Review of multi-agency models for multi-agency risk assessment and management and integrated service delivery

Extracted summary

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Glossary of terms used to describe collaborative initiatives in family violence

Children's Advocacy Centers	Co-located multiple agencies which developed in the USA from 1985 aiming to provide a comprehensive (including forensic) response to children who have experienced abuse
Coordinated Community Responses	Term used to describe a formal and coordinated response to women and children escaping domestic violence, originating in the USA
Family Justice Centers	Co-located multiple agencies which developed in USA from 2002, aiming to provide a 'one stop shop' for women and children escaping domestic violence
Greenbook Initiatives	Collaborative initiatives developed in USA in 2000 aiming to provide enhanced responses to children who experience, or witness family violence, and who have experienced abuse and neglect
High Risk Teams	Term used (most frequently in the USA) to describe a multi-agency panel which meets on a regular basis to consider high risk cases (share information, assess risk, develop risk management plans)
Hub-like models	Co-located agencies and collaborative teams of agencies which aim to assist women and children escaping family violence, and/or children experiencing abuse and neglect. Hub-like models may include co-located agencies, and/or agencies which are incorporated into a 'virtual' hub, by collaborative agreement
Multi Agency Risk Assessment Committee (MARAC)	Multi-agency panels established in the UK which meet on a regular basis to consider high risk cases (share information, assess risk, develop risk management plans)
Multi-Disciplinary Teams	Term used (most frequently in the UK) to describe a multi-agency panel which meets on a regular basis to consider high risk cases (share information, assess risk, develop risk management plans)
Risk Assessment Management Panels	Multi-agency panels established in Victoria which meet on a regular basis to consider high risk cases (share information, assess risk, develop risk management plans)
Support and Safety Hubs	Hubs as recommended by the Victorian Royal Commission into Family Violence, comprising family violence intake and Child FIRST services as a minimum, co-located. Other services may be members of the Hub team or co-located with Hubs.

Reference to hub-like models' is shortened to 'hubs' (i.e., lower case), and reference to Support and Safety Hubs is shortened to 'Hubs' of 'SSH'.

Abbreviations

CAC	Children's Advocacy Center
CCR	Coordinated Community Response
FJC	Family Justice Center
ISR	Integrated Safety Response
MAPPA	Multi Agency Public Protection Arrangements
MAPS	Multi-Agency Protection Service
MARAC	Multi Agency Risk Assessment Committee
MASH	Multi Agency Safeguarding Hubs
MDC	Multi Disciplinary Centre
RAMP	Risk Assessment and Management Panel
RCFV	Royal Commission into Family Violence
SFCU	Safe Families Coordination Unit
SSH	Support and Safety Hub

Executive Summary

In March 2016 the Victorian Royal Commission into Family Violence (RCFV) delivered its report, and made a 227 recommendations. One of the main recommendations was the establishment of Support and Safety Hubs in each of the 17 Victorian Department of Health and Human Services areas. The rationale for the Hubs was based on the Commission's finding that there was inadequate coordination of services for women and children escaping family violence, that family violence services were not adequately assessing and responding to the needs of children, and that children's services (Child FIRST and Integrated Family Services) were not adequately assessing and responding to the needs of families where there was violence. In addition, there was a need to enhance risk management of perpetrators.

The Commission proposed that Support and Safety Hubs would as a minimum, replace the current 23 Child FIRST intake points, the 19 L17 contact points for specialist family violence services and the 20 L17 contact points for men's behaviour change programs.

The Victorian Government has accepted the recommendations of the Commission, and the Department of Premier and Cabinet is responsible for the implementation of the recommendations.

While the Commission's report provides information about many aspects of the proposed Support and Safety Hubs, further work is required to fully design and describe the model. DPC is undertaking a co-design process with the various sectors which are likely to be involved in Support and Safety Hubs (SSHs), with sectors that are likely to have close interface with the Hubs, and with user groups. In addition, DPC is interested in examining models in other jurisdictions which have elements that are similar to the proposed Support and Safety Hubs, particularly where these are considered 'good practice', or where evaluations have shown successful outcomes.

This independent report reviews elements of hub-like models in other jurisdictions. Of particular relevance are hub-like models which have developed in USA and UK over the last 20 years. In the USA, the need for greater coordination between family violence and children's services led to Coordinated Community Responses (CCRs), and subsequent Greenbook Initiatives, followed by Family Justice Centers (FJCs).

Greenbook Initiatives and FJCs have a number of similar elements to those which could be considered for the Support and Safety Hubs. Greenbook Initiatives focus on bringing together the two key partners - domestic violence and children's welfare services..

The FJC model, which has also been established in the UK and other countries, comprises multiple agencies, co-located in major population centres, targeting mainly women and children experiencing domestic violence. FJCs facilitate collaboration and communication between agencies, and offer an accessible and visible 'one stop shop' for victims. There has also been the separate development of Children's Advocacy Centers (CACs) in the USA, which are hubs specifically designed for children who have experienced abuse and neglect. These are similar to the Multi Disciplinary Centres which have been established in Victoria.

In the UK, Multi Agency Safeguarding Hubs (MASHs) have been established, initially for children and young people at risk of abuse and neglect, but some have also been established for adults at risk. These Hubs aim to assess risk to children based on information from multiple agencies, and make referrals to family and other services, including to child protection, if required. The UK also operates Multi-Agency Risk Assessment Conference (MARACs) for victims at high risk of domestic violence (similar to the Risk Assessment and Management Panels in Victoria). UK Police, Probation and Prison Services collaborate to provide Multi Agency Public Protection Arrangements (MAPPAs), in order to protect the community from serious offenders.

There are also examples of hub-like models in other overseas jurisdictions such as New Zealand and Sweden, and multi-agency responses to sharing information and managing serious family violence risk have been established in South Australia (Multi Agency Protection Service, or MAPS) and Tasmania (Safe Families Coordination Unit, or SFCU) in recent years.

Potential key functions of Support and Safety Hubs

Potential key functions for the Hubs (as identified by the author) are outlined below. This draws on elements of the Support and Safety Hubs as proposed by the RCFV or found in hub-like models in other jurisdictions. The identification of these functions informs this review's analysis of hub-like models in other jurisdictions. It does not pre-empt a decision of the Victorian Government about the final form and function of Support and Safety Hubs in Victoria.

The key function of the proposed Support and Safety Hubs as described by the RCFV is to provide intake services for family violence and child and family services. The Royal Commission proposes that the Hubs receive referrals from police (L17), agencies and organisations, friends and family members, and from victims themselves (self-referrals). It proposes that the Hubs assess risks and needs of each referral. In the broader reforms the RCFV proposes, information would be gathered from a Central Information Point, referring agencies, and victims (over the phone, and/or in person). Hubs could also provide a crisis response, and short term case work until victims can be successfully referred to another agency. The RCFV also proposes that the Hubs also take referrals, respond to contacts and respond to men who perpetrate violence.

The proposed intake functions are generally consistent with hub-like models in other jurisdictions, although several models (NZ ISR, MASH, MAPS) provide a two-stage response. The first stage involves information gathering, preliminary risk assessment and triage, followed by referral to appropriate agencies for client follow up, case management, and on-going risk management (ie. the second stage). Hubs such as FJCs are designed to provide intake as well as full range of services ('one stop shop') from the one site.

Membership

The RCFV proposes that the minimum, or 'core' membership of SSHs comprises family violence intake services, and Child FIRST. Other services could be considered as part of the Hubs team or as co-located services including police, health services (including

drug and alcohol services, mental health services), community legal centres, and (some time in the future) Centres Against Sexual Assault. The RCFV recognised that consideration could be given to co-location of these services or to them being part of the Hub team by agreement.

This review of hub-like models reveals a potentially wide membership has been considered in other jurisdictions. Greenbook Initiatives have domestic violence and children's services as a minimum membership, with agreed links to multiple other agencies (ie. part of the virtual hub). Hubs which have direct contact with clients (eg. FJCs) often have a broader membership (usually on-site) and include the broader range of specialist and universal services mentioned by the Commission. In most hubs in the international models examined in this review, police are a key member, and in several hubs police provide a leadership role, because they have developed out of a policy-aim of improving the justice response.

Inclusion for membership in hubs is based on the 'value' to clients, and the 'value' of the member's input to joint risk assessment and risk management. Corrections and education are often 'core' members of hubs. These are not specifically referenced by the Commission as potential members of Support and Safety Hubs.

Co-location

The RCFV proposes that family violence intake services, and Child FIRST be merged, which is likely to imply co-location. The RCFV notes that it may be an option for Victoria Police and other services to also be co-located. A key rationale for bringing the services together is to enhance the assessment of risk of family violence where children are referred to Child FIRST, and to enhance the response to children in families experiencing family violence.

This review of international practice suggests that co-location facilitates agency collaboration (which is essential if organisations are to be merged). Within both the family violence and child protection sectors, multi-agency meetings have been established in order to share private information in a secure environment, make collaborative risk assessment and management decisions within a short time frame (enhanced by the different perspectives), and to provide a co-ordinated multi-disciplinary response, within a shorter time period than would otherwise be the case. Particularly where these meetings are frequent, co-location improves efficiency, and enhances the relationships between agencies.

The international models show that co-location can also provide clients with multiple services on the one site ('one stop shop') providing a more efficient and effective response, especially for women and children in crisis. This was a major rationale for the establishment of Family Justice Centers in the USA. The presence of a number of relevant services on a single site, and the promotion of those services to agencies and the wider community, was also found to have the potential to increase the perceived value, and therefore the demand for hub services.

In several jurisdictions co-location has provided the necessary conditions for accessing, collating and sharing confidential information. In order to comply with privacy legislation, agencies have had to meet together to share confidential information, and

where this is a frequent requirement, co-location was found to be an efficient and effective strategy.

Access

As the proposed primary intake service for family violence and children at risk, it would be essential that Support and Safety Hubs are accessible to women and children. Clear referral pathways to Support and Safety Hubs would need to be developed (in addition to police referrals). Support and Safety Hubs will need to ensure that all agencies, victims and the wider community are aware of the role of Hubs and the assistance which can be provided.

Intake, triage and assessment processes

The RCFV proposes that Support and Safety Hubs undertake intake, triage and risk and needs assessment. This would include information gathering from data bases, referring agencies, and directly from women, children and perpetrators.

Hub-like models arrange intake, triage and assessment activities in various ways. Models which provide direct services to victims (Family Justice Centers and Greenbook Initiatives) have the capacity to contact and engage with victims and perpetrators, and assess risks and needs as part of the initial intake process.

In two stage hub-like models (NZ ISR, SA MAPS, MASH), Stage 1 involves information gathering, preliminary risk assessment, triage and referral, without direct contact with victims or perpetrators. Agencies which accept referrals follow up with contact, engagement and assessment (and subsequent case management, and risk management). Where women and children are assessed to be at high risk, they are referred to a specialist panel or team (MARAC, FJC High Risk Team), which undertakes further specialised risk assessment.

Services provided

Crisis response

The RCFV notes that the Hubs should provide immediate assistance, particularly in response to crisis, and have the capacity to provide access to crisis accommodation and support. This is consistent with hub-like models which provide direct services to women and children (e.g. FJCs and Coordinated Community Responses). In the view of the author, the capacity of a Support and Safety Hubs to provide a crisis response will be essential, given that most police referrals will be the result of a recent incident involving women and/or children. In addition, referrals from other agencies and self-referrals may be the result of recent crises.

Holding capacity

The RCFV recognises that consideration could be given to the capacity for the Support and Safety Hubs to provide an interim (holding) service to support women and children until a successful referral is made to a service for continuing assistance. In hub-like models, this role is often performed by a client Advocate (FJCs, CCRs). These advocates perform a 'key worker' type role, conducting needs and risk assessments, developing safety plans, and making and supporting internal referrals, making external

referrals and providing short term interim support (ie. 'compressed' case management).

Outreach support

The RCFV states that outreach assessment and support will be required for a proportion of clients. Most hub-like models do not include an intake service which provides outreach to victims in the community, but rather they rely on outreach workers in domestic violence agencies to provide this role.

Early intervention

The bringing together of family violence intake and Child FIRST, and the provision of sufficient 'downstream' resources to free up service capacity proposed by the RCFV is expected to provide an enhanced early intervention focus. The RCFV expects that SSHs would enhance early intervention capacity, through the investment in 'downstream' services enabling flow through of clients; information sharing leading to enhanced identification of family violence; increased self referral due to the visibility and accessibility of SSHs; enhanced practices of referring agencies; and enhanced outreach services.

Early intervention is a key aim of most of the hub-like models, including Family Justice Centers, MASHs, and CACs. One of the aims of FJCs is to facilitate and promote access to information and services for women who have had little or no contact with domestic violence services.

Brokerage

The RCFV notes that SSHs should have brokerage/flexible funds. Hubs such as FJCs are able to access funds for temporary assistance for women escaping domestic Violence. Review of hub-like models affirms that having brokerage funds contributes to the effectiveness of these models.

Referral to other agencies

The RCFV highlights the importance of an effective referral mechanism for SSHs, including noting the potential capacity of intake teams to book assessed clients into services such as specialist family violence services, Integrated Family Services and perpetrator programs. In hub-like models such as FJCs and CCRs, Advocates have the capacity to refer clients straight into required services, without re-assessment. Where hubs include housing (short term and transitional) services as partners, Advocates can book clients into accommodation and support services.

Referral of clients to other agencies would be a major role of the proposed SSHs as envisaged by the RCFV. It will be important to establish referral protocols to ensure that clients receive required services and accommodation (as required) as soon as possible, and in accordance with their circumstances.

Staffing

The RCFV proposes that Support and Safety Hubs compromise intake teams, a family violence advanced practitioner, a community based child protection worker, the

RAMP Coordinator, and possibly a police member(s). In addition a navigator function is canvassed in commentary.

Hub-like models demonstrate that staffing structures depend on the role of the hub, co-location arrangements and other factors. Where many key member agencies are co-located, the majority of staff in Hub-like models are re-located from existing agencies, and include intake workers, and Advocates (who provide assessment, support, and other navigation functions), as well as various professional staff from other core member agencies. In smaller hubs the advocacy role or navigation function may be combined with intake.

Hub-like models also include staff responsible for management and administration of facilities, and coordination of services. Management and administration may be undertaken by an auspicing or 'landlord' agency, depending on local arrangements. Service coordination may include administering collaborative partnership agreements, ensuring effective internal and external referrals and communications, multi-agency team building, monitoring of progress, and ensuring accountability. Some hubs (eg. FJCs) include suitably trained volunteer staff, and include volunteer coordinators in larger hubs.

The Advocate position is found in several hub-like models including CCRs, FJCs, NZ ISR and MASHs. The role depends on the length of support, and how quickly clients are referred on to family violence and other services. In models where co-location is minimal, the Advocate position is required to develop victim safety plans, arrange access to agencies, and coordinate agencies' services.

Funding

The RCFV recommends that Support and Safety Hubs are funded for appropriate infrastructure, the establishment of integrated intake teams, an advanced family violence practitioner, capacity for an after-hours face-to-face response, and provision of secondary consultation. Funding is also recommended to increase capacity across specialist family violence services, Integrated Family Services, and for men's services.

A review of hub-like models indicates that additional funds are generally not required for re-located staff, but are required for new staff. Where hubs are located in new and separate premises, new hub management and administration staff may be required, and new service coordination positions are also required in larger hubs.

The review of hub-like models (FJCs, MASH) indicates that funding may also be required for establishment which may include construction of new premises, or renovation and fit out of existing premises.

Various arrangements apply to operating costs. For example, the operating costs of FJCs may be absorbed by the City, the Justice Department or the organisation which owns and operates the building in which the Hub is located. Hubs are generally funded by State and Federal governments, by recurrent and Grant funds. In the USA FJCs rely on Grant funding, and have specialist staff to write grant applications. FJCs also rely on donations.

Promotion

Hubs which have contact with clients are promoted through websites, community based agencies, and with potential referring agencies. Some hubs (eg. FJCs) rely on community donations, and are therefore actively engaged in raising the profile of the hub. Awareness raising and promoting the hub as a 'one stop shop' are important early intervention strategies.

Concluding comments

The review of hub-like models in other jurisdictions reinforces the strong evidential basis for the recommendations of the RCFV. It also highlights key issues for consideration in the design of the proposed SSHs in Victoria:

- The number of services which will be co-located at SSHs
- The way in which Victoria Police will be incorporated into the SSHs
- The way in which Corrections and Education and other agencies will be incorporated into the SSHs
- The role of an advocate or navigation functions
- Daily management of hubs, including service coordination
- The accountability framework including governance, management responsibilities, and IT systems which enable progress to be monitored
- The role of SSHs in relation to perpetrators

OVERVIEW OF HUB-LIKE MODELS

In February 2015 the Victorian Government established the Royal Commission into Family Violence (RCFV). The RCFV was established in the wake of a series of family violence related deaths in Victoria. The Commission's task was to identify the most effective ways to:

- prevent family violence

- improve early intervention

- support victims

- make perpetrators more accountable

- develop and refine systemic responses to family violence

- better coordinate community and government responses to family violence

- evaluate and measure the success of strategies, frameworks, policies, programs and services introduced to put a stop to family violence.

The RCFV tabled its report in March 2016. The RCFV identified a number of current activities and initiatives in Victoria which provided a strong foundation for further development. Importantly, a number of system limitations were also identified including:

- an overwhelming level of demand being experienced by services

- a lack of targeted resources to meet the specific needs of children and young people who have experienced family violence

- a lack of coordination of services for victims

- inadequate efforts at holding perpetrators accountable

- inadequate methods for sharing information between agencies about perpetrator risk

- too little effort on prevention and early intervention

- lack of awareness of services (women do not know where to go for help, and universal service providers do not know where to refer women who disclose family violence)

- a complex system which women find difficult to navigate, particularly in regional and rural areas, with women having to travel to multiple services

- multiple possible entry points to the family violence service system, including 23 Child FIRST, 19 specialist family violence services and 20 L17 referral points for men's behaviour change programs

- a lack of coordination between Integrated Family Services and specialist family violence services[1]

The Commission made 227 recommendations. The Victorian Government has accepted all the recommendations of the RCFV. One of the major recommendations of the Commission was the establishment of Safety and Support Hubs in each of the 17 DHHS areas.

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[1]   RCFV (2016:264-265)

The Royal Commission recommended that:[2]

The Victorian Government introduce Support and Safety Hubs in each of the State's 17 Department of health and Human Services areas. These Hubs should be accessible and safe locations that:

- *receive Police referrals (L17 forms) for victims and perpetrators, referrals from non-family violence services and self-referrals, including from family and friends*
- *provide a single, area based entry point into local specialist family violence services, perpetrator programs and Integrated Family Services and link people to other support services*
- *perform risk and needs assessments and safety planning using information provided by the recommended statewide Central Information Point*
- *provide prompt access to the local Risk Assessment and Management Panel*
- *provide direct assistance until the victim, perpetrator and any children are linked with services for longer term support*
- *book victims into emergency accommodation and facilitate their placement in crisis accommodation*
- *provide secondary consultation services to universal or non family violence services*
- *offer a basis for co-location of other services likely to be required by victims and any children*

This report

The Department of Premier and Cabinet (DPC) has overarching responsibility for progressing the recommendations of the RCFV, including the design of the Support and Safety Hubs. DPC has embarked upon a co-design process, involving consultation with relevant sectors and users across Victoria, focusing on the recommendations of the RCFV. To support the co-design process, DPC has commissioned this independent research to identify and review models in various jurisdictions, which may have similar elements to the recommended Support and Safety Hubs.

The purpose of this report is to provide DPC with information on models in other jurisdictions which are similar to the proposed Support and Safety Hubs, and to assess their functionality, design, and best practice elements and their applicability to Support and Safety Hubs. This will help inform the design and delivery of Support and Safety Hubs.

This report provides a description of Hub-like models in Australia and overseas, and identifies various elements that underpin their operation.

Selection of hub-like models

The RCFV concept of Support and Safety Hubs provides a basis for identifying and reviewing hub-like service delivery models in other jurisdictions. Hubs were chosen for review on the basis that they include a number of the following characteristics:

a)   a key focus on family violence

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[2]   RCFV (2016) Recommendation 37

b)   a key focus on children at risk due to family violence, abuse or neglect

c)   a central point of referral which includes intake, initial assessment and triage (decision making) involving multiple agencies

d)   capacity to provide immediate crisis support, for women and children, and an immediate response to men who use violence

e)   risk assessment and management (multi-agency decision making, safety planning, and agency action plans)

f)   sharing of information between agencies, including family violence and children's agencies, and possibly police

g)   co-located services where information and joint decision making can occur quickly and efficiently

h)   co-located services where victims can readily access a range of services, and

i)   coordinated service delivery and monitoring.

A number of hub-like models are identified:

- Coordinated Community Responses (US)
- Greenbook Initiatives and related service models (US)
- Family Justice Centres (US)
- Multi-Agency Support Hubs (UK)
- Multi Agency Public Protection Arrangements (UK)
- Children's Advocacy Centres (US)
- Karin Project (Sweden)
- Integrated Safety Response (Pilot) New Zealand
- Australian hub-like models (South Australia and Tasmania)

The tables and charts on the following pages summarise each of the models – which are described in detail in the Appendix – according to the following:

- Function of the hub (Table 1)
- Partner agencies and organisations (Table 2)
- Arrangements of intake, triage and assessment (Chart 1).

Table 1: Main functions of selected Hubs

Function	Greenbook/ CCRs	FJCs	MASHs	CACs
Target group	Women and children escaping family violence	Women and children escaping family violence	Children and young people who have experienced neglect and abuse	Children who have experienced abuse and neglect
Intake	Intake workers in domestic violence services receive referrals from CCR partners, others and self-referrals	Intake workers in FJCs take referrals from police. Family violence victims can telephone for an appointment, or drop in.	Intake workers take referrals ('enquiries') from a range of organisations which are notifying concerns about children	Intake workers take referrals for children from a wide range of agencies, and intake workers may conduct a preliminary investigation
Capacity for clients to access hub directly	Clients can visit CCR partners without an appointment	Clients can visit FJCs without an appointment	Referral only	Referral, and/ or appointment is required
Information gathering and sharing	Case coordinator gathers relevant information	Information is shared between partner agencies only	Information is gathered, and shared within the hub, but kept confidential from external agencies	Information is shared within the multidisciplinary team. Information is gathered including through forensic interview with children
Triage and prioritisation of cases	Case coordinator undertakes triage	No. However intake workers do encourage victims to make appointments in order to manage demand	Yes, rating assigned according to urgency	No
Advocate role	Provided by case coordinator	Advocate/ negotiator	No advocate involved within the MASH	Victim (children's) advocates are provided if required
Crisis response	Yes, provided by individual agencies coordinating their efforts	Yes, provided by the Hub	Not provided by the Hub	Yes, if required
Risk and needs assessment	Yes, undertaken by family violence and children's services	Yes, undertaken by the advocate	Yes. Review of initial triage, additional information, decision about referral	Yes, assessment of past harm, and potential future harm to children
Risk and needs analysis and decision making	Yes, initially undertaken by case coordinator	Yes. Undertaken by the advocate for low to moderate risks, and by	Yes, a primary function of the Hub	Yes, undertaken by multi-disciplinary team

		the High Risk Team for high risks		

Table 1:   Main functions of selected Hubs (cont.)

Function	Greenbook/ CCRs	FJCs	MASHs	CACs
Safety and action planning	Yes, undertaken by family violence and children's services	Yes, undertaken by the advocate for low to moderate risks, and by the High Risk Team for high risks	Yes	Yes
Case co-ordination (interim)	Yes, undertaken by the Advocate	Yes, undertaken by the Advocate	Yes	Yes, eg. victim advocate
Referral	Yes, undertaken by the Advocate, and by individual agencies in the CCR	Yes. Many relevant services are on-site, otherwise victims are referred to external agencies	Yes	Yes. Some services (medical, mental health) are available on site. Other services (therapeutic) are on site and off site
Material aid and brokerage	Yes	Yes. Some FJCs include shops which sell clothing and essential items	No	No
Case follow up	Yes	Yes	Yes	Yes
Community education/ prevention	Yes	Yes. FJCs have community outreach workers		Yes
Secondary consultation	Yes	Yes	Yes	Yes

Table 1:   Main functions of selected Hubs (cont)

Function	NZ ISR Pilots	SA MAPs	MAPPA (UK)	High Risk Teams (generic)
Target group	Women and children escaping family violence (Christchurch, and Waikato)	Women and children escaping family violence (whole State)	Violent and sexual offenders who pose a potential risk to the public, including victims of family violence	Women and children escaping family violence, who are at high risk of death or serious injury
Intake	Centralised intake - referrals from Police and some Corrections, only for family violence	Centralised intake – referrals from police family violence reports	Undertaken by MAPPA (Police, Probation and Prison Services	Intake involves screening for 'high risk'
Capacity for clients to access hub directly	Cannot access services at Centralised intake	Cannot access services at Centralised intake	Cannot access services directly	Client do not (usually) attend High Risk team meetings
Information gathering and sharing	Information requests sent to selected agencies	Information sought from databases for medium and high risk cases	Information is pooled by the 3 partner agencies and additional information is sought	Information is shared within the high risk team
Triage and prioritisation of cases	Safety Assessment Meetings (daily) perform triage	Daily triage meetings	Yes, three categories of dangerousness	No triage. All cases referred are given consideration
Advocate role / service navigation	Independent Victim Specialists provide an Advocate service for high risk clients	No	No, individual agencies assume case management responsibility	High risk teams ensure that the victim has a case manager, or an advocate (eg. IDVA)
Crisis response	Provided by family violence services, including IVS for high risk clients	Provided by FSMs and family violence services	Not by MAPPA, but individual member agencies (eg. Police) respond	Yes. members of the team are involved in providing a response.
Risk and needs assessment	Undertaken by SAM, with further assessment undertaken by family violence services following engagement	Undertaken by the MAPS, with further assessment at local level by FSMs (high risk clients) and individual agencies	Formal process undertaken by MAPPA	Yes, main focus is on risk assessment
Analysis and decision making	Triage only by SAM, further analysis and decision making by family violence and other	Triage only by MAPs, further analysis and decision making by FSMs (high risk clients) and	Formal process undertaken by MAPPA, with focus on risk management	Yes, collaborative and creative decision making is essential

	agencies	family violence agencies		

Table 1a: Main functions of selected Hubs (cont.)

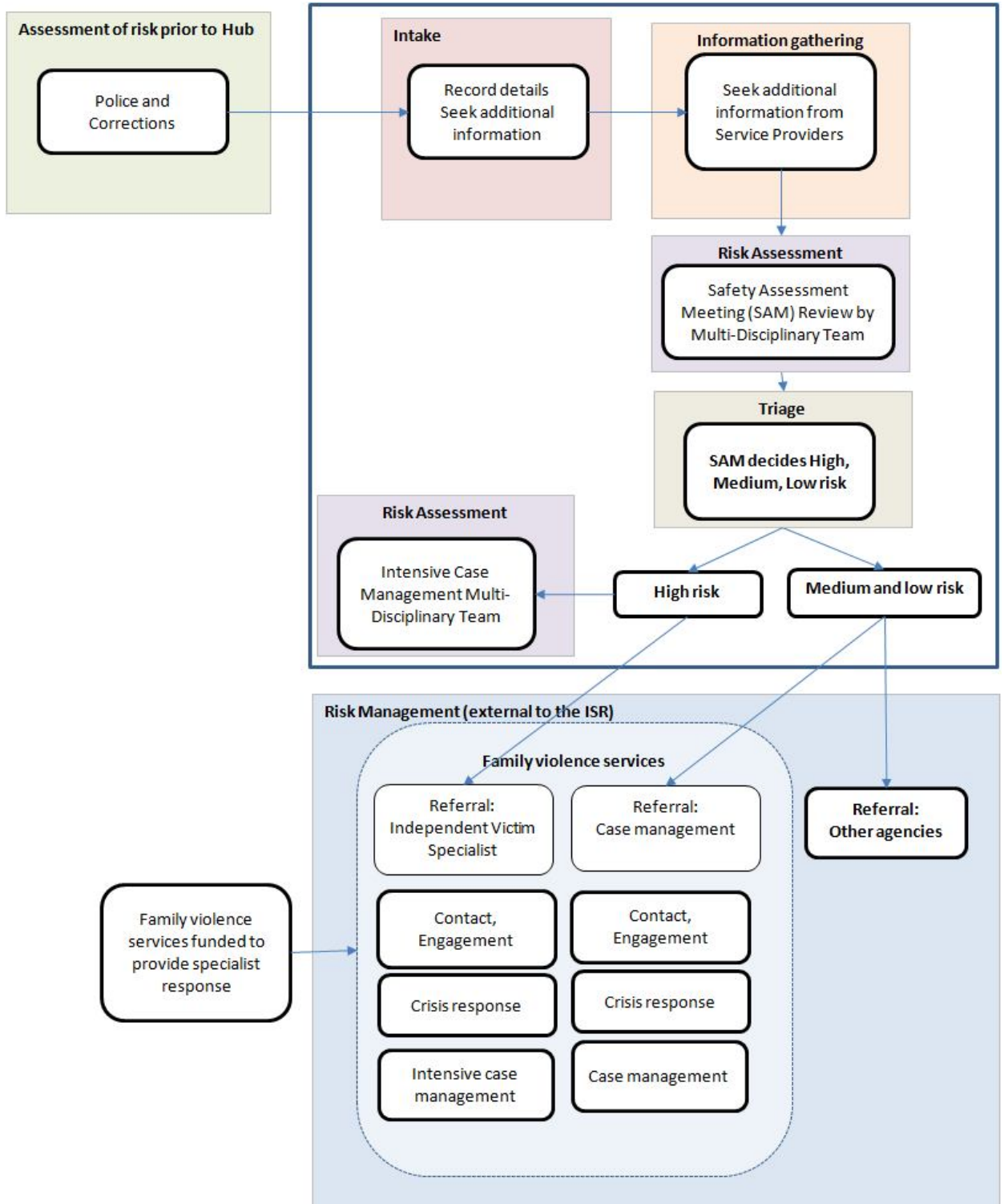| Function	NZ ISR Pilots	SA MAPs	MAPPA	High Risk Teams (generic)
Safety and action planning	Initial plan undertaken by SAM. Further safety and action plan undertaken by family violence agencies. For high risk cases weekly multi-agency Intensive Case Management meetings are held, updating safety and action plans, and allocating responsibilities	Undertaken by family violence agencies. For high risk cases weekly multi-agency Intensive Case Management meetings are held, updating safety and action plans, and allocating responsibilities	Undertaken by MAPPA, there are three levels of risk management	Yes
Case co-ordination (interim)	Undertaken by family violence agencies (including the IVS for high risk cases)	Undertaken by family violence agencies	Undertaken by individual agencies (ie. Police, Probation, or Prison Services	Yes. The high risk team agrees on, and take responsibility for implementing actions. The victim's case manager also coordinates
Referral	SAM makes referrals to family violence and other agencies	MAPs makes referrals to Family Safety Meetings (high risk clients), family violence other agencies	MAPP refers Offenders to various agencies	Yes
Material aid and brokerage	Yes, linked to IVS workers	No	No	Yes
Case follow up	Yes, provided by IVS, and weekly ICM meetings	Yes, via FSMs	MAPPs monitor and review Offenders on a regular basis, depending on the level of risk	Yes
Community education/ prevention	Yes	Yes, at FSM level	No	Not a major role
Secondary consultation	Yes, at agency level by IVS workers	No	No	No

Table 2: Key partners in selected Hubs

Organisation	Greenbook/ CCRs	FJCs	MASHs	CACs
Family violence agencies	Yes	Yes, co-located	IDVA (some)	Advocate (some)
Children's welfare services	Yes	Yes, co-located	Yes, co-located	Yes, co-located
Child Protection	No	No	No	No
Police	Yes	Yes, co-located	Yes, co-located	Yes, co-located
Corrections/ Probation		Yes	Yes, virtual	Some
Health	Yes	Yes	Yes, co-located	Yes
Mental health		Some	Yes	Some
Education	Yes	Some	Yes	
Legal services	Yes	Yes, co-located		
Financial services		Some		
Housing	Yes	Some		
Victim advocate	Yes	Yes		Yes
Prosecution		Yes, co-located		Yes
Sexual Assault services		Yes		Yes

Table 2:   Key partners in selected Hubs (cont.)

Organisation	NZ ISR Pilots	SA MAPs	MAPPA	High Risk Teams (generic)
Family violence agencies	Yes	Yes, virtual		Yes
Children's welfare services	Yes	Yes, virtual		Yes
Child Protection				
Police	Yes	Yes	Yes	Yes
Corrections/ Probation	Yes	Yes	Yes	Yes
Health	Yes	Yes		Yes
Mental health				
Education				
Legal services				Yes
Financial services				
Housing		Yes, virtual		Yes
Victim advocate	Yes			
Prosecution				
Sexual Assault services				

Chart 1.1: ISR Pilots (New Zealand)

Chart 1.2: Multi-Agency Safeguarding Hubs

Assessment of risk prior to MASH

- Police and other agencies

Intake

- Accept referral (feed into IT system)

Triage

- Initial triage to establish urgency, and priority

Information gathering

- Seek additional information from Service Providers

Risk Assessment

- Review by MASH Conference, or Practice Manager

Risk Management

- Referral and Guidance to response teams and agencies

Risk Management (external to the MASH)

- MARAC (high risk domestic violence)
- Children's and family services
- Family violence services
- Child protection
- Other agencies

Assessment of risk prior to MAPS

Police (provide a risk score)

Intake

Accept referral (feed into IT system)

Triage

Initial risk assessment High, medium, low risk

Low risk score

Information gathering

High and medium risk scores

Further research and additional information from Service Providers

Risk Assessment

Review by Multi-Disciplinary Team

Low and Medium risk

High risk

Risk Management (external to the MAPS)

Family violence services

Referral: Case management

Contact

Engagement

Crisis response

Case management

Referral: Other agencies

Referral: Family Safety Meetings

Chart 1.3:   Multi Agency Protection Service (South Australia)

Chart 1.4:   Family Justice Centers

Assessment of risk prior to Hub

Referring agencies

Intake

Record details on intake form, screening

Information gathering

Interview with victim, additional information from Service Providers

Risk Assessment

Safety Planning

Triage

Level of risk identified

Risk Management within FJC

Referral to Multi-Disciplinary Team

High risk

Low and medium risk

Referral to on-site services

Risk Management (external to the FJC

Case management, other services

APPENDIX

This appendix provides a detailed summary of the identified hub-like models This appendix provides a detailed summary of the identified hub-like models according to the framework outlined in Table A. The framework comprises 20 parameters. These are selected based on the applied by the RCFV, as well as the parameters commonly identified in other hub-like models. This framework was used to describe each of the selected hub-like models, however not all descriptions of hub-like models in the Appendix include information for each parameter.

Table A: Framework for assessing hub-like models

Parameter	Key issues
Background	What is the background or history to the development of this type of Hub? How and why did the Hub-like model develop? How is the Hub 'authorised' (eg. government policy and program frameworks, legislation, etc.)?
Aims/ scope and principles of operation	What are the aims of, or the rationale for the Hub? Who are the target groups, what is the scope? What are the principles on which hubs operate, and which underpin best practice?
Functions of the Hub	What are the functions of the Hub? Which of these functions are collaborative? Which are undertaken by individual agencies?
Partner agencies and organisations	In the context of the aims of the Hubs, which agencies are essential partners in the Hub? Are there 'core' and 'non-core' partners?
Co-location of services	Which agencies are co-located to form the Hub (on-site partners)? Which agencies participate in the Hub, but are not necessarily co-located (off-site partners)? Where and how is the Hub physically located? Are agencies co-located all the time, or on a sessional basis? How does the physical location influence the services provided by the Hub? What are the benefits of co-location?
Access (referrals to the Hub)	How do people access the Hub and its services? What are the referral sources (i.e. which agencies, self-referral)?
After hours arrangements	What are the arrangements for the Hub after hours (if any)?
Intake processes	What are the intake processes employed by the Hub? How do these processes differ according to the source of

	referral?
Assessment processes	How are risks and needs of clients assessed by the Hub?
	What are the sources of information accessed by the Hub to inform the assessment?
	Who undertakes assessments (of women, children, and men)?
	How does the Hub provide 'early intervention' services?
	What assessment tools are used by the Hub?
	How are the tools used within the processes for assessing risk and needs
Services for clients	What services does the Hub provide for clients?
Information management	How does the Hub obtain information?
	How is information processed and shared within the Hub?
	What information is recorded by the Hub?
	How does the Hub manage information to ensure confidentiality?
	How are the IT systems of Hub partners linked?
	What Agreement(s) exist covering information management?
Staffing of Hubs	What are the staffing arrangements for the Hub?
Management and governance	What are the governance structures?
	Who is responsible for managing the Hub operations (eg. Operations manager/ Admin Manager)?
	Who is responsible for oversight of the Hub (eg. Board, Committee of Management)?
	To whom are agencies participating in the Hub accountable?
	How is the performance of the Hub monitored (performance measurement, KPIs)?
Funding of Hubs	How is Hub-like model funded
	What are the funds used for?
Links to multi-agency initiatives	What other multi-agency initiatives are important/ relevant to the Hub's client group
	What is the relationship of the Hub to other multi-agency initiatives?
Visibility and 'promotion'	What is the intended 'visibility' of the Hub?
	How does the Hub make itself visible?
	What is the intended perception, and emphasis? Eg.
	- 'One stop shop' for women and children
	- Safety and support (with no expectations)
	- Legal/ justice (expectation of Police and/ or Court

	involvement) - Information processing/ value adding for enhanced professional decision making
Outcomes for clients	What are the expected outcomes for the Hub?
Benefits/ impacts	What are the benefits to the service system?
Evaluations of the Hub	What do the evaluations say about the Hub-like model? How rigorous are the evaluations?
Potential relevance to Victoria	What aspects of the hub-like model are consistent with what the RCFV proposed for Support and Safety Hubs in Victoria? What aspects are not relevant, or do not align with Support and Safety Hubs as proposed by the RCFV? What elements of hub-like models work well? Recognising the different cultural and systemic contexts within other jurisdictions, what aspects might be relevant to be considered for Support and Safety Hubs?

1 COORDINATED COMMUNITY RESPONSES

1.1 Background

Coordinated Community Responses (CCR) involve a network of key participating agencies, which share information and work together to help ensure the safety of women and children who are victims of domestic violence and sexual abuse. The original Coordinated Community Responses did not involve a central 'hub' where multiple agencies were located. Family Justice Centers (a particular form of CCR) were established in the mid 2000s to address some of the shortcomings of CCRs (see Section 5).

CCRs were formally established to better coordinate existing resources for victims of intimate partner violence, to maximize their effectiveness and efficiency, and to avoid duplication. CCRs were expected to enhance safety for women and children, and reduce the number of times women and children would need to visit/ contact services, thus avoiding frustration, and fatigue (and returning to the abusive partner).

The Duluth Domestic Abuse Intervention Project (DAIP) of the 1970s is considered by many to be the first Coordinated Community Response model for women and children. The DAIP has two distinct aspects - the Coordinated Community Response and the "Duluth Model" offender education program.

The 1994 Violence Against Women Act (VAWA) established Coordinated Community Responses as part of US government policy, and federal and state government support became contingent upon domestic violence initiatives being able to demonstrate a CCR. CCRs are generally based on the Duluth model, and have been established according to local circumstances.

The main methods of coordination include:
- Oversight by a representative Coordinating Council, and sub-committees/ working groups, together with MoUs and operating guidelines for the CCR
- Case managers working as client advocates to provide case coordination and ensure that individual clients are able to access various services.
- Inter-agency referrals (supported by protocols)
- Agreed assessment frameworks between agencies
- Joint training of service delivery staff

Coordinating Councils meet on a regular basis to provide oversight, and to foster broader social and policy changes. These include:

- Criminal Justice system reform projects - system wide changes led by police, probation or the judiciary, for example, pro-arrest policies, vigorous prosecution, and supervised probation that includes men participating in behaviour change and treatment programs.

- Community intervention and prevention projects - projects driven by the community sector to reform, improve and coordinate institutional responses to domestic violence within the community. Prevention efforts include educational media health campaigns, in-school programming and parenting

programs to increase awareness of Intimate Partner Violence and its consequences, media messages and school interventions.

Case managers working as advocates are fundamentally important to the success of CCRs. The advocate engages and works closely with the victim, helping her make decisions which will keep her and her children safe, and facilitating access to required services.

CCRs were also supported by the US government to provide an early intervention response through the DELTA program (2002) and DELTA PREP (2007), funded by the Center for Disease Control.[3]

1.2   Aims

CCRs were developed based on the premise that changes were needed to improve the safety and service responses to women and children at the local community level, with enhanced access to services. The aims of CCRs were to:

- Increase opportunities for assistance to women and children, through direct and indirect services
- Improve the efficiency and effectiveness of the service system
- Develop primary and secondary prevention initiatives that would change community attitudes and beliefs about Intimate Partner Violence
- Increase accountability for perpetrators.

1.3   Functions of CCRs

CCRs coordinate and implement a range of activities. Most of these activities involve the following services for victims:

- hot-lines, and emergency call responses
- police attendance at incidents, with referral of the victim to shelters
- intake by emergency shelters
- advocacy support
- short term housing, and transitional housing
- legal services
- support groups
- group and individual counseling
- medical services
- children's services, including education
- child care.

In addition, CCRs invest resources in training, workshops, and conferences to increase awareness and referrals, improve criminal justice policies and practices, and to better coordinate services to victims and their families. CCRs also promote stronger responses to perpetrators associated with police adopting pro-arrest policies, pro-active prosecution, and encouraging victims to proceed with protection orders.

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[3]   An evaluation of DELTA PREP is provided by Freire et. al. (2015)

1.4   Partner agencies and organisations

CCRs commonly involve the following agencies:
- Police
- Legal services
- Social service providers (advocates, domestic violence support, housing, etc.)
- Government services
- Health services
- Educational providers

1.5   Co-location of services

CCRs comprise a network of existing services and do not generally involve co-location.[4] Coordination provided by the network is intended to reduce the number of times women tell their story, and reduce the amount of time and effort involved in accessing required services.

Members of CCRs meet regularly to discuss cases (ie. case coordination meetings). These meetings tend to focus on high risk cases.

1.6   Access (referral to CCRs)

CCRs have multiple entry points. Where violence is identified by Police, or an agency, or women self refer, the 'first to know' agency makes a referral to other service providers, which most commonly includes domestic violence services.

A common process is:
- Police attend a domestic violence incident, and file a report, and refer the victim to a domestic violence service
- Police take appropriate action in relation to the perpetrator
- Police notify the domestic violence service
- The domestic violence service contacts the victim, undertakes a preliminary assessment over the phone
- Police distribute information to members of the network.

1.7   After hours arrangements

CCRs assist women and children after hours (usually domestic violence shelters).

1.8   Intake processes

'Intake' into the CCR is mainly undertaken by domestic violence services. These services provide on-site and outreach responses to women and children, including information on the domestic violence and shelter services, protection orders, court processes, etc. If women want to be assisted, a comprehensive assessment is undertaken.

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[4]   Family Justice Centers are one form of a CCR, and are discussed separately in section 5.

1.9   Assessment processes

A comprehensive assessment of risk and needs is undertaken by an advocate. This may result in progressing a Court order, arranging referrals to various services in the network, and completing a safety plan.

1.10 Services for clients

Advocates help victims obtain services from other parts of the CCR system (eg. legal services, health care), and assist with access to various local services which can meet identified needs such as housing, education, counseling, financial planning, and job placement.[5] Advocates provide women with necessary help to progress orders of protection, filing criminal charges against the perpetrator, and court attendance.

The following range of services available through CCRs and considered essential:[6]

- Criminal Justice System (police, and other officers who assist women in making applications for orders).
- Child services (including services in shelters).
- Health care (hospitals, and community health providers).
- Counselling (in shelters, community health centres, private practice)
- Vocational and employment assistance.

1.11 Information management

Member agencies maintain their own information recording and storage systems. Information is shared within the CCR network to ensure that member agencies are kept up to date with actions, and changing circumstances.

Maintaining confidentiality is a challenge for CCRs, especially as there is variation in privacy legislation across jurisdictions in the USA (ie. States).[7]

1.12 Staffing

Coordinated Community Responses involve existing staff in various agencies. There are generally no additional funded staff required to operate the CCR. There may be a change in emphasis of case management roles to ensure coordination and advocacy. Advocates need to be able to engage with victims, and work closely with them, and at the same time have the capacity to facilitate access to required services across several service systems (criminal justice, family violence, child protection, education, health).[8]

1.13 Management and governance

Agency staff are responsible, and report to their own organisation.

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5   Salazar, Emshoff, Baker, & Crowley (2007)
6   Shorey et al. (2014)
7   See for example, Murphy (2011)
8   The role of the CCR Advocate is explored by Shorey et. al. (2014), Murphy (2011), and Bybee and Sullivan (2002)

CCRs are overseen by Coordinating Councils or Committees. Councils comprise representatives from domestic violence agencies and other organisations.[9] The role of Coordinating Councils is to oversee and assess the legal/justice and social response, policy development, and planning. There are usually sub-committees focusing on different aspects of the community response – accommodation and support services; health and medical services; child abuse/domestic violence collaboration; groups (ie. ethnic) groups; law enforcement; education and prevention.

1.14 Funding

CCRs have been supported by a number of grant programs (eg. Violence Against Women), and pilot projects.

1.15 Links to multi-agency initiatives

CCRs are often linked to multi-agency responses to sexual assault.

1.16 Visibility and promotion

CCRs are promoted within communities, and to agencies and professional who may be in contact with women and children experiencing domestic violence.

1.17 Evaluation

There have been five major demonstration programs, and several reviews have been undertaken, as shown in Table 4.1.

Table 1.1: Demonstration projects and review

Demonstration programs	Reviews
Support for CCRs through the Service, Training, Officers, Prosecutors (STOP) Violence Against Women Formula Grant Program	Burt et al., 2001
15 larger scale community coordination efforts in the President's Family Justice Center Initiative	Townsend, Hunt, and Rhodes, 2005
Judicial Oversight Demonstration program	Visher et al. 2008
10 CCR projects sponsored by the Centers for Disease Control and Prevention (CDC) . This was expanded in 2002 as the Domestic Violence Prevention Enhancement and Leadership Through Alliance Program (DELTA).	Klevens et al., 2008 Post et al., 2008
Greenbook Initiative (see Section 4 below)	Edleson and Malik, 2008

According to Garner and Maxwell (2008) evaluations of CCRs as shown in Table 3.1, are inconclusive:

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[9]   See for example Allen and Hagen (2003)

Three of these large-scale coordinated community response demonstration programs provide no direct assessment of the effects of coordination on repeat offending. Two of them (Burt et al., 2001; Edleson and Malik, 2008) describe variation of coordination in demonstration sites, but they do not compare coordinated and uncoordinated jurisdictions and they provide no systematic comparison of repeat offending.

The two demonstrations (Post et al., 2008; Visher et al., 2008) with evaluation designs that (1) provide some measures of coordination, (2) report repeat offending, and (3) compare coordinated with non-coordinated jurisdictions are, for the foreseeable future, the primary bases for assessing whether coordinated responses improve the safety of women. However the evidence from these two evaluations reports little or no difference in the rates of intimate partner violence between coordinated and comparison jurisdictions

Evaluations have also been conducted on the effectiveness of some components of the CCR (Shorey et. al., 2014). Evaluations of the advocacy component in particular have demonstrated the value of CCR, at least in the short to medium term.[10]

Communities that have developed CCRs have laid the foundation for establishing FJCs. By co-locating all the partners in a CCR model, FJCs can magnify the benefits of coordination while making it easier for victims to obtain the services they need. Many FJCs have effectively established Greenbook initiatives on-site where they bring child welfare professionals into the FJC (or when FJCs co-locate with child welfare agencies). For example, the Nampa FJC has included child welfare professionals and has become a certified Child Advocacy Center (see section 6). FJCs have provided a way of applying the principles of the Greenbook Initiative in dealing with the co-occurrence of child abuse and domestic violence.

1.18 Outcomes for clients

Evaluations of CCRs (see table 1.1) have not clearly demonstrated enhanced outcomes for clients (Klevens and Cox, Garner and Maxwell (2008). Most recently Shorey et al. (2014) note that is evidence that the Advocacy and Counselling service components of CCRs are effective in assisting women and children to access services. However, there is less evidence for the effectiveness of criminal justice (ie. perpetrator accountability and reduced recidivism), and they note:

"There is a dearth of research examining the impact that educational, vocational, media, healthcare, and child services have on the safety and well being of abused women, a notable limitation in providing effective services to victims." (Shorey et al. 2008:12).

The authors also note the lack of evidence on the effectiveness of the CCR system and the interrelations and processes between CCR components.

1.19 Benefits/ impacts

The common view is that CCRs have increased opportunities for assistance to women and children, through direct and indirect services, but that CCRs do not 'go far

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[10]   See Shorey et. Al. (2014:8); Bybee and Sullivan (2002)

enough'. There is also the perception that CCRs have improve the efficiency and effectiveness of the service system, and have developed prevention initiatives. However, these views are not supported by a research base. It does not appear that CCRs have increased accountability for perpetrators.

1.20 Greenbook initiatives

In 1999 the US National Council of Juvenile and Family Court Judges published *Effective Intervention in Domestic Violence and Child maltreatment Cases: Guidelines for Policy and Practice.* This became known as the 'Greenbook'. The Guidelines described how the domestic violence system, child welfare services and the Courts should respond to families experiencing family violence and child maltreatment.

The Greenbook Initiative sought to apply the principles of CCRs to interactions between the courts, child welfare agencies, and domestic violence agencies, with the specific aim of enhancing responses to children experiencing domestic violence. Six demonstration projects were funded for 5 years. Greenbook initiatives are based on:

- a collaborative approach between independent agencies (particularly domestic violence and children's welfare agencies)
- training for domestic violence workers and child welfare workers
- domestic violence specialists working closely with child welfare agencies, and vice versa
- appropriate tools, protocols and guidelines for child welfare workers to screen for domestic violence
- child welfare agencies developing safety plans which include domestic violence
- increased entry points for families experiencing violence, including child welfare agencies
- differentiated responses to domestic violence and child maltreatment, depending on families' needs (ie. those cases where there is a great danger to children are referred to child protection, other cases are referred to children's welfare agencies and family services
- changes to perspectives to reduce blaming of adult victims (ie. for poor parenting).

The Greenbook demonstration projects have been evaluated.[11] Analyses of the Greenbook Initiatives identify a number of benefits from collaboration. The original Greenbook, and the funded demonstration projects increased awareness of the need for significantly improved responses to women and children by both the family violence and children's welfare sectors.

However several Greenbook sites struggled to fully establish the Initiatives, and some analyses considered that child welfare agencies failed to fully understand domestic violence, and have not yielded sufficient benefits.[12]

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[11] See ICF International (2008) *The Greenbook Initiative Final Evaluation Report*; also various articles in the *Journal of Interpersonal Violence* Vol. 23, No. 7.

[12] Kennedy (2013)

Some Greenbook initiatives resulted in domestic violence advocates being co-located in child protection services, for example in the States of Washington,[13] of New York.[14]

Further encouragement and stimulus for a more coordinated approach resulted from 2010 amendments to the US Child Abuse Prevention and Treatment Act (CAPTA), which included grant monies for domestic violence services to address the needs of children exposed to family violence.

Recent articles suggest that a more consolidated or integrated approach is required. Kennedy (2013) proposes integrating family violence and children's services to support families experiencing family violence and families where children are assessed to be at low to moderate risk. Children at high risk would be the responsibility of child protective services. This approach sees an expansion of family violence services to incorporate children welfare services.

Greater responsiveness by children's welfare agencies to family violence has also been progressed through the development of the Safe and Together Program in Ohio, Florida and Connecticut.[15]

There are some examples where domestic violence services and child welfare services have merged services:

Domestic Violence and Child Advocacy Center (Ohio)[16]

The Center is a merger between the Domestic Violence Center of Greater Cleveland and the Bellflower Center for Prevention of Child Abuse. The two organisations were challenged and inspired by Greenbook Initiatives and domestic violence and merged in 2011. DVCAC is considered a national model specifically for the integration of the children's program and domestic violence programming which empowers adult victims.

STAND! For families free of Violence

This is a merger between the Family Stress Centre and STAND! Against Domestic Violence. STAND! Against Domestic Violence and the Family Stress Center were independently founded in Contra Costa County, California in the 1970s. The Family Stress Center was a non government organisation assisting victims of child abuse and neglect. STAND! became one of the leading domestic violence services in the Bay Area, with over 30 staff members. The two organizations merged in 2010, and together provide services to help minimize the devastating impact of domestic violence and child abuse.

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13   Inman, J. (2008) CPS: Closing the Distance Between Domestic Violence Advocacy and Child Protective Services, Washington State Coalition against Domestic Violence.

14   Center for Human Services Research (2014) Evaluation of Co-locating Domestic Violence Advocates in New York State Child Protective Services Offices, Final Report, New York.

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    http://endingviolence.com/our-programs/safe-together/safe-together-overview/evidence-of-model-efficacy/

16   La Piana Consulting (2012) The Power of Partnership: Strategic Restructuring Among Domestic Violence Organisations, Case Studies, Blue Shield of California foundation.

According to Gwinn (2010: 156) the Greenbook Initiative pointed toward multi-agency co-located models, and that the co-located services model was recommended as part of the original the Greenbook Initiative.

1.21 Possible Applications to Support and Safety Hubs

CCRs demonstrate the importance of a coordinated response, and the importance of bringing together family violence and services for children.

CCRs generally do not involve co-location. Evaluations of CCRs suggest that effectiveness can be improved by Hubs where services are co-located.

Greenbook initiatives and other related initiatives have sought to develop collaborative ways of enhancing services for women and children escaping violence, abuse and neglect. Co-location has mainly involved domestic violence advocates being placed in child protection services, or child welfare agencies where there is a differentiated response. There appear to be relatively few examples of integrated intake services. However, the challenges identified by various evaluations suggest that an integrated and co-located response is required.

2   FAMILY JUSTICE CENTRES

2.1   Background

Family Justice Centers (FJCs) provide social and legal support, immediate help line crisis counseling, housing assistance, court accompaniment, safety planning, support groups, counseling and child therapy, and other services.

FJCs exist within domestic violence and child protection service systems, providing a safe and secure 'one stop shop' for women and children experiencing domestic violence. FJCs are located in major population centres, and are visible and accessible, and are intended to facilitate access to a range of services, and in particular justice responses.

Family Justice Centres originated in the USA in 2002.[17] The first FJC was established in San Diego, California. The Centre brought together about 100 staff under one roof:
-    Police Department's domestic violence unit (40 officers)
-    City Attorney's domestic violence unit (35 attorneys)
-    Staff from 20 non profit domestic violence, sexual assault and other agencies

The initiative was led by the Police Department and the Attorney's Office. Two years later a separate department was established. In addition to the professional staff there were around 100 volunteers.

In 2004 President Bush announced the Family Justice Center Initiative (resulting in 15 centers based on the San Diego model). FJCs are specifically defined in federal law (*VAWA 2005, H.R. 3402-17*) and are identified as best practice in the field of domestic violence intervention and prevention services by the United States Department of Justice. State laws also include FJCs.[18]

Much of the information available on FJCs relates to American initiatives. There is a Family Justice Center National Alliance, and the website includes a range of publications and resource material.[19] There are more than 70 operational centers in the USA, and 10 international Centers, including 6 in Europe. Many others are planned internationally.

The FJC National Alliance recognizes smaller FJCs through two levels of affiliation:

Affiliated Multi-agency models – must have at least 3 different co-located service providers.

Affiliated FJC models – must have a centralized intake process, with information sharing, comprising at least a domestic violence organization, law enforcement investigators, a specialized prosecution unit, and civil legal services all co-located on a full-time basis.

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[17]   Gwinn et. al. (2008) p7.

[18]   https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=PEN&division=&title=5.3.&part=4.&chapter=&article

[19]   http://www.familyjusticecenter.org

Affiliation is a formal process, and models must demonstrate compliance with FJC Guiding Principles (see below), and engage with a technical assistance team.

FJCs in Europe

The first FJC in Europe was the UK Croydon FJC established in 2005, bringing together 33 agencies under the one roof.[20] The Centre has around 110 staff and aims to assist 7,000 adults and 14,000 children each year. Agencies represented include police, solicitors, housing, counselors, crisis helpline workers, probation, social work, and Independent Domestic Violence Advisors.[21] Each agency funds its own salary costs for staff working in the Centre. Other FJCs are being developed in Lichfield and Derby in the UK. Other FJCs being established in Europe are noted in Groen and Frank (2014).

2.2 Aims/ scope and principles of operation

Family Justice Centres are intended to be 'one stop shops' for victims of family violence. They are intended to increase the accessibility of victims to services, and increase the use of services by women experiencing violence, by making services more readily accessible and overcome the factors that often constrain women from leaving a violent situation (eg. fear of reprisal, social isolation, financial dependence, social stigma, emotional dependence and low self-esteem).

FJCs are also victim centred, and seek to identify what victims want - rather than pressuring women, they seek to provide information and options, and empower women to take control.[22] FJCs are based on the premise that many women are reluctant to seek help because of the enormity of the task of accessing multiple agencies, or once started, may give up when they find it too difficult. Advocates are specially trained to provide the right balance between support and empowerment, and FJCs operate according to clearly documented guidelines.

Core principles

The US President's Family Justice Center Initiative (2004) included Core Principles which provided a clear framework for the FJC model. The Core Principles are a mixture of structural (co-location), and service mix principles:

- Co-Location of Law Enforcement (Required for affiliation)
- Co-Location of Local Domestic Violence & Sexual Assault Programs (Required for affiliation)
- Co-Location of Prosecutor (Required for affiliation)
- Partnerships with Probation, Community-Based Organizations & Military (if applicable)

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[20]   Hoyle and Palmer (2014)

[21]   IDVAs address the safety of victims at high risk of harm from perpetrators to secure their safety and the safety of their children, in the short to medium term. IDVAs serve as a victim's primary point of contact, and work with their clients to initially assess the level of risk, discuss options leading to a safety plan. IDVAs help implement the safety plans. IDVAs work with Multi-agency Risk Assessment Conferences (MARACs) as well as other organisations. IDVAs receive specialist accredited training and hold a nationally recognised qualification.

[22]   See Hoyle and Palmer (2015)

- Comprehensive Legal Services

- Central Intake System and On-Site Info Sharing which protects Victim Confidentiality

- On-site advocacy for victims (and counseling as requested); advocates available to facilitate access to, and provide coordination of services, and follow up monitor the victim's progress with services

- Personal Safety Planning

- On-site Interfaith Chaplaincy Program (strongly encouraged)

- Provide culturally and linguistically competent services

- On-site Forensic Medical Services (limited)

- On-site Childcare

- Assistance with Transportation in an Emergency and on an As Needed Basis

- Volunteer Component which Includes DV Training

- Site Location is identified to facilitate access (ie. website, published material)

- Facility safety plan which protects victims and staff

Target group

FJCs target assistance to all women and children experiencing domestic violence. FJCs are particularly relevant and valuable for women with higher levels of need and who are experiencing higher levels of risk (and who need to access multiple service providers). FJCs also facilitate self-referral, and with a relatively high police and attorney presence, can progress protective orders, police investigations, and charging of perpetrators.

Some Family Justice Centers also focus on sexual assault and elder abuse, in addition to domestic violence (ie. any form of abuse which occurs within the family).

Practice principles

FJCs were based on the following fundamental practice principles:[23]
  - Co-located services
  - Pro arrest policies
  - Victim safety/ advocacy
  - Victim confidentiality
  - Victim centered facility (perpetrators are prohibited)
  - Domestic violence specialization (all staff)
  - Strong support from local leaders
  - Strategic planning
  - Strong/diverse community support

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[23]   US Department of Justice (2007The President's Family Justice Center Initiative Best Practices Office of Women's Affairs.

2.3 Key Functions

Key functions of FJCs include:

- Intake and screening (telephone, referral, drop in)
- Advocate assistance (key worker role, serving as a primary point of contact for all services, helping with service navigation)
- Crisis intervention
- Ongoing risk and needs assessment, gathering information, sharing information
- Analysis, decision making and draft plans/options (individuals and teams/ groups)
- Safety and Action plans decided with clients
- Referral to local agencies to provide ongoing support and assistance
- Implementation – coordination, direct support, referral follow up
- Case follow up/review/feedback to the Center, mainly provided by the victim's advocate.

2.4 Partner agencies and organisations

Several partners are 'required' for affiliation (see Core principles), participation of other partner agencies varies depending on local circumstances. Most larger FJCs include the following agencies:

- Police
- Criminal justice prosecutors
- Health (medical clinic, mental health, drug and alcohol)
- Civil legal services, family law advice
- Child care/ trauma/ advocacy services
- Specialist Domestic Violence agencies
- Child Protection
- Family Services
- Sexual assault agency
- Homelessness agency
- Education
- Financial and employment agencies
- Church/ faith based organisation

2.5 Co-location of services

Co-location is a fundamental requirement for FJCs, and includes law enforcement, domestic violence and sexual assault programs, and the Prosecutor's Office.

Many of the FJCs have been separately established in new or renovated buildings. A few have been located in leased offices: The requirement for new premises has resulted from:

-   the significant number of staff needing to come together to be available in the one place for women and children
-   efficiencies in communication and information sharing
-   the need to establish a safe and secure space, including fit for purpose areas for intake, drop in, children's areas, meeting rooms, etc.

In addition to services which are required to be co-located, FJCs commonly have 'off-site' partners. The FJC has a management structure which coordinates on-site and off-site partners.

2.6   Access (referrals to the Hub)

Where FJCs exist, police are required to make a referral to FJCs for every domestic violence incident they attend. Community based agencies also refer women to FJCs.

FJCs have a community outreach program, and promotional material to encourage women to make contact. Many women self-refer to FJCs, although it is understood that many women and children contact the FJC after an agency or professional has made the suggestion. Women may also contact one of the FJC partner services directly, for example legal advice, housing, financial planning, etc. and then be assisted to access other services within the Center. Women are also able to contact domestic violence and other services win the community (ie. FJCs are not exclusive entry points).

FJCs are located centrally, mainly serving larger city and metropolitan areas, which rely of women and children travelling to the Centre. While this is recognised as a barrier to access for some women and children, services within the FJC are organised so that women and children can receive a significant number of services on the day that they arrive.

2.7   After hours access

FJC generally operate from 8 am or 9 am to 5 pm. Some FJCs provide after hours (ie. up to 8pm) services on selected days of the week. Some FJCs maintain an after-hours crisis line, and some transfer this responsibility to domestic violence services (shelters).

2.8   Intake processes

Family Justice Centres are based on a one stop shop principle, where the majority of services are provided in person at the Centre. Women and children are assisted through:
-   Drop in, with screening and intake
-   Appointment based meetings
-   Telephone – information and advice, and referral

Upon arrival women and children are welcomed, and asked to complete intake forms.[24] They are then escorted to a comfortable kitchen/ lounge area where they

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[24]   National Family Justice Alliance Client Intake Toolkit

wait for services. They may be offered drinks, snacks, and child care. Clients are allocated an advocate who assists them in contacting the various services in the FJC, scheduling meetings, and accessing services.

In higher risk cases, selected agencies meet to jointly (as a High Risk Team) to develop plans and options, which are then offered to the woman and actioned.

FJCs do not turn any women away. There are a number of demand management strategies including:

- Encouraging women to make appointments

- Having trained volunteers available to assist

- Efficient scheduling of meetings with required services within the FJC.

2.9   Assessment processes

Once the intake form and screening is complete, women and children move from the reception area to a comfortable waiting room inside the center, where they are met by the advocate who undertakes further assessment in an intake room. Most FJCs use the Danger Assessment Tool (including the enhanced DA) as part of the assessment process, and some use MOSAIC – domestic violence Tool.

The advocate sets up appointments and coordinate the required services, and takes women to the various offices in the center. The advocate makes as many appointments as possible on the day, and may make return appointments as required. Advocates develop the safety plan, and arrange access to accommodation and support.

Domestic violence advocates are experienced in providing assistance, practical and emotional support. Advocates are familiar with the criminal justice, court, and social service systems and the community resources that are available.

2.10 Services for clients

FJCs provide short term crisis support, as well as access to longer term programs to assist following the crisis (eg. financial management, housing, parenting). Advocates make follow up calls to clients to provide support, and check on safety and progress.

FJCs do not provide a significant outreach service (ie. for service provision), but many undertake 'outreach' to promote the services of the FJC.

Services provided by FJCs include the following:
- Information and advice
- Advocacy support
- Safety plans
- Progressing criminal justice responses (orders)
- Health and medical services
- Legal services and advice
- Child care and other children's services
- Referral
- Family Services

- Sexual assault services
- Interpreters
- Material aid, living provisions
- Education
- Financial advice
- Employment assistance
- Spiritual support
- Mentoring programs for young people

2.11 Information management

Initially each Family Justice Center developed its own data collection and reporting system, and each of the partners participating in the center continued to use their own systems. There were a variety of systems used, and apparently differing views on the type of information which should be held by the Center (Townsend, 2005). It appears that:

- There are MoUs between agencies which covers a commitment by partner agencies to share information.
- Victim consent is required to share information, however where clients are at serious risk, the FJC discloses client information to the appropriate authorities and parties.
- Data systems are not integrated, rather agencies share information at joint meetings on site, when required. The FJC maintains its own data separate from any of the agencies, but generally limits the amount of data held at the Center.
- The FJC limits the information it provides to any agency which is not a partner agency. Minimal information is provided when referring a client to a non-partner (and with the client's consent).
- Staff working in the FJC secure client information in locked filing cabinets, and staff work in secure offices (ie. not open plan)
- FJC partners retain ownership of their respective data and client records, and complies with its agency confidentiality policies and procedures.

2.12 Staffing of Hubs

The Family Justice Center National Alliance website includes position descriptions for a range of staff in its web 'Resources', including:

- Business Manager
- Coodinator
- Advocate
- Intake worker

The Business Manager and Coordinator positions help ensure collaboration between partners, as well as accountability for the provision of services. This is underpinned by a license agreement or MoU between the partners.

The role of the Advocate is to provide case management services, where the Advocate engages with the victim, and undertakes a comprehensive assessment. The Advocate assists in identifying required services, and helps victims access these services. The Advocate maintains direct contact with victims, and continues to provide support and facilitate access to services. The Advocate monitors progress, and reviews follow through of appointments and other actions, maintains data, and provides reports on progress.

2.13 Management and Governance

Agencies participating in FJC are accountable to an Executive Director, and a representative Board consisting of representatives from the key partner agencies. Many FJCs operate as part of the city or county in which they are located. FJCs also have an on-site Manager or Director, responsible to the Board.

2.14 Funding of FJCs

Most staff are paid and managed by their 'home' agencies. Resources and structures vary. FJCs generally require recurrent funding for lease, utilities, and salaries for key personnel. Larger FJCs have a Director, assistant Director, office assistant and receptionist. Annual budgets for salaries and administration can be $500,000 to 700,000. FJCs receive funding from a range of sources including federal and state grants, and donations.

2.15 Links to other key multi-agency initiatives

FJCs can provide a substantial range of services 'in-house', but also make referrals to partner agencies outside the Centre, as required.

Some FJCs have established capabilities to provide Children's Advocacy Centres (CACs), certified under the National Children's Alliance.

2.16 Visibility and 'promotion'

An important aspect of FJCs is that they are visible, and accessible within the community. FJCs are widely promoted within the service sector to a wide range of agencies and professionals. FJCs each have their own website, and there is a wide range of information abut FJCs on the national FJC website.

FJCs are located in purpose-built facilities, often in renovated public buildings close to city centres and transport routes. FJCs are readily identified with external signage, and are easy to locate and access on a 'drop in' basis.

2.17 Evaluations

There have been some evaluations undertaken, mainly based on client surveys and interviews, and analysis of crime and police data. Early in the development of FJCs, Townsend et al. (2005) conducted an evaluability study which provides an evaluation framework. The National FJC Alliance lists several evaluations, including two relevant recent ones:

- EMT Associates (2013) Final Evaluation Results Phase II California Family Justice Initiative Statewide Evaluation

- Nampa FJC outcome evaluation (Bostaph, 2010).

2.18 Outcomes for clients

Family Justice Centres are identified as best practice models in the field of domestic violence. Documented and published outcomes for women and children include:[25]
- reduced homicides (eg. 70% reduction in Alameda County, 90% reduction in San Diego)
- increased victim safety
- increased empowerment for victims
- reduced fear and anxiety
- reduced recantation and minimization by victims
- increased prosecution of offenders
- increased community support for services to victims and their children.

Outcomes for services include:
- increased efficiency of collaboration among service providers
- improved relationship between agencies
- less duplication of services
- increased opportunity to deliver services
- serving more clients
- being able to address more complicated issues
- better investigations

2.19 Benefits/ impacts

Benefits include:
- a dramatic reduction in the effort involved in accessing services, reduced travel time and difficulty negotiating the system, often with children, not having to repeat the story multiple times
- opportunities to access additional services, of which victims were not aware
- much shorter time frame to obtain services
- less duplication of services
- capacity to assist more clients
- being able to address more complicated issues
- conducting better investigations
- providing better quality services

2.20 Potential relevance to Victoria

Good practice elements of the FJC model include:

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[25]   See for example Townsend et. al. (2005)

- Co-location of multiple services (full time presence) including family violence, Child FIRST, police family violence member(s), and legal advisory services, as well as a range of other key services
- A primary focus on intake, crisis response, assessment and safety planning, with referral to domestic violence and other services
- Commitment to share information and work collaboratively on-site (regular meetings, etc.)
- Establishment of a physical building, with offices, meeting rooms, and capacity for women and children to attend (reception, lounge, play areas, etc.)
- Funding for management/ administration
- Perpetrators are excluded from physically attending the Hub
- Advocates have the capacity to provide on-going support and follow up until the victim is safe, or referred to a domestic violence service
- Capacity to provide short term crisis/ case management (in addition to intake and referral)
- Incorporation of High Risk Teams, to assess risk and manage cases which are categorised as high risk (similar to RAMPs)
- Early intervention capacity by promoting and increasing self-referrals (and family and friends) and providing convenient access to a 'one stop shop', and enhanced referral from external agencies and professionals
- Capacity to provide children's services, and provide a response to sexual assault, and elder abuse.

Aspects of FJCs which may not be consistent with the model proposed by the RCFV include:
- FJCs require a minimum number of agencies to be co-located (police, domestic violence, sexual assault, Corrections, prosecutor, health)
- FJCs are not an exclusive entry (intake) point for women and children
- FJCs have an internal capacity to pursue justice and prosecute

3   Multi Agency Safeguarding Hubs (MASH)

3.1   Background

In the UK, Local Safeguarding Children Boards (LSCBs) are responsible for ensuring that agencies work effectively together. A 2010 audit commissioned by the Devon LSCB found that that despite a collaborative model being in place, information was not being shared between agencies and as a result outcomes for children and young people were being jeopardised.

As a result, the Devon LSCB established a Multi Agency Safeguarding Hub (MASH). A number of Boards have followed suit and established Multi-Agency Safeguarding Hubs or similar hub like models.   There is some variation according to local circumstances, but most follow the initial model established by the LSCB in Devon.

While the priority of Hubs is safeguarding children, some Hubs have also included responses to adults, including women experiencing domestic violence.   Similar hub-like models have been established to safeguard vulnerable adults (eg. people with a disability), and these may also include women experiencing violence.

MASHs focus on the point at which child protection referrals are initially received. The value of a MASH is in the sharing and assessment of information from a range of sources including health, education, police and children's services, resulting in a comprehensive and timely picture of the child and circumstances, with which to inform decision making.   The MASH model provides a more timely and unified multi-agency response, rather than children's social care services making unilateral decisions in response to referrals.

MASHs operate as a separate entity, and information and activities are kept confidential and separate from operational activities external to the MASH. There is an agreed process for sharing information, analysing and assessing risk, and then disseminating suitable information and guidance to the most appropriate agency(ies) for action.

3.2   Aims scope and principles of operation
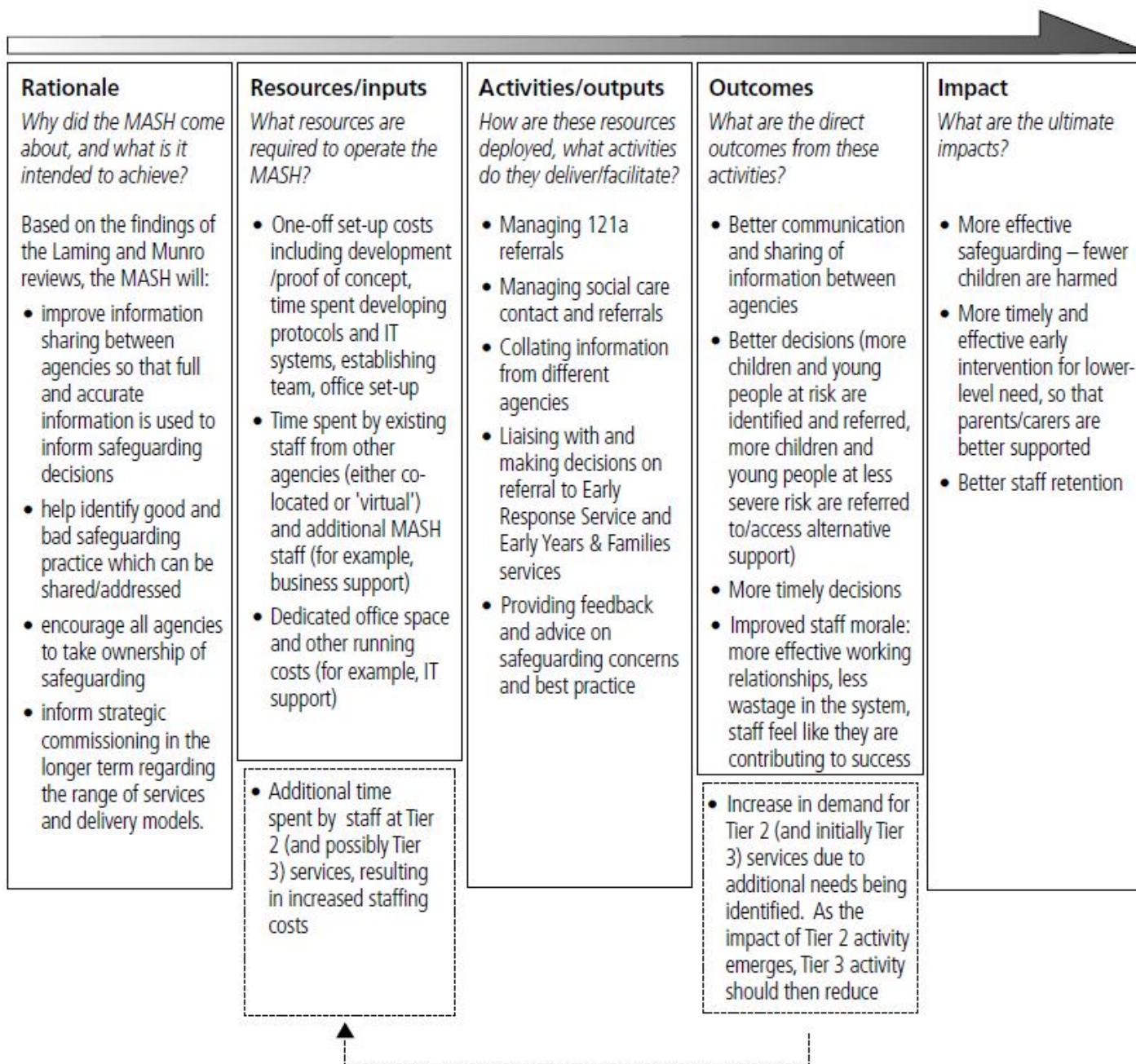
Example of the aims of MASHs are:

> *to provide a single gateway for safeguarding children and young people, to improve the quality of information sharing and decision making at the earliest opportunity, and reduce the potential risk to children and young people*

> *to provide the highest level of knowledge and analysis of all known intelligence and information across the safeguarding partnership to ensure all safeguarding activity and intervention is timely, proportionate and necessary.*

The majority of MASHs target children and young people. Some MASHs have also included vulnerable adults within the MASH including women experiencing violence. Some MASHs assess and refer women experiencing family violence, usually by co-locating an IDVA within the MASH.

A Logic Model for MASH is shown on the following page (Figure 6.1).

Figure 3.1:   MASH Logic model (Golden et. al., 2011)

Rationale	Resources/inputs	Activities/outputs	Outcomes	Impact
Why did the MASH come about, and what is it intended to achieve?	*What resources are required to operate the MASH?*	*How are these resources deployed, what activities do they deliver/facilitate?*	*What are the direct outcomes from these activities?*	*What are the ultimate impacts?*
Based on the findings of the Laming and Munro reviews, the MASH will: • improve information sharing between agencies so that full and accurate information is used to inform safeguarding decisions • help identify good and bad safeguarding practice which can be shared/addressed • encourage all agencies to take ownership of safeguarding • inform strategic commissioning in the longer term regarding the range of services and delivery models.	• One-off set-up costs including development /proof of concept, time spent developing protocols and IT systems, establishing team, office set-up • Time spent by existing staff from other agencies (either co-located or 'virtual') and additional MASH staff (for example, business support) • Dedicated office space and other running costs (for example, IT support)	• Managing 121a referrals • Managing social care contact and referrals • Collating information from different agencies • Liaising with and making decisions on referral to Early Response Service and Early Years & Families services • Providing feedback and advice on safeguarding concerns and best practice	• Better communication and sharing of information between agencies • Better decisions (more children and young people at risk are identified and referred, more children and young people at less severe risk are referred to/access alternative support) • More timely decisions • Improved staff morale: more effective working relationships, less wastage in the system, staff feel like they are contributing to success	• More effective safeguarding – fewer children are harmed • More timely and effective early intervention for lower-level need, so that parents/carers are better supported • Better staff retention
	• Additional time spent by staff at Tier 2 (and possibly Tier 3) services, resulting in increased staffing costs		• Increase in demand for Tier 2 (and initially Tier 3) services due to additional needs being identified. As the impact of Tier 2 activity emerges, Tier 3 activity should then reduce	

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The London LSCB initiated a project which resulted in the establishment of multiple MASHs. Because of the wide differences across London boroughs, it was agreed that there would be no single MASH type model, but that MASHs should incorporate agreed core elements. By the end of 2013, there were 26 Multi Agency Safeguarding Hubs operating in London, with the remaining boroughs to implement MASH by the end of 2013/14 financial year.

The five core elements of the London MASH are:
- All notifications relating to safeguarding and promoting the welfare of children go through the hub.
- A co-located team of professionals from core agencies (Children's Social Care, Police, Health, Education, Probation, Housing and Youth Offending Service) deliver an integrated service with the aim to research, interpret and determine what is proportionate and relevant to share.
- The hub is fire walled, keeping MASH activity confidential and separate from operational activity and providing a confidential record system of activity to support this.
- An agreed process for analysing and assessing risk, based on the fullest information picture and dissemination of a suitable information product to the most appropriate agency for necessary action.
- A process to identify potential and actual victims, and emerging harm through research and analysis.

3.3   Functions of MASHs [26]

Key functions include:
- Provide a single point of entry/referral
- Provide information and advice to external agencies and professionals
- Receive referrals from external agencies and professionals, family members, and members of the community
- Conduct thorough research, access databases and collate information
- Contact children and family (early intervention team)
- Assess risk, and provide a rating which determines the decision making time frame (red = information gathered and decision within 4 hours; amber = by the end of next working day; green = within 3 working days). Triage referrals.
- Gather, share and collate information from across partner agencies
- Undertake joint decision making – develop action plans
- Facilitate early intervention to prevent the need for more intensive interventions at a later stage
- Coordinate and assign work to social workers and response teams
- Provide guidance to social workers and response teams based on relevant information

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[26]   See for example Home Office (2014:9)

The MASH takes enquiries (rather than referrals to Social Care, the statutory organisation). One of the outcomes of a MASH enquiry could be a referral to Social Care. MASHs provides improved decision making, regarding what is, and what is not, a safeguarding concern. The MASH process is an enhanced method of identifying children and families that may require intervention. The key steps are:

- An initial enquiry, where information is taken and fed into an IT system
- The initial enquiry is triaged by a qualified social worker, and a rating is assigned to the case (blue, red, amber or green – this decides the urgency of the case)
- A request is sent to the business resource team to enter information onto a spreadsheet. The business resource team sends out information on secure emails to partner agencies (co-located and virtual) seeking further information held by those agencies, to help inform decision making
- MASH social workers obtain further information by follow up consultation with workers who are familiar with the case
- Agencies respond to the information request, highlighting information that is sensitive. Agencies also give information a rating (red, amber or green), to indicate the urgency of the matter
- A Practice Manager reviews all information and makes a decision regarding whether a referral is made, and to whom.

If children meet the threshold for an assessment they will be referred to children's Social Care, otherwise, they will be referred to another appropriate service.

Police use the Merlin Pre-assessment Checklist (Merlin PAC) for children and young people. If police consider that a child is at risk of significant harm, a referral is made directly to children's Social Care. Otherwise all Merlin referrals are made to the MASH. MASHs use a triage system which identified level of need (eg. red, amber, green).[27]

3.4   Partner agencies and organisations

MASHs predominantly involve co-location of a number of agencies. There are some MASHs which have a co-located group of agencies, plus a virtual interface with other agencies. For example, the Devon MASH comprises:

- Children's Social Care (co-located)
- Police (co-located)
- Education (co-located)
- Health (co-located)
- Probation (virtual)
- Youth Offending Team (virtual)
- Children and Adolescent Mental Health Service (virtual)
- Early Years and Families (virtual)

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[27]   A detailed process description is provided by Coventry City Council Children's Services Procedure manual, MASH Procedures. Flow charts identified include Golden et. al. (2011), and Coventry Children's Services Procedures Manual

Organisations may seek information from the MASH regarding a safeguarding concern, make a referral to the MASH, respond to a request for information from the MASH, about a case that has been referred to the MASH, and take action as a result of a MASH decision.

3.5 Co-location of services

The UK government identifies a number of 'preferred' practices, and recognises that good practice can take many forms.

- Co-location of agencies - Timely exchange of information between agencies; greater understanding and mutual respect among different agencies; better working relationships. Virtual communication and decision making can be a complementary addition to co-location.
- Shared risk assessment tool - Used by all referral agencies and the multi-agency team to convey clear and sufficient information about cases
- Good leadership, clear governance and accountability with an operational manager who is seen to be independent
- Strategic buy-in from all agencies involved, including health services, family services, and housing services
- Integrated IT system
- Rotating staff between intake/ triage, risk assessment, and frontline work (develops competence, transfers knowledge, and helps avoid burn out)
- Capacity to monitor risk levels (reviewing up to date data and information), enabling early identification of potential harm, and to identify trends and potential dangers (includes capacity for outreach contact with children and their families)
- Training (including joint training)
- Shared risk assessment framework
- Information sharing protocols
- Documented guidelines, policies, and processes
- Communication / promotion strategy (with external agencies and the wider community)
- Appropriate accommodation for the Hub

MASHs are essentially facilities for intake, sharing information and decision making. MASHs generally do not offer a 'drop in' capacity, rather contact with children and their families is undertaken by partner agencies, which then feed information to the MASH. Crisis work, and outreach work are undertaken by other organisations.

Good practice requires co-location, and capacity to secure and firewall information and multi-agency discussions. Key partner organisations are located in the same building. The physical space needs to be arranged according to the operation of agencies and multi-disciplinary teams. A key challenge is predicting the staffing levels required to met expected demand over several years.

Co-location of key staff (including Police, Children's Services, Health and Education) is considered the most effective and practical way of operating a MASH. Co-location

facilitates information sharing and decision making, and also builds relationships, trust and understanding between agencies, and staff are more confident about sharing information. Co-located services have greater capacity to 'firewall' and hold information.

While co-location is a 'necessary condition', it is recognised that a number of key elements are required for it to be successful, including:

- staff with a 'joined up' attitude, enthusiastic about collaborative working,
- common training, and development of teams with a shared commitment
- trust within the teams, and between co-located agencies
- clarity about the contribution of each agency
- clarity about information sharing and data protection

3.6 Access (referrals to MASH)

Professional staff may make an enquiry, rather than a referral. The enquiry is a request that research be undertaken in relation to a particular case.

3.7 After hours arrangements

MASHs operate from 9 am to 5 pm.

3.8 Intake processes

Not relevant, as MASHs do not conduct intake.

3.9 Assessment processes

There does not appear to be a consistent risk assessment tool/ process. Apart from the BRAG rating, MASHs may use:

- Child and Family Assessment Form (CAF).
- Health based tools (health triangle)
- Child Risk Assessment Matrix (CRAM) which is part of the Merlin.
- Signs of Safety template (developed in Australia)
- Brearley Risk Assessment tool
- Barnardo's Screening Tool DV RIM (where domestic violence is indicated)

If there is capacity within a MASH to assess for domestic violence (eg. an IDVA), a CAADA DASH risk assessment tool is used. Other tools used include MASH referral forms, and pre CAF forms.

3.10 Services for clients

There are no direct services for clients. MASHs provide services for professional staff.

3.11 Information management

A MASH operates on the basis of a sealed intelligence Hub where information sharing protocols govern how, and what information can be released from the central intelligence unit to professional staff who action the decisions made by the MASH.

The MASH team provides guidance and direction, and sufficient ('need to know') information to operational staff.

MASHs have developed their own (bespoke) IT systems to record and collate information on cases. Information sharing is covered by protocols and agreements.

Protocols govern how and what information can be released from the MASH to professional staff.

All relevant information is gathered using secure email, and agencies' secure databases, and collated into a MASH form. Information is thus gathered from a range of agencies each with separate databases and IT systems.

Reviews have shown a desire by MASH agencies to streamline and integrate IT systems, but for many this has proven too difficult for a range of reasons. There are also concerns that too much integration may reduce the weight given to professional opinion.

3.12 Staffing of MASH

The MASH is a multi agency group of people who work together but continue to be employed by their own agencies. The MASH does not have any operational staff - its only purpose is to build an intelligence picture to inform better decision making, and then to guide operating practice in external agencies. This does not replace the assessment process in local children's social care assessment teams.

The staff structure in the original Devon team comprised:[28]

- an Operations (Service) Manager (CYPS)
- 2 Practice Managers (CYPS)
- 2 Social Workers (CYPS)
- 11 FTE referral coordinators (receive referrals, collate information)
- 2 Police Sergeants
- 4 police 'evaluators' who assess referrals from police officers who have concerns about a child or young person
- Police research officers
- Business/ office support
- Educational representative.

3.13 Management and Governance[29]

Local authorities (councils) have responsibility for safeguarding children. This responsibility is exercised through the Local Safeguarding Children's Board (LSCB). Some Councils have established a specific MASH Local Project Board for the establishment phase, following by an on-going strategic Board (monthly meetings), once the MASH is established.

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[28]   Golden et. al. (2011)

[29]   See for example London Borough of Merton, MASH Governance (2013)

There is a MASH Service Manager, who has the final say in all safeguarding decisions (employed by Children's Social Care). The Service Manager may convene an operational Steering Group. All staff with MASHs retain accountability to their own organisation.

3.14 Funding of MASH

MASHs require additional expenditure to establish office facilities and infrastructure, and ongoing accommodation and utility costs.

Organisationally, the MASH may be divided into two parts:

- Initial Contact and Triage – receives referrals, undertakes initial checks and information gathering
- Information gathering and decision making – undertakes research and in depth information collection from selected agencies/ sources; joint meetings to discuss and assess risk, and to decide appropriate course of action, and allocate actions to social work and other professional teams in the district.

3.15 Links with other multi-agency initiatives

Alongside managing the safeguarding enquiries, some MASHs have also set up an interface with the Multi-Agency Risk Assessment Conference (MARAC) process (eg. Devon), and the Multi-Agency Public Protection Arrangements (MAPPA) process. There is also a link with the Missing Children sub group.

MASHs have established communication links with MARACs, and exchange information where they have common clients. These are based on clear information sharing protocols, which provides a consistent basis for sharing and storing information safely in cases involving domestic abuse.

In cases involving the same family at both forums, the MASH, or an identified lead professional, is kept informed of the progress and the IDVA is kept informed of MASH safeguarding plans for the children.

Some MASHs co-locate a domestic abuse expert (eg. IDVA) within the MASH, to complete a risk assessment (CAADA – DASH) for adults identified as domestic abuse victims.

3.16 Visibility and promotion

It is important that MASHs are 'visible' to agencies, but not to clients and the wider community. MASHs do not have a 'drop in' capacity, but may be located within an existing agency which does.

3.17 Outcomes for clients[30]

Impacts identified include:

- More robust decision making
- avoiding duplication of processes across agencies, and improved efficiencies
- faster responses and greater efficiency in decision making

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[30]   Home Office 2014:8

- increased uptake of services
- increased early intervention
- a reduction in repeat referrals
- better information sharing, and added value and context to information
- improved engagement of (and referrals from) some external partners (who are more prepared to collaborate with a larger and more formal initiative)
- improved knowledge management, and understanding of other agencies work
- reduced risk of 'borderline cases' not being actioned, and increased likelihood of some action resulting from a referral to MASH
- better informed 'downstream' services

3.18 Evaluations of MASHs

There are relatively few evaluations as MASH have only been established for a few years. Golden et. al. (2011) carried out a case study review of Devon MASH.

In a report assessing the early impact of MASH in London (Crockett et. al. 2013) found a number of positive indications, including a reduction in decision making time, enhanced decision making through information sharing,

3.19 Benefits/ impacts
- a reduction in the effort involved in accessing information
- enhanced time management
- capacity to assist more clients
- being able to address more complicated issues
- conducting better investigations
- providing better quality services

3.20 Potential relevance to Victoria

In summary:

- MASHs affirm the value of placing children's intake services within a Hub where information can be shared, and where additional information is available to enhance decision making. Intake services for vulnerable children benefit from additional information from a range of agencies, enabling better decision making.

- MASHs demonstrate benefits of police members and other agencies being co-located within the Hub to enable information sharing within legislative constraints, and to contribute to risk assessment and developing appropriate risk management plans and actions.

- Because MASHs are information/ intelligence centres only, there is no 'drop in' capacity for clients. Some MASHs have an early intervention outreach capacity, where MASH social workers make contact with children and their families

- Some MASHs include domestic violence as part of their assessment. Some co-locate IDVAs within the MASH (Nottinghamshire); some have a more comprehensive and integrated procedure (eg Coventry MASH DV interagency review); some include domestic violence as part of a combined Children and Adults MASH (Gateshead); and some locate the MASH in the same building as IDVAs and other family support services (Oldham).[31]

The success of MASHs also depends on the capacity of downstream agencies to respond to the decisions made by the MASH.

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[31]   See Centre of Excellence for Information Sharing (2015:9)

4   CHILDREN'S ADVOCACY CENTERS

4.1   Background

The Child Advocacy Center model was developed in the USA during the early 1980s, based on a multidisciplinary response to child sexual abuse. Up to this time, the United States response to child sexual abuse was poorly coordinated. The first Child Advocacy Center was established in 1985 in Huntsville Alabama.[32]

This model proposed a public-private partnership, with various agencies and departments responsible for the protection of children working together to respond to assure the protection of children, recognising that no one agency could do this on its own.

The model has been widely adopted as a best practice in responding to child sexual abuse in the United States, and there are now more than 950 Children's Advocacy Centers assisting more than 270,000 clients (2009 data), and this model has also been implemented in more than 25 countries throughout the world.

Children's Advocacy Centers (CAC) are community-level innovations that strive to streamline child maltreatment investigations and minimize the trauma of revictimization caused by multiple forensic interviews.

In contrast to the traditional investigation of child abuse cases by child protection, CACs bring together child protection investigators, police, prosecutors, physicians, and mental health professionals as a multidisciplinary team to investigate and prosecute child maltreatment allegations, and provide/ arrange timely treatment to child victims and their families. Many CACs have specialized interviewers with education and training in child development and forensic interviewing.

In the USA, a National Children's Alliance provides leadership, standards, and guidance for CACs.

4.2   Aims, scope and principles of operation

The original function of CACs was to respond to cases of child sexual abuse. CACs have broadened their target group to include child victims of serious physical abuse, child witnesses to domestic violence, and children affected by other forms of victimisation.

CACs achieve their aims by successfully accomplishing the following program objectives:
-    To develop a formal comprehensive, multidisciplinary response to child abuse which is designed to meet the needs of child victims and their families.
-    To establish a neutral facility where interviews of and services for children who are alleged to have been abused may be provided.
-    To prevent further trauma to the child which may be caused by multiple, repetitive contacts with different community professionals.
-    To provide services to families that will assist them in regaining maximum functioning.

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[32]   Child Advocacy Centers were first proposed by District Attorney Robert Cramer.

- To maintain open communication and case coordination among community professionals and agencies involved in child protection efforts.
- To coordinate and track investigative, prosecutorial, and treatment efforts.
- To develop information that may be useful in criminal and civil proceedings.
- To hold more offenders accountable through improved prosecution of child abuse cases.
- To develop the professional skills necessary to effectively respond to cases of child abuse.
- To develop community outreach programs to enhance the communities' understanding of child abuse.

Principles

CACs operate on a core set of beliefs:
- The intervention system must be sensitive to the needs of abused children and their families and meet their needs by respecting the uniqueness of each child and family.
- Child abuse is a community problem. No single agency, individual or discipline has the necessary knowledge, skills or resources to successfully intervene in child abuse cases and to provide the assistance needed by the children and families involved in these cases.
- The combined wisdom and professional knowledge of child protective services, law enforcement, prosecution, medical, mental health and victim advocacy will result in a more complete understanding of case issues and the most effective system response possible.

Most communities have adopted a shared philosophy and goals similar to those listed above. This gives the different philosophies among interacting agencies a context that allows them to develop procedures for responding together to child abuse cases quickly and effectively. It also enables participating professionals to address, together, problems as they arise.

4.3 Key functions and activities

There is wide variation in the way CACs have been established (Walsh et al. 2003). There are however, 10 standards which define the minimum functions and activities that must be met by a Children's Advocacy Centre to receive accreditation. CACs provide many services, providing in a coordinated way:
- Child-Appropriate/Child-Friendly Facility: The children's advocacy center provides a comfortable, private, child-friendly setting that is both physically and psychologically safe for clients.
- Organizational Capacity: There is a designated legal entity responsible for program and fiscal operations has been established and implements basic sound administrative practices.
- Cultural Competency and Diversity: The CAC promotes policies, practices and procedures that are culturally competent. Cultural competency is defined as the capacity to function in more than one culture, requiring the ability to

appreciate, understand and interact with members of diverse populations within the local community.

- Multidisciplinary Team (MDT): The multidisciplinary team for response to child abuse allegations includes representation from the following:
    - law enforcement
    - child protective services
    - prosecution
    - mental health
    - medical
    - victim advocacy.
- Forensic Interviews: Forensic interviews are conducted in a manner which is of a neutral, fact finding nature, and coordinated to avoid duplicative interviewing.
- Medical Evaluation: Specialized medical evaluation and treatment are made available to CAC clients as part of the team response, either at the CAC or through coordination and referral with other specialized medical providers.
- Therapeutic Intervention: Specialized mental health services are made available as part of the team response, either at the CAC or through coordination and referral with other appropriate treatment providers.
- Victim Support/Advocacy: Victim support and advocacy are made available as part of the team response, either at the CAC or through coordination with other providers, throughout the investigation and subsequent legal proceedings.
- Case Review: Team discussion and information sharing regarding the investigation, case status and services needed by the child and family occur on a routine basis.
- Case Tracking: CACs must develop and implement a system for monitoring case progress and tracking case outcomes for team components.[33]

4.4 Partner agencies and organisations

Partner agencies include:
- Child Protective Services (CPS)
- Police, law enforcement
- Prosecution
- Medical, Health care professionals (forensic)
- Mental health professionals
- Victim Advocates
- Forensic interviewers

In larger CACs, there may also be representatives of:
- Juvenile court

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[33]   Herbert and Bromfield (2016:1)

- domestic violence advocate
- schools
- probation/ parole

4.5   Co-location of services

CACs are established as independent centers, or as units in hospitals, or as departments in other agencies such as district attorney's offices or mental health centers. It is important that they present as a neutral designated facility. The location and facility is clearly separate from any agency involved in the intervention process. In addition, it aims to create a sense of safety and security for the children.

Co-location of all relevant services in a purpose built facility is recognised as the ideal arrangement, and CAC programs have increasingly co-located services. In some more urban areas, this has meant that the entire CPS and law enforcement units responsible for child abuse investigations are housed at the center, with other staff also co-located as appropriate. This has arisen the need for greater access to multi-disciplinary team members for assessment, as well as to support services. In other sites co-location might involve one or two CPS staff, one or two law enforcement personnel, a designated prosecutor, and the forensic medical examination unit housed at the CAC.

Some CACs have set up in buildings next to FJCs. In San Diego the Chadwick Center has co-located its child trauma therapists at the FJC, and have provided cross training in domestic violence services. In South Bend Indiana, the FJC and CAC are nearby, and have developed excellent relationships.

CACs include the following physical areas:[34]
- Waiting rooms for children and their families.
- Safe play areas for children.
- Investigative interview rooms.
- Separate offices for treatment staff (if treatment is offered).
- A conference room to be used for team review and meetings.
- Office space for the staff using the Center.
- Kitchen and bathroom facilities.
- A private entrance for CAC staff and the investigative team.
- Parking accommodations (including handicapped spaces).

CACs establish multidisciplinary team as the primary method for working in collaboration. This multidisciplinary response is based on written agreements among the agencies involved in the intervention system. These agreements are based on the integration of services provided by the various agencies.

While each agency (child protective services, law enforcement, prosecution, etc.) maintains its legally mandated role for handling child abuse cases, these agencies modify their response using mutually agreed upon procedures.

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[34]   National Children's Alliance (2000)

4.6 Access (referrals to CACs)

CACs take referrals from a wide range of agencies and organisations including:
- Police, and prosecutors
- Child Protection
- Hospitals
- Mental health and drug and alcohol services
- Schools
- Family support services.

4.7 After hours arrangements

CACs operate 9 am to 5 pm.

4.8 Intake processes

A preliminary investigation may be completed before a case is assigned to a multidisciplinary team. The preliminary investigation seeks to verify the preliminary report, reviewing the information, and checking information with the reporting agency or person. This information is important in determining the appropriate agency response.[35]

4.9 Assessment processes

CACs cover a full spectrum of risk for children, including sexual abuse, physical abuse, family violence and the risk of other forms of victimisation. Only about half of the CACs undertake domestic violence assessments.[36]

The assessment process is usually focused on a forensic interview, to establish the allegations, and information about the abuse.

4.10 Services for clients

To the maximum extent possible, components of the team response are provided at the CAC (children's advocacy center) in order to promote a sense of safety and consistency to the child and family.

Specific Uses of a Children's Advocacy Center include:
- Interviewing child victims and witnesses.
- Interviewing non-offending family members.
- Providing a location for the forensic medical examination.
- Providing assessment and mental health treatment for children and nonoffending family members.
- Providing on-site consultation for team members.
- Conducting multi-disciplinary team case review meetings.

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[35] Sorenson, E., Bottoms, B., and Perona, A. (2002) Handbook on Intake and Forensic Interviewing in the Children's Advocacy Cebter Setiing, National Children's Alliance

[36] Thackeray et. al. (2010)

- Conducting Board of Directors meetings.
- Providing a place for liaison staff to work.
- Providing a place for interagency meetings.
- Providing a consistent, comfortable place for all personnel to be introduced to the child.
- Providing a place and a process to prepare children and their families for court.
- Providing a place for children and witnesses to wait prior to a court hearing.

4.11 Information management

Each partner agency maintains its own information systems. CACs establish a separate case tracking system, which provides summary information about the client, services provided, and progress in relation to client plans.

4.12 Staffing of CAC

The majority of CAC staff are funded by their auspice agency.

CACs usually include a number of paid staff, depending on the size and configuration of the CAC. The Director is the most common full time paid position, reporting to a Board. The Director of the CAC is responsible for operations of the CAC program, achievement of CAC goals, maintaining inter-agency and community relationships, and funding. The Director is usually supported by a secretary/ administrator.

In larger CACs a Team Coordinator may coordinate the activities of staff of each member agency, and manage the flow of cases through the CAC. Additional staff members, employed by the CAC may include a Clinical Coordinator, Therapist, Case Manager, and Volunteer Coordinator.

4.13 Management and governance

CACs are governed by a representative Board.

Successful community coordination in cases of child abuse requires an agreement among the leaders of the key participating agencies on the intervention process and the roles and responsibilities of the different professionals/agencies. This is best accomplished through the development of an Interagency Agreement.

An Interagency Agreement is a written agreement signed by the heads of the appropriate participating agencies that establishes and formalizes cooperation among the involved agencies. The purpose of the Interagency Agreement is to coordinate intervention in child abuse cases in a manner that lays out an intervention process that preserves and respects the right and obligation of each agency to pursue its own mandate and at the same time allows them to work together on behalf of abused children and their families. Interagency Agreements establish and formalize cooperation among the agencies involved in the community's intervention system by defining a coordinated system's response to cases of child abuse.

4.14 Funding of CACs

The majority of CACs in the United States are state funded.

4.15 Links to other multi-agency initiatives

CACs are linked to Family Justice Centers, and a number of CACs and FJCs are co-located (eg. Boston).

4.16 Visibility and promotion

MDCs and CACs are not set up to encourage direct contact and access by victims (thus differing from Family Justice Centers). They are intended to be visible, and well promoted to referring agencies and the wider sector.

4.17 Evaluations of CACs

Various evaluations have been undertaken focusing on particular aspects of CACs.

Herbert and Bromfield (2016) provide a comprehensive and recent review of evaluations of the CAC model. They conclude that the CAC model contains a number of commonsense benefits (eg. see 7.20below), and contains a number of practice elements which are well evidenced, such as multi-disciplinary teams; evidence informed forensic interviewing , and victim advocacy. They note however, that there is limited evidence base that exists for the model as a whole.

4.18 Outcomes for clients

CACs serve children who are alleged to have been abused as well as their families and the professionals working with them. As a result, the following benefits can be expected:[37]

- The trauma (associated with interviews and other processes) experienced by children is reduced.[38]
- Children receive prompt and ongoing services that are tailored to their specific needs and family situations.
- Children receive a better quality and more comprehensive service.

4.19 Benefits/ impacts

- Better decision making - professionals are able to receive input from other professionals before making decisions regarding a case.
- More non-offending parents are empowered to protect and support their children throughout the intervention process and beyond.
- Centrally held information allows the progress to be monitored and minimizes the possibility of cases "following through the cracks".
- More offenders are held accountable because of coordinated investigative and interview procedures.[39]
- The decision to prosecute is based on input from the child and family as well as other professionals acting on their behalf.
- Additional specialized mental health treatment resources become available.

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[37] National Children's Alliance (2000)
[38] Jones et al. (2007)
[39] Miller and Rubin (2009)

- Professionals gain a better understanding of and respect for each other's roles and expertise.
- Professionals are better able to meet the needs of abused children and their families due to training and through informal learning opportunities
- Allegations of abuse are more completely investigated, including a higher rate of medical examination,[40] producing more usable information.
- False allegations are quickly and efficiently dealt with, creating safeguards for all involved.
- Cases are more quickly dealt with[41] and are less likely to "fall through the cracks" in the system.
- The community is better educated about the problem of child abuse and the appropriate methods of responding to child abuse.
- Communities are better able to identify gaps in the system and are challenged to develop more resources for children and their families.
- Professionals interact regularly providing each other with support, reducing staff burnout.
- Lower cost of investigation[42]

4.20 Potential relevance to Victoria

CACs demonstrate the following elements of a hub=like model:
- Co-location of multiple services (full time presence) of police, child welfare staff, established in a physical building/ offices, with meeting rooms, counselling rooms, play areas, etc.
- Acceptance of diversity in models, provided standards are met
- Commitment to a multidisciplinary team approach including police, social services, and medical/ health professionals
- Commitment to minimising any adverse impact of the service system on the victim
- Provision of a welcoming environment.

Points of difference to the model proposed by the RCFV may be that CACs:
- exclude a 'drop in' capacity
- include Child Protection workers
- include police investigative and forensic capacity
- lack a focus on family violence.

In the USA, some Family Justice Centres and CACs are located close to each other (but not co-located), to facilitate responses to women and children who are victims of domestic violence.

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40   Walsh et. al (2008)
41   Walsh et. al. (2008)
42   Formby et. al. (2006)

5 SWEDEN – KARIN PROJECT

5.1 Background

In 2008. the Swedish government established the Karin project, a cooperative model with a focus on assisting victims of family violence, and which is located in a physical environment which enables enhanced investigation and response to domestic violence. The Karin Project has been established similar to a Family Justice Center, with minimal co-location.

The Karin Project is housed in the Malmo police station. The purpose-built environment and facilities are separate within the police station, and are more comfortable and welcoming than a normal police station, and there are a range of services are conveniently co-located and accessible for the victim. Victims can avoid having to contact different authorities at different addresses, while still in a vulnerable situation.

5.2 Aims and objectives of the Karin project

The aim of the Karin project is to provide support to victims through the implementation of new methods of cooperation between authorities, with a focus on the victim. This includes constructing an appropriate physical environment, interrogation technology, and model for cooperation between the different authorities.

5.3 Activities

Key activities of the Karin project include:
- police criminal investigation activities
- social supports for victims (from Malmo municipality crisis centers for abused women)
- Forensic Medicine staff to document the physical evidence if needed.

The police investigators and social workers work together closely as a team.

There are about 30 investigators and a handful of specially trained police interrogators for children, who work at Karin. In the same location there are also representatives from the Malmo municipality social resource management.

Police provide social workers with information about victims as soon as it comes to hand. Social workers seek to contact victims within 24 hours to assess their need for support, and protection.

Every morning, Monday to Friday, the police, prosecutors and social workers from the Crisis Centre for Women who have been exposed to violence and their children, meet to assess risk, and develop plans for women. Plans also include actions in relation to perpetrators and children.

Karin workers offer social support and practical help before, during and after the criminal process at an individual level, focusing on women's experiences and taking a holistic perspective including looking at the entire family/s needs.

5.4   Results and impact

An evaluation has been conducted by the University of Lund. The evaluation shows that a whole new target group has sought help at Karin.[43] There are many women who have previously not wanted to contact the police or other authorities because of shame, feeling extremely vulnerable and fearful.

The government appointed the Swedish national Council for Crime Prevention (Brå) to evaluate the Karin project. The work also involved examining the extent to which the Karin project differed from other similar programs in Sweden, such as the Partner Violence Centre (PVC) in Stockholm, and the Family and Partner Violence Section in Vasterås. The evaluation concluded that situating the police and social services in the same premises makes it easier to support victims, including conducting outreach.[44]

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[43]   The Lund University evaluation has not been sighted.
[44]   The full report has not been sighted, only the Summary is available on the internet.

6   NEW ZEALAND

6.1   Background

New Zealand has a history of innovation in the area of family violence. The Hamilton Abuse Intervention Project (HAIP) was established as a coordinated community response to domestic violence based on the Duluth Model. This had a significant influence in government family violence policy.

Over the last decade New Zealand has worked to enhance police responses to family violence, and to develop a response system which coordinate local agency responses and services, including interagency case referral.

The NZ government provided funding for the Family Violence Response Coordination (FVRC) program, which supports 38 networks in towns and cities around New Zealand. These networks comprise a range of government and community agencies to provide a local joined-up response to family (whānau) violence.

There are a variety of models. Some only involve coordination, others focus on primary prevention, while others are comprehensive multi-agency networks encompassing many of the other inter-agency activities in the particular region/local area.[45]

6.2   Family Violence Interagency Response System (FVIARS)

The Family Violence Interagency Response System (FVIARS) is a collaborative inter-agency initiative led by the Police in partnership with Child, Youth and Family and the National Collective of Independent Women's Refuges to more effectively manage cases of domestic violence reported to the Police. Most FVIARS groups also include a range of other government and NGO agencies from the local area.

FVIARS groups meet regularly to discuss family violence intervention around specific cases of family violence. FVIARS has significantly contributed to the greater involvement of police in responding to family violence, but there reportedly needs to be greater standardisation of responses. Some FVIARS meetings have become inefficient, with far too many people attending to share information and contribute views.

There have been changes in recent years with meetings being restricted to fewer people from 2 key agencies (family violence and children's services), conducting daily triage, and greater outsourcing of information, and enhanced pre-meeting preparation.

6.3   Reviews

Coordinated and collaborative responses (Murphy and Fanslow, 2012)

A 2012 review (Murphy and Fanslow) stressed the importance of coordinated collaborative responses to family violence, and in developing comprehensive primary prevention strategies. The report concludes:

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[45]   Herbert and MacKenzie (2014, p 143)

- Coordinated and collaborative responses to family violence result in better outcomes for victims and perpetrators, enhanced processes in and between agencies, improved service delivery and provision and reduces violence.
- There needs to be strong national mandate and leadership for agencies to work collaboratively. A centralised information source is required to feed information out to, and in from local networks, in order to better coordinate response and minimise the risk of duplication.
- All members of a collaborative response need written agreements on shared aims and objectives based on a commonly agreed values-based framework.
- Roles, responsibilities and expectations need to be clearly defined and specified. Transparent decision-making, participatory planning and continual monitoring and evaluation are key components of successful collaborations.
- A dedicated Coordinator is required. Agencies also need to support staff to invest time and resources into collaborative activities. Funding needs to support the networks to collaborate on primary prevention as well as intervention activities.
- Training is required, and this assists in building shared understanding and promote trust and respect.

Regional hubs (Herbert and Mackenzie, 2014)

The need for a more integrated response, particularly between Intimate Partner Violence (IPV) and Child Abuse and Neglect (CAN) was identified by a sector initiated study in 2014 (Herbert and Mackenzie, 2014). They proposed the establishment of regional hubs:

> *"Regional hubs would oversee and coordinate the Integrated System infrastructure in each region by connecting all local agencies, structures and processes together, linking existing local interagency networks, undertaking regional service mapping and population needs, maintaining and strengthening local referral pathways, facilitating the development of local solutions, community engagement and building on existing networks.*

The report did not however, focus on co-location of services.

Greater integration (FVDRC, 2016)

The Family Violence Death Review Committee (2016) Commission provides a comprehensive review and critique of New Zealand's current response to family violence, and identifies the need for greater integration of service responses. The Committee proposes a complex structure of services, which includes the option of co-location, but which is not a prominent strategy. Th Commission also proposes a particular role for the Police which has been influential in the formation of the Integrated Safety Response model.

6.4 Current government priorities

The four priority projects of the family violence work programme, which is jointly led by the Ministers of Justice and Social Development, are:

- Piloting an Integrated Safety Response model, where government and community services work together more closely to ensure families experiencing violence receive the support they need. This includes new services, intensive support for high-risk victims, and assistance for perpetrators change their behaviour (see below).
- Creating a Common Risk Assessment and Management Framework that people who work in the family violence sector can use to determine risks
- Implementing a Workforce Development Project, which will identify and put in place 'best practice' core competencies
- Appointing agencies to lead coordination of primary prevention and perpetrator programmes.

These projects will be supported by a cross-agency research and evaluation programme, led by Superu.[46]

New Zealand Integrated Safety Response (ISR) Pilots

Background

The development of the ISR Pilots followed the reviews of the NZ family violence system, where need for an enhanced response was identified. The Pilots are broadly based on the UK domestic violence and MARAC model where relevant agencies meet to assess and manage risk.

ISR Pilots are currently limited to referrals from Police and Corrections. There is a two stage risk assessment and management process. Safety Assessment Meetings provide the initial process which results in a plan for high, medium and low risk cases. High risk cases are referred to Independent Victim Specialists (IVS) located in family violence agencies, with ongoing risk assessment and management overseen by multi-agency Intensive Case Management meetings. Medium and low risk cases are referred to family violence and other agencies for follow up. Christchurch was the first ISR pilot site, commencing operations on 4 July 2016. A second site was established in Waikato (October 2016).

Aims and objectives[47]

The purpose of the ISR is to provide safe, effective, and efficient services for victims/ perpetrators/ whānau immediately after a Police reported family violence incident, or on receipt of a referral from Corrections. This involves:
- ensuring decisions are based on the right information
- safe, coordinated assessment and management relative to risk/ needs
- providing evidence, based around demand and supply, within the family violence sector

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[46] Social Policy and Evaluation Research Unit (Superu) is a NZ government agency, see http://thehub.superu.govt.nz/
[47] ISR Guidelines, Christchurch Pilot

Principles

The principles underlying the ISR model are:
- putting families/ whānau at the centre of the system
- addressing the risk and full range of needs of a family through early identification and collective impact using evidence based assessments to inform responses
- changing the behaviours of those using violence is the most effective way to prevent violence
- timely and accurate information sharing that respects the privacy and dignity of family members
- improving the collective understanding of family violence and having the right service at the right time
- acknowledging and respecting the diverse cultures, communities and populations that are affected by family violence

Partner agencies

The pilots involve Police, Child Youth and Family Services (CYFS), Corrections, Health, specialist family violence agencies and kaupapa Māori services, as members of the initial Safety Assessment Team (usually about 5 people in each SAM). These agencies are also members of the Intensive Case Management Team, as well as Justice, Education, Housing, Work and Income, and Accident Compensation.

Co-location

Police and CYFS are co-located. Other partners attend daily Safety Assessment Meetings (SAMs) with Police and CYFS. In Christchurch, the ISR has been established in a Police Station. In the Waikato IFS, Police and CYFS staff, are accommodated in a separate building. Agencies also attend ICM meetings at these locations.

Intake

The IFS Pilots only accept referrals from Police (following an incident), and from Corrections (eg. where a perpetrator is about to be released from prison). Agency referrals and self-referrals are made to family violence services. Children experiencing abuse and neglect are referred to children's services.

Assessment

NZ Police have developed a shortened form of incident report. Police consider it important to focus on investigating an incident, while taking into account the context, but not to conduct a full risk assessment.

Basic information (names) on each Police report of family violence in the area (Christchurch and Waikato) is sent to relevant agencies seeking further information (with a next day turnaround). Agencies include family violence providers, family support services, children's services, aged services, alcohol and drug services, disability services, and the accident claim system. The information is collated and cases are

presented to a Safety Assessment Meeting (held each day Monday to Friday).[48] The SAM decides the risk level – High, Medium or Low. A Family Safety Plan[49] is created for all levels of risk, actions are agreed, and tasks assigned. Initially the SAM had difficulty with the volume of referrals, and did not consider and develop plans for all the 'low' risk cases.[50] It now develops plans for all cases. SAMs assign tasks to members agencies, and makes referrals to other agencies, based on the agreed actions. Agencies accept the referral, and an engagement process ensues.

High risk cases

Cases which are identified as high risk are referred to family violence agencies for intensive case management which is provided by an Independent Victim Specialist Worker (IVS). These are new positions funded by the Pilot, and auspiced by family violence agencies. Medium and Low risk cases are referred to family violence and other agencies.

The IVS engages and meets with victims, conducts a risk assessment, obtains relevant information, updates the Family Safety Plan and provides a case co-ordination function, ensuring that other SAM directed actions are being completed. Planned caseloads are around 20, with a 12 week average length of support.

High risk cases are monitored by weekly Intensive Case Management Meetings (ICMs), comprising Police, CYF, Corrections, NGO Coordinator, IVS worker, POS worker, Health, Accident Compensation Commission, Education and Iwi. ICMs consider each high risk case, and agree an updated plan, including roles and responsibilities. The IVS worker continues to support victims, ensuring actions are completed, and reporting back to the ICM meetings. When risk is reduced to an agreed level, the case is transitioned back to SAM, and family violence services, for on-going management at the appropriate level.

Perpetrator Outreach

Referrals are also made to the new Perpetrator Outreach Service, which includes specialist men's workers who seek to contact and engage men, and assist them to make appropriate decisions, and change their behaviours, as well as keep track of their activities.[51]

Case management system

An electronic Case Management System (CMS) has been established (still in proof of concept stage) to improve information sharing between agencies, and to keep track of progress. The CMS has also promoted collaboration between agencies. The Coordinator monitors progress using the CMS, and prepares reports for the SAM for

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[48] It has recently been decided that SAMs will operate 6 days per week.

[49] This is effectively a case management plan detailing agency actions (rather than a Safety Plan to protect the victim).

[50] These referrals were passed on to family violence services, for follow up. However these were treated a slow priority, and many women were not contacted.

[51] The Outreach Service may also engage men who are accommodated in specialist rooming house style accommodation, following their exclusion from the family home when a Police Safety Notice is issued.

follow up and review. There are different levels of authorised access to the CMS, depending on agency and seniority.

Planning for offenders prior to their release from prison

The involvement of Corrections is essential, including pre-release planning where family violence offenders are to be released from prison. In this regard, the SAMs operate similar to MAPPAs, with plans developed according to the risk posed by the offender.

Governance and leadership

The family violence initiatives are led at a Ministerial level, involving 14 ministers. The Minster for Justice and the Minister for Social Development co-chair the oversight of family violence initiatives. A Commissioners (of Chief Executive) Group sits below the Ministers, responsible for implementation. Below this there is a Governance Committee. This structure, and ministerial involvement, is considered essential in order for agencies and organisations at all levels to support the reforms.

NZ Police have provided an effective leadership role in implementing the ISR Pilots. Once the pilots are fully established, it is expected that leadership will be handed back to the Ministry of Social Development.

Prosecutors

Police prosecutors attend SAMs and ICMs. This considerably improves the quality of information which Police prosecutors bring to the Court. The SAMs provide prosecutors with information which is more accurate and comprehensive, as well as current plans. These can be useful when Magistrates come to make decisions about Orders, Bail Conditions, etc. The Courts recognise these benefits, and there have been instances where Court proceedings have been held over until SAMs have met.

Culturally appropriate

The Pilots (and the whole approach to family violence in NZ) seeks to be culturally appropriate. There is a strong Maori influence in the risk assessment, tools, and risk management frameworks. NZ Police have a number of Maori members who are able to access Maori families and communities.

Early intervention and prevention

NZ Police are committed to prevention, and particularly target families where the risk is assessed as low, but where there is a high frequency of incidents, especially as these take up police resources.

Funding

The pilots were scheduled to run for one year and are expected to cost around $1 million per annum. The funds are being used to fund the IVS workers, the Perpetrator Outreach Service, family violence staff, and management and administrative staff.

Evaluation

The first evaluation report is due by the end of 2016, and a second stage evaluation is due in mid-2017.[52] Preliminary indications are that:[53]

- there has been some good work done with women and children, especially those at high risk

- levels of contact and engagement with women have increased significantly

- resourcing is proving to be inadequate in relation to the level of demand (family violence agencies may find it difficult to immediately accept referrals)

- IVS workers are employed by family violence agencies. A more consistent approach may be achieved if the Pilots employed the IVS workers

- additional funding is required in the family violence sector in order to adequately respond to demand. The original staffing complement appears inadequate

- co-location of key agencies is valuable, and an independent site may be preferable (ie. not within a Police station)

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[52] The evaluation report is likely to be available in January 2017
[53] Discussions with Jane Morgan, Director of the Christchurch IFS Pilot (November, 2016)

Staffing

The Pilots include the following 5 staff: [54]

- Director – operational and strategic oversight
- Coordinator (also called the Operations Manager) – coordinates day to day operations, chairs both Safety Assessment Meetings and Intensive Case Management meetings; liaises with local agencies; monitors outcomes; prepares reports and provides feedback to the SAM
- Administrator – provides administrative support; monitors progress of Family Safety Plans on the CMS
- Independent Victim Specialist (IVS) – ensures the safety of high risk victims by providing intensive support
- Perpetrator Outreach Worker – provides case work (risk management) assistance for the perpetrator, and helps change behaviours

Potential relevance to proposed Safety and Support Hubs in Victoria

The ISR Pilots include:

- The 'hub' includes Police, CYFS (co-located), as well as Corrections, Health, and specialist family violence agencies
- The focus is on family violence
- Pilots undertakes multi-agency risk assessment and planning (at two stages)
- The Pilots provides a family violence intake service
- Intensive Case Management Meetings are similar to RAMPs
- There are specialist family violence workers (IVS) for high risk cases (SSHs will have advocates)
- A high proportion of referrals are from Police reports
- Assessments are conducted based on pooled information from a number of data sources

Differences to the model proposed by the RCFV include:

- There are no internal intake staff at co-located site
- Police and Corrections are actively involved in the intake process together with family violence and children's intake services
- The Accident Compensation Commission provides valuable data
- No direct services or contact with victims within the co-location site, and no 'holding' capacity (this is provided by agencies to which victims and perpetrators are referred)
- Does not take family violence referrals from agencies, self-referrals, or family and friends of victims
- Does not take referrals for children experiencing abuse and neglect, and does not specifically seek to address family violence and child protection 'cross-over'.

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[54] http://www.police.govt.nz/sites/default/files/publications/isr-graphic-overview.pdf

7 AUSTRALIAN 'HUB LIKE' MODELS

7.1 Western Australia (CAC)

The George Jones Child Advocacy Centre in WA commenced in 2011 at the Parkerville Children and Youth Care Centre. The Child Advocacy Centre included professionals from different agencies including doctors, police, child protection workers, psychologists, and child and family advocates working as a multi-disciplinary team.

In 2015, a Multi-agency Investigation and Support Team (MIST) was established at the George Jones Child Advocacy Centre to respond to child sexual abuse cases. The team comprises an investigation team, child protection workers, specialist child interviewers, medical services, psychological therapeutic services and two Child and Family Advocates.

The Child Advocacy Centre is an easily accessible and visible service in the community, promoting the importance of child safety and wellbeing. The Centre runs community activities and programs and supports professionals in their work, facilitating ongoing learning for those who work with children.

7.2 The Multi Agency Protection Service (South Australia)

The South Australian Multi-Agency Protection Service (MAPS) was set up as a trial in 2015 to co-ordinate family violence information, and to enhance coordination of police and various government and support agencies.

MAPs aims to help ensure that both medium and high risk cases are adequately managed, and provide a more consistent approach to risk assessment across the State (especially within the Police).

The Multi Agency Protection Service (MAPS) is a partnership between 5 key organisations:
-   South Australia Police
-   Department for Communities and Social Inclusion
-   Department for Education and Child Development
-   SA Health (includes mental health, drug and alcohol, and sexual assault)
-   Department for Correctional Services.

South Australia Police leads this initiative which is based in Adelaide's CBD. Non government (family violence) organisations will be added to the partnership in the near future.

Police refer cases to the MAPS where there are domestic violence and child protection concerns. Every week about 400 high-risk cases are referred to the MAPs by SA Police. This represents the majority of police incident reports.

MAPS staff assess the level of risk based on the assessment forms receives (which include a score) and conduct further research on medium and high risk cases,

accessing Police and other data bases. Cases are brought to a multidiciplinary meeting for discussion. The meeting may result in a referral to Family Safety Meetings, or other referrals. There is no capacity for direct services, intake capacity or drop-in facility for women and children.

MAPS establishes a process for gathering and sharing information, and for multi-agency action planning to reduce risk and harm. This aims to respond to incidents more quickly, and enhance the capacity to intervene earlier and contribute to preventing the escalation of risk and harm. Co-location of partner agencies enables the integration of information from multiple sources, and the development of a shared knowledge base to inform timely action.

The Multi-Agency Protection Service incorporates a Domestic Violence Response Review, which has been established to address any process gaps in any of the agencies' response to cases of domestic violence. This helps ensure that interventions are timely, and not determined by administrative processes.

Currently MAPS referrals come from SAPOL only, but when fully implemented the service will extend to include referrals from all partner agencies, covering domestic violence and child protection concerns. Early intervention is recognised as a significant service challenge.

Family Safety Meetings receive MAPS referrals, and decide local strategies and actions. SA has removed the 'imminency' criteria for FSM, so FSMs can now consider a wider range of risk.

MAPS complements the South Australian Family Safety Framework through which government and non-government agencies hold meetings in local areas to share information about families most at risk of violence. Family safety Meetings have expanded scope to consider medium and high level services. Family Safety Meetings have a wider representation than the MAPS.

An internal review of MAPS has been undertaken.

7.3   Tasmania (SFCU)

The Tasmanian Government has established a $26 million Family Violence Action Plan, which comprises several programs.

Safe Families is a new program, which has just been established (August 2106) to coordinate support services for victims and to hold perpetrators to account. The Safe Families program includes two key actions - the Safe Families Coordination Unit, and Safe Choices. The Safe Families Coordination Unit (SFCU) is based on the South Australian Multi Agency Protection Service (MAPS) model, and on the UK Multi Agency Safeguarding Hubs.

The Tasmanian Government has committed $8 million over four years to support the implementation of the Safe Families Tasmania Coordination Unit and Safe Choices actions.

The Safe Families Coordination Unit (SFCU) is a state-wide collaborative unit which undertakes a cumulative assessment of risk and harm to coordinate support services for victims of family violence and to hold perpetrators to account.

Agencies co-located within a Hub includes representatives from:

- Tasmanian Police
- Emergency services
- Justice Department
- Health services
- Child protection agencies
- Department of Education.

Tasmania Police reviews all of the incidents that have occurred across the state in the past 24 hours, and assess and identify those incidents where the victim is at greatest risk (triage). The focus is on high-risk family violence situations, and recidivist offenders.

The SFCU collates the best available information from across government together in one place to ensure families at risk are identified and supported as early as possible.

Members of the SFCU operate as a multidisciplinary team, participating in and contributing to the multi-agency risk assessment to inform case management. The multidisciplinary team meets twice a day to assess referrals, prioritise cases, and agree on safety and action plans. Actions agreed by the SFCU are acted on by Agency representatives and outcomes are reported back to the SFCU. The Safe Families Coordination Unit is particularly concerned with the impact of family violence on children, especially those of school age.

The Unit is led by Police, and includes 11 police staff; an investigator and analyst from both Department of Justice and the Department of Health and Human Services, an investigator from Department of Education, and a review officer from the Department of Police, Fire and Emergency Management.

The unit aims to ensure families at risk are identified and supported as early as possible, and that perpetrators are prosecuted, through dedicated information gathering and intelligence development activities.

Safe Choices assists people who are experiencing family violence with a wraparound service to meet their needs and circumstances, whether they wish to leave or stay in a relationship. Safe Choices involves partnerships between domestic violence workers from multiple departments and non-government organisations. Following a trial period, *Safe Choices* will be extended to the North and North West of the State.

Safe Choices works closely with the Safe Families Coordination Unit to deliver early intervention and prevention support to anyone affected by family violence, including those who want to exit violent relationships.

8   Multi-Agency Public Protection Arrangements (MAPPA)

Multi-Agency Public Protection Arrangements were established in the UK (and subsequently in Scotland and Ireland), based on legislation introduced in 2000.

MAPPA is the process through which the Police, Probation and Prison Services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public. Agencies meet together to assess and manage risk, in order to protect victims, and the wider community in a co-ordinated manner. Agencies retain their full statutory responsibilities and obligations.

MAPPA assume responsibility for risk assessment and management of violent and sexual offenders, including where women and children are at risk of domestic violence.

Target group

There are three categories of violent and sexual offenders who are managed through MAPPA:

1. Registered sexual offenders are required to notify the police of their name, address and personal details, under the terms of the Sexual Offences Act 2003.

2. Violent offenders who have been sentenced to 12 months or more in custody and who are living in the community subject to Probation supervision.

3. Other dangerous offenders who have committed an offence in the past and who are considered to pose a risk of serious harm to individuals and/ or the wider community.

All MAPPA offenders are assessed to establish the level of risk of harm they pose to the public. Risk management plans are then established for each offender. MAPPA allows agencies to share information, assess and manage offenders on a multi-agency basis, and ensuring that effective plans are in place.

There are three levels of MAPPA risk management.

1   Ordinary agency management is for offenders who can be managed by one or two agencies (e.g. police and/or probation), and involves on-going liaison and sharing information about the offender with other agencies, if necessary and appropriate.

2   Active multi-agency management is for offenders where the ongoing involvement of several agencies is needed to manage the offender. This involves regular Multi-Agency Public Protection (MAPP) meetings to review risks and plans.

3   Same arrangements as level 2 but cases qualifying for level 3 tend to be more demanding and require the involvement of senior staff from the agencies, who can authorise the use of extra resources. For example, surveillance of an offender or emergency accommodation.

A proportion of MAPPA clients pose a risk to women and children.

Where an offender is a MAPPA client and meets the criteria for Level 2 or 3 MAPPA management, and there is a risk of domestic violence, MAPPAs collaborate with MARACs. MAPPs refer to MARACs, and vice versa. Independent Domestic Violence Advisers are invited to the MAPP meeting, together with any other professional with relevant information about the victim. The MAPP meeting ensures that the risk assessment and the MAPPA Risk Management Plan effectively identify and put in place actions to protect the victim. The quality of the MAPPA Risk Management Plan is enhanced with the additional information that the IDVA and others can provide. The Risk Management Plan is communicated to the MARAC.

Risk assessment

Before a management plan is put in place a detailed risk assessment will take place to identify the circumstances and opportunities that are most likely to lead to a further serious offence in this particular offender and the steps that can help reduce this risk. This will study the offender's previous offending history, life circumstances, include psychological assessments (where relevant) and any work in prison that the offender has completed.

The Police and the National Probation Service use a risk assessment tool called Risk Matrix 2000 which assesses the statistical likelihood of re-offending by adult male convicted sex offenders only. The Probation Service use a nationally validated risk assessment tool called OASys which help predict the likelihood and circumstances of future offending behaviour. For young offenders, the Youth Justice Board uses a system called ASSET which is specifically designed to understand the behaviours of offenders under the age of eighteen. Where domestic violence is indicated the SARA risk assessment tool is used.

Risk management plan

- A risk management plan is highly specific to each offender and their offending history, and might include any of the following:
- Accommodation at an Approved Premises where the offender can be monitored.
- A set of licence conditions such as having contact with children, or going within an exclusion zone in a town/city.
- A Civil Order such as a Sex Offender Prevention Order (SOPO) to prevent the offender doing certain activities, such as not entering a town where a victim resides, not to have unsupervised contact with children.
- A duty to report to an Offender Manager every week to undertake offending reduction counselling and work as part of their licence.
- In some very extreme cases there may be covert monitoring of offenders to protect the public.
- A disclosure of information to a member of the public for their protection.

9:   Position Description for Advocate/Independent Domestic Violence Advisor

Source: SafeLives website, Resources for domestic abuse service managers

http://www.safelives.org.uk/practice-support/resources-domestic-abuse-and-idva-service-managers/resources-domestic-abuse-service

Responsible to: *IDVA Service Manager and/or Senior IDVA*

Context of job: *Insert service and partnership context, and in which area the role will be based.*

Purpose of job: To provide a high-quality frontline service to victims of domestic abuse, delivering a service to those at highest risk. To work within a multi-agency framework consisting of the MARAC and local partnership responses to domestic abuse.

Main duties:

❑ Identify and assess the risks and needs of domestic abuse victims using an evidence-based risk identification checklist.

❑ Focus on and prioritise high risk cases and provide a pro-active, short to medium term crisis intervention service through individual safety planning and personal support.

❑ Work with high risk victims of domestic abuse to help them access services to keep them and their children safe.

❑ Advocate for high risk victims with agencies who can help to address the domestic abuse by**:**

   a) Understanding the role of all relevant statutory and non-statutory services available to domestic abuse victims and how your role fits into them.

   b) Providing advocacy, emotional and practical support and information to victims including in relation to legal options, housing, health and finance.

   c) Working directly with all key agency partners to address the safety of high risk victims and ensuring that their safety plans are coordinated particularly through the MARAC.

❑ Mange a case load ensuring each client receives the appropriate service individual to their needs.

❑ Support the empowerment of the client and assist them in recognising the features and dynamics of domestic abuse present in their situation, and help them regain control of their lives.

❑ Understand multi-agency partnership structures and work within a multi-agency setting which will include participation at the MARAC. You will contribute interventions and help design a plan to protect victims and any children, while

maintaining an independent role on behalf of your client, keeping their safety as central to any response.

❑ *In accordance with your organisation's case management policy:* Be proactive with your *line manager* in carrying out periodic case reviews based on a review of risk and abuse which:

   a) Feeds back into action planning to further progress, signpost or close cases and;

   b) Provides feedback to your clients/agencies.

❑ Help maintain accurate and confidential case management records *and databases* and contribute to monitoring information for the service.

❑ Comply with data protection legislation, confidentiality and information sharing policy and procedures and all legislation connected to your work.

❑ Support colleagues and partner agencies, through awareness raising and institutional advocacy, in order to provide the best possible service for victims of domestic abuse. *May wish to define training events/roles.*

❑ Respect and value the diversity of the community in which the services works in, and recognise the needs and concerns of a diverse range of survivors ensuring the service is accessible to all.

❑ Remain up-to-date and compliant with all organisational procedures policies and professional codes of conduct and uphold standards of best practice.

Person specification

Knowledge

You are required to:

❑ Have a good understanding of domestic abuse including the impact of domestic abuse on victims and their children.

❑ Have theoretical, practical and procedural knowledge of civil and criminal justice remedies for victims of domestic abuse and their children.

❑ Understand child protection issues, and the legal responsibilities surrounding these issues.

❑ Understand the principles of risk assessment, safety planning and risk management for victims of domestic abuse and their children.

❑ Understand the remits and resources of relevant statutory bodies and voluntary agencies.

❑ Understand and be committed to equal opportunities and diversity issues in policy and practice.

Experience

You are required to have experience of:

❑ Working with vulnerable people.

❑ Managing a caseload.

❑ Working within a multi-agency and legislative framework.

Skills/ Qualifications/ Professional Membership:

You are required to:

❑ Have computer literacy skills *and have some experience of working with databases.*

❑ Hold a SafeLives IDVA training certificate, or a relevant degree, or demonstrable equivalent experience, or a vocational qualification, *or be willing to undertake relevant study?*

❑ Have excellent communication, negotiation and advisory skills, both written and verbal when interacting with a range of agencies and individuals.

❑ Have strong crisis management skills and the ability to deal with stressful and difficult situations.

Personal qualities

You will be required to:

❑ Be compassionate and empathetic with your client's situation.

❑ Show initiative and be proactive when managing your case load and interacting with your clients and agencies you're working with.

❑ Act with integrity and respect when working with all clients, agencies and individuals.

❑ Work flexibly as part of a team.

❑ Be optimistic about the possibility of personal growth and change.

❑ Motivate individuals and agencies to move through courses of action and decision making processes.

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