Has the other parent been emotionally or verbally abusive to you? Please explain.

Has the other parent, in order to control, used threats about custody or loss of the child(ren)'s love?

Have you been denied access to finances for food, shelter, medical needs, clothing, etc.?

Is the other parent an extremely jealous person?
Have you ever been prevented from having contact with family or friends?

Did the other parent open your mail, listen to your phone calls, or harass in other ways?

Has there been any physical confrontation with family members, friends, co-workers?

What kind of things makes the other parent angry? What would happen if you had a fight? What would you/he/she do? What other ways would you fight?

What makes you angry? How do you handle arguments*?*

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10. Are there now, or have there previously been Orders of Protection? If yes, expiration date ____.

What happened? Who called the police? Criminal or Civil Order of Protection?

Is/was the child(ren) included in the Order of Protection?

If Order of Protection was granted, do each of you have a copy?

Were either of you arrested? Charges pressed?

Have charges been pressed for a violation of an Order of Protection?

Was there a time when you could have called your partner's violation of the OP to the attention of the authorities and you did not do so? Why didn't you?

11. Are you in any way afraid to meet the other parent and the mediator?

What is it that concerns you most about mediating with the other parent?

Do you believe that the other parent will have more influence on the mediator than you?

In mediation, how would the mediator know that you are angry? That the other parent is angry?

Do you usually give in to settle an argument? Under what circumstances do you cave in?

Would you benefit from talking to a counselor before mediation begins? Would you like a referral?

Would you feel safer sitting in a separate waiting room or leaving at different times?

12. Do you feel you are/were an equal partner in your relationship?

Who made most decisions about how money was to be spent?

Do you have equal access to shared/marital funds and resources?

Who made decisions about your employment?

Who made decisions about whether or not to have child(ren)?

Who made decisions about the child(ren)'s schooling?

Were you able to spend time with your family (of origin) and your friends?

Who made decisions regarding your wardrobe?

Were you "allowed" to work? Were you forced to work?

How have you dealt with and/or resolved problems in the past?

13. Do you feel you are ready to begin working with the other parent to develop a parenting plan? If no, please explain.

Is there anything you would be uncomfortable discussing regarding your relationship, partner, or the child(ren) with the other parent present?

Do you feel your thoughts and/or feelings are heard, acknowledged, or accepted by the other parent?

How might the other parent undermine mediation?

What conditions need to be met to develop and carry out a parenting agreement?

14. Do you have any fear about answering these questions?

If yes, please explain.

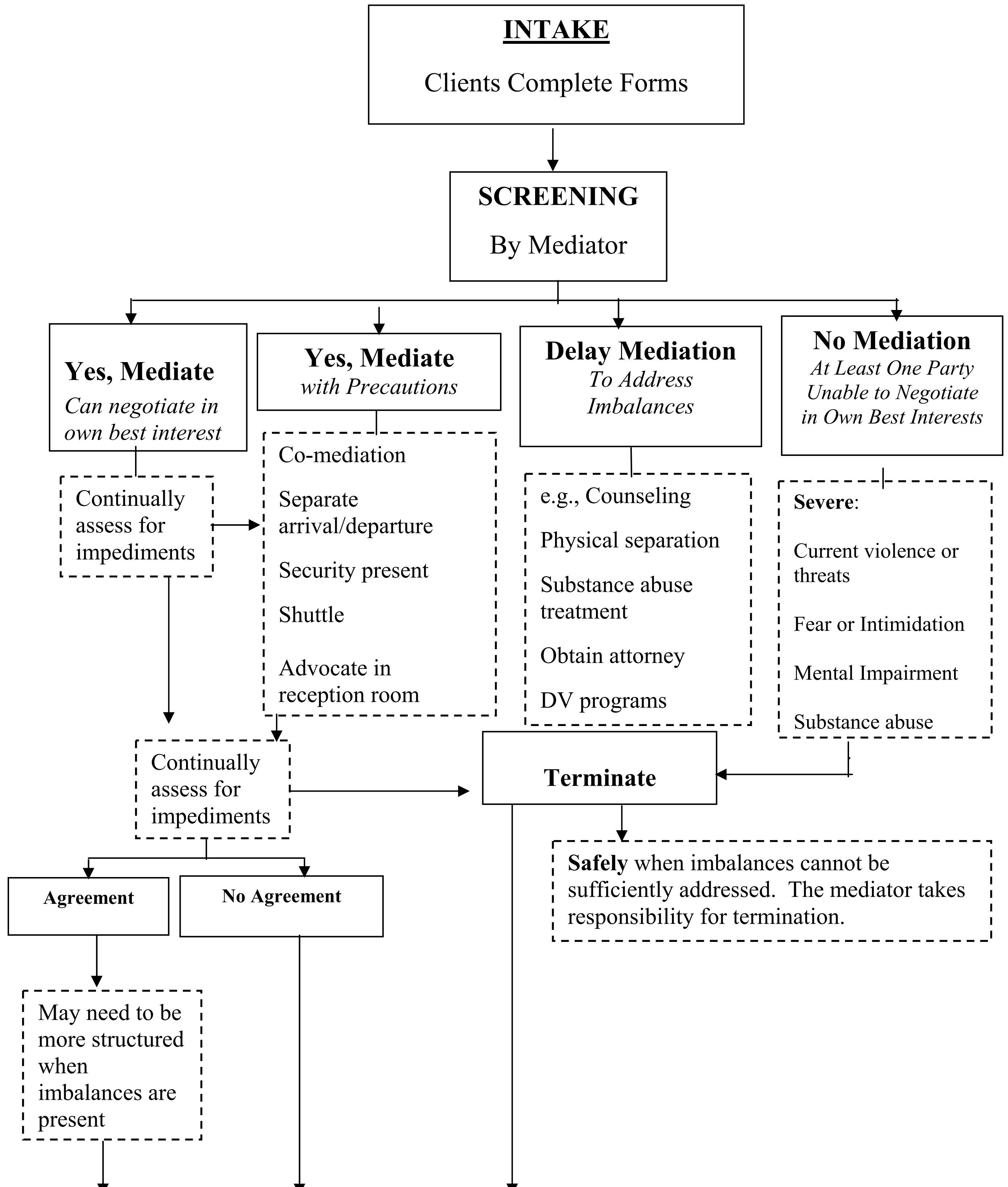
Are you concerned about how the other parent is answering these questions?

* * * * * * * * * *

Marriage and Family Counseling Service, Circuit Court of Cook County, Chicago, IL © 1992

Developed by the Family Violence Committee of the
Marriage and Family Counseling Service (312-603-1540)
Circuit Court of Cook County
Office of the Chief Judge
Domestic Relations Division
69 West Washington, Suite 1000
Chicago, Illinois 60602

MEDIATION SCREENING PROTOCOL FLOW CHART

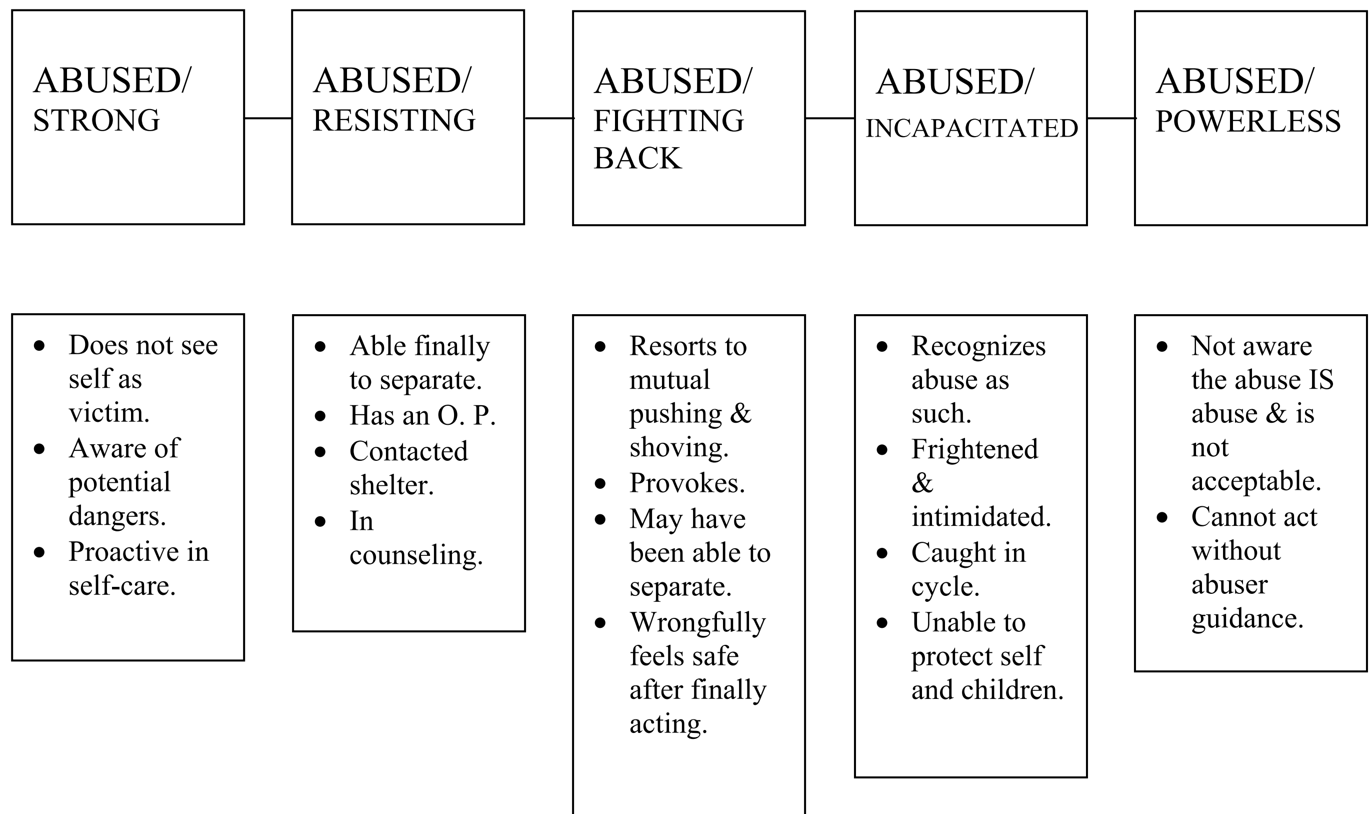


Corinne "Cookie" Levitz, cookie.levitz@alumni.carleton.edu © 2000

Graphics by Zingery

ONE MEDIATOR'S VIEW: Victim Spectrum --
Assessing Capacity of the Victim to Participate in Mediation

Each mediator determines his or her capacity to handle the different categories and when he or she would or would not mediate.



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ONE MEDIATOR'S VIEW: Batterer Spectrum

Each mediator determines his or her ability to mediate with individuals and when he or she would terminate

OWNS ABUSE & ACCEPTS TREATMENT No longer in control or seeking it. Never achieved control.	INTIMIDATING & BATTERING EMOTIONALLY WHEN HAD OPPORTUNITY Moved on, No longer seeking control generally	NOT PHYSICALLY ABUSING NOW But intimidates & seeks to control when victim available	ABUSED IN RECENT PAST Control is diminishing but continues efforts to control	CURRENTLY ABUSING BUT DENIES IT Absolute Control
• Used psychological and/or physical force in attempt to gain power, but far failed to intimidate or control • In treatment • Lives apart • Not under undue stress (other than divorce) • No violence for about 2 years • Takes responsibility • Violence was non-systemic • Complies with any OPs	• Mother wants father involved • Abusive relationship was short-lived • Stable work history • No abuse problems with new partner • Few serious incidents & not recent • May have fought OP but now complies	• Minimizes but admits some violence • Wish perhaps to reconcile • Accepts finality though of separation • Shaky job history • Multiple incidents, some quite dangerous but none recent • Violence was non-escalating • Less access to victim • No OP	• Denigrates partner • Attempts to control the mediation process • In rehab, but lapsing • Desires to reconcile • No independent housing • Support group in denial as well • Pattern of abuse with others • Poor parenting skills • No OP	• Actively violent & psychologically abusive • No admission • Blames victim • Stalks • Abusive outside relationships • Family enables • Sexually abusive • Abusing drugs • Few if any parenting skills • Tries to control mediator • No regular home • Unemployed, itinerant, or unstable work • Suicidal • Refuses treatment • Did not attend final OP hearing • Non-compliant

[The factors listed in the columns are examples. Not all need to be present.]

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IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, DOMESTIC RELATIONS CALENDAR________
MUNICIPAL DEPARTMENT DISTRICT ______ BRANCH_______________

____ **PETITIONER**	
v.	**NO.**
____ **RESPONDENT**	

MEDIATION STATUS REPORT

1. ☐ **DOMESTIC RELATIONS** ☐ **PARENTAGE**

2. **COURT STATUS DATE**____**TIME**______________________________

3. **JUDGE**____

4. **COURTROOM**____________________ **LOCATION**____

5. **FATHER'S ATTORNEY**____

   MOTHER'S ATTORNEY____

   GAL/ATTORNEY FOR CHILD____

6. **CHILD(REN)** **INTERVIEWED**

   ____________________________________**AGE**____________ ______**YES** ______**NO**
   NAME

   ____________________________________**AGE**____________ ______**YES** ______**NO**
   NAME

   ____________________________________**AGE**___________ ______**YES** ______**NO**
   NAME

   ____________________________________**AGE**___________ ______**YES** ______**NO**
   NAME

7. **DATES SEEN BY MEDIATOR:**

   FATHER__________________________________ **MOTHER**__________________________________

8. **MEDIATION OUTCOMES:**

   ☐ **FULL AGREEMENT** ☐ **PARTIAL AGREEMENT** ☐ **NO AGREEMENT**

   ☐ **TEMPORARY AGREEMENT** ☐ **MEDIATION NOT COMPLETED**

   ☐ **MEDIATION DID NOT OCCUR** ☐ **NOT APPROPRIATE FOR MEDIATION**

   ☐ **TERMINATED** ☐ **REPORT MADE TO DCFS BY MEDIATOR**

____ ____
MEDIATOR **DATE**

THE CASE IS APPROPRIATE FOR MEDIATION BUT ARE YOU THE APPROPRIATE MEDIATOR?

WHERE ARE YOU ON THE "READINESS TO MEDIATE" SPECTRUM?

NEW MEDIATOR	VETERAN MEDIATOR
LITTLE EXPERIENCE	EXTENSIVE EXPERIENCE
LITTLE TRAINING	EXTENSIVE TRAINING
COMFORT LEVEL?	COMFORT LEVEL?
IMPARTIAL?	IMPARTIAL?
UNSAFE ENVIRONMENT	SAFER ENVIRONMENT
NO SAFETY PRECAUTIONS	SAFETY PRECAUTIONS

ERR ON THE SIDE OF CAUTION OR SEEK OUT AN EXPERIENCED MEDIATOR TO WORK WITH YOU.

Appendix A

STATE OF NEW MEXICO
COUNTY OF BERNALILLO
SECOND JUDICIAL DISTRICT

____
Petitioner,

vs. **No. ______________________**

____
Respondent.

FAIR PROGRAM REFERRAL ORDER

THIS MATTER came before the Court on ______________________________, _________ on ____. Petitioner was present and represented by ___________________________. Respondent was present and represented by ________________________________. The Court, having heard testimony, offers of proof and argument, and having examined the pleadings, enters these Findings and Recommends/Orders:

1. [ ] An order of protection was entered against Petitioner/Respondent.

   or

   [ ] There is, or has been, domestic abuse between the parties.

   or

   [ ] The parties have been referred to the FAIR Program pursuant to an order adopting Court Clinic recommendations, prepared by Court Clinician, ____________________________________.

2. The parties are parents of the following minor children:

Name	Age/DOB	Relation to Petitioner	Relation to Respondent
____________________________	_________	________________	__________________
____________________________	_________	________________	__________________
____________________________	_________	________________	__________________
____________________________	_________	________________	__________________
____________________________	_________	________________	__________________

1 3. The parties shall submit to the Court Clinic for an assessment to determine
2 whether this family is appropriate for participation in the Family Assessment and
3 Intervention Resources Program ("FAIR Program").
4 4. [ ] The parties shall immediately report to the Court Clinic in room 210 to
5 schedule an appointment for the assessment.
6 or
7 [ ] The parties shall contact the FAIR Program at 841-7579 within five days
8 of the date of this order to schedule an appointment for the assessment.
9 5. A Notice of FAIR Program Referral Results shall be filed in the above-captioned
10 cause.
11 6. If the family is accepted into the FAIR Program, [ ] the restrained party [ ] both
12 parties shall comply with the treatment recommendations of the FAIR Program,
13 including any recommendations regarding the children.
14 7. [ ] Petitioner [ ] Respondent shall appear for a Review Hearing on
15 ________________________, ________, at ______a.m./p.m. **Failure to appear**
16 **may result in a bench warrant for your arrest.**
17
18
19 **RECOMMENDED BY:**
20
21 ____
22 SPECIAL COMMISSIONER/HEARING OFFICER
23
24 **ORDERED:**
25
26 ____
27 DISTRICT COURT JUDGE
28
29
30
31 [ ] A copy of this document was [ ] hand delivered [ ] faxed [ ] mailed to [ ] respondent
32 [ ] respondent's counsel on ________________________ .
33 [ ] A copy of this document was [ ] hand delivered [ ] faxed [ ] mailed to [ ] petitioner
34 [ ] petitioner's counsel on __________________________.
35
36 ____
37 Signed
38

Notice of the foregoing was hand-delivered/mailed to Petitioner/Respondent and/or counsel of record on
________________________.
By ____________________________

39 Appendix B
40 **STATE OF NEW MEXICO**
41 **COUNTY OF BERNALILLO**
42 **SECOND JUDICIAL DISTRICT**
43
44 ______________________________
45 **Petitioner,**
46
47 **vs.** **No. DV** ____________________
48
49 ______________________________
50 **Respondent.**
51
52 **NOTICE OF FAIR PROGRAM REFERRAL RESULTS**

53 This matter was referred to the Court Clinic for an assessment to determine whether this
54 family is appropriate for participation in the Family Assessment and Intervention Resources
55 Program ("FAIR Program"). The following has occurred since the date of the referral to the
56 FAIR Program:
57
58 [ ] The FAIR Program is not recommended for ____________________________.
59 It is recommended that: ____
60 ____
61 ____
62 ____
63 ____
64 ____.
65
66 [ ] _________________________ is suitable for the FAIR Program, and counseling is
67 scheduled to begin on ____.
68
69 Referral Source ________________________________
70 Group Number ________
71 RESPECTFULLY SUBMITTED BY:
72
73 ______________________________________
74 KATHLEEN CLAPP, Ph.D.
75 FAIR Program Director

Notice of the foregoing was hand-delivered/mailed to Petitioner/Respondent and/or counsel of record on
________________________.
By ____________________________

76 Appendix C
77
78 **STATE OF NEW MEXICO**
79 **COUNTY OF BERNALILLO**
80 **SECOND JUDICIAL DISTRICT**
81
82 ____________________________
83 **Petitioner,**
84
85 **vs.** **No. DV** ____________________
86
87 ____________________________
88 **Respondent.**
89
90 **FAIR PROGRAM NOTICE OF NON-COMPLIANCE**
91

92 [ ] Petitioner / Respondent:

93 ____

94 ____

95 ____

96 ____

97 The following attempts have been made to contact the party(ies):

98 [ ] Phone call

99 [ ] Phone call to attorney(s)

100 [ ] Letter from Court Clinic

101 [ ] Other: ____

102 Comments (if any): ____

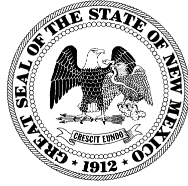
103 ____

104 [ ] A hearing [ ] **IS** [ ] **IS NOT** being requested.

105 Referral Source ____________________________

106 Group ____________

107
108 ___________________________________
109 KATHLEEN CLAPP, Ph.D.
110 FAIR Program Director
111
112 xc: Special Commissioner _____________________



State of New Mexico
County of Bernalillo
Second Judicial District

F.A.I.R. Program Questionnaire

Please complete and bring with you to your intake appointment.

Thank you.

400 Lomas NW*Second Floor (room 210)*Albuquerque, NM 87102*(505-841-7579)

Date: ___________________

Your case number: DV-________________________ DM-________________________

Judge or Special Commissioner/Hearing Officer:____

Your Name:____

Your Name on the case file (*if different from above*):____

Your Attorney (*if applicable*):___________________________________ Phone:_________________

1. Educational History:

High School:_____________(year graduated)

If you did NOT graduate from high school, what was the last grade you completed?________________

Name of high school:____

GED:______________ (year received)

Technical School: Course of study:___________________________ Completed:____________(year)

College: Name:____

Degree:____ Graduated:___________(year)

If you did NOT graduate from college, how many years did you complete?______________________

Graduate School: Name:____

Degree:____ Graduated:___________(year)

General school information:

When you were in school, were you ever classified as: (circle) Learning Disabled Gifted

Did you ever receive Special Education? Y N *If yes,* what kind?________________________

Did you ever receive pull-out services? Y N *If yes,* what kind?________________________

Were you ever held back? Y N *If yes,* what grade?_______________________

2. Residence History:

Please list addresses where you have lived for the last 2 years, including dates you were at each address and the reason for moving:

Address	Dates at Address	Reason for Moving

3. Employment History:

3a. Current employer(s):____

Length of unemployment (*if applicable*):_____________________________

Type of work:___________________________________ Job Title/Position_____________________

Typical work hours (days & times)____

____ (circle): Full Time Part Time

How long have you worked at this job?___________________________

3b. Employment History:

Please list where you have worked during the past 5 years:

Employer Type of Work Dates Employed Reason for Leaving

____

____

____

____

____

4. Military Experience:

Have you been in the in the military? Y N *If yes,* what branch?____________________

Number of years:_______ Type of discharge:____

Date of discharge:______________________ Have you ever been in combat? Y N

If yes, when/where:____

5. Prior Relationship History:

Please list all other marriages or significant relationships you have had in the past, and list the names and ages of any children that resulted from those relationships. Please list **all** of your children.

Name of Person **Length of Relationship** **Child(ren)'s Name/Age**

____

____

____

____

6. Current Relationship: Are you currently in a new relationship? Y N

(*If no, s*kip to next section.)

If *yes,* how long have you been in this relationship?_________________

Are you living with this person? Y N

Are you married to this person? Y N *If yes,* date of marriage:______________________

List the names and ages of the children and step-children you have with this person:

____

____

7. Personal History:

Do you have medical insurance? Y N

If yes, name of provider:____

Do you have an illness or a medical condition? Y N

If yes, what kind of illness or medical condition?______________________________

Are you currently under a doctor's care? Y N

If yes, who is your doctor?____

Are you currently taking any prescription medication(s)? Y N

If yes, list prescription medication(s) and reason for taking medication(s):

Medication(s):	Reasons:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Were you ever unconscious due to an illness (meningitis, encephalitis, high fever, etc.)? Y N

If yes, at what age?___________ For how long?________________________

Have you ever been in an accident (car, motorcycle, bicycle, work, etc.)? Y N

If yes, how many? __________________

Were you ever hospitalized due to an accident? Y N

8. Time sharing:

What is the current time-sharing plan? ____________________________________

____

How long have you been following this plan? ______________________________

Is it working for your child(ren)? Y N

If no, please describe why in more detail: ______________________________

____

If you have any additional information that was not requested, and you believe it is important for the F.A.I.R. Program to have this information, please attach it to this questionnaire.

PLEASE MAKE YOURSELF A COPY OF THIS QUESTIONNAIRE AND OF ANY OTHER DOCUMENTS YOU HAVE ATTACHED.

Please complete the following information on each child in the household:

	Child #1	**Child #2**	**Child #3**	**Child #4**
Name				
Date of Birth				
Age				
Residence (City & State)				
Counselor(s) [Name(s) & Phone Number]				
School [Name, Grade, & Teacher]				
Child Care Provider [Name & Phone Number]				
Major Organized Recreational Activities				
Special Needs [medical, physical, educational, any medications]				

STRUCTURED CLINICAL INTERVIEW

Date: ___________________________ Case #___________________

Name: ____
Date of Birth: ___________________________________ Age: ____________________
Social Security #: _______________________________
Address: ____
City ____ State: ______________ Zip: ____________
Home: _________________________ Work Phone: ________________ Cell Phone: _____________
E-mail Address: ____

Ethnicity (check as many as apply):

(1) Anglo _________
(2) Asian _________
(3) Black _________
(4) Chicano/a _________
(5) Hispanic _________
(6) Latino/a _________
(7) Mexican American _________
(8) Native American _________
Tribe: ______________________
(9) Other ______________________

Current Marital Status (indicate number of years):

(1) Single, never married ______________
(2) Married _________________________
(3) Living together ___________________
(4) Separated _________________________
(5) Divorced ___________________________

Sexuality:

(1) Straight/Heterosexual _________
(2) Gay _________
(3) Lesbian _________
(4) Bisexual _________
(5) Other ______________________

Living Situation (List all the people who live with you now):

(1) Living with spouse _________
(2) Living with partner __________
(3) Living alone _________
(4) Living with roommate _________
(5) Living with children _________
(6) Living with parents _________
(7) Living with other-specify _________
Relationship to other party ______________________

Annual Income: [Job:____]

(1) Under $10,000 _________
(2) $10,000-$19,000 _________
(3) $20,000-$29,000 _________
(4) $30,000-$39,000 _________
(5) $40,000-$49,000 _________
(6) Over $50,000 _________

Education (indicate year):

(1) Grades 1-8 _________
(2) Grades 9-12 _________ Last grade completed: _________
(3) High School Graduate _________ GED? _________
(4) 1-2 years of college _________
(5) 2+ years of college _________
(6) College graduate _________ Type of Degree: ____________________
(7) Post graduate work _________
(8) Graduate degree _________ Type of Degree: ____________________
(9) Technical/Vocational _________ What Type? ____________________

Relationship Overview:

How long have you known the other parent (*current opposing party)?* ____________________

Dated: __________ Lived together: __________ Married: ________________ (dates, length)

Are you together now? Y N

If no, date of separation/divorce: ______________________________

When did you last live together? ______________________________

Is there a restraining order in place? Y N

If yes, when does the order expire (date)?_________________ Is it stipulated? Y N

Have there been previous restraining orders? Y N *If yes*, how many? ________

How many times have you been before a Domestic Violence Commissioner/Judge? __________

Family of Origin:

Where were you raised? ____

What was the primary language spoken in your home during childhood? __________________

Growing up, who was in your family: ____

____

____

What was your relationship like with (e.g., parents, siblings, grandparents)?________________

____

____

____

Parents' current marital status: (circle)

Still Married Divorced Remarried Deceased

If deceased: (circle) Mother Father

If deceased: client's age at time of parent's death? _________

If divorced: client's age at time of divorce? _________

If divorced: step-parents? Y N

What was your relationship with your step-parents like? ______________________________

____

Did you see both parents regularly after the divorce? Y N

If no, why not?____

Did your mother drink alcohol and/or use drugs? Y N DK

If yes: Alcohol Drugs Both

If yes, how much did your mother drink alcohol/use drugs? (circle one)

Never Occasionally Regularly

Was it ever a problem for your family? _________

If yes, tell me more: ____

____

Did your father drink alcohol and/or use drugs? Y N DK

If yes: Alcohol Drugs Both

If yes, how much did your father drink alcohol/use drugs? (circle one)

Never Occasionally Regularly

Was it ever a problem for your family? _________

If yes, tell me more:____

____

Growing up, did one of parents ever hit or beat up your other parent? Y N

If yes, how many times can you recall this happening? _____________times.

Did your father ever hit your mother? Y N How old were you? _____________

Did your mother ever hit your father? Y N How old were you? _____________

Did your parents ever hit or beat up each other at the same time? Y N DK

If yes, how often?____

When these kinds of incidents happened……

Were alcohol and/or drugs involve? Y N DK

Did you see it happen? Y N

If yes, how old were you? _____________

Did it result in someone needing medical care of the police being called? Y N

Did your family have any other stressors or problems (financial, legal, medical, unemployment, child behavioral problems, drug abuse, physical/mental illness, extra marital affairs, etc.)? _____

____

____

Childhood Physical Abuse:

Growing up, did a parent or another adult ever do anything to you on purpose that made you bleed, that gave you bruises, or that broke bones or teeth? Y N

If yes, how often*?* ____

How old were you the first time? __________________________ Last time? _______________

Did you ever receive medical attention as a result? Y N

Childhood Sexual Abuse:

Growing up, did anyone ever touch or kiss you in a sexual or inappropriate way? Y N

Did anyone ever do anything to you sexually that you did not consent to? Y N

If yes, with who? ____

____

If yes, did you tell anyone about it? Y N

If yes, who did you tell and what happened? ______________________________________

____

History of Abusive Relationship

Have you ever been hit or hurt by the other parent? Y N

If yes, how many times? ____________

Has there been verbal, emotional, and/or sexual abuse? Y N

If yes, please describe: ____

____

If yes, were alcohol and/or drugs involved? Y N

If yes, how much had you usually had to drink? ____________________________

How much had the other person to drink? ____________________________

What kinds of drugs had you used? ____________________________

What kinds of drugs had the other person used? ____________________________

Have you ever hit or hurt your spouse/partner? Y N

If yes, how many times? ____________

Has there been verbal, emotional, and/or sexual abuse? Y N

If yes, please describe: ____

____

If yes, were alcohol and/or drugs involved? Y N

If yes, how much had you usually to drink? ____________________________

How much had the other person to drink? ____________________________

What kinds of drugs had you used? ____________________________

What kinds of drugs had the other person used? ____________________________

Have you been in any other relationship in which your spouse/partner hit/hurt you? Y N

If yes, when? ____

Have you ever received medical treatment as a result of a spouse/partner hitting you? Y N

If yes, when? ____

Have you ever been hospitalized as a result of a spouse/partner hitting you? Y N

If yes, when? ____

Have you ever had an affair with someone while you were in this relationship? Y N

Does your spouse/partner accuse you of having affairs? Y N

Has your relationship with your family changed since you have been in this relationship? Y N

If yes, how? ____

Has your relationship with you friends changed since you have been in this relationship? Y N

If yes, how? ____

Have you shared a checking account or a savings account with your spouse/partner? Y N

Do you feel like financial decisions were made fairly? Y N

If no, why? ____

Do you believe your spouse/partner would feel that financial decisions were made fairly? Y N

If no, why? ____

Do you feel like you were not allowed to work outside the home? Y N

If yes, how? ____

Have you ever tried to end the relationship? Y N

If yes, how many times (date)? ____________________________

Are you planning to end the relationship? Y N *If already ended, when?* __________

Describe the incident(s) that precipitated the restraining order (give date, describe what led up to incident, incident in detail, were weapons used, who was present, what happened afterward, were drugs or alcohol involved, was there kicking, pushing, etc.) ________________________________

Juvenile Legal History [Note: Age, Charge, Outcome]

Before age 18, were you ever arrested? Y N

If yes, tell me more:________________________________

Adult Legal History:

Do you have any *charges pending*? Y N

If yes, for what? ________________________________

Have you ever been *arrested?* Y N

If yes, when? ________________________________

Have you ever spent *time in jail*? Y N

If yes, for what and for how long? ________________________________

Have you ever been *convicted*? Y N

If yes, when and what was the sentence? ________________________________

If on probation, name of officer: ________________________________

Have you ever been *accused* of child abuse? Y N

If yes, when and for what? ________________________________

Have you ever been *convicted* of child abuse? Y N

If yes, what was the sentence? ________________________________

Partner's History:

Did the other parent (current opposing party) have problems with:

Maintaining jobs (being fired, unemployed)?	Y	N	DK
Maintaining a permanent residence?	Y	N	DK
Maintaining relationships (family, friends, partners)?	Y	N	DK
Being responsible (money, driving, parenting)?	Y	N	DK
Using excessive amounts of alcohol &/or drugs?	Y	N	DK
Getting into fights?	Y	N	DK
Weapons? Y N			
Making threats?	Y	N	DK
Weapons? Y N			
Being involved in criminal activities?	Y	N	DK
Destroying property?	Y	N	DK
Stealing (family, friends, outside the home)?	Y	N	DK
Being physically cruel to animals?	Y	N	DK

Children:

(1) Name: ______________________________________ (circle) Male Female

Age: ____________ DOB: ____________________

Is this child a child of the party in this case? Y N

With whom is the child living? Mother Father other: __________________

When was the last time you saw this child? ____

Is there a time-share order? Y N

If yes, describe: ____

Supervised visits? Y N (circle) Mother Father

If yes, supervised by whom? ____

Is this child experiencing any emotional or behavioral problems? (circle all that apply)

Sadness Anger Aggression Irritability Crying Fighting

Nightmares Wetting the bed Eating/appetite problems Sleep problems

School problems Desire to see the other parent Other: ____________________

Has your child been diagnosed with any medical or learning problems? Y N

Depression ADHD autism other: ________________________________

Has the child witnessed any violence? Y N

If yes, when? ____

Describe incident(s): ____

____

Has your child received counseling? Y N

If yes, with whom? ____

Has your child ever been hurt by anyone (parent, step-parent, family member)? Y N

If yes, how, who, and when? ____

____

If yes, is it likely that this will ever happen again? Y N

Is Child Protective Services (CYFD) involved? Y N

Would your child benefit from counseling? Y N

____

(2) Name: ______________________________________ (circle) Male Female
Age: _____________ DOB: ___________________
Is this child a child of the party in this case? Y N
With whom is the child living? Mother Father other: __________________
When was the last time you saw this child? ____
Is there a time-share order? Y N
If yes, describe: ____
Supervised visits? Y N (circle) Mother Father
If yes, supervised by whom? ____
Is this child experiencing any emotional or behavioral problems? (circle all that apply)
Sadness Anger Aggression Irritability Crying Fighting
Nightmares Wetting the bed Eating/appetite problems Sleep problems
School problems Desire to see the other parent Other: ___________________
Has your child been diagnosed with any medical or learning problems? Y N
Depression ADHD autism other: ________________________________
Has the child witnessed any violence? Y N
If yes, when? ____
Describe incident(s): ____
____
Has your child received counseling? Y N
If yes, with whom? ____
Has your child ever been hurt by anyone (parent, step-parent, family member)? Y N
If yes, how, who, and when? ____
____
If yes, is it likely that this will ever happen again? Y N
Is Child Protective Services (CYFD) involved? Y N
Would your child benefit from counseling? Y N

---

(3) Name: ______________________________________ (circle) Male Female
Age: _____________ DOB: ___________________
Is this child a child of the party in this case? Y N
With whom is the child living? Mother Father other: __________________
When was the last time you saw this child? ____
Is there a time-share order? Y N
If yes, describe: ____
Supervised visits? Y N (circle) Mother Father
If yes, supervised by whom? ____
Is this child experiencing any emotional or behavioral problems? (circle all that apply)
Sadness Anger Aggression Irritability Crying Fighting
Nightmares Wetting the bed Eating/appetite problems Sleep problems
School problems Desire to see the other parent Other: ___________________
Has your child been diagnosed with any medical or learning problems? Y N
Depression ADHD autism other: ________________________________
Has the child witnessed any violence? Y N
If yes, when? ____

Describe incident(s): ____
____
Has your child received counseling? Y N
If yes, with whom? ____
Has your child ever been hurt by anyone (parent, step-parent, family member)? Y N
If yes, how, who, and when? ____
____
If yes, is it likely that this will ever happen again? Y N
Is Child Protective Services (CYFD) involved? Y N
Would your child benefit from counseling? Y N

---

(4) Name: ______________________________ (circle) Male Female
Age: __________ DOB: ______________
Is this child a child of the party in this case? Y N
With whom is the child living? Mother Father other: ______________
When was the last time you saw this child? ____
Is there a time-share order? Y N
If yes, describe: ____
Supervised visits? Y N (circle) Mother Father
If yes, supervised by whom? ____
Is this child experiencing any emotional or behavioral problems? (circle all that apply)
Sadness Anger Aggression Irritability Crying Fighting
Nightmares Wetting the bed Eating/appetite problems Sleep problems
School problems Desire to see the other parent Other: ______________
Has your child been diagnosed with any medical or learning problems? Y N
Depression ADHD autism other: ______________________
Has the child witnessed any violence? Y N
If yes, when? ____
Describe incident(s): ____
____
Has your child received counseling? Y N
If yes, with whom? ____
Has your child ever been hurt by anyone (parent, step-parent, family member)? Y N
If yes, how, who, and when? ____
____
If yes, is it likely that this will ever happen again? Y N
Is Child Protective Services (CYFD) involved? Y N
Would your child benefit from counseling? Y N

Sources of Support: [family, friends, church, hobbies, etc.]

____
____
____
____

Medical History:

Have you ever had a head injury (e.g., concussion, "knocked out")? Y N

If yes, how old were you? ______________

Have you ever lost consciousness? Y N

If yes, what was the longest length of time you were unconscious?____________________

What was the cause of injury? ____

____

[*Ask about anything on F.A.I.R. Questionnaire that needs clarification:*____________________

____].

Psychiatric History:

Before the age of 18, did you ever see a counselor for any reasons? Y N

If yes, why?____

____

Have you seen a counselor, psychologist, etc. since age 18? Y N

If yes, what kind? ____

Have you ever been in a hospital for emotional problems? Y N

If yes, what kind? ____

How long (dates)? ____

Have you ever taken medication for emotional problems (depression, anxiety, etc.)? Y N

If yes, what kind of medication? ____

Who prescribed the medication (name; psychiatrist, primary care physician, etc.)?_____________

____

Do you believe that you currently have (or have had in the past) an alcohol problem? Y N

If yes, have you received treatment? Y N

If yes, describe: ____

____

Do you believe that you currently have (or have had in the past) a drug problem? Y N

If yes, have you received treatment? Y N

If yes, describe: ____

____

Are you currently having any sleep difficulties? Y N

If yes, describe: ____

Duration of problem: ____

Are you having any appetite problems? Y N

If yes, describe: ____

Are you experiencing any weight loss or gain? Y N Intentional? Y N

If yes, how much? ____

Have you ever experienced episodes of depression? Y N

If yes, when ? ________________________ duration? __________________ no.? ______

Have you ever received treatment for depression? Y N

If yes, describe treatment: ____

Have you ever tried to hurt yourself or commit suicide? Y N

If yes, when? ____

During the past year have you felt like hurting yourself or committing suicide? Y N

Do you currently feel like hurting yourself? Y N

If yes, tell me more: ____

____

Do you currently feel like hurting anyone? Y N

If yes, who (*get as much information as possible*)? ______________________

____

Do you feel hopeless, like things will only get worse? Y N

Anxiety: (circle one) none mild moderate severe
[Are you anxious? Do you feel nervous, tense, on edge, etc.]
Have you ever received treatment for anxiety? Y N

If yes, describe treatment: ____

Obsessions: (circle one) none presenting problems other
[Do you ever have thoughts that you can't get out of your mind, no matter how hard you try?]

Other: ____

Compulsions: Y N *If yes*: ____
[Any rituals/routines that you have to do in a certain way, or else you get upset?]

Thought Content-Hallucinations: (circle one) none auditory visual olfactory
[Do you ever feel like your mind is playing tricks on you-hearing things, seeing thing, smelling thing no one else can?]

Thought Content- Delusions: (circle) none persecution somatic
ideas of reference thought broadcasting jealousy grandiosity
control by others religious influence by others other: ____________________

Memory concerns: (circle) Y N
[Is your memory as good as it has always been?]

*If yes, (describe):*____

Mental Status Examination (to be completed by clinician):

Appearance ☐ Well groomed ☐ Disheveled ☐ Bizarre ☐ Inappropriate
Attitude ☐ Cooperative ☐ Guarded ☐ Suspicious ☐ Uncooperative ☐ Belligerent
Motor Activity ☐ Normal ☐ Hypoactive ☐ Hyperactive ☐ Agitated ☐ Tremors/Tics ☐ Others
Mood ☐ Euthymic ☐ Depressed ☐ Anxious ☐ Euphoric ☐ Other
Affect ☐ Appropriate ☐ Labile ☐ Expansive ☐ Constricted
Speech ☐ Normal ☐ Delayed ☐ Slurred ☐ Excessive ☐ Loud ☐ Soft
☐ Perseverating ☐ Pressured ☐ Incoherent ☐ Paucity ☐ Errors
Self-Perception ☐ No Impairment ☐ Derealization ☐ Depersonalized
Orientation ☐ Intact ☐ Impairment: ☐ Always ☐ Sometimes ☐ Time ☐ Place ☐ Person
Attention/Concentration ☐ Normal ☐ Fluctuating ☐ Distractible ☐ Hyper?
Memory ☐ Intact ☐ Impairment: ☐ Immediate ☐ Recent ☐Remote ☐Blackouts ☐ Amnesia
Cognitive Function General Knowledge Intact ☐ Yes ☐ No
Thought Process ☐ Intact ☐ Circumstantial ☐ Tangential ☐ Flight of Ideas
☐ Loose Associations

Thought Content/Perception
1. Hallucination: ☐ Not Apparent ☐ Present, impairment: ☐ Mild ☐ Moderate ☐ Severe
2. Delusions: ☐ Not Apparent ☐ Present, impairment: ☐ Mild ☐ Moderate ☐ Severe

Apparent Impulse Control ☐ Normal ☐ Undercontrolled ☐ Overcontrolled
Judgment ☐ Within Normal Limits ☐ Impairment: ☐ Minimal ☐ Moderate ☐Severe
Insight ☐ Within Normal Limits ☐ Impairment: ☐ Minimal ☐ Moderate ☐ Severe
Comments:____
____
____
____

Goals for Treatment:

Given that you have been ordered to participate in this program, what would you like to get out of treatment? ____
____
____
____
____
____
____

Need for Referral:

If this individual needs outside referral, describe issue: ______________________________
____
____

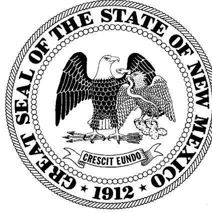
Children's Need for Referral (6 and under)

If the child(ren) needs an outside referral, describe issue: ______________________________
____
____

Additional Notes: ____
____
____
____
____
____
____
____
____
____
____
____

Completion Times for Intake Assessment Measures

Type of Measure	**Measure**	**Completion Time**
Cognitive:	Wide Range Achievement Test-3rd Edition: Reading	5 minutes
	Wechsler Abbreviated Scale of Intelligence	30-45 minutes
	Controlled Oral Word Association Test	5 minutes
	Trail-Making Test	5 minutes
Personality:	Personality Assessment Inventory	45-60 minutes
	Millon Clinical Multiaxial Inventory-3rd Edition	25-30 minutes
	Trait Meta-Mood Scale	5-10 minutes
	Mindful Attention and Awareness Scale	5 minutes
Trauma History:	Traumatic Life Events Questionnaire	10-15 minutes
	Posttraumatic Stress Disorder Screening and Diagnostic Scale	5-15 minutes
Substance Use:	Inventory of Drug Use Consequences	5-10 minutes
	Inventory of Drug Use Consequences-SO [proxy]	5-10 minutes
	Alcohol Use Disorders Identification Test	5 minutes
Parenting:	Parenting Alliance Measure	5 minutes
	Parenting Styles and Dimensions Questionnaire-Short Version	10 minutes
Relationship:	Revised Conflict Tactics Scale	10 minutes
	Inventory of Interpersonal Problems	10-15 minutes
Treatment:	What I Want from Treatment	5 minutes



STATE OF NEW MEXICO
SECOND JUDICIAL DISTRICT
F.A.I.R. Program

Date: ____________________________________

Name: ___________________________________

Dear Parent:

You have been ordered to the F.A.I.R. program by a Special Commissioner/Judge for Domestic Violence. Your Court-Ordered appointment has been scheduled as follows:

☐ **Intake:** ____

with _________________________________.

(Please make sure to bring the questionnaire, completed, to this appointment)

☐ **Individual Counseling:** ____

with ________________________________.

☐ **Exit Interview:** ____

with _________________________________.

Your child(ren) will NOT be participating and may NOT attend any of the appointments or groups. The other parent has been scheduled for the appointment(s) at a different time. The information gathered will NOT be given to the Court; however, the Court will be notified of your attendance. Please remember, ALL APPOINTMENTS ARE COURT ORDERED.

The appointment will be held in the Court Clinic, which is on the second floor (room 210) of the Bernalillo County Courthouse (400 Lomas NW, Corner of 4th Street and Lomas).
Our phone number is (505) 841-7579.

Thank you.
F.A.I.R. Program

Case # ____________________

CLIENT FORM

UMASS FAMILY COURT CLINIC INFORMATION SHEET – rev 2/07

Please fill out this form and bring to your evaluation appointment. If you have any questions about the form, please ask the clinician during your appointment.

1. Your Name ______________________________Date: ___________I am : Male or Female (circle one)

Do you have a lawyer for this case? Yes No (circle one)
Does your ex-partner have a lawyer for this case? Yes No Don't know
Do you have a CURRENT restraining order against your ex-partner? Yes No If yes, order expires: ____ (date)
Did you ever have a restraining order against your ex-partner? Yes No If yes, date of order: _____

2. For the list below, place a #1 next to the MOST important issue in your court case. Identify any other issues in order of importance by placing numbers in the spaces provided.

______Paterninity
______Visitation
______Custody dispute
______Child with special needs
______Child refuses visits
______Mental illness of: Self Ex-Partner (circle one)
______Substance Abuse by: Self Ex-Partner
______Domestic violence by: Self Ex-Partner
______Ex-Partner alienates child from you
______Child hasn't seen parent for a long time

Allegation of: Physical abuse____ Sexual abuse____ Neglect____ Emotional Abuse____
Other (specify): ____

Does DSS have an open case involving you, your former partner and the children? Yes No
Did DSS ever open a case involving you, your former partner and the children? Yes No
Number of child abuse reports (51A's) supported: ______ Number 51A's not supported: ______

3. Parents' Relationship history: Fill in approximate **month/year**

a) Date you and your ex-partner began dating each other: __________________
b) Date you first lived together: _____________
c) Date you last lived together: _______________
d) Date of marriage (if applicable):__________________
e) Date divorce filed (if applicable): ______________
f) Name of person who filed for divorce: ________________________
g) Date divorce final (if applicable): __________
h) Number of times you separated or broke off relationship for at least 24 hours during the time you lived together and / or were married: ______________

4. List all ADULTS living in your household now, including yourself:

First name of Adult	Sex	Age	Ethnicity (indicate number)	Role of Adult (indicate number)	Ethnicity	Role of Adult
Your first name:	M / F				1 = White	1. Biological parent
	M / F				2 = Asian	2. Stepparent
	M / F				3 = Hispanic	3. Live-in partner
	M / F				4 = Black	4. Grandparent
	M / F				5 = Other	5. Other relative
						6. Other non-relative

List first names of all CHILDREN living in your household now:	Sex	Age	Ethnicity (Indicate number)	Name of Biological mother	Name of Biological father
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				

5. **Educational Level:**
   Please list highest grade or level of schooling you completed: ______________________________
   Schooling (check all that apply):
   ____GED
   ____HS Graduate
   ____Vocational Tech (High School)
   ____Vocational /Technical After High School
   ____College Graduate (2yr __) (4yr__)
   ____Post graduate

6. **What is your current job: ________________________________ Hours worked per week _______**
   Did you work consistently in the last 2 years: Yes No

   Are you on AFDC? Yes No
   Do you get food Stamps? Yes No
   Are you on SSDI or any other disability program? Yes No

   Your last year's approximate income: (check one)
   ___Less than $10,000
   ___$10,000 - $20,000
   ___$20,000 - $30,000
   ___$30,000 - $50,000
   ___$50,000- $70,000 ___
   ___over $70,000

   Total approximate household income: (check one)
   ___less than $10,000 ___
   ___$10,000 - $20,000___
   ___$20,000 - $30,000 ___
   ___$30,000 - $50,000 ___
   ___$50,000- $70,000 ___
   ___over $70,000

7. **Your Psychiatric Treatment:**
   Are you in therapy now? **Yes No**
   Were you ever in therapy? **Yes No** If yes, how many sessions? _____ (best estimate)
   If yes, how helpful was therapy? Not at all A little A lot

Have you ever been hospitalized for psychiatric treatment? **Yes No**
Are you on psychiatric medication now? **Yes No** If yes, specify medication: __________________
Have you taken psychiatric medication in the past? **Yes No** If yes, specify medication & how long you took it:
____

8. **Substance Abuse** (illegal drugs or abuse of prescription medication)**, if applicable:** (if Not, skip to #9)

List any prescription medicines you abused or illegal substances you have used and approximate years of use:

Substances:	How Long Used	How often: (once, a few times, regularly)
Substance abuse by your ex-partner (below):		

9. Alcohol use:

Please specify the average NUMBER of drinks per day or write "don't know":	You	Your Partner
During relationship with ex-partner		
After Separation or currently		

Please specify the average NUMBER of days per week that alcohol is used or write don't know:	You	Your partner
During relationship with ex-partner		
After Separation or currently		

Please specify how often **DURING** the relationship you or your ex-partner became intoxicated:	You	Your partner
Never		
Rarely: 1-2 times per year		
Every month		
Every week		
Almost daily		
Don't know		

Please specify how often **AFTER** separation you or your ex-partner become intoxicated:	You	Your partner
Never		
Rarely: 1-2 times per year		
Every month		
Every week		
Almost daily		
Don't know or N/A		

Type of Substance Abuse Treatment	**For Which Substance**	**Dates YOU attended (began/ended)**	**Dates ex- partner attended (began/ended)**
Therapy			
Detox			
Rehab Inpatient			
Rehab Outpatient			
AA/NA			

10. Arrest Record: Father

Specify total number of arrests: _______
Specify number of convictions: DUI _________ Other convictions _______
Spent time in prison or jail: Yes No If yes, total time spent: days_______ months________

Arrest Record: Mother

Specify total number of arrests: _______
Specify number of convictions: DUI _________ Other convictions: _______
Spent time in prison or jail: Yes No If yes, total time spent: days_______ months________

11. Parenting history:

Usually parents share the care of their children. For the last year that you lived together estimate what percent of the care giving each of you performed. **You _______ % + Ex-partner _______ % = 100%**

When the child(ren) were under age five, estimate percentage of time each parent performed these tasks:

	You %		**Ex-partner %**		**Total 100%**
Basic care (e.g. bathing, feeding, changing	_________	+	_________	=	100 %
Getting up during the night	_________	+	_________	=	100 %
Reading & playing with the child	_________	+	_________	=	100 %
Taking the child to daycare/school	_________	+	_________	=	100 %
Staying home from work when child sick	_________	+	_________	=	100 %

Please check off one column for each question:

	Not at all	Sometimes	Usually	Always
1. How satisfied were you with how you shared child care during the relationship?				
2. Was your ex-partner a good parent to your children during your relationship?				
3. Is your ex-partner currently a good parent to your child(ren)?				
4. During your relationship, did you agree about how to raise the child(ren)?				
5. Since your separation, do you agree about how to raise the child(ren)?				

Please complete for each child named in the proceeding:

	Child #1	**Child #2**	**Child #3**	**Child #4**
Child grade in school (circle)	PS K Grade _____	PS K Grade _____	PS K Grade _____	PS K Grade _____
School performance	Above average ___ Average ___ Below Average ___	Above average ___ Average ___ Below Average ___	Above average ___ Average ___ Below Average ___	Above average ___ Average ___ Below Average ___
Special Education?	Yes No	Yes No	Yes No	Yes No
Child ever in therapy?	Yes No	Yes No	Yes No	Yes No
IF YES, **Child Diagnosis**				
Child Medications				
Dates of treatment				

12. Listed below are a number of acts or behaviors. Has your ex-partner done any of these to you? Please check off one column for each question: first, for during the year <u>prior</u> to your separation and then since you separated.

	During the year **<u>prior</u>** to separating			**<u>Since</u>** you separated		
	Not at all	1-3 times	4+ times	Not at all	1-3 times	4+ times
Prevented you from contacting family or friends						
Restricted your use of the car or the telephone						
Made major decisions without your input						
Made you ask for money to buy the basic necessities, such as food						
Threatened to come after you if you tried to leave						
Threatened to kill you						
Threatened to kill the children						
Threatened to take children or get custody if you tried to leave						
Threatened to deny you contact with the children						
Put you down, called you names, swore at you, insulted you in public						
Said nasty things about you to the children						
Followed you around (stalking)						
Violated restraining orders						
Showed excessive jealousy by constantly questioning, accusing or monitoring you.						

	During the year **prior** to separating			**Since** you separated		
	Not at all	1-3 times	4+ times	Not at all	1-3 times	4+ times
Physically restrained you						
Pushed, shoved or grabbed you						
Threw, slapped, shook, pinned you to the floor or wall						
Pressured or forced you to have sex against your will						
Choked or strangled you, punched you with his/her fist, kicked you, hit you with something						
Threatened you with a gun, knife or other weapon.						
Other (describe)						

13. At the time of your final separation who moved out of the family home? Me Partner Both (circle one)

Who made the decision to separate? Me Partner Both (circle one)

14. Are you and your ex-partner living in separate residences at the present time? Yes No (circle one)

With whom did the children live when you separated? Me Partner Both Other (who)______________________

With whom are the children living now? Me Partner Both Other (who) _________________________________

What days and times are the children usually with you? Please specify: _______________________________________

Rev. 2/07

UMASS FAMILY COURT CLINIC

INFORMATION SHEET

Name:		DOB:	
Address:			
Home phone: ( )		Cell phone: ( )	
Employer:			
Work phone: ( )		Fax: ( )	
E-Mail address:			
Name of your attorney:			
Address:			
Phone: ( )		Fax: ( )	
Name of your therapist:			
Address:			
Phone: ( )		Fax: ( )	
Child's Name:		Child's Name:	
DOB:		DOB:	
School:		School:	
Phone: ( )		Phone: ( )	
Fax: ( )		Fax: ( )	
Teacher:	Grade:	Teacher:	Grade:
Child's Name:		Child's Name:	
DOB:		DOB:	
School:		School:	
Phone: ( )		Phone: ( )	
Fax: ( )		Fax: ( )	
Teacher:	Grade:	Teacher:	Grade:
Children's Pediatrician:			
Address:			
Phone: ( )		Fax: ( )	
Children's Therapist:			
Address:			
Phone: ( )		Fax: ( )	

Rev. 1/07

Date

Client Name

Dear :

On January 21, 2010 Judge King ordered your brief family assessment. This letter is confirmation of your appointment at the UMass Family Court Clinic on **November 9, 2009 @ 3:00 pm. Please note that_____will be interviewed first and will bring in the children and someone to watch the children while she is in with the clinician.** ***(This is a clinic rule which applies even if you believe your child is mature enough to wait alone.)*** The clinic is located at 306 Belmont Street, Worcester, MA 01604. You will be meeting with **Dr. Linda Cavallero.** Directions to the clinic are enclosed.

We attempt to provide a safe environment for all parties to be interviewed. Many families have an active restraining order, and we have provisions to keep everyone separate when necessary. However, it is important that you arrive on time for your appointment.

You will be interviewed for approximately one hour, and will have a brief, observed interaction with your child(ren). Unless there is an active restraining order or other reason why it is contraindicated, each parent will spend time with the child(ren). Your child(ren) will also be interviewed individually. You should allow at least two and a half hours to complete the interviews and all accompanying paperwork, so please make appropriate arrangements in your schedule.

Please bring the following information with you:

- Copies of any documents important to your case. For example: court and police records, previous evaluations or DSS service plans.

- Names, addresses, phone numbers and fax numbers of all relevant professionals involved in your family. For example: school or day care personnel, DSS caseworkers, pediatricians, therapists.

Also enclosed are a Client Form and Information Sheet. Please complete these forms and bring them with you to your appointment. Your preparation will allow the evaluation to proceed as smoothly and quickly as possible.

If you have any questions about the schedule or procedures, please contact me at the UMass Family Court Clinic at 508-793-6915 between 9:00 am and 5:00 pm Tuesday through Thursday or 8:00 am and 4:00 pm on Friday.

Thank you,

Laurel Post
UMass Family Court Clinic

cc:

Enclosures

UMASS FAMILY COURT CLINIC

INFORMATION SHEET

Name:	DOB:
Address:	
Home phone: ( )	Cell phone: ( )
Employer:	
Work phone: ( )	Fax: ( )
E-Mail address:	
Name of your attorney:	
Address:	
Phone: ( )	Fax: ( )
Name of your therapist:	
Address:	
Phone: ( )	Fax: ( )
Child's Name:	Child's Name:
DOB:	DOB:
School:	School:
Phone: ( )	Phone: ( )
Fax: ( )	Fax: ( )
Teacher: Grade:	Teacher: Grade:
Child's Name:	Child's Name:
DOB:	DOB:
School:	School:
Phone: ( )	Phone: ( )
Fax: ( )	Fax: ( )
Teacher: Grade:	Teacher: Grade:
Children's Pediatrician:	
Address:	
Phone: ( )	Fax: ( )
Children's Therapist:	
Address:	
Phone: ( )	Fax: ( )

Rev. 1/07

Date

Client Name

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Thank you,

Laurel Post
UMass Family Court Clinic

cc:

Enclosures

UMASS FAMILY COURT CLINIC

Department of Psychiatry, University of Massachusetts Medical School

REFERRAL FORM

The UMass Family Court Clinic provides brief, focused evaluations of urgent family matters presenting to Worcester Probate and Family Court judges. Urgent, but clearly circumscribed family disputes are most amenable to brief evaluations. Due to the brief nature of the assessments, recommendations are generally centered on the short term needs of the family. A written report of the evaluation is sent to the Court within the time frame determined by the urgency of the issues. Emergency request for evaluations are handled as quickly as possible. To expedite an urgent request, please contact the clinic secretary or ________________ (see below).

Person Completing Form: ____ **Phone:** ____________________

Date of Court Order: _________________________ **Referring Judge:** ____

Case Name: ___________________________________ **Docket #:** _________________ **Return Court Date:** ______________

PLAINTIFF

Name: ______________________________________ **Phone (home):** __________ **(work):** ____________ **(cell):** ___________

Address: ____

Attorney Name/Address: ____ **Phone:** ____________________

DEFENDANT

Name: ______________________________________ **Phone (home):** __________ **(work):** ____________ **(cell):** ___________

Address: ____

Attorney Name/Address: ____ **Phone:** ____________________

CHILDREN **Name:** ____________________________ **Age:** ____ **Name:** _______________________________ **Age:** ____

Name: ____________________________ **Age:** ____ **Name:** _______________________________ **Age:** ____

Legal proceeding before the Court (please specify): ____

____

____

Any Current 209A: Yes ____ No ____ Children on 209A: Yes ____ No ____ Any Noncurrent 209A*:* Yes ____ No ___

Present Custody Status: Sole legal_______________ Joint Legal________________

The Court's reason for referral for Brief Psychological Evaluation (Please check or circle all that apply).

- **Interparental: a) conflict _____ b) violence_____**
- **Mental status of: a) mother _____ b) father _____**
- **Substance abuse: a) mother _____ b) father _____**
- **Disputed visitation/access: _____ Current adjustment of child(ren): _____**
- **Safety of child(ren) with parent(s): _____ (Please specify parent): ____________________________**
- **Question of: a) emotional abuse _____ b) physical abuse _____ c) sexual abuse _____ d) neglect ______**
- **Ability of parent to provide adequate care for child: _____ (please specify parent): __________________**

Please state the focus of the assessment: ____

____

____

____

Please call or fax in this information to ____________ at the Department of Psychiatry, UMMS, XXX-XXX-XXXX and FAX Court order to XXX-XXX-XXXX. Please contact _______________ at XXX-XXX-XXXX for further information. Rev. 9/3/08

Form 1B

Appendix C

Department of Psychiatry
Child and Family Forensic Center

306 Belmont Street
Worcester, MA 01604
Tel: 508-793-6910
Fax: 508-793-6917
www.umassmemorial.org

UMASS FAMILY COURT CLINIC

BRIEF CLINICAL EVALUATION

GENERAL INFORMATION AND INFORMED CONSENT AGREEMENT

1. The mission of the UMass Family Court Clinic is to provide judges, attorneys, and families in the Worcester Probate and Family Court system with clinical expertise as an aid in effective and efficient decision-making for the benefit of children. The mission is achieved through the provision of brief clinical evaluations addressing specific concerns of the Court, consultation to attorneys and parents, and research.
2. In its order of _________, the Worcester Probate and Family Court has ordered me to undergo this evaluation of myself and/or my children. A brief assessment is a form of consultation to the Court.
3. Any information that I offer or grant access to may be shared with the other party in this dispute. Some or all of this information may be included in a report, which will be sent to the Worcester Probate and Family Court. If there is a reasonable basis for suspecting that my child is being abused, any clinician in the Court Clinic must report that to the Department of Children and Families. If I express specific intent to harm myself or someone else, the clinician is required to take appropriate protective action.
4. I further am aware that the Court Clinic will not give me a copy of this report. However, with the Court's permission, I may be able to read it in the presence of my attorney. If I am *pro se*, that is I represent myself, I must request a release of the report from the court.
5. I understand that I am not to discuss the contents of the report with my child(ren).

My signature below indicates that I have read and understood the information above.

Signature: ______________________________ Date: _____________

______________________________ Date: _____________

______________________________ Date: _____________
Witness

Rev. 08/09

APPENDIX D

OUTLINE OF CLINICAL MODEL OF ASSESSMENT:

A. Custodial parent interview: 50-70 minutes (approximate)
- review of limits of confidentiality
- parents' immediate concerns about the child or other parent
- brief background history
- history of relationship with noncustodial parent
- child's developmental history
- parenting history
- parents' understanding of the child's needs
- parents' concerns and wishes in the present litigation
- optional psychological testing (can be done on a subsequent day)
- obtain releases of information for relevant collaterals

B. Observation of child and custodial parent in play setting: 20-30 minutes.
- review of limits of confidentiality and explanation of the role of the evaluator
- note quality of the interaction between parent and child
- structured tasks

C. Individual interview of the child: 30-40 minutes.
- start with open ended play and general questions to put the child at ease
- try to get a sense of the child's concerns and experience of the family disruption
- move to more direct questions about specific issues in the case
- give the child an opportunity to ask questions and ask if there is anything he or she wants the evaluator to tell the judge for him or her

D. Observation of the noncustodial parent in play setting: 20-30 minutes (as above).

E. Noncustodial parent interview: 50-70 minutes (as above).

F. Collateral contacts
Record Review

IV. Report writing

Documentation of the family's current presentation is important to future legal proceedings which are common in this population.

The report will consist primarily of the clinician's interviews, descriptive observations of family members and their interaction.

Conclusions will be limited and recommendations will be primarily of a short term nature due to the limited data available to the clinician.

Sample Report Outline

BRIEF FAMILY ASSESSMENT

FAMILY NAME

DOCKET NUMBER

This report is confidential within the confines
of the present legal matter. It cannot be released
without the permission of the Court.

DATE OF REPORT:

EVALUATOR: Name
Title

FAMILY MEMBERS INTERVIEWED: **(names, dates of birth)**

FAMILY MEMBERS NOT INTERVIEWED: **(names, dates of birth)**

REASON FOR REFERRAL: **(includes focused question(s) of the judge)**

DATES OF CONTACT: **(date and time spent in each activity**

COLLATERAL CONTACTS:

RECORDS REVIEWED:

STATEMENT OF THE LIMITS OF CONFIDENTIALITY:

At the beginning of the initial interviews with the parents the nature and purpose of the evaluation were discussed. The parents were given a written “General Information and Informed Consent Agreement” which details the mission of the Family Court Clinic and the limits of confidentiality of information shared in interviews, as well as the written report and protective concerns. Both parents signed the agreement indicating that they understood the circumstances of the evaluation and agreed to participate. The limits of confidentiality were also explained to (child’s name) in language appropriate to his or her age and developmental status.

HISTORY OF THE MARRIAGE (or Relationship) ACCORDING TO (the Parents)

(NAME) Parent #1

BEHAVIORAL OBSERVATIONS: (Clinical Impressions)

BACKGROUND HISTORY:

(NAME)'S CONCERNS AND WISHES:

(NAME) Parent #2

BEHAVIORAL OBSERVATIONS:

BACKGROUND HISTORY:

(NAME)'S CONCERNS AND WISHES:

(NAME) Child #1, #2 etc.

DEVELOPMENTAL HISTORY:

INTERVIEW WITH: (CHILD'S NAME)

PARENTING HISTORY:

OBSERVATION OF CHILD(REN) AND PARENT #1:

OBSERVATION OF CHILD(REN) AND PARENT #2:

COLLATERAL CONTACTS:

RECORDS REVIEWED:

CONCLUSIONS:

This has been a brief evaluation which leaves the evaluator with limited data upon which to form conclusions. Care must be taken in extrapolating from this report (these results.)

RECOMMENDATIONS:

(Signature)

____

Evaluator's name
Title

Application for Final Orders

FORM 1 Family Law Rules ~ RULE **2.01**

Please type or print clearly and mark [**X**] all boxes that apply. Attach extra pages if you need more space to answer any questions.

Filed in:

- [ ] Family Court of Australia
- [ ] Family Court of Western Australia
- [ ] Federal Magistrates Court of Australia
- [ ] Other (specify) ____________________

This form is used by an **applicant** who is seeking final Court orders, other than a divorce.

IMPORTANT: Information for respondents to the application is on page 9.

COURT USE ONLY

Client ID ____________________

File number ____________________

Filed at

Filed on

Court location

Court date ____________________

Time ____________________

- [ ] Procedural Hearing
- [ ] Case Assessment Conference
- [ ] Hearing

Part A About the final orders you [THE APPLICANT] are seeking

1 What type of orders are you seeking? Mark [**X**] all boxes that apply.

- [ ] **Children** (Parenting – with whom a child lives, spends time or communicates)
- [ ] **Financial** (Property and/or maintenance - you must file a Financial Statement (Form 13) with this application)
- [ ] **Child support** (Other documents that must be filed with this application are set out in Rule 4.19)
- [ ] **Other** (eg. medical procedures, injunction for personal protection, passport application, nullity of a marriage or a declaration as to validity of a marriage)

Please specify ____________________

Part B About the parties

■ **COMPLETE YOUR COLUMN AND AS MUCH OF THE OTHER COLUMN AS YOU CAN**

2

APPLICANT 1	**RESPONDENT 1**
What is your family name as used now?	Family name as used now
Given names?	Given names
[ ] Male [ ] Female	[ ] Male [ ] Female
APPLICANT 2	**RESPONDENT 2**
What is your family name as used now?	Family name as used now
Given names?	Given names
[ ] Male [ ] Female	[ ] Male [ ] Female

	APPLICANT 1	RESPONDENT 1
3	What is your contact address (address for service) in Australia? You do not have to give your residential address. You may give another address at which you are satisfied that you will receive documents. If you give a lawyer's address, include the name of the law firm.	Respondent's address
	State Postcode	State Postcode
	Phone Fax *	Phone
	DX	
	Lawyer's code	
	Email *	

* **Please do not include email or fax addresses unless you are willing to receive documents from the Court and other parties in that way.**

♦ 4 Are you of Aboriginal and/or of Torres Strait Islander origin?

- ☐ **No**
- ☐ **Yes** Aboriginal
- ☐ **Yes** Torres Strait Islander
- ☐ **Yes** Aboriginal and Torres Strait Islander

5 When and in what country were you born?	Respondent's date of birth
DAY/MONTH/YEAR COUNTRY	DAY/MONTH/YEAR
/ /	/ /

6 What is your usual occupation?

♦ 7 In which country was your mother born?

♦ 8 In which country was your father born?

9 How well do you speak English?

- ☐ Very well
- ☐ Well
- ☐ Not well
- ☐ Not at all

10 If an interpreter is needed, in what language and in what dialect?

Note: If you require an interpreter, you must advise Court staff in advance.

♦ You are not required to answer this question, but it will greatly assist the Court if you do. The information sought is being collected to assist the Court in planning and delivering client services. It is possible that you may be contacted to participate in a review of a particular aspect of the Court's services, although your right not to participate will be respected. The information you provide may be shared with researchers approved by the Court, and may be included in publications in statistical form in a way that does not identify you.

APPLICANT 1 (CONTINUED)	**RESPONDENT 1** (CONTINUED)

11 Which of the following applies?

MARK [X] **EVERY** BOX THAT APPLIES TO APPLICANT 1 AND **EVERY** BOX THAT APPLIES TO RESPONDENT 1

Applicant 1	Respondent 1
☐ I am present in Australia	☐ Present in Australia
☐ I am ordinarily resident in Australia	☐ Ordinarily resident in Australia
☐ I am an Australian citizen	☐ An Australian citizen
☐ I am domiciled in Australia (country to which I belong)	☐ Is domiciled in Australia (country to which respondent belongs)

12 In this case which of the following descriptions applies?

Applicant 1	Respondent 1
☐ husband/father	☐ husband/father
☐ wife/mother	☐ wife/mother
☐ other (specify) ______________________	☐ other (specify) ______________________

If there is a second applicant or second respondent attach a separate sheet answering Items 3-12 for Applicant 2 and Items 3, 11 and 12 for Respondent 2.

Part C About the relationship(s) of parties

NOT APPLICABLE

13 When did you and the respondent begin living together? ☐

DATE: / /

14 When and where did you and the respondent marry? ☐

DATE	TOWN/CITY	COUNTRY
/ /		

15 When did you and the respondent finally separate? ☐

DATE: / /

16 When and where did you and the respondent get divorced? ☐

DATE	TOWN/CITY	COUNTRY
/ /		

Part D About the children

17

Child 1

Child's family name

Given names

Child's date of birth / /

☐ Male ☐ Female

Full name of mother

Full name of father

State with whom the child lives

Child 2

Child's family name

Given names

Child's date of birth / /

☐ Male ☐ Female

Full name of mother

Full name of father

State with whom the child lives

Child 3

Child's family name

Given names

Child's date of birth / /

☐ Male ☐ Female

Full name of mother

Full name of father

State with whom the child lives

Child 4

Child's family name

Given names

Child's date of birth / /

☐ Male ☐ Female

Full name of mother

Full name of father

State with whom the child lives

If you need more space for any other children, attach an extra page.

Part E About other Court cases and orders

18 Are there any **ongoing cases** in this or any other Court about family law, child support, family violence or child welfare that involve any of the parties or any of the children listed on this form?

☐ **No** **GO TO ITEM 19**

☐ **Yes** **GIVE THE FOLLOWING DETAILS**

Court name and place	Next Court date
	/ /

State the names of the parties

State the nature of the orders sought **(EG: PROPERTY SETTLEMENT, PARENTING ORDERS, CHILD SUPPORT)**

IF THERE IS MORE THAN ONE CASE PLEASE ATTACH AN EXTRA PAGE, NUMBERING IT ITEM 18 – PAGE 2

19 Are there any **existing orders**, agreements, parenting plans or undertakings to a court about family law, child support, family violence or child welfare concerning any of the parties or children listed on this form?

☐ **No** **GO TO ITEM 20**

☐ **Yes** **EITHER** attach a full copy of the order, agreement, parenting plan or undertaking **or** set out details below (attach an extra page if you need more space, numbering the page/s Item 19 page 2 and so on).

☐ Attached is a copy/copies of the following (mark [**X**] the boxes that apply):

☐ order ☐ undertaking

☐ parenting plan ☐ agreement

OR

☐ **GIVE THE FOLLOWING DETAILS**

Court name and place	Date
	/ /

Names of the parties to the order/agreement/parenting plan/undertaking

CONTINUE ON PAGE 6 FOR DETAILS OF THE ORDER / AGREEMENT / PARENTING PLAN / UNDERTAKING

Details of the order/agreement/parenting plan/undertaking

1.

IF THERE IS MORE THAN ONE CASE PLEASE ATTACH AN EXTRA PAGE, NUMBERING IT ITEM 19 – PAGE 2

FOR PROPERTY AND/OR SPOUSE MAINTENANCE APPLICATIONS

20 Have the parties entered into a binding financial agreement under Part VIIIA of the *Family Law Act* or under any relevant State or Territory legislation?

☐ **No**

☐ **Yes**

21 If either party has a superannuation interest, have the parties entered into a binding superannuation agreement in relation to that superannuation interest?

☐ **No**

☐ **Yes**

22 Is any party currently bankrupt or currently a debtor in bankruptcy proceedings started by either a creditor's petition or a debtor's petition or currently a debtor subject to a personal insolvency agreement?

☐ **No**

☐ **Yes**

PROCEEDS OF CRIME LEGISLATION – FOR PROPERTY AND/OR SPOUSE MAINTENANCE APPLICATIONS

23 Is there a proceeds of crime order or current forfeiture application in relation to any of the property of any of the parties (see *Proceeds of Crime Act 2002* (C'wlth))?

☐ **No**

☐ **Yes** **ATTACH A SEALED COPY OF THE ORDER OR APPLICATION.**

Part F The final orders you [THE APPLICANT] are seeking

24 State the orders that you are seeking. (**GIVE A NUMBER TO EACH ORDER SOUGHT**)

1.

Attach extra pages if you need more space.

Part G Cross-vested jurisdiction

- **COMPLETE ONLY IF RELYING ON CROSS-VESTED JURISDICTION**
- **PLEASE NOTE, YOU MUST FILE AN AFFIDAVIT (SEE RULE 4.06)**

25 If you are relying on a cross-vesting law specify the State or Territory law upon which you rely.

Part H Affidavit of applicant(s)

PLEASE DO NOT COMPLETE THIS PART OF THE FORM UNTIL YOU ARE WITH A PERSON WHO IS LEGALLY ABLE TO WITNESS YOUR SIGNATURE

You must complete the following affidavit. You must sign it in the presence of a Justice of the Peace, notary public or lawyer. The person witnessing the affidavit will fill in the place and date.

I swear* /affirm* that:

- ☐ I am the applicant
- ☐ I have read this Application
- ☐ The facts of which I have personal knowledge are true
- ☐ All other facts are true to the best of my knowledge, information and belief and the orders sought in this application are supported by evidence
- ☐ I am aware that I have a duty to the Court and to each other party to give full and frank disclosure of all information relevant to the issues of the case, in a timely manner

Signature of Applicant 1

Place Date / /

Before me (signature of witness)

Full name of witness (please print)

- ☐ Justice of the Peace
- ☐ Notary public
- ☐ Lawyer

I swear* /affirm* that:

- ☐ I am the second applicant
- ☐ I have read this Application
- ☐ The facts of which I have personal knowledge are true
- ☐ All other facts are true to the best of my knowledge, information and belief and the orders sought in this application are supported by evidence
- ☐ I am aware that I have a duty to the Court and to each other party to give full and frank disclosure of all information relevant to the issues of the case, in a timely manner

Signature of Applicant 2

Place Date / /

Before me (signature of witness)

Full name of witness (please print)

- ☐ Justice of the Peace
- ☐ Notary public
- ☐ Lawyer

* delete whichever is inapplicable

This application was prepared by ☐ applicant/s ☐ lawyer

PRINT NAME AND LAWYER'S CODE

Please go to page 9 for an Important Notice to Respondent/s

Part I Your lawyer's declaration

If you are filing this application yourself then you do not need to complete this part. However make sure you receive a copy of the information brochure *Marriage, Families and Separation*. Court staff will give you this brochure when you file your application. If a lawyer is filing the application for you then the lawyer must give you a copy of the brochure and complete and sign the declaration that follows.

☐ I gave the applicant(s) a copy of the Family Court brochure *Marriage, Families and Separation.*

Signature of lawyer	Print full name	Date / /

Important Notice to the Respondent/s

If you oppose the orders sought in this application or want the Court to make other orders **you must:**

- file with the Court a Response (Form 1A) **and**

  ~ **in a financial case** a Financial Statement (Form 13).
- serve copies of the documents filed by you on each other party at least seven days before the court date shown on page 1 of this form; **and**
- attend the hearing. If you do not attend the hearing orders may be made in your absence.

You may also need to file other documents depending on the orders you seek in response.
[See Rule 4.19 and Rule 9.02]

If this application seeks orders about maintenance or child support, when you are served with the application you should receive a brochure called, either, *Maintenance Applications* or *Child Support Applications*.

You should seek legal advice about this application.

FAMILY CIVIL INTAKE SCREEN

Court Location:___________________
Intake Counselor:_______________________________
Intake Date:_____________

GENERAL CASE INFORMATION

Defendant ___________________	Defendant ___________________	Docket # ________
Gender: Male ☐ Female ☐	Gender: Male ☐ Female ☐	CMIS # _________
DOB: ___________________	DOB: ___________________	
Address: ___________________ ___________________	Address: ___________________ ___________________	
Phone: ___________________	Phone: ___________________	
Employer: ___________________	Employer: ___________________	
Address: ___________________ ___________________	Address: ___________________ ___________________	
Phone: ___________________	Phone: ___________________	
Work Hours: ___________________	Work Hours: ___________________	
Attorney: ___________________	Attorney: ___________________	
Address: ___________________ ___________________	Address: ___________________ ___________________	
Phone: ___________________	Phone: ___________________	

Children_______________________________
DOB__________Gender___ Resides with_________________

____
______________ ___ _________________

____
______________ ___ _________________

____
______________ ___ _________________

____
______________ ___ _________________

Children's Attorney/GAL: ____________________________
Phone: ________________________

Plaintiff attended/completed Parenting Education Program:
______ N _____Y _______Date completed ______Waived

Defendant attended/completed Parenting Education Program:
______ N _____Y _______Date completed ______Waived

Who presently has legal custody of the child(ren)?
Father Mother Joint No Arrangement Other________

Who presently has physical custody of the child(ren)?
Father Mother Joint No Arrangement Other________

What is the current parenting plan/access schedule?

How long have these arrangements been in place? _____________________

Supervisor Assignment Information

Referred for: o Mediation o Conflict Resolution Conference
o Issue Focused Evaluation o Comprehensive Evaluation
Assigned to: ____
Date Assigned: ____

Additional Referral Information
* Copies of this page and first page are to be retained in the case file.
* If this screen is being completed in the automated format most of the information on this page will auto-filled from information that will be entered in the screen that follows. When the screen is complete return to this page and review for accuracy
* If the screen is being completed on paper, skip this section and return to it at the end
Family Violence Screening:

Prior Arrests:	o No o Yes Comments:__________________________________ ____
PO/RO in effect:	o No o Yes Comments: __________________________________ ____

Referral Status:

Source of Referral:	o Court o Self
Case status:	o Pendente Lite o Pre Judgment o Post Judgment
Type of Case:	o Dissolution o Unmarried o TRO
Issues Referred:	o Custody o Out of State o Financial o Access o Reconciliation o Other:__________________________
Forms Distributed:	o Brochure o Questionnaire o Release of Info

Previous Referrals to FRO for services (dates): _____________________________

ADDITIONAL PERTINENT INFORMATION

Level of Conflict:					
Which of the following best describes your relationship with your child(ren)'s other parent?	o Divorcing/ separating and living apart LOW	o °°°° Divorcing/ separating but still living together LOW	o Already Divorced MODERATE	o Never Married Used to live together MODERATE	o Never Married Never lived together HIGH

How many times have you utilized Court interventions to deal with child related disagreements between yourself and your child(ren)'s other parent?	o No prior times; this is the first referral LOW	o Two or three times ODERATE	o Four or more times HIGH

At what stages of the Court process have you returned to Court with disputes about your parenting arrangement?	o No prior Court services LOW	o Pendente Lite/Pre-Judgment LOW	o Post Judgment LOW/MODERATE	o Pendente Lite/Pre-Judgment and Post Judgment HIGH

Which of the following Court processes usually resolved your prior parenting disputes?	o No Prior Court Service LOW	o Negotiation LOW	o Mediation/ Conflict Resolution Conference LOW	o Evaluation MODERATE	o Trial/ Hearing HIGH

Current level of Conflict	o LOW TO MODERATE	o MODERATE TO HIGH	o HIGH

Ability to Cooperate/Communicate:

How well do you and your child(ren)'s other parent cooperate and communicate over your child(ren)	○ We generally cooperate well POSITIVE	○ We cooperate some of the time POSITIVE	○ We do not cooperate well LIMITED	○ Cooperation is almost impossible LIMITED TO NO ABILITY	○ No Contact or cooperation is possible NONE
How were your present custody and access /visitation arrangements made?	○ A mutual decision was made together by you and the child(ren)'s other parent POSITIVE	○ A decision was made with the help of a counselor, attorney, or mediator/negotiator LIMITED	○ A decision was made by someone in authority like a judge or after an evaluation LIMITED TO NO ABILITY	○ The arrangements were made by you without discussing it with anyone NONE	
How important is the other parent to the welfare of your child(ren)?	○ Very important (has many valuable things to offer as a parent) POSITIVE	○ Important (has some valuable things to offer as a parent) POSITIVE	○ Somewhat Important(some value but some problems/ limitations as a parent) LIMITED	○ Not important (has little to offer; problems/ deficits as a parent) LIMITED TO NO ABILITY	○ Very Unimportant (has nothing to offer as a parent) NONE
Overall level of communication / cooperation	○ Parties communicate and consider the other parent's opinion POSITIVE	○ Minimal communication, passive cooperation LIMITED	○ Communication tends to be conflicted or done so in a challenging manner; reliance on others for direction LIMITED TO NO ABILITY		○ No Communication, Avoidant NONE

Complexity of Issues:		
What do you believe are the issues currently in dispute between you and your child(ren)'s other parent?	○ Relocation of one parent	HIGH
	○ Medical, educational and religious decisions for your children	HIGH
	○ Threatening or violent behavior between other family members	HIGH
	○ Time sharing and holiday schedules (access issues) and/or arrangements for picking up/ exchanging children	MODERATE
	○ Financial issues (child support/alimony, maintaining the family home)	MODERATE

	o Other parent and friends/family speaking negatively about you to the child(ren)	LOW
	o Appropriate daily care and discipline of your child(ren)	LOW
	o Other:________________________	Counselor needs to rate:

Child Abuse/Neglect Concerns of: o Physically hurting the child(ren) o Emotional abusing your children o Neglecting to feed, supervise, etc. the child(ren) o Driving unsafely with the child(ren) in the car o Exposing children to dangerous/criminal behavior o Parent is engaging in sexually inappropriate behavior	o Past only; No current allegations; one parent may have underlying concern that abuse/neglect may reoccur in the future LOW	o Current allegation; behavior not denied; currently in treatment or recently completed; recognition that behaviors have impacted relationship with child(ren); no agreement on how this should impact parenting plan MODERATE	o Current allegation; minimizes behavior; may or may not be in treatment; ambivalent about if/how behavior impacts relationship with child; no agreement on how this should impact parenting plan MODERATE/ HIGH	o Child abuse issue totally denied by one party HIGH	o Not an issue
Substance abuse Concerns of: o Drinking too much o Using illegal drugs o Abusing prescription meds	o Past only; Agreement that there is no current use; one parent may have underlying concern that substance abuse may reoccur LOW	o Currently using, no denial of use; currently in treatment/or recently completed; agreement that use has impact on ability to parent; no agreement on how this should impact parenting plan MODERATE	o Currently using, no denial of use; may or may not be in treatment; ambivalent about how use impacts parenting ability; no agreement on how this should impact parenting plan MODERATE/ HIGH	o Substance use totally denied by one party HIGH	o Not an issue
Mental Health Concerns of: o Being mentally or emotionally unstable o Depression o Personality Disorder	o Past only; Agreement there is no impact on current functioning; one parent may have underlying concern that functioning may be compromised in the future LOW	o Currently an issue, not denied; currently in treatment or recently completed; agreement that issue has impact on ability to parent; no agreement on how this should impact parenting plan MODERATE	o Currently an issue; may or may not be in treatment; ambivalent about if/how issue impacts parenting ability; no agreement on how this should impact parenting plan MODERATE/ HIGH	o Mental Health issue totally denied by one party HIGH	o Not an issue

Domestic Violence	o	o	o	o	o
Concerns of: o Behaving violently towards you o Behaving violently towards their new significant other/spouse o Violence between current and past significant other/spouse	Past only; No current allegations or DV arrests; **NO** underlying fear of the other parent LOW	Current allegation or DV arrest; behavior not denied; currently in treatment or recently completed; recognition that behaviors have impacted on parenting relationships; no agreement on how this should impact parenting plan Past DV incident(s). However one parent continues to be concerned about interactions MODERATE	Current allegation or DV arrest; minimizes behavior; may or may not be in treatment; ambivalent about if/how behavior impacts parenting relationships; no agreement on how this should impact parenting plan Past DV incident(s). One parent continues to be fearful MODERATE/ HIGH	Denial of allegations by one party ***Past DV incident(s). One parent continues to be fearful*** HIGH	Not an issue

Issues Identified : (To be filled out on the automated format only)
Issues: **Rating:**

Complexity of Issues	o	o	o	o
	Parenting time; Primary Residence; No current DV; Mental Health, and Substance abuse issues not present or if so do not impair ability to mediate LOW/MODERATE	Parenting time; Primary residence; DV, Mental Health, Child abuse /neglect, Substance abuse present and not denied; impact of issue on parenting recognized; how issue impacts parenting plan in dispute; current or recently completed treatment a must MODERATE	Parenting time; Primary residence; DV, Mental Health, Child abuse /neglect, Substance abuse present, parent has ambivalence on if /how this impacts parenting ability; how issue impacts parenting plan in dispute; may or may not be in current treatment MODERATE/ HIGH	Parenting time; Primary residence; DV, Mental Health, Child abuse /neglect, Substance abuse denied by one parent HIGH

Level of Dangerousness

How frightened are you of your child(ren)'s other parent at this time?	○ Not at all LOW	○ Somewhat MODERATE	○ Very much HIGH	○ Very much HIGH

During your relationship with the child(ren)'s other parent, how often did the following occur: (See Below)	○ **Occurred in the past: (prior to past 12 months)**	○ **Occurrences within the past 12 Months:**				**Overall Rating****
		Never	**Once**	**Several Times**	**Frequently**	
Threats to hurt or punish	Low	Low	Low	Moderate	Moderate/ High	
Push, grab, shove, bully	Low	Low	Low	Moderate	High	
Slap, hit, kick, bite, etc.	Low or Mod.	Low	Moderate	Moderate/ High	High	
Choke, beat up the other (repeated blows)	Mod or High	Low	Moderate/ High	High	High	
Threat of/use of a weapon	Mod. or High	Low	High	High	High	
Sexual abuse or rape	Mod or High	Low	High	High	High	
			○ **Occurred in the past: (prior to past 12 months) Ratings if yes:**		○ **Current – Within the past 12 months Ratings if yes:**	Overall Rating **

Legal Response To Family Violence	Have police been called because of allegations of violence or abuse by you or the other parent?	Low or Mod.	Moderate	
	Have criminal charges been filed against you or the other parent as a result of alleged violence? (assaultive behavior)	Moderate	Moderate or High	
	Has there ever been a restraining or protective orders in place between you and the other parent?	Low	Moderate	
	Has there been an arrest for a violation of a protective order or restraining order?	Low or Moderate	High	
	Have you ever received medical treatment for injuries intentionally caused by the other parent?	Moderate or High	High	
	Has DCF opened a file as a result of allegations of child abuse or neglect against either parent?	Low or Moderate	Moderate/High	
Level of Dangerousness (choose highest rating from above)	o **LOW**	o **MODERATE**	o **MODERATE /HIGH**	o **HIGH**

Service Options/Definitions

LEVEL OF CONFLICT	o LOW TO MODERATE	o MODERATE TO HIGH	o MODERATE TO HIGH	o HIGH
LEVEL OF COMMUNICATION /COOPERATION	o POSITIVE Parents communicate and consider the other parent's opinion	o LIMITED Minimal communication, passive cooperation	o LIMITED TO NO ABILITY Communication tends to be conflicted or done so in a challenging manner, rely on others for direction	o NONE No communication, Avoidant None

COMPLEXITY OF ISSUES	o LOW/MODERATE Parenting time; Primary Residence; No current DV; Mental Health, and Substance abuse issues not present or if so do not impair ability to mediate	o MODERATE Parenting time; Primary residence; DV, Mental Health, Child abuse /neglect, Substance abuse present and not denied; impact of issue on parenting recognized; how issue impacts parenting plan in dispute; current or recently completed treatment a must	o MODERATE/HIGH Parenting time; Primary residence; DV, Mental Health, Child abuse /neglect, Substance abuse present, parent has ambivalence on if /how this impacts parenting ability; how issue impacts parenting plan in dispute; may or may not be in current treatment	o HIGH Parenting time; Primary residence; DV, Mental Health, Child abuse /neglect, Substance abuse denied by one parent
LEVEL OF DANGEROUSNESS	o LOW	o MODERATE OR MODERATE/ HIGH	o MODERATE/ HIGH OR HIGH	O MODERATE /HIGH OR HIGH
Disparity of facts/ Need for corroborating evidence	o Minor to moderate differences in facts or position No immediate need for corroborating evidence	o Moderate differences in facts or position Very limited need for corroborating evidence (1or 2 collateral resources needed)	o Moderate differences in facts or position Limited need for corroborating evidence (no more than 4 collateral resources needed)	o Significant differences in fact or position. Strong need to share their perspective Significant need for corroborating evidence and expanded interviews with clients
Service Selection	o **MEDIATION**	o **CONFLICT RESOLUTION**	o **FOCUSED EVALUATION**	o **COMPRE HENSIVE EVALUAT ION**

Appendix B- Case Flow