

MULTI-AGENCY TRIAGE PROJECT

Implementing Stage 3
of the Multi-Agency
Triage Model

Final Report

Cathy Humphreys & Deb Nicholson
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PROJECT PARTNERS

Multi-Agency Triage (MAT) Project partners:

- Victorian State Government, Department of Health and Human Services, North Division - principal funding body
- Department of Health and Human Services, Child Protection North Division
- Berry Street Family Violence Services - host agency
- UnitingCare (formerly Kildonan) - Hume Moreland Child FIRST
- Children's Protection Society - North East Child FIRST
- Victorian Aboriginal Child Care Agency (VACCA)
- Plenty Valley Community Health - Men's Active Referral Service (MARS)



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Cathy Humphreys & Deb Nicholson

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Background

The Multi-Agency Triage (MAT) project was delivered in three stages between 2012 and 2017. The Final Report tells the story of the successes and challenges of the third stage of the innovative MAT pilot. From December 2015 to December 2017 the MAT delivered daily collaborative multi-agency triaging of all police family violence reports (L17s) in the north-eastern region of Melbourne. An important part of this story is the operational and strategic collaboration between the University of Melbourne, DHHS Child Protection, Child FIRST, Victorian Aboriginal Child Care Agency, Plenty Valley Community Health Men's Active Referral Service (MARS) and Berry Street Specialist Family Violence Service, that enabled the project to achieve its aims. The report shows how the MAT project explored and developed a different way of managing and responding to police referrals of family violence incidents and the results of that. It also shows how the triage process was informed by the *Safe and Together™* principles and lens at the "front-end" of intake and triage and how this can influence the whole case progression.

The MAT demonstrated, through collaborative multi-agency triage, risk assessment and referral using the Safe and Together™ Model better management for intake and intervention for children affected by family violence.

Aims of the MAT Project

- To model a "single door approach" where all police reports enter a central point in order that multi-agency representatives collaborate to undertake risk assessments, triage and referral
- To model a "differential response" where all women who are the subjects of police family violence reports, and who have children are not referred automatically to statutory Child Protection if they do not meet the threshold for further child protection investigation
- To adapt the *Safe and Together™* Model for use in a front-end triage process
- To collaborate effectively at operational and strategic governance levels

The Safe & Together Model provides a framework that is critical to good outcomes and we need to ensure that the guiding principles are embedded in practice from the point of triage and assessment and then throughout the life of the case.

Operations Group member

Methodology

An action research process was used throughout the project that enabled active problem solving in the MAT room and by the strategic partners. The presence of an action research project manager (University of Melbourne) throughout the project ensured that reflective processes, observations, professional development and active problem solving were fundamental features of the daily work of the MAT and the strategic groups. Mixed methods were used for data gathering including: collection of administrative data over three separate time periods; data from two questionnaires with the MAT team and their managers; and qualitative data gathering using semi structured interviews and surveys. This mixed method approach contributed to providing insights into different aspects of the project.


Results

By undertaking collaborative information sharing and multi-agency triage (risk assessment and referral) over two time periods in 2016 and 2017 the following results were seen:

3224
L17s WITH CHILDREN
WERE TRIAGED BY THE MAT TEAM



7342 CHILDREN INCL. UNBORN INFANTS
AFFECTED BY FAMILY VIOLENCE
WERE IDENTIFIED ON L17 REPORTS OR BY PARTNER AGENCIES AT THE MAT



275 CASES INVOLVING CHILDREN
WERE REFERRED TO CHILD PROTECTION FROM MAT FOR PROTECTIVE INVESTIGATION REPRESENTING JUST OVER 10% OF CASES TRIAGED



THIS EQUATES TO ALMOST **90%** BEING DIVERTED FROM **UNNECESSARY INTERVENTION** FROM STATUTORY CHILD PROTECTION

7

This achievement of providing a differential response for large numbers of children and their parents away from the tertiary statutory system is remarkable - most families did not proceed to protective investigation. The practice of sending all referrals to Child Protection has been proven in other studies to be both inefficient and problematic given the stress that such referrals create for families (particularly women) living with domestic and family violence.

Also, the MAT project helped to identify the key attributes, skills and support requirements for staff from different agencies working collaboratively in a shared space.

In addition to the above results, the Tracking Project pointed to the uptake of referral pathways and suggests this is the next stage in which there needs to be a concentration of effort, as the responses to children in their family context were not well developed at the point of the project's conclusion.

Conclusions

1. That a single door model of L17s intake and risk assessment is a significant factor in ensuring the efficient and effective risk assessment and referral of women and children.
2. That a differential response is possible and desirable to ensure women and children are only referred to Child Protection if they meet the threshold for a statutory response.
3. That multi-agency information sharing and collaboration at an operational level (in the MAT room) is effective for ensuring the most comprehensive view of the risk indicators for women and children and dangerousness indicators for male perpetrators. Structured application of *Safe and Together™* as part of this collaborative approach ensured the focus on the perpetrator's pattern of behavior.
4. That multi-agency collaboration is challenging and worthwhile at a strategic partnership level and is critical to providing the overall governance to the MAT process.
5. That appropriate supervision and support, professional development and opportunities for reflective practice are critical to MAT team well-being and effective functioning.

"I think it is imperative that a MAT worker is ... competent in assessment, confident to work in a group, understands the need to participate, demonstrates respect to all, has an understanding for the need to work together for better outcomes and has institutional empathy in regards to other staff/organisations roles and limitations."

(Operations Group member)

Challenges

1. Absence of police in the MAT room - this is a critical deficiency in terms of the *Safe and Together™* key principle of keeping the perpetrator in view, therefore enabling improved risk assessments for women and children (based on information that may highlight the danger a perpetrator poses).
2. Lack of consistency with L17 police reports - this is a statewide issue that was amplified in the MAT project when significant numbers of children were identified by collaborative information sharing, despite frequent gaps in reporting on the L17.
3. Lack of services available to refer men, female respondents and violent adolescent subjects of L17s.

Next steps

All stakeholders in the MAT project have been driven by the desire to create a more effective, efficient, efficacious and ethical response to children living with domestic and family violence. The MAT project is a step in this direction and provides the foundation for future developments, especially in the context of the rollout of Support and Safety Hubs in Victoria which can create greater accountability and safety for children and their families.

1. INTRODUCTION

The Multi-Agency Triage project (MAT) is the final stage of a three-stage project that began in 2012. The model has changed significantly since this time and now involves daily collaborative triage of L17s (domestic and family violence incident reports) referred by Victoria Police in the northern metropolitan areas of Melbourne. Funded by the Department of Health and Human Services (DHHS), the MAT project was implemented as an action research and co-design approach by the University of Melbourne (UoM) to enable stakeholders to inform the model's development. The approach is based on a collaborative approach to assessing risk to women and children (Affected Family Members) to determine an appropriate service response.

The project has been delivered in three stages:

Stage 1 began in November 2012 and explored the model, resulting in the development of weekly multi-agency case conferencing of domestic and family violence (DFV) cases in a process chaired by a Child Protection manager. It involved weekly discussion of cases of concern to Child Protection, Child FIRST and family services, and the specialist domestic violence organisation, Berry Street Family Violence Services. These discussions included: information sharing about risk, agreement about appropriate referral pathways and the management of risk. Although this process was referred to as 'triage', it was actually case conferencing and multi-agency case discussion of families referred by different organisations.

An evaluation of Stage 1 informed the development of the next phase of the project. This evaluation highlighted the inefficiency of double and sometimes triple referral pathways from Police family violence incidents (L17 reports); the many children referred to Child Protection (CP) who did not progress to investigation; and the slowness of response when meetings were only once a week.

Stage 2 began the process of developing a model, to establish and monitor a 'genuine' triage where L17s could be rapidly risk assessed and referred on a daily basis. Two progress reports (May 2016, March 2017) of these first two stages have been delivered and provide the foundation for the Stage 3 Report.

Stage 3 is the basis for this final report. It provides an analysis of the process and data derived from the triage 'going live' to a full five day a week operation, with a co-located multi-agency team meeting to assess risk and manage the process of referral of families subjected to DFV.

This report documents the third stage of the action research process which has established and developed the Multi-Agency Triage. It refers to previous Multi-Agency Triage (MAT) reports developed by the University of Melbourne, but provides a focus on the third and final stage of the project. This report's discussion of the work of the MAT has the potential to inform the development and implementation of the Support and Safety Hubs (the Hubs). To this end, part of the discussion has been structured to enable the findings of the MAT project to align with the key functions and goals described in the *Support and Safety Hubs: Statewide Concept* (Victoria State Government, 2017). However, whilst this report does provide evidence to inform some aspects of the Hubs, other issues are also raised and explored.

The report tells the story of a successful project where the MAT team learned ways to:

1. Model a single door approach for receiving and rapidly triaging police family violence reports avoiding multiple uncoordinated service responses;
2. Strengthen the pathway for women and children;
3. Create a differential response that is significant enough to impact on state-wide child protection intake data;
4. Provide a “safety net” due to multi-agency information sharing that ensures that the large number of children not named on an L17 police report are identified, and referred appropriately;
5. Adapt the *Safe and Together™* Model for use in a front-end triage process;
6. Collaborate effectively at operational and strategic levels;
7. Accommodate and organise a team of people operating in a hub-like environment;
8. Deliver and adapt training, support and facilitation for effective functioning of a co-located multi-agency triage team; and
9. Identify opportunities for systemic advocacy (women as respondents).¹

2. POLICY CONTEXT

Implementation has commenced on many Royal Commission into Family Violence (RCFV) recommendations, a number of which will inform the ongoing development of triage models for intake into the hub. The recommendation to develop Support and Safety Hubs (“Hubs”) in each of the 17 DHHS areas is significant for victims and their families. The RCFV has recommended that the Hubs consolidate intake for each of the DHHS areas providing a single area-based entry point into local specialist family violence services, perpetrator programs and integrated family services. The Hubs are intended to be a visible contact point for victim survivors and will provide the community with access to highly skilled workers that are integrated into the broader social service and justice systems. (Royal Commission into Family Violence, 2016). A key function of the Hubs will be to provide wrap-around support, safety and recovery services, including initial contact, screening and multi-disciplinary triage, specialist risk assessment and safety planning.

The RCFV also recommended that Hubs focus on perpetrators of family violence, “to keep them in view and play a role in holding them accountable for their actions and changing their behaviour” and “to help tilt the focus of the whole service system towards tackling the source of the violence: the perpetrator” (Victoria State Government, 2017, p. 10).

While the early developments of the MAT project pre-dated the RCFV, these recommendations provided the policy context in which the MAT project was situated. The project actively developed the triage, risk assessment and referral processes involved in accepting police referrals of family violence with a particular focus on children living with DFV. It also developed strategies to develop, apply and contextualise the *Safe and Together™* Model (developed by David Mandel and associates from the Safe and Together Institute) which provides a shift in focus to the perpetrator and is sensitised to the way in which mother-blaming rather than partnering with the non-offending parent (usually mother) occurs.

While the Victorian context is relevant, there are also other important policy initiatives which underpinned the work of the MAT project. Although child protection systems differ between Australian states and territories, there has been a growing preference nationwide for early intervention to ensure that families gain timely access to community-

¹ The Key Learnings section of this report is organised in this order.

based child and family services before their circumstances deteriorate and warrant an intrusive statutory response. Developing alternative pathways, otherwise known as a differential response, also constitutes a way of managing the inundation of Child Protection with referrals of children living with DFV, many which do not go through to investigation (Australian Institute of Health & Welfare, (AIHW) 2017; Matthews, Bromfield, Walsh & Vimpani, 2015). The MAT project was concerned with engaging with this issue and developing processes which were attuned to this policy development.

3. FRAMEWORKS UNDERPINNING THE WORK OF THE MAT

The MAT project was guided by three key frameworks, the *Common Risk Assessment Framework* (CRAF; Department of Human Services, 2012), *Best Interests Case Practice Model* (BICP Model; Miller, 2012) and the *Safe and Together™* Model (developed by David Mandel and associates, from the Safe and Together Institute). Each brought a different dimension and lens to the work and ensured that the model developed throughout this project was cognisant of, and contextualised, to local application. While the CRAF and BICP Model are specific to Victoria, the *Safe and Together™* Model, developed in the US, provided an overarching theoretical model which helped to integrate the practice for both DFV workers and Child Protection workers, and within statutory and non-government sectors.

3.1 Victorian Common Risk Assessment Framework

The *Victorian Family Violence Risk Assessment and Risk Management Framework* (known as CRAF; Department of Human Services, 2012) was developed to assist professionals and practitioners working with women to identify risk factors associated with family violence and to respond appropriately. In Victoria, the set of risk factors used by police on their L17 reports of incidents of family violence reflect the indicators used in the CRAF by other professionals working in the area and help in creating a common language for risk and risk management across the sector. The CRAF also aligns with similar risk assessment and management frameworks which guide DFV work both nationally and internationally (Stanley & Humphreys, 2014). The MAT project used the CRAF indicators as well as the designated categories of risk (standard, elevated and immediate risk) to guide the practice and decision making of the triage.

3.2 Best Interests Case Practice Model

The *Best Interests Case Practice Model* provides a foundation for working with children (including the unborn child) young people and families in Victoria (Miller, 2012). It aims to reflect the case practice directions arising from the *Children, Youth and Families Act 2005* and the *Child Wellbeing and Safety Act 2005*. Designed to inform and support professional practice in family services, child protection and placement and support services, the model aims to achieve successful outcomes for children and their families (Miller, 2012).

3.3 The Safe and Together™ Model

The *Safe and Together™* Model (Mandel, 2014) is a suite of tools and interventions to transform child welfare practice in cases of domestic violence. It is child focused, strengths based and family centred practice. The model supports a differential response by focusing on improved assessment, and better partnerships with the non-offending parent (adult survivor). It also ensures a clear decision-making and case planning focus on the source of the danger and harm to child and family functioning: the perpetrator's behaviour pattern (Mandel, 2014). The usefulness of the *Safe and Together™* Model lies in its ability

to provide a clear set of principles that specialist FV, family services, and Child Protection workers can agree with and actively use to shift practice from destructive (mother-blaming) practices, which close down help-seeking and may increase the risks to the non-offending parent (usually mother) and children, to practice which is proficient, targeted towards the perpetrator of violence and supportive and encouraging of protective steps taken by women with their children (Humphreys, Healey & Mandel, 2018).

4. MAT processes

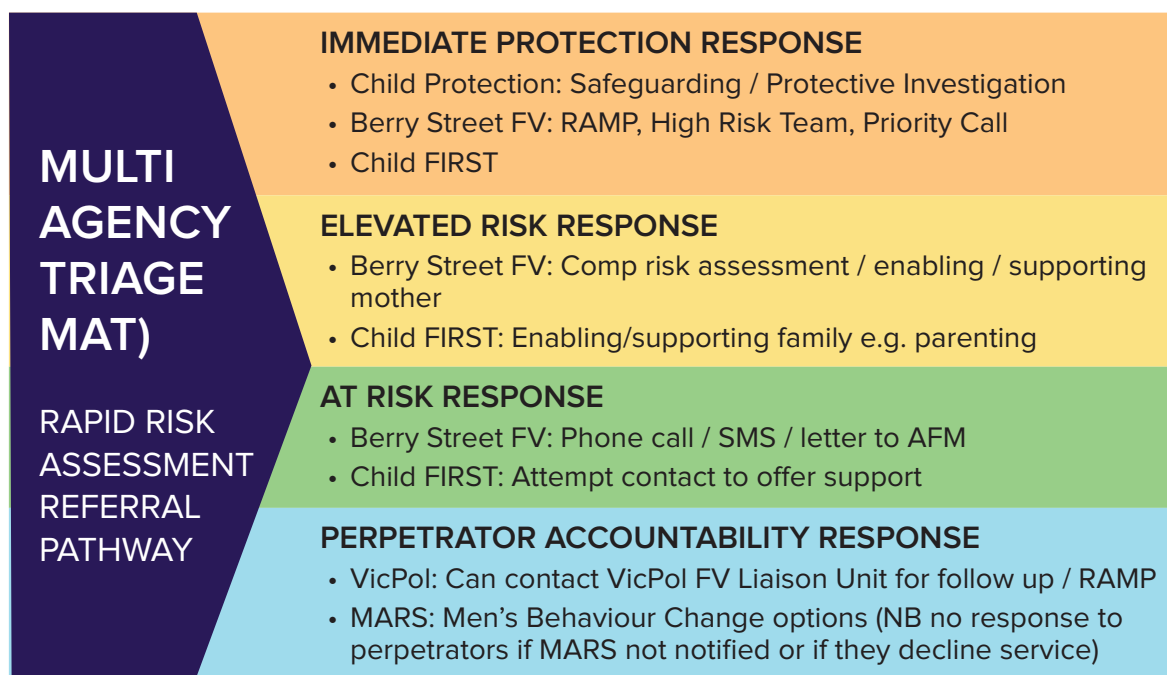
4.1 Work flow in the MAT room

The work flow of MAT has evolved over the two years of the project as part of the action research and co-design process. Initially, L17s were assessed and prioritised which resulted in cases being “picked up and put down” multiple times. Following Berry Street’s involvement with the Toyota Project, which sought to maximise efficiencies through changes in work practice, it was agreed to trial a parallel process in the MAT room. This process (which remains today) involved assessing and completing each case before moving onto the next one. This process was the basis of the “staged approach” summarised below. A comprehensive flow chart has been developed to describe this process (see Appendix 1). In summary, the collaborative (joint) risk assessment process used in the MAT room functions to:

1. Scrutinise all L17s received overnight or over the weekend into the Berry Street, Specialist FV Team;
2. Identify children of Affected Family Members (AFM’s) where they have not been noted on the L17 (the safety net);
3. Identify where an AFM or child may already be linked to a service provider and if a case is active or ‘open’ in Child Protection;
4. Risk assess in a multi-agency team and prioritise risk for all L17s where there are children involved;
5. Pay primary attention to the risks from the perpetrator of violence by training workers to use the Aide Memoire (see Appendix 2), thereby shifting the focus to where the risk of harm lies; and
6. Refer the woman and children to the appropriate service for a response.

The diagram on the next page illustrates the referral pathway out of MAT based on the risk assessment finding:

Figure 1. Referral pathway out of MAT.



NB: If both mother and children are at immediate risk there may be a dual allocation to Berry Street FV & Child FIRST. If for example, mother is 'at risk' and children are 'elevated risk' they will only be referred to CF, not both

4.2 About the Initial Multi-Agency Risk Assessment Practice Tool²

The Practice Tool was developed as a method to assist the MAT team to maintain their focus on the perpetrator's behaviour when assessing risk to women and children. It was informed by the *Safe and Together™* Model (Mandel, 2014), taking its key principles and adapting them to a tool which is specific to the MAT project and its rapid risk assessment process. The Practice Tool has evolved over time through its use in the MAT room and has most recently been updated to reflect the current practice, using a three-stage process (see Appendix 1). The Practice Tool is no longer used to formally guide every risk assessment but is referred to by the facilitator if the process gets "stuck" or if the discussion drifts from a focus on the perpetrator. The MAT team and facilitator have reacted positively to the Practice Tool and have been instrumental in its development over the life of the project.

The Practice Tool was designed to be used by the Multi-Agency Triage Facilitator in the triage room when undertaking multi agency risk assessments and referrals. The aim of the Tool was to keep the partner agencies undertaking collaborative risk assessment (of police family violence incident reports) focused on the perpetrator's role in causing the family violence, and the impact on the mother and children.

The first question in the Practice Tool is "What perpetrator behaviours led to the police family violence report?" This question establishes the focus for a line of questioning that pivots to the perpetrator. MAT practitioners have found this to be very useful in helping to understand from the outset (at triage of the L17) how to assess risk and make appropriate referrals for the mother and children, that acknowledges her efforts in protecting her children, rather than blaming her for failing to do so.

Another key question in the Practice Tool is "What don't we know?". This question

² The Practice Tool was called the MAT Aide Memoire in earlier iterations of the project.

encourages the practitioner to acknowledge early when they don't know the perpetrator's whereabouts, his mental health status, his use of alcohol or other drugs, any history of FV, for example. Before this question was added, it was common for practitioners to fill the "unknown" space with speculation about the perpetrator, or tellingly, further discussion and speculation about the mother. This ensured that the father/perpetrator was invisible or less visible in the risk assessment process. Including this question also led to triage practice decisions such as finding out more about the perpetrator from police or the men's service.

5. METHODOLOGY

5.1 Overview

The action research process continued into Stage 3 of the project, with active problem solving by the operations steering group and the MAT team as each new problem arose. An action research design was chosen as the most appropriate approach in an area where knowledge is partial and where the commitment to 'situation improvement' is a priority (Ison, 2008). The action research project manager assisted the process by providing reflective processes which allowed the emergence of new ideas and the validation of different perspectives. Active problem-solving through iterative processes were a feature of the development of the model and included both the Operations Group of managers as well as the MAT team members. A democratised decision-making process provided the milieu through which MAT team members and the operations governance group agreed to decisions and adopted changes to strengthen the functionality of the MAT process.

Within the iterative processes of the action research cycles (see Stage 2 Interim Report), mixed methods (qualitative and quantitative) were used to explore the following research questions:

- Can co-design using action research principles demonstrate the characteristics required to support a multi-agency risk assessment and risk management response to FV from statutory and community based services?
- Can the inundation of the Child Protection system with referrals of children who do not reach the threshold for investigation be addressed through a differential response?
- Can dual pathways of referral by police to Child Protection and specialist DFV services which threaten to overwhelm both systems be changed?
- What are the elements in collaboration that contribute to strong multi-agency functioning?

The mixed method approach (Creswell & Plano Clark, 2011) was adopted to ensure that different sources of data could be used: a pragmatic decision to realise the aims of the project (Tashakkori & Teddlie, 2003). Administrative data, questionnaire data and semi-structured interviews all contributed to provide an expanded understanding of the different aspects of the project.

5.2 Administrative data

- Administrative data was collected over three time periods (November 2012 - November 2013, July - December 2016 and July - October 2017). This data was collected routinely as part of the daily work of the MAT team. An administrative worker recorded administrative data about AFM and children, risk outcomes, referrals and rationale in relation to decisions.

- One month snapshots were taken of the client's pathway following the MAT risk assessment and referral process. The June 2017 data is reported below.

The administrative data collection for the MAT project evolved between December 2015 and November 2017.

- For the July 2016 commencement of 5 day a week triage, a spreadsheet was developed and implemented for recording outcomes.
- A purpose-built database was commissioned by Berry Street alongside continuation of a separate spreadsheet for Child Protection to capture additional specific data.
- An unintended consequence of the introduction of the L17 Portal resulted in the need to develop two new spreadsheets to capture all data. For example, the new portal does not count children, only L17s. It had been anticipated that the MAT database could integrate with the L17 portal from the outset, however, this was not possible during the life of the MAT project.
- The analysis undertaken in this report is based on extensive cleaning of the data from the spreadsheets.

5.3 Questionnaire data

- Surveys were conducted with the MAT team and the Operations steering group via Survey Monkey. Anonymous responses were returned to yield qualitative data (see below).

5.4 Qualitative data

- Interviews (N=9) were undertaken with practitioners and their managers to provide points of review on both the immediate and wider goals of the project. These partnership review interviews were based on the *Safe and Together™ Collaborative Practice Matrix* (Connolly, Healey & Humphreys, 2017) and used to provide rich information about the collaborative partnership and suggestions for moving forward. The interviews with the MAT Team members provided important reflections on the processes required to manage and develop a multi-agency triage.
- A survey of the MAT Team (N=9 of possible 16) and the Operations Group (N=5 of a possible 6) was undertaken.
- Ethical approval for the project was provided by University of Melbourne.³

6. DISCUSSION OF THE DATA

6.1 Overview

This section provides a discussion of data collected July - December 2016 (Time 2), with a brief comparison to data collected during Stage 1 of the MAT Project in November 2012 - November 2013 (Time 1), and an introduction to the Time 3 data (July - November, 2017).

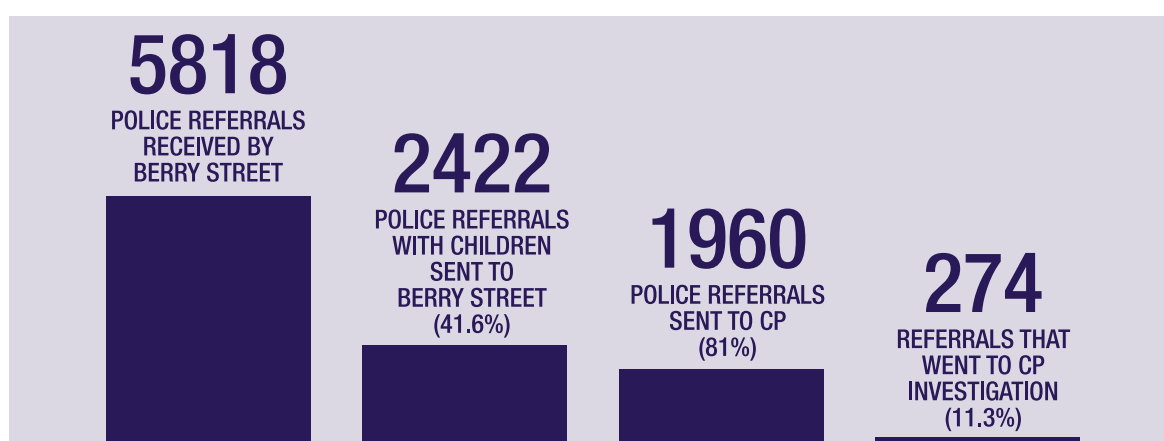
The second data period was chosen because it was the start of the full time “live” phase of MAT after six months of part-time trialling up to the point of the L17 Portal going live on 9 December 2016. Data collection for the MAT has evolved considerably since the first triage trial in December 2015. The challenges the MAT project faced to achieve consistent data collection during a live triage process highlighted the importance of having clear

³ HREC ID: 1340974.1

and comprehensive systems to record numbers of L17s coming in, numbers triaged, risk assessment outcomes and referral outcomes at a minimum. Issues with data collection also highlighted the need for a data system that goes beyond collecting information in the MAT room to the referral agencies, in order to track women and children's progress through the agency. It is also critical to track male perpetrators to keep them in view.

The early *administrative data* showed significant shifts in the police referrals to Child Protection. Due to different time periods (12 months for Time 1 data; 6 months for Time 2 data), a direct representation of the change between Time 1 and 2 data cannot be made. However, the trend was clear: at Time 1, from November 2012 to November 2013 when the MAT project was becoming established, baseline data was collected. Child Protection data for the project's catchment recorded a total of 1960 police referrals of families to CP (See Table 1). Of these 1960 referrals, only 14% (N=274) resulted in a Child Protection investigation. For the similar time period, the specialist DFV service recorded a total of 5818 police referrals, of which 42% (N=2422) involved children and therefore indicated dual Child Protection and specialist DFV referrals of many children and families and only a minority of families referred to Child Protection moving onto investigation (Humphreys, Healey, & Nicholson, 2017).

Table 1: Time 1 data November 2012 - November 2013



At Time 2, (See Table 2) from July to December 2016, a total of 5,266 police reports relating to adult victims of FV were received at the specialist FV service in the catchment area. Of these, 63% (N=2041 reports) had children identified in the police form, which amounted to a total of 3311 children⁴ identified in the reports. More importantly, 52% (N=1707) of police reports relating to adult and child victims of FV were triaged (the remaining 13% (N=449) were already open in Child Protection or family services). Of these, 8.2% (N=125) police reports were referred to Child Protection for investigation; and 16.9% (N=289) police reports identifying children involved were referred for a child and family service intervention including 1.2% (N=22) referred to the specialist Aboriginal child care agency, VACCA (Humphreys, Healey & Nicholson, 2017, p.7).

The data for Time 3 (See Table 2) represents five months of data rather than the six months of data represented in Table 2. Time 3 also provides an enhancement of data fields. It indicates the importance of sharing data from the different agencies, an issue which will be discussed in further detail below. Of note are the number of children *not identified* in the police L17, but later identified by agencies (L17 N=2041; multi-agency databases N=3311). It also shows that a significant group of cases were already opened in Child Protection highlighting the importance of the communication about Child Protection data to the triage.

⁴ NB In Progress Report 2, 75 unborn children were identified in the data. However, Time 3 data does not include information about unborn children, which is an oversight.

Table 2: The referral flow of L17 police family violence incident reports

TIME 2	TIME 3
27th July - 6th December 2016	July - November 2017 (full calendar months)
<ul style="list-style-type: none"> • 5266 L17s (with and without children) were received by Berry Street • Of these, 63% (n = 2041) L17s had children for attention in the MAT process (Av 107 per week) • There were 3311 children plus 75 unborn infants identified in the 2041 L17s. • 449 of the L17s related to cases already open in CP or Integrated Family Services (and were not triaged at MAT) • 1707 L17s in total were triaged at MAT 	<ul style="list-style-type: none"> • 2196 L17s (with and without children) received by Berry Street • Of these, 68.5% (N=1505) L17s had children for attention in the MAT process (Av 72 per week*) • There were 3956 children identified in the L17s • 673 L17s related to cases already open in Child Protection (case management, intake and protective investigation). • Cases open in CP Case Management and CP Investigation (N= 554) are not triaged • Cases open in CP intake (N=119) are triaged** • 190 L17s related to cases already open in Family Services were triaged in this time period • 1517 L17s in total were triaged at MAT

*The number of L17 referrals in Sept. 2017 were unusually low, creating a different average for the period Time 3.

**Some anomalies arose in administrative data but none create a significant difference in the pattern of the data.

7. KEY LEARNINGS

The discussion of the data on the following pages have been organised under each key learning for Time Periods 2 and 3 only. A summary identifies the following developments:

1. Model a single door approach for receiving and rapidly triaging police family violence reports avoiding multiple uncoordinated service responses;
2. Strengthen the pathway for women and children;
3. Create a differential response that is significant enough to impact on state-wide child protection intake data;
4. Provide a “safety net” through multi-agency information sharing, ensuring the identification of children not recorded on the L17 police report and enabling them to be triaged;
5. Adapt the *Safe and Together™* Model for use in a front-end triage process;
6. Build on existing collaborations (partnerships) at operational and strategic levels, and find ways to strengthen such partnerships;
7. Accommodate and organise a team of people operating in a hub-like environment;
8. Deliver and adapt training, support and facilitation for effective functioning of a co-located multi-agency triage team; and
9. Identify opportunities for systemic advocacy (women as respondents).

7.1 Key learnings 1 and 2: Modelling a single door approach and strengthening pathways for women and children

The MAT project modelled a single door approach for receiving and rapidly triaging police family violence reports (L17 reports). Co-location of intake workers representing the specialist family violence service (Berry Street), two Child FIRST teams located within the catchment for the specialist service, the Men's Referral Service, the Aboriginal child care organisation (VACCA), and Child Protection provided the basis for the single door approach. Due to technological difficulties, there were several weeks when Child Protection was not able to be in the MAT room and accessed the triage remotely. This experience highlighted the problems with remote access, slowing down the process and making it difficult for Child Protection to actively participate in the risk assessment discussions while not physically present.

Similarly, the lack of police presence at the MAT undermined the efficiency and the ability of the project to respond with a perpetrator focused intervention. Without police present, it was difficult for the MAT to fill in gaps in missing data or clarify the current actions of police in relation to cases. The issues experienced due to a lack of police presence highlight the central role of police in risk management.

Formalising agreements between organisations and holding regular meetings of operational managers from partner agencies facilitated the authorising environment required to share information and risk assessment based on the databases of each organisation in the single door approach. The data demonstrates a steady flow-through of L17 referrals.⁵

Building on the previous tables of data about the flow of work, the following table provides a different lens and highlights the single door approach.

Appendix 2 outlines the process followed to assess risk for both AFM and children. Separating L17 referrals with and without children (discussed in Key Learning 3: Safety Net) and identifying cases already open with an agency are critical steps and ensure that children are not missed, and that cases are not inadvertently (and inefficiently) referred to other organisations.

Based on the experiences of the MAT team, minor changes were made to the process between Time 2 and Time 3. For example, it was agreed that the dynamic nature of risk meant that it was preferable to triage cases already open in Child Protection Intake, Child FIRST and family services to update the risk assessment and to then provide appropriate feedback to the case worker.

There are fluctuations in the data which suggest that trend data over time is important. Time taken on referrals may also vary. At Time 2, "rapid" risk assessment (triage) took on average 10 minutes, with some cases taking up to 30 minutes. At Time 3, after the "staged approach" (See Appendix 2) was introduced, further analysis of the time taken showed that cases were triaged in an average of 8.6 minutes, with most of the time taken at Stage 2. At this stage, all agencies (except Child Protection) check their agency databases for prior contact with the woman named on the L17. If there is relevant history from any agency that informs risk, the case proceeds to Stage 3 for a full risk assessment (including Child Protection history). The evidence shows that most time is spent sharing relevant agency-specific history amongst the team. It appears conclusive that the collaborative history sharing at Stage 2 is effective in terms of being able to create efficiencies in the actual risk assessment process across the day. The data highlights the importance of keeping a focus on throughput and timing through a clear and consistent triage.

⁵ Note that the time periods in Table 1 and subsequent tables in the Key Learnings section are different. Time 2 is six months and Time 3 is five months.

Table 3: Time 2: Levels of risk for children

CRAF RISK LEVEL	TIME 2	
Requires immediate protection (highest risk)	273	18%
Elevated risk (medium risk)	710	47%
At risk (lowest risk)	269	18%

Table 4 below provides the breakdown of risk levels for children in Time 3 across the four months.

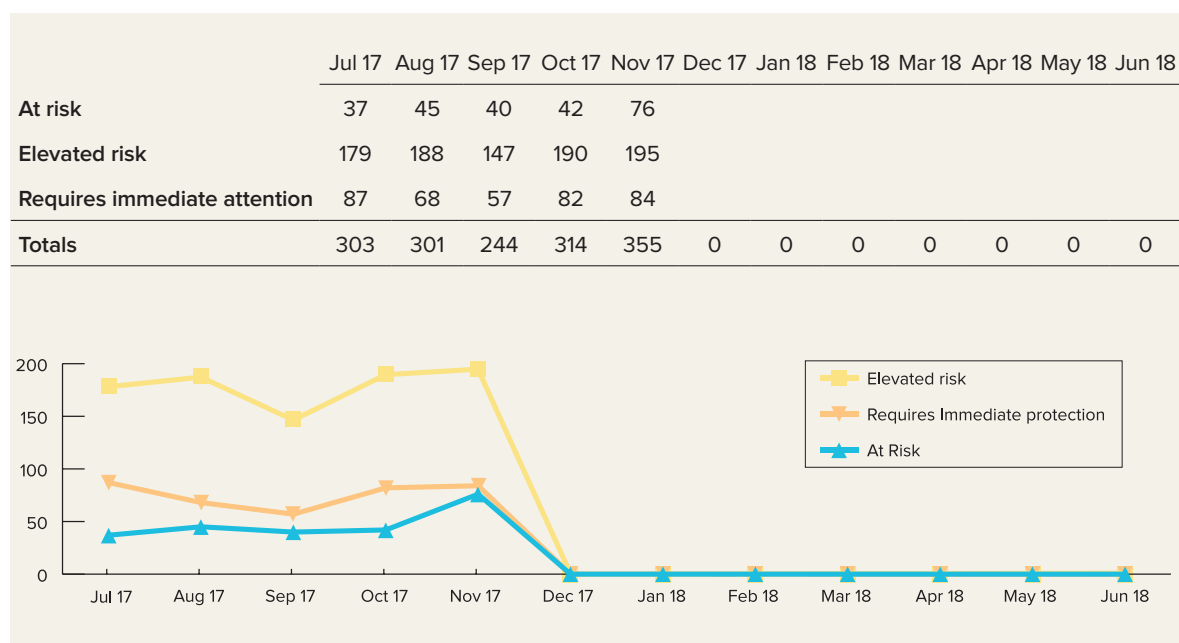
Table 4: Time 3: Risk outcomes for children for all L17 reports triaged (excludes 'open' in CP)

Table 3 and 4 provides the evidence of the assessment by the triage of different levels of risk. The guidance for the categorisation of risk levels (at risk, elevated risk, requires immediate protection) is drawn from the CRAF. The majority of cases are assessed as 'elevated risk', with fewer cases assessed as requiring 'immediate protection' or being 'at risk'. The risk levels in Time 2 and Time 3 show a trend to a greater number of children being assessed as at immediate risk. This is possibly due to more detailed information available from MARS about the history of the perpetrator, or it may be that the staged approach creates a stronger focus on the history sharing from each organisation. Further data over time would be needed to understand the consistency of the trend.

The risk level does not necessarily determine the pathway. For example, children in need of 'immediate protection' are not necessarily always referred to Child Protection. Many of these cases involve post-separation violence and involve an immediate police response to support the non-offending parent and children to stay safe. A referral to Child Protection may not necessarily assist with the issues of post-separation violence. The level of risk does, however, determine the type of intervention (e.g. SMS, immediate and direct contact etc.) each organisation provides if the referral goes to their agency.

7.2 Key learning 2: How to create a differential response to divert children from unnecessary Child Protection intervention

A significant inefficiency and problematic practice has been the referral of all children living with FV to Child Protection intake. This is a practice that creates fear in women living with FV that their children will be removed and potentially closes down help-seeking with many vulnerable women (Stanley, Miller, Richardson-Foster & Thomson, 2011). However, the majority of referrals do not result in an investigation and are either referred to community services or no further action is taken. The MAT project sought to establish different pathways based on risk assessment and risk management that do not result in unnecessary referrals to Child Protection. The data very clearly shows that a differential response is not only possible, but achievable.

In addition to these results, DHHS data shows that the State-wide intake data for Child Protection decreased over the same time periods and appeared to be related to the decrease in the Northern Region referrals.

Summary of key points in the shift to a differential response

- At Time 1, the majority of referrals or notifications (86%) to Child Protection did not meet the threshold for an appropriate referral to intake.
- The police practice of referring to both Child Protection and FV services resulted in dual referrals, increasing the potential for duplication of effort and lack of coordination of responses.
- The MAT project brought together organisations receiving police referrals involving children to assess risk (based on shared databases), using this assessment to decide the appropriate pathway for service. This resulted in only 8% of police referrals going forward to Child Protection, a major and significant change as a result of a more targeted and timely response based on a joint risk assessment.
- In Time 3, 14% of cases were referred to Child Protection. This meant that the average number of cases referred to Child Protection over the two time periods in 2016 and 2017 was 11%. Of course, this can also be understood as meaning that 89% of L17s where there were children did not meet the threshold for investigation, and were therefore diverted from referral to Child Protection.
- There was a 6% increase in referrals to Child Protection from Time 2 to Time 3. This may be explained by a recent increase in cases being referred straight through to Protective Investigation (PI) rather than to Intake by the Child Protection worker in the MAT room. In addition to the increase in FV reports in November, it has been reported anecdotally that there have been more children involved in cases of more extreme violence, necessitating a referral straight to the investigation phase. This highlights the importance of having a Child Protection worker in the MAT room who can make direct referrals to investigation as appropriate. It may also highlight the need for consistency across workers and for documenting the rationale for decision making.
- Well-developed collaborations between organisations are required to enable a differential response (See Key Learning 5).

The data that outlines the differential response is captured in Tables 5, 6 and 7.

Table 5: Referrals from MAT to Child Protection

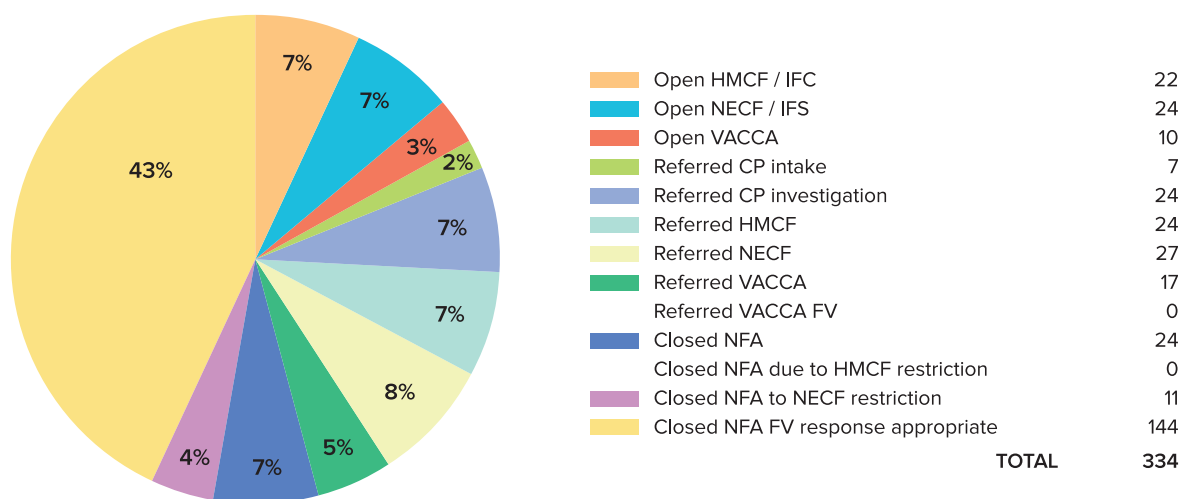
TIME 2	TIME 3
27th July - 6th December 2016	July - November 2017 (full calendar months)
<ul style="list-style-type: none"> • 108 of 1505 cases were referred from MAT to Child Protection. • 8.2% of cases 	<ul style="list-style-type: none"> • 167 of 1162 cases were referred from MAT to Child Protection Intake (N=55) and Protective Investigation (N=112) • 14.3% of cases

The data below provides information about the referral pathways for children at Times 2 and 3.

Table 6: Time 2: Total referral outcomes for women and children

Time 2 Outcomes for women	#	%	Time 2 Outcomes for children	#	%
High Risk Team	273	19.5%	Hume Moreland Child FIRST	183	13.9%
Intake	415	29.7%	North East Child FIRST	283	21.6%
Intake Priority	228	16.3%	DHHS Child Protection	108	8.2%
Letter to AFM	43	3.0%	Integrated Family Services Hume Moreland	33	2.5%
NFA	236	16.9%	Integrated Family Services North East	59	4.5%
SMS to AFM	199	14.2%	Victorian Aboriginal Child Care Agency FV Services	24	1.8%
			No Further Action	621	47.3%
			Berry Street	0	0%
			Pending at end of collection period	2	0.2%
Total recorded outcomes	1394	99.6%	Total recorded outcomes	1313	100%

Table 7: Total referral outcomes for children/family (excludes open in Child Protection)

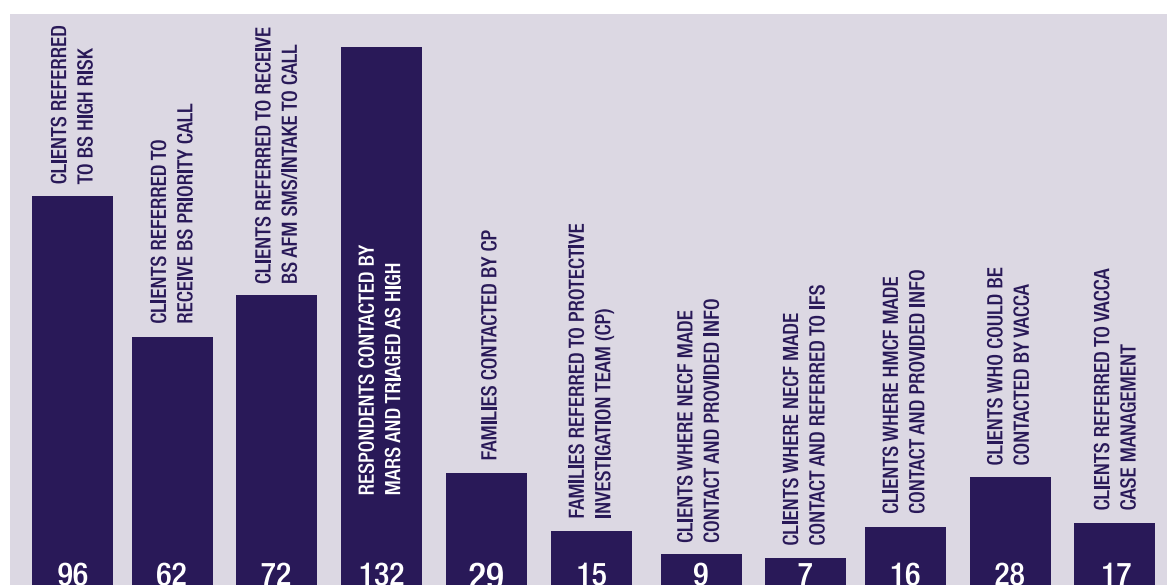


The data in Table 6 identifies new referrals to Child Protection intake and investigation. This figure represents 8.2% of referrals at Time 2 and 14.3% of referrals at Time 3. Interestingly, at baseline (Time 1) prior to a multi-agency triage process, only 14% of L17 referrals from the police went forward to investigation, with the majority of referred cases receiving no further action or referral to other agencies. The triage process has ensured that cases that will not go to investigation are not referred to Child Protection inappropriately in the first instance. This has illustrated that a differential response has been provided to women and children affected by family violence.

Referrals to partner agencies out of MAT do not necessarily result in engagement by the woman (AFM). This is a particular problem when families require both a crisis response and a longer-term family service response, and when particular attention to children is required. These 'dual pathways' remain an inefficiency in the referral system. The experience of the MAT has illustrated that a more integrated approach for both women and children should be an aim in establishing the Hubs. It is likely that new practice frameworks and potentially legislative changes will be required to support this outcome.

In June 2017, a one-month "snapshot" of the pathway for women and children following the triage assessment decisions was created to provide preliminary information about the pathway for women and children following the triage. The triage process in June 2017 averaged an assessment of 100 cases per week of FV where there were children. The adult victim/survivors without children were not triaged by the MAT but were provided with a specialist family violence response by Berry Street. As shown in the earlier tables, the referrals to Child Protection indicate that a differential response was in place, only referring children into the statutory service system who would be considered for investigation by members of the MAT team. The numbers of children and their families who were actually referred to the two Child FIRST services were small. Sometimes this was due to a cap being placed on the numbers that could be referred into the service because the service was 'in restriction'. Furthermore, many of the referrals to Child Protection and Child FIRST did not result in contact with children and families, often due to both services already operating well above funded capacity. The bulk of the work with cases seen by the MAT team was undertaken by the crisis response from the specialist family violence services (Berry Street and MARS).

Table 8: Outcomes of MAT referrals June 2017

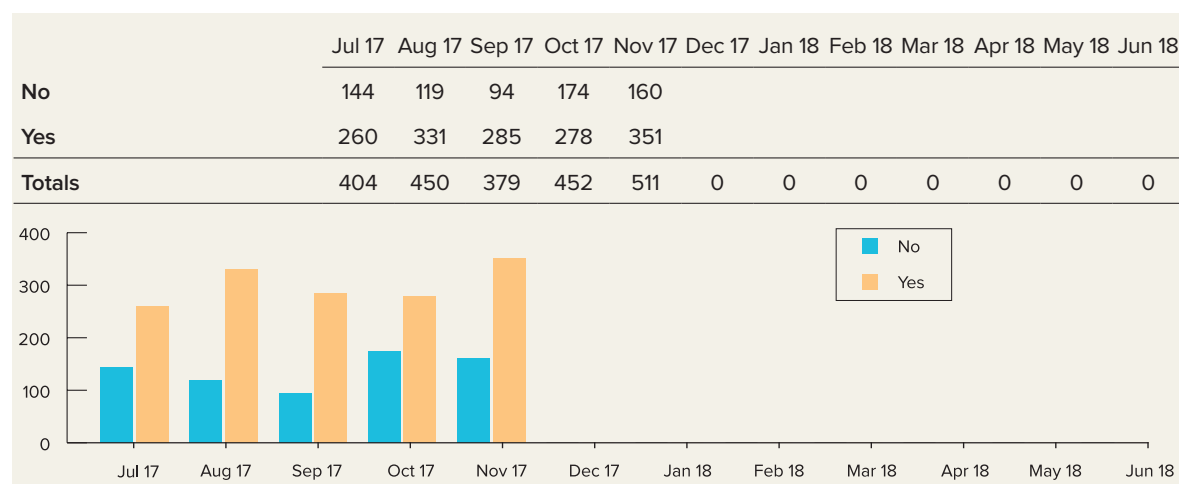


In summary, the differential response indicates that children who are living with family violence do not all need to be referred to Child Protection. However, this preliminary data suggests that while a crisis response is in place, there is a need for further development of the pathways for children and their families beyond crisis. The “tracking data” only begins to provide a picture of what happens post-triage and also provides insight into where the pressure lies.

7.3 Key Learning 3: How to establish a safety net to ensure that the large number of children not named on an L17 police report are identified

An important issue which surfaced through the MAT process and information sharing via multiple databases was that many more children were identified than noted in the police L17 referral. At baseline (Time 1), 44% of L17s formally recorded the presence of children, a number which proved incorrect and illustrative of under-reporting of children once multiple databases were checked. It is not clear whether this under-reporting was because children were not present (or seen) by police members at the time of incident. It does raise the question of how police practice can be improved by police asking an AFM and/or perpetrator if there are children in the family. The Time 3 data (See Table 9) showed that between July - October 2017, 25% - 38% of children were missing from police data, but identified at the triage through the history of families on the databases ('No' refers to L17 with no children, but the triage picking up the presence of children).

Table 9: Total L17s with children identified (by Victoria Police) on the L17 form



The MAT team refers to this process of checking histories as establishing a “safety net”, to ensure that children in their client families are identified. The identification procedure takes some time in the MAT process at the beginning of each day, as the women-only reports to Berry Street need to be checked with other databases to establish the presence of children. Hence, the necessity for triage. The safety net is achieved through the following functions:

- All partner agencies check their client databases to identify the presence of children (for example, children not living full-time with their mother);
- Determining whether a child is a client of Child Protection (i.e. already open in protective investigation or case management) to enable the L17 to be expediently forwarded to the relevant case worker; and
- Liaising in the MAT room with VACCA to facilitate immediate referral ensures early identification of Aboriginal/Torres Strait Islander clients and provides a direct pathway to the appropriate Aboriginal Controlled Community Organisation.

To support the triage process, it will be important in the establishment of the Hubs to ensure that current information about child protection status is readily available. The MAT experience of having an outreach Child Protection intake worker as part of the MAT team has proved to be an effective way of ensuring this information is available in a timely manner and therefore reducing the potential to re-refer a family already engaged in the Child Protection system. This has been highlighted through practice as efficient, effective and a way of focusing effort on L17s requiring assessment, particularly considering the high number of cases. The MAT team have reflected that this is a fundamental and critical aspect of the work, highlighting the value of the Child Protection worker being able to action a referral to either intake or protective investigation directly from the MAT room. This is strongly supported by the evidence documented every day where children are not identified in police reports but show up in other databases. It is understood that if a practitioner from another part of the program attended the triage meetings, instead of an Intake practitioner, that practitioner would be able to fulfil the same role the Intake practitioner has been undertaking, so long as they have the same level of delegation. Intake practitioners who have been participating in the MAT team are at a Senior Child Protection Practitioner level. Currently, the Community Based Child Protection Practitioner role has the same delegation as the Senior Child Protection Practitioner role.

7.4 Key learning 4: How to keep the perpetrator in view through use of the Safe and Together™ Model

The adaptation and application of the *Safe and Together™* Model in the MAT room has been instrumental in enabling the perpetrator / father to be kept in view. Over time, the MAT team have become proficient in the use of the *Safe and Together™* Model to inform discussions during the information sharing stage, the risk assessment stage and the referral stage of the MAT. The MAT team have recognised that ‘pivoting to the perpetrator’ requires a paradigm shift, and observations in the MAT room over time have highlighted the importance of the facilitator (and at times the project manager/observer) intervening when “mother blaming” occurs. It has been interesting to note that this high level of scrutiny on the mother (for example, her parenting, her mental health, her alcohol and drug use, and her relationship history) usually occurs when there is not enough information about the perpetrator. In the absence of such information to inform a more accurate view of the risk he poses to mother and children it has been observed how easily (and swiftly) the focus pivots back to the mother in ways that don’t deal with the accountability of the perpetrator. The aide-memoire (Appendix 2) was developed specifically as a tool for the MAT facilitator and team to keep the focus on the perpetrator.

Results from the MAT team survey (November 2017) showed that the team’s understanding of the *Safe and Together™* Model assisted them with their work in the MAT room. Participants commented on the importance of the shift from focus on the woman to “pivoting to the perpetrator”, their patterns of behaviour and how they can be held accountable. Respondents also commented on how their understanding and application of *Safe and Together™* in the MAT room had influenced their work in other roles they held.

“My understanding of the Safe and Together Model has assisted me greatly in the development and documentation of referral rationales. I have initiated questions in my rationales as to the perpetrator’s parental capacity, roles and expectations. There has been a huge shift from the available protective factors for adult survivors to perpetrator parental deficits. I think for all intents and purposes we must consider and discuss with survivors what the true definition of a ‘good parent’ is in terms

of providing the best outcomes for children (safety, stability and development). We need to bring the perpetrator's abusive, neglectful behaviours to the fore. Perpetrators need to be made more accountable. We cannot do that when the role of a good parent is obscured." (MAT Team member)

"As I work in another program with Child Protection, Safe and Together has been very useful in influencing CP practice." (MAT Team member)

"I also work in Initial Response, so yes, I would say that the Safe and Together Model definitely assists with the short-term crisis work that I complete with women and their children." (MAT Team member)

When Operations Group members were asked if the *Safe and Together*™ Model was helpful for understanding the MAT process, they universally agreed that it was:

"The provision of training and materials provided by the University of Melbourne has assisted the ongoing learning of this model and ensured the principles of the model are understood." (Operations Group member)

"This model provides a framework that is critical to good outcomes and we need to ensure that the guiding principles are embedded in practice from the point of triage and assessment and then throughout the life of the case." (Operations Group member)

"The MAT staff in our organisation generally hold other positions within the program and their knowledge of Safe and Together has been brought into their work in those roles. So, we have observed the use of the language and principles in other aspects of our program." (Operations Group member)

The MARS service has a high number of men who are regarded as high risk following the triage. Data gathered from interviews with MARS team members highlighted that attendance at the MAT had led to a number of promising practice changes to risk assessments made on male respondents. It exemplifies the way in which multi-agency information sharing can change the assessment of risk and the subsequent response to manage the risk. As a result of increased staffing in MARS (from one staff member to two), efforts are made to telephone all men identified at MAT even when they are assessed as 'low risk' in MAT. In the past, this assessment would usually result in a mail out of information only, but with the additional staff member, all men can be called and information packs are sent to men unable to be reached.

PRACTICE EXAMPLE: Benefit of MARS being able to share other L17s linked with perpetrators

- *An L17 was received and history was shared from all agencies with concerning high risk factors.*
- *By conducting a name search on the L17 portal, MARS was able to identify that the same perpetrator had seriously assaulted another woman with a knife. This information significantly contributed to the final risk assessment and referral for the AFM and child, as the perpetrator's level of violence could be comprehensively understood.*
- *The Berry Street Family Violence Practitioners who responded were also alerted to this information.*

7.5 Key learning 5: The importance of effective collaboration at operational and strategic levels

The single door triage and the differential response could not have been established without high levels of collaboration between organisations. The interview data provided the basis for a case study of the MAT project, which was placed alongside four other case studies from different states of Australia for the national ANROWS funded PATRICIA project. These case studies were all chosen for their contribution to promising collaborative practice between Child Protection and Specialist Family Violence services. The synthesis of these case studies provided a model for collaborative working which incorporated challenges and enablers to multi-agency working (Humphreys, Healey, Nicholson & Kirkwood, 2018). The interview data was analysed utilising the key enablers and challenges from the PATRICIA learnings and is reported in the development of the collaborative diagram in Figure 2.

As with previous studies (Ross, Healey & Humphreys, 2005), there was no single factor that consistently stood out as more important than another factor. Instead, interview data suggested that a complex array of factors need to come together to ensure functional collaborative working. The model is dynamic and recognises that at any one time a factor which was an enabler could change to be a challenge (e.g. leadership when key people leave).

Figure 2 Challenges and Enablers to collaborative practice



In summary, while all the interviews spoke of the challenges of collaboration, all the elements in the collaborative model (Figure 1) were addressed at least to some degree. Although participants would have liked more resources to respond to service demand, and the strength of cultural change ebbed and flowed as new workers came to the triage, overall, the elements required for a functional collaboration were in place and spoken about positively by the participants in the interviews.

In this diagram, key themes are placed evenly in each circle: leadership, shared vision

and commitment, authorising environment, information sharing, and formalisation of the model in one circle and perpetrator accountability, culturally appropriate, sustainability, resources, and cultural change in the other circle. The arrows between the circles indicate the dynamic nature of the factors involved, which can move from enabling to challenging as the context changes.

Particular themes from the interview data can be discussed alongside some of the elements in the diagram to illustrate the consistency between MAT learnings and PATRICIA outcomes. All quotes below are from participants in the PATRICIA Project (Humphreys & Healey, 2017).

Theme 1: Leadership

Leadership provided by the Department of Health and Human Services (DHHS) was considered of critical importance. All the participants noted the involvement of a senior level manager from DHHS as a significant factor. This DHHS representative was seen to be an important driving force, championing the project and providing strong support.

“Leadership is key. Having a champion or at least someone who was prepared to get us through the hurdles was so important.”

This theme was present in interviews with all participants, suggesting that leadership may be a critical factor in making collaborative partnerships work well in the development of a project, potentially even having greater weight than other factors.

“Shared vision, commitment and cultural change.”

While there were a number of aims and objectives for the Triage Project, the overriding impetus was to develop and implement a multi-agency approach to improve outcomes for vulnerable children and their families experiencing family violence. This shared vision was held and supported by management in the partner organisations, and was identified as being critical to achieving cultural change:

“To support cultural change, you need the commitment and interest of the leaders in the organisations. If you have that higher-level support from the CEO and a director who’s really interested in the collaboration, that’s encouraged all the way through.”

This shared vision was supported by the political vision for family violence reform. One participant stated:

“The government’s overriding approach to Family Violence... is what drives cultural change.”

Others spoke enthusiastically about the underpinnings of the shared commitment:

“Fundamentally, it’s the goodwill - there’s an enormous amount of goodwill for the organisations to work collaboratively in a way that’s different.”

Participants described a shared sense of responsibility and commitment by the partners to work collaboratively to develop and implement the triage model.

Theme 2: Formalisation of the model and an authorising environment

The structures in place for the governance and operation of the triage model supported the development of effective relationships and systems. Participants noted the importance

of having a Steering Committee and Operations Group, and of communications and accountability between the two. The structure enabled collaborative input into the development of the model. All participants pointed to the involvement and support of managers as a critical element of the collaborative process. The involvement of managers from different tiers or levels of authority in the partner organisations was identified as an important factor:

“Informal relationships are really good but they don’t necessarily happen. You need to set up the formal processes.”

“There’s been senior level, CEO and next layer down, and further layer down management support. At all levels there’s strong desire for collaboration, and fundamentally people want to do things better for women and children.”

One participant pointed out that often workers try to develop collaborative processes in service responses; however, if they don’t have the support of management it can be very difficult to sustain. The involvement of senior level management provides an imprimatur for the work and gives the project credibility within the organisations involved.

Theme 3: Information sharing

“Bringing information together is really critical for responses and determining risk.”

“Your risk assessment is only as good as the information that you’ve got.”

Information sharing is the basis of the triage model. The information from each agency was drawn together to enable risk assessment and referral, rather than just relying on what was in the police referral. All participants highlighted the significance of effective information sharing for assessing risk and improving responses to family violence.

“Just that sense of it being so powerful, to see all the players around a table and how things can come into place to change a plan for a woman - that’s difficult to do if you’re a case manager on the phone. It just doesn’t happen the same way.”

Theme 4: Culturally appropriate

The presence of the Aboriginal Child Care Agency (VACCA) at the MAT provided attention to the specific needs of Aboriginal children and their families. The number of Aboriginal families were small in relation to the overall number of L17 referrals to be processed. However, the funding to support participation was agreed at the establishment of the triage and seen as a necessary to ensure culturally appropriate practice for Aboriginal families.

Though not explicit as part of the triage process, observations of the triage process found that the MAT team used culturally aware practice when discussing cases involving people from a culturally and linguistically diverse (CALD) backgrounds. In addition, diversity of cultural backgrounds is evident when reviewing client records: using the sole identifier of name to search the L17 portal finds a significant number (more than 50%) of CALD AFMs and Respondents. The triage process did not enable a CALD specific response, with families referred to mainstream agencies only from the MAT. It is assumed that if a more comprehensive risk assessment needs to be undertaken, there will be specific supports available, such as interpreters or access to specialist services like InTOUCH Multicultural Women’s Family Violence Service.

Whether a person’s disability was a factor in responding to family violence was not captured in the databases.

Theme 5: Resources

All Triage Project partners committed substantial resources over an extended period. These resources were primarily in staff time, including the involvement of senior management in meetings and workshops. DHHS provided funding for partner organisations to support the staffing model and other infrastructure costs for the triage model. They also provided the funding for the MAT Project Action Research Coordinator, employed through the University of Melbourne - a resource fundamental to ensuring the ongoing adaption of the model over time.

All of the organisations involved in the Triage Project experienced heavy demand pressures and had limited resources to adequately meet the demand. Whilst services actively sought to respond to women and children within their existing funding, this was not always possible. For instance, the Child FIRST organisations sometimes implemented partial restrictions (limiting L17 referrals for defined periods of time), impacting on the prioritisation of referrals through the triage process. Whilst a child/family specific response wasn't achieved, the family violence service responded to all L17s based on risk and could refer to Child Protection or Child FIRST if concerns for children were identified.

"There are the constant issues of demand - the family violence system and Child Protection were constantly inundated with more and more demand without a lot of resourcing and funding. So, the pressures around that often played out."

Theme 6: Sustainability

To date, the triage model has been sustained due to the long-term commitment of the partner organisations, the development of good relationships, strong high-level leadership, and external coordination. The collaborative approach to developing and implementing the model has contributed to achieving practices and processes that are effective and efficient in responding to understanding risk and risk management.

"We've somehow managed to keep this going against all odds, really."

PRACTICE EXAMPLE: Benefits of multiple agencies working together for best outcomes for woman and child

- An L17 was presented in the MAT room that was extremely concerning, with risk factors of assault, threats to kill, extreme isolation and vulnerability and the AFM believing she may be murdered by her husband.
- Police attempted to obtain a statement from her but she was too fearful. Police completed a welfare check but no further evidence emerged.
- The names of the child and the perpetrator were not provided.
- All MAT team members were very concerned. After a complex discussion analysing risk to the AFM and child, it was determined that Child Protection would conduct a home visit.
- A Berry Street High Risk worker spoke with the AFM briefly. The AFM stated that she was going overseas for five weeks the next day but would be open to Family Violence assistance upon her return.
- Child Protection were then able to follow up with Immigration to confirm if the AFM and her child had left the country and then followed up with the case from that point.

7.6 Key learning 6: The importance of support, training and reflective practice for the MAT team

Supporting the staff delivering triage and risk assessment services requires specific strategies to ensure that staff are supported to do the daily work and given structured opportunities to develop professionally and reflect on their practice and the various impacts the work has. Over the life of the project there have been many changes in the MAT room and a process of resource availability, goodwill, co-design and action research has seen the room evolve into the space it is now. It is still not ideal, but the physical space and processes established to support the team seem to be hitting the mark.

“Honestly, from working now in the MAT room to when I first started in 8/2016, the current working pace is absolutely perfect. I feel that the MAT room has come a long way since I began in the program over a year ago. The working pace is great, not rushed but also not slow and prolonged (which it tended to be in the past).”
(MAT Team member)

In responding to the second MAT Team survey, most respondents believed their contributions were always accepted and valued in the MAT room. Comments made by team members highlighted the value of practitioners respecting each other's opinions in the room (particularly when it is difficult for the team to reach an agreement on risk assessment) and practitioners being encouraged by the MAT facilitator to contribute.

“I feel that everyone is encouraged or has the opportunity to contribute. Although we don't always agree, I do feel that people are respectful of different opinions”
(MAT Team member)

During the two years of Stage 3 of the project, the MAT team were provided with four training days. Each training day comprised a session on the *Safe and Together™* Model, collaborative practice, reflective practice, vicarious trauma and opportunities to share feedback to the project management team at UoM, and their managers. The two sessions held in 2017 provided MAT team members with the opportunity to undertake Modules 1 and 2 of the *Safe and Together™* online training program. The UoM project manager facilitated the sessions, and the team members later completed the certificated modules during their work time. The Operations Group members were invited to attend part of each session and this provided an opportunity for team members to communicate directly with their managers and other partners, rather than via the Operations Group.

It took some time for the reflective practice process to commence, due to the challenges involved in enabling all MAT team members to meet as a team. However, the team has now had consistent monthly team meetings since April 2017. These sessions were facilitated by a Berry Street senior employee with significant experience in family violence practice. The MAT team valued the opportunity for structured discussion around the challenges of their role, including vicarious trauma, which is also recognised by individual agency managers.

“The nature and circumstances of the cases definitely have an impact on staff and this needs to be reflected on and worked through in supervision and general support. Part-time workers have also been used for this reason. However, the physical environment and the nature of the triage tasks simultaneously present challenges for workers.” (Operations Group member)

It is important to note that when questioned about the identification of and response

to vicarious trauma, MAT team members and Operations Group members spoke of the need to establish staff flexibility so that staff were not in the triage room every day. Suggestions put forward included a part time roster, and capacity for “backfilling” where staff needed to take time out. Team members and their managers spoke of managing vicarious trauma by using support and supervision processes, reflective practice and role flexibility.

The MAT pilot has helped to understand the requirements of a team of people operating in a multi-agency hub-like environment and sharing information that leads to effective risk assessment and referral. It is critical to pay attention to the make-up of the staff group – their skill level, seniority and capacity for decision making in a time framework are important elements highlighted by both the MAT team and their team leaders. It is also important to be clear about how support and supervision is provided in the room by the MAT Facilitator and by home agency managers. As the role of the MAT Team Leader and MAT Facilitator developed over time, tensions emerged between who is best placed to provide support and supervision - the team leader or the home agency supervisor? It became clear there is a need to have a mix of both so that workers feel well supported in doing difficult and traumatic work. Issues of vicarious trauma arise in the MAT room that require immediate management and the Team Leader / Facilitator must be equipped and supported to respond.

“To ensure that organisations and supervisors have a good understanding of the challenges of working in MAT. The number of difficult cases we read each day and the pace with which they need to be completed.” (MAT Team member)

“Confidence in their ability to share professional assessments. Able to work within a multi-agency setting. Ability to make decisions for their agency Feminist framework” (Operations Group member)

“I think there is limited capacity for informal or live supervision for individual staff by the facilitator whilst in the room. I do believe there is a broad range of opportunities for group supervision by the facilitator. I think that agency staff could be well supported if their supervisor from their agency attended the MAT on a semi-regular basis to have a better understanding of the work and the environment in which their employee works.” (Operations Group member)

Another important learning lay in identifying essential and desirable qualities of a MAT room worker and the best work arrangements for staff. The Operations Group survey respondents reinforced that practice experience was necessary, particularly, knowledge of family violence and the other participating agencies. One respondent commented that it was an ideal role for workers not wanting direct client work, but who still want to use their risk assessment knowledge. Given the nature of the collaborative decision making in the MAT room, survey respondents were united in their opinions that staff need to be experienced, comfortable having their opinions challenged, competent in risk assessment and able to work well with other agencies.

“I think it is imperative that a MAT worker is competent in assessment - confident to work in a group - understands the need to participate - demonstrates respect to all - has an understanding for the need to work together for better outcomes - has institutional empathy in regards to other staff/organisations roles and limitations.” (Operations Group member)

7.7 Key learning 7: Identified opportunities for systemic advocacy (women as respondents)

In order to better understand anecdotal evidence about a high number of women being named as respondents in L17s, the MAT team leader facilitated the collection of data on women who were named as respondents, during a one-month period (June 2017). These were compared with the Berry Street family violence database to identify if the women had previously been recorded on L17s as Affected Family Members (AFM). Of the women who were identified as being AFMs in previous L17s, more than two thirds (68.5%) were named as AFMs. These women were identified on average three times as an AFM, and the highest number for an individual woman was six times previously as an AFM. Analysis of the data showed that almost half of the women (48%) listed as respondents were not considered by Berry Street Family Violence workers to be respondents at all. In some of these cases where women were identified as respondents, it was possible to identify contextual factors such as mental health issues and protecting others, including children. This data provides some insight into what appears to be a systemic issue with women being incorrectly identified as respondents when they may be the AFM and supports what is emerging from current research underway in Australia and internationally in this area.

8. DISCUSSION OF KEY LEARNINGS IN CONTEXT OF SUPPORT AND SAFETY HUBS

8.1 Overview

The *Support and Safety Hubs: Statewide Concept* (Victoria State Government, 2017) identifies six elements under the first key function of “wrap-around support, safety and recovery”. These elements are:

1. Initial contact
2. Screening and multi-disciplinary triage
3. Specialist multi-disciplinary risk assessment and management (including safety planning and access to RAMPs)
4. Immediate crisis response
5. Multi-disciplinary needs assessment and planning (this is post triage)
6. Navigation through the system (as above)

As a multi-agency triage process (or more correctly, set of processes) the MAT has most relevance under element number 2, and to some degree, number 3 and these are discussed below at 8.2 and 8.3. Additionally, there are learnings that relate to delivery of core functions of a Hub. Broadly, the experience of the MAT Project can help inform these core functions, such as the logistics for establishing a multi-agency triage; professional development and staff support needs; and the development and application of replicable practice developments and tools, for example, the ‘aide-memoire’, based on *Safe and Together™* Model core principles.

To facilitate understanding of how the MAT is aligned to aspects of the Support and Safety Hubs, the findings below have been organised under the headings “Screening and multi-disciplinary triage”, “Specialist multi-disciplinary risk assessment and management” and

“Features of the Hub Team to deliver on core functions”. While there are aspects of the other key functions where MAT could inform the Hubs, this discussion adheres to the main functions of triage and risk assessment.

8.2 Screening and multi-disciplinary triage

1. A system for prioritising police FV referrals has been developed.
2. Through multi-agency joint risk assessment and history sharing a differential response to children living with DFV has been established and ensures that only a minority of cases (average over the two data time periods is 11%) are referred to CP. Some cases are already open in Child Protection.
3. Through a shared process of searching member agency databases, more children have been identified where they may be ‘missing’ from the L17, or from, for example, the Child Protection database. MAT workers have expressed this process as providing a valuable “safety net” to ensure that all children who require risk assessment and protection can be identified.
4. The use of and adaptation of the *Safe and Together™* Model alongside the *BICP model* has created a shared understanding for the work of the triage, particularly the *Safe and Together™* notion of ‘pivoting to the perpetrator’.

8.3 Specialist multi-disciplinary risk assessment and management (including safety planning and access to RAMPs)

1. MAT processes have demonstrated that a single door model of intake referral can work, with particular regard to diverting families from multiple referral pathways: that is, one for the mother and one for the child. Whilst the MAT did not operate as a single door during the pilot stage, learnings emerged that support the introduction of a single door approach.
2. The MAT utilises the CRAF indicators and risk assessment definitions i.e. “requires immediate protection”, “elevated” and “at risk”, plus additional risk assessment indicators for children developed in consultation with the University of Melbourne team.
3. Whilst Police are not represented in the MAT room, there is evidence (Progress Report 2) that when they do attend and participate in MAT processes they can provide a level of knowledge about perpetrators that enables a more accurate collective risk assessment and risk management. Over the life of the MAT project there has been consideration of the most useful way to receive information about perpetrators that can inform more accurate risk assessment, including formal information sharing processes as currently being established for the Hubs, and the Central Information Point.
4. Men’s Active Referral Service (MARS) participation at MAT has at times resulted in review (to higher risk) of risk assessments given at MARS intake.

9. CHALLENGES

A range of issues continue to be raised from the triage which will need to be addressed in the future development of the Hubs:

1. How to keep the perpetrator in view (a key principle of the *Safe and Together™* Model) in the management of the family violence incident;

2. How to ensure that the perpetrator's behaviour, and its impact, is central to assessing the risk to women and children. This issue was highlighted across all stages of the project by the absence of police data to provide more detailed knowledge about the perpetrator;
3. How to resolve the systemic issue with the quality of information included on L17s
- the lack of consistent provision of information, missing and incorrect information e.g. identification of children and demographic and other data, continues to present challenges at MAT. The MAT process has illustrated the importance of information sharing as a key mechanism to "fill in the gaps" missing from the L17;
4. How to resolve the issue of CHILD First restrictions and caps, which has been a challenge for the project that is reflected in the referral outcome data. This is clearly related to existing funding imperatives and limitations. There is not enough capacity in the service system to respond to the number of referrals. Child FIRST are consistently operating well above funded capacity. The issue of demand is illustrated by the need to contain the numbers through restrictions and, in the MAT room, the need to place a cap on the number of referrals able to be received. Conversely, crisis services such as Berry Street FV Services are unable to contain or restrict response, highlighting how different expectations under each funding agreement mirror overall funding challenges related to establishing an integrated service system;
5. How to address the problem of dual referral for a crisis response (currently the specialist FV support service) and the family service response (currently Child FIRST) to ensure the ongoing engagement of families with children whilst also addressing their safety and support needs. While the specialist women's FV service often sees women and children together, it sees its core business as responding to the crisis for women. At times this results in a dual pathway for families who are referred to both the specialist women's service and family services;
6. How to address the lack of services available for men, (genuine, not misidentified) female respondents, adolescents who are violent in the home, and services for children and their families;
7. How to increase the pace of the triage (currently averaging 8 minutes per case) without compromising risk assessment and referral decision-making;
8. How to streamline record keeping in the MAT room. Currently each agency records each outcome and the rationale for decision making in their own databases. There is no centralised documentation of this critical information, which is imperative in terms of accountability, and is in the interest of consistent practice;
9. How to formalise the role of the facilitator in the MAT room, which despite being well established and supported, remains challenging. The MAT Team Leader has a dual role which has emerged over time, as both facilitator and 'on-site supervisor' with a role in observing and managing practice. This tension will remain unresolved if there is a need for supervision in the triage process, and "support and supervision" at the home agency.

10. CONCLUSIONS

The MAT project has successfully demonstrated:

1. That a single door model of L17s intake and risk assessment is a significant factor in ensuring the efficient and effective risk assessment and referral of women and children.
2. That a differential response is possible and desirable to ensure women and children are only referred to Child Protection if they meet the threshold for a statutory response. The findings from this project are stark, compelling and promising in terms of resolving the ethical dilemma of women and children being exposed to state intervention when they are victims of family violence. There is also great advantage to the State with the proven easing of the intake burden on Child Protection.
3. That multi-agency collaboration at an operational level (in the MAT room) is effective for ensuring the most comprehensive view of the risk indicators for women and children and dangerousness indicators for male perpetrators. Information sharing is critical, as is the presence of (or facilitated access to) police and the Men's Active Referral Service who have the most relevant and up-to-date view of the perpetrator's offending history (including other FV history) and an understanding of their likelihood of re-offending and complying with intervention orders or men's behaviour change programs. In addition, structured application of the *Safe and Together™* Model as part of this collaborative approach ensured there was focus on the perpetrator's pattern of behaviour.
4. That multi-agency collaboration at a strategic level (Operations Group and Steering Group) is critical to providing the overall governance to the MAT process. The development and application of an MOU to guide the collaboration is critical for providing the authorising environment for the collaboration to succeed. By paying attention to collaboration enablers and barriers throughout the project, and keeping lines of communication open, more sustainable and effective partnerships can be built.
5. That appropriate supervision and support, professional development and opportunities for reflective practice are critical to triage team well-being and effective functioning. It is also critical to ensure that triage workers are supported in the room through active facilitation. Facilitation helps keep the triage process moving quickly and efficiently and ensures that appropriate discussion about each case leads to shared agreement on the assessment of risk and the most suitable referral pathway. The facilitator also plays a critical role in supporting the team to avoid stress and vicarious trauma due to the continual exposure to incident reports and detailed narratives of violence and abuse.

11. FINAL COMMENTS

The MAT project was guided by ideas derived from complex systems thinking (Checkland & Poulter, 2006) which explores the notion of outcomes for a functional system. In the context of the MAT project this refers to the effective management and response to police referrals of families involved in FV incidents to Child Protection and the human services system. It draws on and applies the criteria developed in an Issues Paper on Child Protection and Domestic Violence (Humphreys, 2007, p. 2):

- efficacy (does it produce its intended outcome - a satisfactory management of the intake and intervention for children affected by domestic violence?);
- efficiency (does it do this with the best use of resources?);

- effectiveness (does it achieve a higher-level or longer-term aim - the safety and protection of children?); and
- ethicality (are the purposes of the system met in ways which are congruent with principles and values which promote respect and justice for children and others affected by domestic violence (usually women?).

The MAT project was a pilot project used to explore and develop a different way of managing and responding to police referrals of FV incidents. We believe it demonstrates a more satisfactory management of the intake and intervention of children affected by family violence through multi-agency triage. The project achieved its aim of diverting large numbers of children and their mothers and fathers away from the tertiary, statutory system in which most families do not proceed to investigation: a practice which is both inefficient and problematic (if not unethical) given the stress that such referrals create for families (particularly women) living with DFV. The tracking project points to the uptake of referral pathways and suggests that this is the next stage in which there needs to be a concentration of effort, as the responses to children in their family context are not well developed at this point in time.

All stakeholders in the MAT project (the MAT team, the Operations Group, the University of Melbourne researchers) have been driven by the desire to create a more effective, efficient, efficacious and ethical response to children living with domestic and family violence. The MAT project is a step in this direction and provides the foundation for future developments, which we envisage will create greater accountability and safety for children and their families.

I very much enjoyed working in the MAT team, far more than I have ... in the past. I have amazing colleagues and very supportive managers so I [am] absolutely happy and enjoy coming to work in the MAT room.

(MAT Team member)

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13. APPENDICES

APPENDIX 1: MULTI-AGENCY TRIAGE STAGED RESPONSE (Version 8: 10/17)

MULTI-AGENCY TRIAGE (MAT) STAGES		
STAGE 1	Staffing	<ul style="list-style-type: none"> High Risk team (BS) & MAT team members - undertaken concurrently
	Purpose	<ul style="list-style-type: none"> Filter all L17s (AFM only/AFM + children) based on high-risk indicators, available history, ATSI status. At this stage, all partners including CP may identify children where not identified on L17 to determine initial response. No detailed sharing of information occurs at this Stage. CP only accesses CRIS to determine people's details by first name or address to determine if children are registered and if open in CP
	Outcomes Stage 1	<ul style="list-style-type: none"> All L17s deemed high risk move to Stage 3 L17s open in CP forwarded to CP Intake/PI/case management L17s open in CF/IFS referred to designated agency (unless new significant risks present then refer to Stage 3) Note: If a case is open with CP and IFS and is therefore not triaged – CP can pass the case onto the appropriate CF, who can then forward the narrative to the IFS program. If a case is open with IFS but not CP - then the L17 is triaged as per usual process. L17s (CP ticked) move to Stage 2 L17s (CF/BS ticked) with children requiring shared conversation to ascertain risk to Stage Two All identified ATSI to Stage 2 All L17s are checked for children, including any out of catchment in case they have had previous involvement with agencies.
	Benefits	<ul style="list-style-type: none"> Integrates initial risk assessment (AFM only & AFM/children) to identify high risk L17s Streamlines identification of children Identifies L17s less likely to receive service response (demand management strategy)
STAGE 2	Staffing	<ul style="list-style-type: none"> MAT team (noting at this Stage, CP worker assesses L17s forwarded to CP independently of MAT team)
	Purpose	<ul style="list-style-type: none"> Further initial risk assessment of L17s based on risk indicators Utilising available history Follow up with Victoria Police (TBD) or Corrections as required Underpinned by <i>Safe and Together™</i> principles to determine Stage 3 priorities

STAGE 2	Outcomes Stage 2	<ul style="list-style-type: none"> • For non-CP-ticked requiring collaborative triage refer to Stage 3 • L17s requiring a BS only response • L17s with CP ticked assessed by CP only and may be closed or report to intake/PI or move to Stage 3. No S38 consultations occur at Stage 2. CP do not participate in collaborative history sharing at Stage 2 but can close, refer or send cases to Stage 3. CF may identify cases as appropriate for CF allocation at Stage 2 however outcome decisions delayed until assessment of all Stage 3 cases has occurred. This is to ensure that when there is a cap on numbers, the highest priority cases can be accepted • Note for CF: If CF staff cannot confirm if a case is still open on IRIS and if an appropriate staff member cannot be reached to confirm then the case will be held until the next day. • Aboriginal families can go direct from Stage 2 to FV team at VACCA • Note: Once VACCA make contact with the client and if they find they are not Aboriginal then VACCA can refer back to the appropriate CF. • Note: If a Cradle to Kinder referral is appropriate for NECF then consent needs to be obtained from a Berry Street Family Violence worker before the referral can be made. • Note: L17s where the client is in the early stages of pregnancy; these will not be triaged until it is confirmed that she is at least 15 weeks pregnant, unless she has other children. If the client is Aboriginal then a consult with VACCA can be completed.
	Benefits	<ul style="list-style-type: none"> • Utilises expertise and experience of FV and family services community based workers (non CP) to identify L17s with children more likely to require statutory response
STAGE 3	Staffing	<ul style="list-style-type: none"> • All MAT team members (including CP)
	Purpose	<ul style="list-style-type: none"> • Collaborative assessment of deemed high risk L17s (with children) using available history including access to CRIS history • Underpinned by Safe & Together principles
	Outcomes Stage 3	<ul style="list-style-type: none"> • Sec. 38 consultation & refer to ChildFIRST/VACCA for further assessment to inform service response decisions • Report to CP Intake/Protective Investigation • Berry Street (AFM/child) response. • CF decisions for Stage 3 cases & those identified at Stage 2 are informed by prioritisation of greatest need & available service capacity
	Benefits	<ul style="list-style-type: none"> • CP only involved in discussions where statutory response more likely (consistent with differential response)

- | | | | |
|--------------------------|----------------------------------|--------------------------------|-----------------------------|
| 1. Physical (indictable) | 6. Other | 11. Stalking (b/w 2-4 weeks) | 16. Verbal |
| 2. Physical (summary) | 7. Damage (indictable) | 12. Stalking (more than weeks) | 17. Social |
| 3. Sexual | 8. Damage (summary) | 13. Breach only | 18. Economic |
| 4. Threats | 9. Theft | 14. Breach and other | 19. Spiritual |
| 5. Pet abuse | 10. Stalking (less than 2 weeks) | 15. Emotional | 20. Non-violent/non abusive |

APPENDIX 2 INITIAL MULTI-AGENCY RISK ASSESSMENT PRACTICE TOOL

L17 MULTI-AGENCY TRIAGE INITIAL MULTI-AGENCY RISK ASSESSMENT PRACTICE TOOL	
STAGE 1	<ul style="list-style-type: none"> List of L17s provided to team. List is prioritised (1) BS/CP received (2) VACCA (3) L17 Codes 1 & 2 All agencies check databases to see if any children identified If no children identified it is not triaged and the L17 is dealt with by Berry Street FV Service If children identified case moves to Stage 2 or directly to Stage 3
STAGE 2	<ul style="list-style-type: none"> All agencies <i>except</i> CP scan and share history. Purpose is to assess whether there is enough risk to continue with a full collaborative RA (that includes CP information) to do “stage 2 risk assessment” If not deemed high risk and/or case is open in IFS, VACCA or Berry Street, case can be closed at Stage 2 If risk is identified, case is continued to Stage 3
	1 Brief (and relevant to the risk) history from each agency (except CP)
	2 What RESPONDENT / FATHER / PERPETRATOR behaviours led to the L17?
	3 How is the AFM / MOTHER supporting the safety and wellbeing of the child? (protective factors)
STAGE 3	<ul style="list-style-type: none"> All agencies share relevant (to risk assessment) and succinct case history in order to make collaborative risk assessments and referrals for woman and children
	4 (a) What are the risks THE PERPETRATOR poses to the woman? (Use CRAF indicators) <ul style="list-style-type: none"> Risks based on the current L17 Risks based on the multi agency history (this informs the collaborative RA) (b) What are the risks he poses to the children? (Use indicators for children at risk) <ul style="list-style-type: none"> Risks based on the current L17 Risks based on the multi agency history (this informs the collaborative RA)
	5 What are the risks he poses to the mother-child relationship?
	6 How is the mother supporting the safety and wellbeing of the child? (protective factors)

STAGE 3	7	What is the AFM's level of fear? (Has it been ticked on the L17?)
	8	What <u>don't</u> we know?
	9	What is each team member's individual risk assessment of a) AFM and b) child (it may differ depending on the circumstances) <div> <div>Requires immediate protection</div> <div>➔ Highest risk</div> </div> <div> <div>Elevated risk</div> <div>➔ Medium / moderate risk</div> </div> <div> <div>At risk</div> <div>➔ Lowest</div> </div>
	10	What is the collaborative risk assessment of a) AFM and b) child (it may differ depending on the circumstances)? <div> <div>Requires immediate protection</div> <div>➔ Highest risk</div> </div> <div> <div>Elevated risk</div> <div>➔ Medium / moderate risk</div> </div> <div> <div>At risk</div> <div>➔ Lowest</div> </div>
	11	What is the referral pathway and rationale? <ul style="list-style-type: none"> • Which agency is taking this case?



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