Toward a Model for an Integrated, Safety Focused & Child Centered Community Response to Domestic Violence

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Executive Summary

The impetus for this project was based on the recommendations of the Domestic Violence Death Review Committee and our desire, as a community, to develop an integrated model of service to identify risks to women and children who experience violence in their intimate partner relationships.

Background Information and Context for Exploring a Coordinated Model

Partners from the London community (see Appendix J for a list of partners) participated in a one-year project aimed at 1) better identifying potential child victims of physical or emotional harm due to exposure to domestic violence and 2) providing more effective, customized intervention to all family members to alleviate the risk of future harm. This is a two phase project with the first phase focusing on the development of an integrated model of community intervention to help protect child victims.

Guiding Principles of the Model

The protection of children is the highest priority

Children's safety and well-being can be enhanced by increasing their mother's safety

Children's safety is increased by supporting the autonomy of the mother

The person responsible for the harm, not the person harmed, is held accountable for the abusive behaviour

Community service providers have a responsibility to provide direct services and support education and treatment services for abusive adult partners.

London CAS will promote a comprehensive, coordinated community response to address family violence and alleviate its consequences.

In London, and across the province, there is a lack of effective coordinated services and gaps in information sharing among helping systems such as criminal justice, child protection, women's advocacy and batterer treatment programs. Consistent with the findings of the Death Review Committee, gaps in service, especially around monitoring of perpetrators and changes in risk factors (particularly during periods of increased risk), were identified as areas where more needed to be done to prevent the deaths of the children.

Overview of the Proposed Model

The proposed model recognizes community service providers often work directly with families where violence is present, or where the risk of violence is present. Current community practice reveals we are each taking responsibility for assessment and safety planning with these families, however sharing and coordinating safety planning with families and each other has been minimal. **The proposed model allows for community partners to follow a process for family and community consultation that will address the need for comprehensive safety planning and coordinated service delivery.**

To this end, we are proposing a consultative model meant to coordinate services among agencies working in the violence prevention field (and overlapping sectors), with a focus on ongoing, dynamic assessment of risk. Service coordination is meant to produce 1)enhanced safety planning with the family 2) transparent, consistent sharing of information between community partners in collaboration with the family, 2) joint case

planning and shared responsibility for the forward momentum of the plan, 3) assessment of risk from multiple systems, and 4) regular opportunities for case conferencing.

Developing the Proposed Model

Using a variety of different methods, including a qualitative study of child protection practice, two community forums, and organizational site visits across Ontario and in Minnesota, we gained meaningful information about the families we serve and identified key components of an integrated model based on community feedback.

Findings from our Children's Aid Society study highlighted the multiple stressors and risks already facing families engaged with child protection, police and VAW services. Lack of access to mental health and addiction services, unemployment or under-employment, previous history of abuse for men and women (including childhood abuse), and poverty stood out as considerable stressors in families also experiencing or perpetrating violence.

Objectives of the Model

Conduct complex, dynamic assessments of safety and risk to women and children;

Offer strength-based assessment and intervention with men and other offending caregivers;

Increase family engagement, especially with men (fathers);

Share responsibility, in terms of case planning and intervention, for high risk families;

Inform change of organizational culture and practice regarding working with women and families experiencing co-occurring child maltreatment and woman abuse;

Increase capacity of frontline staff to work inter-organizationally;

Capitalize on knowledge and expertise of the London community to inform community understanding and response to family violence;

Inform and shape ongoing and future dialogue about how to best respond and serve families experiencing violence.

Similarly, the community forums, with participants from child protection, law enforcement, criminal justice, violence against women, and forensic psychiatry sectors, allowed community members to highlight the features of an integrated model considered to be most important. Namely, an integrated response would be client-centred; focus on information sharing between organizations; maintain open and transparent dialogue between organizations; create opportunities for sharing resources and staff; and encourage stronger working alliances.

Finally, upon visiting other organizations across Ontario and in Olmsted County, MN USA that are already implementing various models of response to domestic violence, we were able to observe different approaches to service delivery, protocol development, community relationship building, and case management practices. Based on these visits we determined a high-risk, consultative model of service delivery was best suited to the needs and expertise of the London community.

Benefits of a Coordinated Model

Working together in a consultative, coordinated manner, has the potential to positively impact all sectors working to end violence against women and their children. Community

partners will benefit from this proposed model, designed to 1) decrease the potential for violence and/or child maltreatment to escalate and/or mitigate increasing risk for harm, 2) increase the visibility of available services and supports to women, her children, and men, 3) fortify working relationships between service providers, child protection workers, and families, 4) create case plans that recognize the dynamic nature of risk and are tailored to the unique needs and changing risks for women and children, 5) work towards decreasing lethality risks to women and children, and 6) identifying how agency resources can be shared or aligned in a way to better serve the families we work with.

The Coordinated Response to DomesticViolence Model

Identifying a high-risk (or potentially high-risk) case is a complex process. Coordinating services and sharing information to get a complete 'picture' of risk within the context of collaboration with families has been difficult to achieve for many communities. This model is designed to allow community partners and those working with high-risk families to trigger a coordinated response by:

1. Identifying red flags through standardized risk assessment and/or safety planning
2. Clinical judgment regarding the potential and/or increasing risk

Following the identification of risk, a coordinated response may or may not be indicated. The specifics of how and when a case would be managed through a coordinated response will need to be determined during the next phase of model development. However, generally speaking, the expected trajectory of a case will follow one of three potential paths. The case:

1. Does not require coordinated response
2. Requires coordinated response,
3. Presents an immediate crisis/safety risk to women and/or their children and a high risk case consultation is required

The coordinated response model will provide a mechanism (i.e. high-risk case consultation) for front-line staff, managers, and family members to respond to increasing risk to mothers and children. Participating community partners will have the opportunity to meet on a regular and/or as-needed basis to assess and actively manage high risk cases of domestic violence. Cases will be discussed in detail and specific strategies will be agreed upon, with case management and planning to be assumed by the appropriate partner. Community partners participating in the consultative process will continue to communicate, update each other, and report on outcomes at subsequent meetings.

Next Steps

We are eager to move into the next phase of model development - implementation. This will include focusing on fine tuning the model and continuing to anchor this model as a component of standard practice across the community. Some of the anticipated activities associated with implementation include 1) further testing of the proposed model, 2) fine

tuning and revising components of the model (i.e. high-risk screening), 3) developing cross-training opportunities across sectors, 4) developing dynamic screening and assessment tools to be shared by service providers, 5) integrating the model design with the initiatives being developed in the law enforcement and child protection sectors 6) developing an evaluation protocol, and 6) developing a conflict resolution mechanisms.

We are also interested in maintaining the momentum of this work, as a community, so we might learn more about how changes in CAS and police practices (i.e. creating dedicated domestic violence teams) impact the effectiveness of this coordinated model.

Toward a Model for An Integrated, Safety Focused & Child Centered Community Response to Domestic Violence

History and Context

In 2005, the Domestic Violence Review Committee identified 1) lack of effective coordination of services and 2) gaps in information sharing to be a major concern for child protection services working with women and children who experience violence. Gaps in services, especially around monitoring of male perpetrators and the changes in risk factors during periods of increased risk, were suggested as areas where opportunities existed to prevent the deaths of the children.

Of the 1,695 family-related homicides in Canada, 25% involved children as victims (Statistics Canada, 2005). A parent was the offender in 90% of these cases, with fathers as perpetrators in 58% of cases and mothers in 32% of cases (Statistics Canada, 2005). In 25% of parent-child murders, the perpetrator had a history of domestic violence, and this history was twice as likely when the offender was the father as opposed to the mother (31% vs. 16%, respectively) (Statistics Canada, 2005).

Between 1961 and 2003, there were 1,994 homicide victim deaths followed by perpetrator suicide; 76% were committed by family members, of which, 57% were intimate partner homicides, and 33% were committed by parents against children (Statistics Canada, 2005). In 85% of the homicide-suicide cases, men killed only their partners, but in 15% of the cases they killed others, with the next most common victim being their children (Statistics Canada, 2005). In addition to the 834 women killed in homicide-suicides, there were an additional 214 victims, of which, 71% were children (Statistics Canada, 2005).

In 2006 approximately one-third of all child protection cases opened by London & Middlesex Children's Aid Society involved domestic violence was identified as a significant risk concern. In addition one of our local women's shelters, Women's Community House, provided services to 331 children in shelter.

In November 2006, at a presentation of the findings of the Death Review Committee Dr. Peter Jaffe, Professor and Academic Director, Centre for Research on Violence Against Women and Children, University of Western Ontario, reported that in two thirds of the cases reviewed seven or more risk factors were present at the time of the homicide, and in many of these cases the father had not abused the children previously. Dr Jaffe also noted that family, friends, colleagues, and/or front line staff at service agencies knew of factors that if shared might have prevented the tragedies that occurred. Dr. Peter Collins, forensic psychiatrist with the Ontario Provincial Police, suggested that most intimate partner homicides occur at times where increased risk should have been anticipated (triggers that were perceived by the perpetrator as ‘dramatic moments’) and these risks need to be identified, communicated and factored into safety planning with all family members and community partners. There is also a need to expand and coordinate the involvement of

community partners servicing family members in domestic violence cases in order to customize safety planning. For example, in one researcher's findings of the risk factors in domestic violence homicides, it was determined that unemployment was a significant risk factor. Service providers working in the area of employment counselling, who are not traditionally consulted in safety planning or intervention, could be engaged in the safety and intervention planning as a way to reduce the risk of harm to children in families.

This impetus for this project is based on the recommendations of the Domestic Violence Death Review Committee, and the Advisory Committee's desire to develop an integrated model of service to avoid future harm to children and their mothers.

Introduction

The London community participated in a one-year project aimed at 1) increasing the capacity to identify potential child victims of (or at-risk of) physical or emotional harm due to exposure to domestic violence and 2) providing more effective, customized intervention to all family members to alleviate the risk of future harm. This is a two phase project with the first phase focusing on the development of an integrated model of community intervention to help protect child victims.

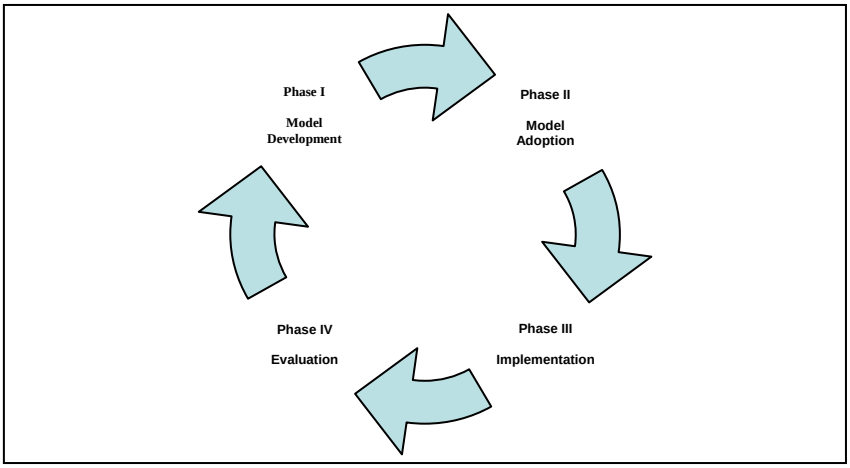
In London, and across the province, there is a lack of effective coordinated services and gaps in information sharing among helping systems such as criminal justice, child protection, women's advocacy and batterer treatment programs. Consistent with the findings of the Death Review Committee, gaps in service, especially around monitoring of perpetrators and changes in risk factors (particularly during periods of increased risk), were identified as areas where more needed to be done to prevent the deaths of the children. We know families can fall through the gaps for a number of reasons, including but not limited to:

- Dynamic, complex nature of families, especially those where domestic violence is present,
- Insufficient evidence or incomplete information related to the degree and severity of risk,
- Lack of critical information, often spread out between multiple organizations, such as history of violence, degree and severity of injury, fear, stalking behaviour, etc.,
- Professional juristictions,
- Families fail to meet differing organizational mandates and service criteria,
- Other family members and friends often hold critical information about the family and this information may be missing or witheld from service providers,
- Perpetrators hold critical information or manipulate information which accurately completes the picture of risk for child victims.

Addressing these potential gaps served as the foundation for developing a community model for integrated services to families. To this end, an Advisory Committee was formed and members participated in regular meetings to develop a plan to 1) increase capacity to identify high risk cases in the community, 2) create opportunities to share

information and case plan together in a meaningful and timely manner and 3) to establish and grow working relationships between community organizations and families.

Phase I of this project involved developing a model of service, with Phase II (not yet undertaken) focusing on further refining the model, incorporating the proposed model into the culture of service delivery in the London community, including the implementation and evaluation of the model. Phases III & IV are considered to be the next logical steps in fully incorporating this model into the London community.



Methodology: Building the Model

In addition to purposeful dialogue between the Advisory committee, front-line staff, and larger VAW community, the development of this model was closely tied to five main activities:

- Organizational site visits
- VAW Community forum feedback
- Pilot testing
- Study of domestic violence cases within CAS (N=40)
- Envisioning and analysis of ideas, within the Advisory Committee, among service providers, and with the London Coordinating Committee to End Woman Abuse

Organizational Site Visits

Members of the Advisory Committee and front line staff from local service providers visited four communities already implementing various models of response to domestic violence within the context of child protection. A brief description of each agency's approach to working with families is provided below.

- Child & Family Services of Olmsted County, Minnesota
    - Purpose is to provide differential response in the context of child protection
    - Developed specific protocols for intervening in domestic violence cases
    - Strength-based approach
    - Utilizes family conferencing within the Signs of Safety in child protection framework
    - Integrated pool of staff from child protection and VAW sector

The Olmsted model, while very successful in meeting the needs of its community, is supported by legislation and child protection policies different from those in Canada. Therefore, the exact procedures and policies would not translate exactly to local child protection practice. Also, their model of differential response in child protection was less connected to services for men who have been abusive (PAR programs), the inclusion of which our community considers essential to a true coordinated response.

- Peel Safer Families Project
    - Purpose is to provide a joint response to families with child protection and VAW in order to provide support as quickly as possible and reduce risks to children and therefore reducing the number of cases that require ongoing child protection services
    - Focus is on diversion of cases to community service providers
    - Maximizes the link of families to the community
    - Strong relationship between child protection and VAW services
    - Designated liaisons to maintain communication between partners

The Peel project was very effective in enhancing community links to families who had come to the attention of child protection services however it was not seen to be a flexible service model in that families receiving ongoing service were ineligible unless the case was transferred to a specially trained social worker. Most importantly, the program was not designed to deal with cases deemed to be high risk; rather it diverted moderate risk cases. Thus while it was a useful for engaging families in counselling services on a voluntary basis, we felt further development of services for high risk cases would be important.

- Hamilton Catholic Children's Aid Society
    - Purpose is to strengthen relationships between child protection and mothers who are victims of domestic violence
    - Focus is on embedding anti-oppressive, feminist framework in child protection practice
    - They had an integrated team approach (cases were serviced from point of referral to closing by the same child protection worker)
    - Woman's advocate from the local shelter was a member of the team on a part time basis and this enhanced the engagement of mothers and allowed

for improved and more effective relationships with VAW sector, more meaningful change in culture

The limitations that we identified included our concern that they had a limited focus on engaging men in the safety planning and that the one team could not keep up with the volume of cases so while it was seen to be effective service for families, not all families received that service.

- Family Violence Project of Waterloo Region
    - Services for victims of family violence are jointly located therefore supporting greater collaboration between service providers and reducing access barriers
    - Purpose is to offer victims and their family access to timely, seamless and holistic services.
    - Focus is on minimizing barriers to service and ensuring families access as many services as possible
    - Client-directed model of service
    - Services are justice focused and include police, victim witness, crown attorney and child protection
    - Funded coordinator who works to keep mandates, communication and information flowing.

While the co-location of services is victim focused and effective there are a few areas were identified as problematic. For example, the men's programs seemed less coordinated with the other services and the high risk case conferences were limited to criminal justice partners (to avoid issues of disclosure) and didn't include community partners (with the exception of the occasional attendance of the CAS social worker- for the purpose of providing information).

From the perspective of monitoring and identifying dynamic risks posed by the man perpetrating the abuse, each of the models we observed appeared to lack an integrated understanding of how to include the offender in the dialogue. At best there was an acknowledgement of the need for treatment. This oversight does not allow for an ongoing assessment of the risks posed by the offender and continues to put the responsibility for risk management on the mother to monitor and protect herself and her children.

Each of these site visits offered the opportunity to observe service delivery, protocol development, community relationships and case management practices. These visits highlighted the important, but very different, approaches based on each community's demographic profile, organizational resources, and community relationships. From these visits, we were able to distil policy and practice information relevant to the needs and issues most pressing in the London community.

Community Forum Feedback

Two community forums were held to gather qualitative data from members of the London community, as well as other communities across Ontario.

The first community forum was held during the "Lesson Learned from Domestic Violence Tragedies- An International and Ontario Perspective" conference on September 17th, 2007. The conference focus was to examine the work of domestic violence death review committees in the United States and Ontario and to discuss the challenges for communities in coordinating services. The purpose of this community forum was to gather information about, 1) what collaborative or integrated service delivery entails, 2) best practices for an integrated model, and 3) anticipated challenges to an effective model. Experts in the fields of child welfare, law enforcement, criminal justice, violence against women and forensic psychiatry sectors gathered to learn about integrated service delivery and provide feedback about developing the proposed model. Questionnaires were administered during a break-out session at the conclusion of the conference. Data were coded, grouped thematically, and used to inform and refine the development of the proposed model (see Table 1).

Table 1. Community forum feedback – Forum #1

Collaborative Service Delivery Should Be:	Promising Practices For Integrated Response Should Be:	Current Barriers to Integrated Response Are:
Family Centred Needs of families shape agency response	Accountable Engage men and organizations working with men	Access to Services Language, culture, transportation, poverty, discrimination hinder access/availability
Transparent Uninhibited flow of information and resources between professionals and families	Motivational Strength based practice that capitalizes on the expertise and capability of the family and all service providers	Common Understanding of Integration Roles (responsibilities and limitations) of each service provider needs to be outlined and acknowledged by each service provider
Non-Hierarchal Front line staff and supervisors equally involved in development and implementation of services	Practical Financially sustainable, utilizing creative staffing Eliminate overlap in services and territorial service provision	Despair Significant stigma attached to help-seeking, problem of DV/CA&N and re-victimization
Community Oriented Assumes a shared community responsibility for child protection and well-being	Community Driven Information is shared easily between service providers. Front line staff drive the work, not system protocols	
Unified Families and service providers jointly create goals reflecting shared vision and respecting perspectives		

The second community forum was held during the "Innovations in Saving Lives of Domestic Violence Victims and Their Children: Achieving an Integrated, Safety Focused, Community Response to Domestic Violence", hosted by the Centre for Research and Education on Violence Against Women and Children, the University of Western Ontario, the Children's Aid Society of London and Middlesex, and the Ontario Ministry of the Attorney General on October 3, 2008.

The purpose of this conference was to bring together members of the violence prevention community in London, and across Ontario, to share information, strategies, and identify current barriers to achieving an integrated system. The keynote speaker, Casey Gwinn, from the National Family Justice Center Alliance in San Diego, shared his experience developing a nationally recognized, integrated response system. Panel presentations, focused on the barriers to achieving integrated response, as well as, break-out discussions among conference participants provided rich information about the challenges facing communities. During the break-out discussions, feedback was gathered and utilized in further refining the proposed model.

This forum was used to gather information about 1) the barriers to achieving integrated services and 2) identify effective strategies for achieving integrated services. Two questionnaires: one requesting information about barriers and one requesting information about strategies, were distributed to conference participants. Data from these questionnaires were coded, grouped thematically, and used to inform and refine the development of the proposed model (see Table 2).

Table 2. Community forum feedback – Forum #2

Barriers to Achieving Integrated Services	Effective Strategies for Achieving Integrated Services
Confidentiality and Sharing of Information	**Share Information**
Lack of Knowledge about Agency Roles & Services	**Agree to Client-Centred Approach to Working with Families**
Differing Ideas About "Best Interest" • Women-centered vs. child centered vs. family centered • Men's accountability • Supporting women in staying vs. encouraging to leave	**Generate Good Working Relationships** • On-site visits • Board participation • Create opportunities for staff to work together inter-organizationally • Participate in community functions
Conflicting Mandates and Ideologies • Trust between service providers under-developed	**Maintain Open, Transparent Dialogue**

• Enforcing organizational protocols rather vs. advocating for families • Front-line staff and organization leaders often have different ideas/expectations about collaboration	
Time and Resources • Limited staff time • Limited space • Limited budgets to share expense of developing better working relationships	**Creative funding and sustainability** • Share staff • Share leadership • Commitment from community organizations of in-kind and actual funding

Pilot Testing

During the course of developing this integrated response, Advisory committee members took the opportunity to test aspects of the proposed model.

On six occasions, a family was brought to the attention of the Advisory Committee due to the identification of multiple high risk factors for child maltreatment, woman abuse or a combination of co-occurring abuse. The members of the Advisory Committee and front line staff conducted a high risk case consultation with each family to test some of the emerging features of the model, namely bringing all involved service providers to the table to share information and create a sustainable, dynamic and safety informed plan,

Based on the agreed upon success of the consultations, Advisory members were reassured in the direction and emerging structure of the model.

Study of Domestic Violence Cases within CAS (N=40)

During the course of developing the proposed model, the Advisory Committee expressed interest in better knowing what the domestic violence caseload at London Middlesex Children's Aid Society looked like. The purpose of this study was to better understand the risks and needs of families where children are in need of protection in order to illuminate 1) already existing approaches to working with these families, 2) description of family characteristics and 3) identify barriers to working with these families.

Advisory Committee members generated a broad list of areas of inquiry, mostly demographic in nature. From this list, an interview tool was developed (see Appendix B).

Cases that had Domestic Violence as a concern (either primary or secondary reason for service) were included in the sample. A list of cases from August 2007 – December 2007 was generated automatically resulting in 221 active Family Service files and 114 Intake files. From this list, 40 files (32 Family Service files and 8 Intake files) were randomly selected. Using the interview tool, members of the Advisory Committee conducted one-on-one interviews with the front-line Child protection worker associated with each randomly selected case.

The findings of this study (detailed information can be found in the Appendix B-G), while descriptive in nature, provided excellent information for discussion and guiding the development of an informed and targeted coordinated model.

We were particularly interested to find an almost even split between the number of voluntary and mandated clients in the sample. There are a number of questions about what this might mean in terms rapport building and relationship building with families. Are we already beginning to engage families in a less intrusive, more motivationally enhanced way? Are we already moving towards a client-centered approach to working with families, and as such, will a coordinated service model further compliment these emerging relationships between service providers and families? Feedback from the community forums identified client-centred and motivationally enhanced approaches to working with families to be an important component of an integrated response, and it was encouraging to have these sentiments echoed in our own data.

The violence against women sector, as well as other intersecting systems of child protection, criminal justice, and healthcare, is often faced with the challenges associated with trends in the literature, policy, and practice (i.e. dual arrests, primary aggressor language, etc), around women's use of violence. Our data revealed no instances of women being identified as the sole perpetrator (furthermore, no identification of men being the sole victim). In 5 families, the child protection worker acknowledged both partners to be "equally" violent towards each other. In these cases the workers were clearly cued to consider fear, injury and possibility of death for women before deciding both the male and female caregivers were considered to be perpetrators and/or victims. This finding was encouraging as one of the guiding principles for the proposed model states, "Children's safety and well-being can be enhanced by increasing their mother's safety". This statement continues to be very important guideline considering our data revealed women to be the victim of domestic violence in all of the families included in the study.

We know the families we work with face considerable obstacles and challenges including financial, social, emotional and psychological stressors. As suspected, in families where violence is perpetrated there are additional risk factors including; lack of formal education, poverty, and lack of access to mental health and addiction resources. Our study revealed, of the families where their education history was known: ,

- almost the entire sample had high school education or less;
- more than half the sample was reported to have a household income of less than $20,000 annually;
- few women and even fewer men utilized mental health and addiction resources (because there are few, or because connection to services were not made, remains to be answered).

Some interesting findings related to case planning and understanding of the complexity of domestic violence also emerged from the data. This information was extremely useful to our recognizing the importance of ongoing cross-training and increasing awareness

among service providers and the general community. For instance, 23% of child protection workers indicated they were “unsure” about women’s interest in reconciling (or maintaining) an intimate relationship with their violent partner. This is an interesting piece of information in terms of safety planning and assessing risk for women and children given what we know about the escalation of danger for women who separate or end violent relationships. An important training piece exists here in terms of lethality and danger assessment.

Another potential indication for further training around lethality and dangerousness arose when we looked at the change in family structure over time. The number of caregivers residing in the home at referral vs. at the time of interview was cut by half62.5% of families had both partners in the home at the time of referral, while 32.5% of families were reported to have both parents in home at the time of the interview. So what might this mean for the safety of women and children? Were these separations voluntary or at the request of criminal justice or child protection? Are the implications of this separation known and understood by front-line staff?

Finally, even though 73% of men from the sample were interviewed by a child protection worker, in 70% of the cases we had no information about men’s previous history of abuse (confirmed or suspected). A history of domestic violence is known risk factor for ongoing/future violence. This finding indicates further reasons for cross-training and knowledge enhancement.

Findings from this study provided Advisory members with the opportunity to think critically about how families engage with systems and further informed their understanding of current risk and safety planning needs based on the current approach to case planning. These discussions cemented what would eventually become the overarching ideology and philosophical framework governing the proposed model.

Philosophy of the London Coordinated Model

Overarching Ideology

The following theoretical and clinical perspectives influenced the creation of the model.

- Feminist trauma theory
- Motivational enhanced techniques
- Client-centered, solution-oriented approaches to problem solving

- Collaborative approach to service planning and delivery

*Guiding Principles**

1. The protection of children is the highest priority
2. Children's safety and well-being can be enhanced by increasing their mother's safety
3. Children's safety is increased by supporting the autonomy of the mother
4. The person responsible for the harm, not the person harmed, is held accountable for the abusive behaviour
5. Community service providers have a responsibility to provide direct services and support education and treatment services for abusive adult partners.
6. In cooperation with community service providers, child protection (London CAS) will promote a comprehensive, coordinated community response to address family violence and alleviate its consequences.

*Adopted from the Olmsted County guiding principles for differential response.

Objectives

The main objectives of this integrated model are to:

1. Conduct complex, dynamic assessments of safety and risk to women and children;
2. Offer strength-based assessment and intervention with men and other offending caregivers;
3. Increase family engagement, especially with men (fathers);
4. Share responsibility, in terms of case planning and intervention, for high risk families;
5. Inform change to organizational culture and practice regarding working with women and families experiencing co-occurring child maltreatment and woman abuse;
6. Increase capacity of frontline staff to work inter-organizationally;
7. Capitalize on knowledge and expertise of the London community to inform community understanding and response to family violence;
8. Inform and shape ongoing and future dialogue about how to best respond and serve families experience violence.

Definitions

The Advisory Committee developed these working definitions to guide the development of this model.

Collaboration is a mutually beneficial and well defined relationship entered into by two or more organizations to achieve common goals. It is a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible. The individuals who represent collaborating organizations are **partners.**

Partnership implies the sharing of resources, responsibilities, decision-making, power and benefits between two or more parties. Partnerships can vary from short term to long term, from formal to informal.

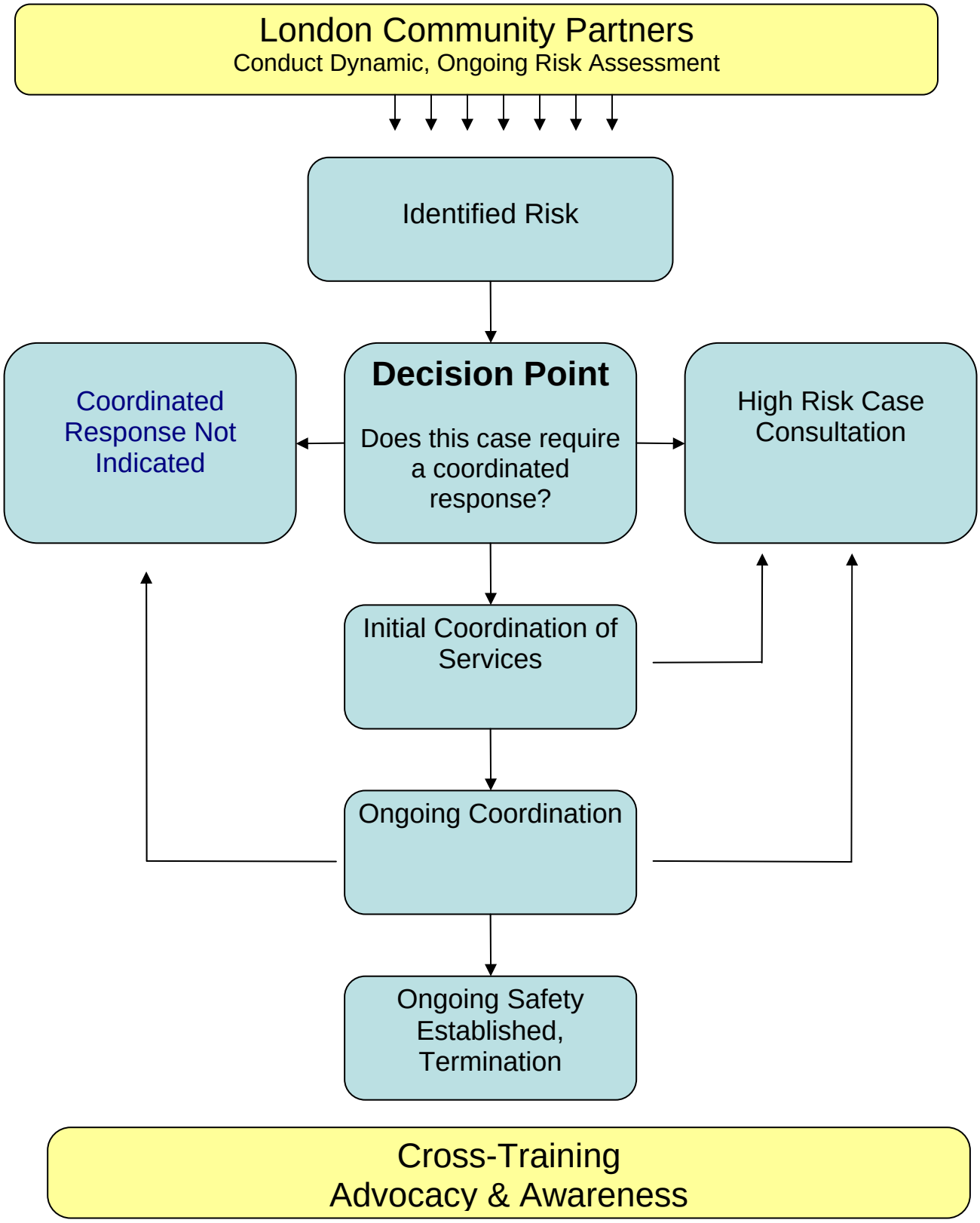
Cooperation is an informal relationship that exists without an commonly defined mission, structure or planning. Information is shared as needed an authority is retained by each organization.

Coordination is a more formal relationship and an understanding of compatible missions. Some planning and division of roles are required and communication channels are established. Authority still remains with the individual organizations.

Inter-sectoral Collaboration involved different levels of sectors such as the public, the government, the voluntary and the private sectors. Cross system collaboration and Inter-agency networking are similar concepts.

The proposed model (Table 9) is governed by the ideology, guiding principles, objectives and definitions outlined above, and built upon a foundation of cross-training and advocacy. The crux of the model is focused on providing a coordinated response, mobilizing community resources and expertise with the option of high risk case consultation.

Table 9. London Coordinated Response to Family Violence Model



The proposed model recognizes each community partner often works directly with families where violence is present, or where the risk of violence is present. Current community practice reveals we are each taking responsibility for assessment and safety planning with these families, however sharing and coordinating around this information has been minimal. The proposed model allows for community partners to follow a somewhat traditional case management framework, with elements of community consultation influencing the safety planning and directing the decision-making process.

Triggering a Coordinated Response

Determining high-risk or dangerousness is often difficult, as situations change quickly and are often in flux. The proposed model seeks to assess the current climate of risk for women and their children, as well as how the most recent incident of violence (or other "red flag") contributes to the overall picture of violence in the family and the potential for future harm.

Some of the well known risk factors* contributing to serious injury and death include:

- Violent and constant jealousy
- Controlling behaviour
- Use of weapons or threats to use weapons
- Increase in physical violence in frequency and severity
- Violence outside the home
- Threatened or tried to commit suicide
- Criminal harassment or stalking
- Attempted to choke victim
- Access to guns or weapons
- Delusion, paranoia or depression (no hope)
- Alcohol or drug addiction
- Difficult separation
- Stepchildren in home

*As identified by the Huron Assessment Risk Reduction Team (HAART)**,** Goderich, Ontario, 2007

In the collective experience of the Advisory Committee, identifying a high risk (or potentially high risk) case is not difficult. Rather, coordinating services and sharing information to get a complete 'picture' of risk is the more challenging piece of serving high risk families. Keeping these red flags in mind, the coordinated response can be triggered by any community partner by:

3. Identifying red flags through standardized risk assessment and/or safety planning
4. Intuition or clinical judgment regarding potential or increasing risk

Decision Making and Coordination of Services

Following the identification of risk, a coordinated response may or may not be indicated. The specifics of how and when a case would be indicated or not indicated for a coordinated response will need to be further fleshed out during the next phase of model development (discussed further below). However, generally speaking, the expected trajectory of a case will follow on of three potential paths:

4. The case does not require coordinated response
5. The case requires coordinated response, with the possibility of high risk case consultation
6. The case presents an immediate crisis/safety risk to women and/or their children and a high risk case consultation is required

The coordination of services, with a focus on ongoing, dynamic assessment of risk, lies at the heart of the proposed model. Again, the finer details of the model remain to be developed, but in general the initial and ongoing coordinated response will focus on:

- Transparent, consistent sharing of information,
- Joint case planning and shared responsibility for the forward momentum of the plan,
- Assessment of risk from multiple systems
- Regular case conferencing

As discussed previously, aspects of the proposed model have been tested with high-risk families. The basic structure, including entry and exit points to the high risk consultative process, is considered to be a viable and sustainable framework for the London community. While this testing was very helpful in demonstrating the utility and viability of a high risk case consultation model among community partners, the cases used for testing were already in crisis or at considerable high risk for crisis. As such, the tested cases did not necessarily lend themselves well to fleshing out components of the model where coordinated response may not be indicated or requiring a less rigorous form of coordinated response. Therefore, to better shape our understanding of how cases will flow through the model, we will be mindful of some of these questions in the next phase of development:

- How are decisions made as group?
- What standardized tools may be used to help inform the decision to utilize a coordinated response?
- Who takes the 'lead' in managing the coordination of services for each case?
- How will the sharing of information and a feedback loop be maintained?
- How is the family involved in the high risk case consultation?

High Risk Case Consultation

A standing committee consisting of community partner leaders (i.e. managers, supervisors, executive directors of community service providers) will come together, with the family and front-line staff to make decisions around safety planning and decision-making with the aim of:

1. Decreasing the potential for violence and/or child maltreatment to escalate and/or working towards mitigating increasing risk for harm,
2. Increasing the visibility of available services and supports to women, her children, and men,
3. Fortifying working relationships between service providers, the assigned Child protection worker, and families, and,
4. Creating case plans that recognize the dynamic nature of risk and are tailored to the unique needs and changing risks for women and children.

We have been mindful to consider the potential safety implications case conferencing may present for women. As a group, we will remain vigilant in assuring case conferences mitigate

risk to women and children rather than increasing risk. Typically, a case conference will include a review of the case history from all perspectives including the family's, already identified risk factors, any necessity for immediate intervention, safeguarding the victim, and managing the offending adult. Once a complete picture of the family is provided, strategies are agreed upon with a particular service provider (or combination of service providers) taking the lead to ensure the agreed upon steps are followed through on. Often times this role will fall to the child protection worker involved, however, in some cases it may be more logical for another service provider to take the lead. It is understood all members of the case conferencing group will continue to communicate with and support each other between meetings.

Cross-Training

This component of the model captures the education piece of the integrated response. The importance of including a training piece to this model came up at numerous points as the model evolved, but was especially noticeable in the community forum feedback and during data collection for the child protection study.

The proposed model relies heavily on the strong working relationships and already established rapport across sectors. However, even with such strong ties and a shared commitment to working together, cross-training remains an essential activity for all front line staff and managers working with high risk families. Given the level of integration and community collaboration required in case conferencing and shared case management, cross-training between the VAW, child protection, criminal justice and PAR sectors is integral to the ongoing success and sustainability of the model.

It was evident to Advisory committee members, and self-identified by front-line staff, the current understanding of the roles, responsibilities and capabilities of various service providers in the London community were not as well understood as they could be. Furthermore, some staff were often unable to articulate how the purpose and perspectives, in regards to serving women and children, differ. The purpose of creating cross-training opportunities for service providers working with high risk families would be to 1) create a more informed, shared understanding and definition of what "high-risk" families looks like, 2) identify the challenges faced in serving these families, both intra-organizationally and inter-organizationally, and 3) create stronger alliances and bonds between staff in each sector, encouraging shifts in organizational practice and cultural to best serve high risk families.

Advocacy & Awareness

This component of the model captures the prevention piece of the integrated response. Marrying intervention and education efforts with prevention activities is not a new concept in anti-violence work. However, members of the VAW sector in London are uniquely positioned to champion this model, locally and regionally, given their experience, expertise, and reputation as leaders in the field.

Capitalizing on this already established network of leaders in the field of research, education and prevention, Advisory committee members support opportunities to bring these people together in an effort to maintain an open dialogue about the proposed integration model.

Future Directions

Members of the Advisory committee are eager to move into the next phase of model development - implementation. This will include focusing on fine tuning the model and continuing to anchor this model as a component of standard practice across the community. Some of the anticipated activities associated with implementation include:

- Further testing of the proposed model to ensuring that the model achieves the objectives
- Fine tune and revise pieces of the model based on the findings of testing to ensure quality and strengthen accountability
- Develop, coordinate and offer cross-training opportunities across sectors
- Develop dynamic screening and assessment tools to be applied by service providers
- Develop an evaluation protocol to study the implementation process of the model and impact on families and the community
- Develop a conflict resolution mechanism

We are also interested in maintaining the momentum of this work, as a community, so that we might learn more about how changes in child protection practice (i.e. creating a dedicated Domestic Violence team) may impact the effectiveness of this coordinated model.

References

Ministry of Community Safety & Correctional Services. (2005). *Domestic violence death review committee annual report to the chief coroner.* Toronto, ON: Office of the Chief Coroner:

Statistics Canada. (2005). *Family violence in Canada: A statistical profile*. Catalogue #85.224.XIE. Ottawa: Canadian Centre for Justice Statistics.

Appendix A: CAS Study Demographic Interview Tool

Voluntary _____
Mandated _____

1. *Age:*

Female Parent/Caregiver _____
Male Parent/Caregiver _____

Child 1 _____
Child 2 _____
Child 3 _____
Child 4 _____

Age gap between adult caregivers (in years) _____
Number of children under the age of 2 _____

2. *Gender:*

Adults

Perpetrator	M	F	Both M & F caregivers
Victim	M	F	

Child(ren)

Child 1	M	F
Child 2	M	F
Child 3	M	F
Child 4	M	F

3. *Social Identity:*

___ Dutch ___ Chinese ___ Irish ___ South Asian
___ French ___ Jewish ___ Italian ___ African Canadian/American
___ English ___ Polish ___ Ukrainian ___ First Nations/Metis/Inuit
___ Canadian ___ American

___ Other (please specify _____
___ Unknown

4. *Family Location*

Rural
Urban
Unknown

Number of caregivers residing in the home at referral: _____
Number of caregivers residing in the home at disposition: _____

5. *Religion/Faith*

Please specify_____
Unknown

6. *Resident Status*
Female Parent/Caregiver
Citizen
Permanent Resident/Landed Immigrant
Immigration Status Unknown

If a newcomer to Canada, approx length of time residing in Canada (in years) _____

Male Parent/Caregiver
Citizen
Permanent Resident/Landed Immigrant
Immigration Status Unknown

If a newcomer to Canada, approx length of time residing in Canada (in years) _____

7. *Marital status:*

Married
Common Law
Single
Separated
Previously Married
Divorced
Unknown

8. *Employment*

Female Parent/Caregiver

Employed, outside the home
Full time ____
Part time ____
Unknown ____
Stay at home caregiver
Unemployed

Male Parent/Caregiver
Employed, outside the home
Full time ____
Part time ____
Unknown ____
Stay at home caregiver
Unemployed

9. *Income (include all that apply)*

Wages/Salaries
Social assistance
Disability
Pension
Other (specify) _____

10. *SES*

Approximate family income level?

_____ under 10, 000
_____ 10, 000 – 14, 999
_____ 15, 000 – 19, 999
_____ 20, 000 – 24, 999
_____ 25, 000 – 29, 999
_____ 30, 000 – 34, 999
_____ 35, 000 – 39, 999
_____ 40, 000 – 44, 999
_____ 45, 000 – and over
_____ Unknown

11. *Education*

Female Parent/Caregiver (highest level of education achieved)

____grade school/elementary school
____did not complete high school
____high school diploma
____college diploma
____ unknown
____ trade school
____ vocational degree
____ bachelor's degree
____ post graduate or professional degree

Male Parent/Caregiver (highest level of education achieved)

____grade school/elementary school
____did not complete high school
____high school diploma
____college diploma
____ unknown
____ trade school
____ vocational degree
____ bachelor's degree
____ post graduate or professional degree

12. *Domestic Violence*

<u>Female Parent/Caregiver</u>

Answer the following questions related to their CURRENT partner

	Past case openings (or more than 1 year ago)			Current case openings		
	Yes	**No**	**Unknown**	**Yes**	**No**	**Unknown**
Physical assault						

Physical assault during pregnancy						
Confirmed childhood experience of abuse						
Suspected childhood experience of abuse						
Confirmed adult victimization						
Suspected adult victimization						
Domestic violence with other partners –Victim						
Domestic violence with other partners - Perp						

CAS involvement for DV concerns prior to this case opening Y N UK

Interested in reconciliation/maintenance of the relationship Y N Unsure UK

Male Parent/Caregiver (identified perpetrator)

Answer the following questions related to their CURRENT partner

	Past case openings (or more than 1 year ago)			Current case openings		
	Yes	**No**	**Unknown**	**Yes**	**No**	**Unknown**
Physical assault of current partner						
Physical assault of previous partner(s)						
Confirmed childhood experience of abuse						
Suspected childhood experience of abuse						
Confirmed adult victimization						
Suspected adult victimization						
Domestic violence with other partners –Victim						
Domestic violence with other partners - Perp						

CAS involvement for DV concerns prior to this case opening Y N UK

Interested in reconciliation/maintenance of the relationship Y N Unsure UK

If currently separated:
____ Voluntary
____ Involuntary (at CAS/LPD/PO request)
____ Unknown
____ N/A

13. *Criminal Justice Involvement*

Female Parent/Caregiver

Answer the following questions related to their CURRENT partner

	Past case openings (or more than 1 year ago)	Current case openings

	Yes	No	Unknown	Yes	No	Unknown
DV **charge** against current partner						
If yes, more than one **charge** (specify #)						
Are there probation terms						
If yes, batterer intervention treatment?						
Non-association order in place						
Other terms of probation (specify below)						
DV **conviction** against current partner						
If yes, more than one **conviction**						

DV **charge(s)** against previous partner(s)? Y N UK

DV **conviction(s)** against previous partner(s)? Y N UK

Male Parent/Caregiver

Answer the following questions related to their CURRENT partner

	Past case openings (or more than 1 year ago)			Current case openings		
	Yes	**No**	**Unknown**	**Yes**	**No**	**Unknown**
DV **charge** against current partner						
If yes, more than one **charge** (specify #)						
Are there probation terms						
If yes, batterer intervention treatment?						
Non-association order in place						
Other terms of probation (specify below)						
DV **conviction** against current partner						
If yes, more than one **conviction**						

DV **charge(s)** against previous partner(s)? Y N UK

DV **conviction(s)** against previous partner(s)? Y N UK

14. *Child witnessing/exposure to DV (check all that apply)*

Sustained physical injury
Attempted to intervene (physically)
Reported seeing abusive behaviours
Reported hearing abusive behaviours
Other exposure
(specify)_____

15. *Co-morbidity*

Female Parent/Caregiver

Mental health concerns	Y	N	Suspected	UK
Addiction	Y	N	Suspected	UK
Child maltreatment	Y	N	Suspected	UK
Suicide	Y	N	Suspected	UK

Male Parent/Caregiver

Mental health concerns	Y	N	Suspected	UK
Addiction	Y	N	Suspected	UK
Child maltreatment	Y	N	Suspected	UK
Suicide	Y	N	Suspected	UK

16. *Source of referral*

Police
Teacher
Neighbour
Friend of family
Family member
Concerned citizen
Other (specify)
_____

17. *Previous CAS involvement*

Female Parent/Caregiver Y N UK
If yes, # of previous case openings _____
Specify reasons for openings (with spectrum codes when available)
_____
_____
_____
_____
_____

Male Parent/Caregiver Y N UK
If yes, # of previous case openings _____
Specify reasons for openings (with spectrum codes when available)
_____
_____
_____
_____
_____

18. *Custody*

Female Parent/Caregiver (if not the same for all children please specify)
- Full Custody
- Joint Custody
- No custody
- Unknown

Male Parent/Caregiver (if not the same for all children please specify)
- Full Custody
- Joint Custody
- No custody
- Unknown

19. *Access*

- Supervised visitation with perpetrator
- Unsupervised visitation with perpetrator
- No access

If there is a supervision arrangement with the victim (female parent) please specify:

_____
_____
_____

Is the child(ren) in out of home care Y N UK

If yes, please specify:
- Wardship
- Kinship
- Foster Care
- Group Home
- Other _____

20. *Safety Planning*

Safety planning with female parent/caregiver Y N UK
Completed by Child protection worker Y N UK
Completed by community advocate Y N UK

If no, reason for not completing safety plan_____
_____
_____

21. *Inclusion of Male Parent/Caregiver in case planning*

Was the male parent/caregiver interviewed by worker Y N UK

22. *Community Access*

Female Parent/Caregiver

	Past case openings (or more than 1 year ago)			Current case openings		
	Yes	**No**	**Unknown**	**Yes**	**No**	**Unknown**
Utilized shelter services						
Counselling services						
Addiction/alcohol treatment						
Legal aid						
Housing advocacy						
Food bank						
Other (specify)						

Male Parent/Caregiver

	Past case openings (or more than 1 year ago)			Current case openings		
	Yes	**No**	**Unknown**	**Yes**	**No**	**Unknown**
Utilized shelter services						
Counselling services						
Addiction/alcohol treatment						
Legal aid						
Housing advocacy						
Food bank						
Other (specify)						

Appendix B. Caregiver Demographics

	Men	Women
Age[1]	31	29
Perpetrator Gender	100%[2]	0%
Victim Gender	0%	100%[3]
Employment (full or part-time)	53%	23%
Education		
Did not complete high school	23%	28%
Completed high school	10%	20%
Unknown	63%	43%
Interested in Reconciliation	50%	38%[4]
Mental Health Concerns	23%	35%[5]
Addiction	45%	33%
Child Maltreatment	35%	28%
Suicide Risk/Attempt	8%	13%
Child Custody		
Full custody	35%	50%
Joint custody	18%	15%
No custody	38%	30%

[1] Average age gap between caregivers is 4 years.
[2] 87% of perpetrators were identified as men only; in 12.5% (5 cases) both men & women were identified as perpetrators.
[3] 87% of victims were identified as women only; in 12.5% (5 cases) both men & women were identified as victims.
[4] 23% of the Child protection workers responded "unsure" regarding women's interest in reconciliation.
[5] In addition, 18% of women were "suspected" of having difficulties with mental health.

Appendix C. Family Demographics

Number of children in family	2
Average age of children	7[6]
Social Identity	
Caucasian	48%
First Nation	20%
Canadian Citizenship	100%
Social Location – Urban	98%
Both caregivers residing in the home at referral	63%
Both caregivers residing in the home at time of interview	33%
Relationship Status	
Married	8%
Common-law	38%
Single	28%
Separated	23%
Income source[7]	
Wages/Salaries	35%
Social Assistance/Disability	51%
Income	48% under 20K annually

[6] 16 families had a child under the age of 2 (40% of the sample); 2 families had more than five children.
[7] In 13% of families, source of family income was unknown.

Appendix D. Child Demographics

Child Exposure to Domestic Violence[8]	
Sustained Physical Injury	23%
Attempted to Intervene	28%
Reported Seeing Abuse	48%
Reported Hearing Abuse	55%
Other Exposure[9]	42%
Child Access to Perpetrator	
Supervised	25%
Unsupervised	28%
No Access	25%
Child in out-of-home care	15%

[8] There was some form of child exposure to domestic violence reported (by Child protection workers) in every family.

[9] Infant in bedroom 5%; infant in the room 7.5%; infant in the home 2.5%; child in bedroom 2.5%; child info gatherer 2.5%; saw injuries on mom 2.5%; child suspects abuse 2.5%; Threatened with a gun 2.5%; withdraws from other children 2.5%; witness to previous abuse 2.5%.

Appendix E. Case Management Information

Voluntary Client	38%
Mandated Client	40%
Previous CAS Involvement	
Men	38%
Women	33%
Referral Source	
Police	40%
Teacher/School	10%
Family/Friend	5%
Other[10]	43%
Safety Planning with Victim	85%
Men/Father Interviewed by CAS	73%

Female Referrals and Resource Utilization (current case opening)

	Yes	No	Unknown
Shelter services	18%	50%	30%
Counselling services	40%	33%	25%
Addiction/alcohol treatment	13%	60%	25%
Legal aid	28%	38%	33%
Housing advocacy	25%	50%	23%
Food bank	30%	38%	30%

[10] Another CAS 15%; hospital 5%; self-referral 5%; addiction services 2.5%; birthing centre 2.5%; crown 2.5%; Changing Ways 2.5%; mental health 2.5%.

Male Referrals and Resource Utilization (current case opening)

	Yes	No	Unknown
Utilized shelter services	3%	58%	38%
Counselling services	25%	40%	33%
Addiction/alcohol treatment	10%	53%	35%
Legal aid	23%	40%	35%
Housing advocacy	3%	58%	38%
Food bank	5%	50%	43%

Appendix F. Domestic Violence

Female	Past case openings (or more than 1 year ago)			Current case openings		
	Yes	**No**	**Unknown**	**Yes**	**No**	**Unknown**
Physical assault	48%	13%	40%	65%	25%	10%
Physical assault during pregnancy	8%	18%	75%	18%	33%	50%
Confirmed childhood experience of abuse	20%	20%	60%	28%	23%	50%
Suspected childhood experience of abuse	15%	15%	45%	10%	23%	40%
Confirmed adult victimization	18%	23%	58%	25%	28%	48%
Suspected adult victimization	15%	13%	50%	10%	25%	43%
Domestic violence with other partners – Victim	25%	13%	63%	15%	35%	50%
Domestic violence with other partners – Perpetrator	15%	28%	58%	0%	50%	50%

Male	Past case openings (or more than 1 year ago)			Current case openings		
	Yes	**No**	**Unknown**	**Yes**	**No**	**Unknown**
Physical assault of current partner	43%	10%	45%	62%	28%	8%
Physical assault of previous partner(s)	18%	10%	70%	8%	20%	70%
Confirmed childhood experience of abuse	13%	15%	68%	15%	25%	55%
Suspected childhood experience of abuse	23%	60%	13%	18%	10%	55%
Confirmed adult victimization	10%	18%	70%	8%	33%	58%
Suspected adult victimization	5%	18%	68%	3%	30%	58%
Domestic violence with other partners –	0%	23%	75%	0%	33%	65%

Victim						
Domestic violence with other partners – Perp	18%	10%	70%	8%	20%	70%

Appendix G. Domestic Violence Charge and Conviction Information

Female	Past case openings (or more than 1 year ago)			Current case openings		
	Yes	**No**	**Unknown**	**Yes**	**No**	**Unknown**
DV charge against current partner	20%	28%	50%	48%	43%	8%
If yes, more than one charge[11]	10%	30%	58%	15%	60%	23%
Are there probation terms	10%	33%	55%	23%	50%	25%
Batterer intervention a component of PO terms	10%	30%	58%	18%	53%	28%
Non-association order in place	18%	28%	53%	45%	45%	8%
Other terms of probation[12]	8%	25%	65%	13%	43%	43%
DV conviction against current partner	8%	28%	63%	15%	58%	25%
More than one DV conviction against current partner	8%	28%	63%	5%	58%	35%

Male	Past case openings (or more than 1 year ago)			Current case openings		
	Yes	**No**	**Unknown**	**Yes**	**No**	**Unknown**
DV charge against current partner	5%	48%	45%	13%	78%	8%
If yes, more than one charge	0%	53%	45%	3%	78%	18%
Are there probation terms	5%	50%	43%	5%	78%	15%
Batterer intervention a component of PO terms	3%	50%	45%	3%	78%	18%
Non-association order in place	8%	45%	45%	8%	75%	15%
DV conviction against current partner	3%	50%	45%	3%	78%	18%
More than one DV conviction against current partner	0%	53%	45%	0%	85%	13%

[11] Assault; breach; illegal firearm; uttering

[12] AA; PAR group or Caring Dads group; no electronic devices; supervised access

Appendix I: London Community Partners and Advisory Committee Members

Children's Aid Society of London and Middlesex
Maureen Reid
Victoria Hathaway
Derrick Drouillard
Larry Marshall

Changing Ways, Inc.
Tim Kelly

Women's Community House
Kate Wiggins

London Police
Paul Martin
Lisa Heslop

Child Abuse Expert Consultant
Rhonda Hallberg

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