Social Policy Evaluation and Research Unit

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Evaluation of the family violence Integrated Safety Response pilot

Final report

AUGUST 2017

By Elaine Mossman, Judy Paulin and Nan Wehipeihana

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The purpose of the Social Policy Evaluation and Research Unit (Superu) is to increase the use of evidence by people across the social sector so that they can make better decisions – about funding, policies or services – to improve the lives of New Zealanders and New Zealand's communities, families and whānau.

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Disclaimer

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The final report has benefited from reviews and valuable feedback provided by two independent peer reviewers.

Particular acknowledgement needs to be made of all those involved with the oversight and delivery of the Integrated Safety Response who, while managing high workloads associated with ISR, still made the time to share their views with us.

Finally, special recognition needs to be given to the women and men who shared personal stories and valuable insights from their experiences of the Integrated Safety Response.

Executive summary

The family violence Integrated Safety Response (ISR) pilot was officially launched in Christchurch on 4 July 2016. A second pilot site in Waikato came into operation on 25 October 2016. The ISR pilot is one element of a larger cross-agency work programme overseen by the Ministerial Group on Family Violence and Sexual Violence.

Government ministers asked the Social Policy Evaluation and Research Unit (Superu) to commission a supplier to carry out an evaluation of the ISR pilot. Superu selected a consortium of three independent evaluators: Dr Elaine Mossman (sole trader), Judy Paulin (Artemis Research NZ Ltd), and Nan Wehipeihana (Research Evaluation Consultancy Ltd).

This final report follows an interim report completed in November 2016 that focused on the early implementation of the ISR model in the first pilot site (Christchurch). This final report reviews emerging evidence of the effectiveness of the ISR model together with any changes in practice. It also considers the extent to which the implementation of the model has taken account of early findings from the evaluation (ie, evidence of continuous improvement). The Christchurch pilot remains the focus of the report, but data from Waikato is included where applicable, especially to assess the ability of the ISR model to be generalised to other sites, and to consider impacts of local variations to the model.

Aim and key features of Integrated Safety Response

The central aim of the Integrated Safety Response is to deliver more effective safety responses to families referred to it via a Police call-out to a family harm episode or via Corrections where there is imminent prison release of a high-risk perpetrator of family harm. This is achieved through relevant agencies and social service providers working collectively for victims, children and perpetrators of family violence. The model includes multi-agency governance and management structures to provide support and strategic oversight. At the heart of the ISR response are daily collaborative meetings of personnel to identify risks and issues, problem-solve, plan a co-ordinated response, and review case progress, together with the weekly Intensive Case Management (ICM) of high-risk cases. Cases are closed once safety has reasonably been assured, and appropriate supports are in place. The new operating model is an end-to-end process involving shared expertise and knowledge, timely decision making, and focused actions. The goals are keeping families safe, and reducing re-victimisation.

Since the pilots began, multi-agency safety plans have been developed for nearly 10,000 families, involving just under 30,000 individuals. Close to 400 of these families have been identified as high risk (4% of all plans). Every week, an average of 183 episodes of family harm are being processed through ISR in Christchurch, with an average of 209 in Waikato.[1]

1 The term 'family harm episode' has been adopted by Police to encompass the broad range of harm that can arise as a consequence of family violence or that can be linked to family violence (eg, inter-generational violence and criminal behaviours, drug and alcohol abuse, and other social and health impacts). It also more accurately captures that family violence is not a series of isolated incidents affecting an individual, but rather a pattern of abusive behaviour over time that can affect multiple victims.

Implementation of ISR model and evidence of continual improvement

The ISR model constitutes a significant change in the ways in which family harm is responded to in New Zealand. The ISR model is multi-faceted, involving a range of government and non-government agencies. Implementing, training, resourcing, mobilising and continuing to maintain engagement of all the key players required for ISR to operate, is no small feat. Hence, it is a considerable achievement that in under a year the ISR model has been implemented, largely as intended, in two large centres.

The addition of the second pilot site in Waikato provides an opportunity to assess how well the ISR model works across a more diverse population, one that features a higher proportion of people from rural and Māori communities. The fact that the ISR model is now successfully running in two pilot sites indicates that the model is robust enough and flexible enough to be transferred and implemented successfully in varying local conditions.

Key learnings that may assist with any further roll-out of ISR include the importance of:

- consultation with all groups prior to implementation (NGOs and government agencies),
- selection of sites with strong established relationships among sufficient service providers who want to make it work,
- finding facilities with sufficient space to allow a co-located ISR team, and
- ensuring ISR training includes practice-oriented guidelines, reaches the wider community of organisations and is ongoing to ensure all new staff are fully informed around ISR.

The addition of the Waikato site also enables the impact of local variations to the model to be understood. Across the two sites there have been a number of differences in how ISR has been implemented, including: the number and frequency of Safety Assessment Meetings (SAMs); whether the SAM tables are able to review all ISR-referred episodes of family harm, including low-risk cases; the set-up and allocation of ISR specialist victim and perpetrator supports across non-government organisations (NGOs); and the representation of NGOs at the SAM table. Over time, personnel at both sites appear to be sharing ideas and moving in similar directions (eg, both sites currently moving to new premises to enable co-location of ISR teams and key agencies).

Operating the ISR model is resource intensive, and getting the right level of resources to meet demand has been challenging for teams at both sites. Resourcing provided by the government agencies involved has increased; the government has also provided additional funding for the ISR pilot. In Christchurch, workloads have become more manageable, particularly for the government agencies, making delivery of the SAM and Intensive Case Management elements more sustainable. While pressure has eased, working effectively with such high volumes remains an ongoing challenge (eg, the ability of SAMs to review all cases, including low-risk cases, and the ability of NGOs to manage high volumes of referrals and carry high caseloads).

Waikato appears to be at a place similar to Christchurch at the time of the interim evaluation, and to be struggling to adequately resource its ISR commitments. This may be because Waikato is at an earlier developmental stage, or simply because demands on resources are higher in Waikato, which has higher volumes (currently requiring 11 SAM tables to review all cases) and a far wider geographical area to cover.

There has been clear evidence of continued improvement in the model's operation across both sites. Christchurch has improved or remedied all implementation issues identified in the interim report (except for the recording of interventions in the Case Management System (CMS)). Waikato has also shown a commitment to continual improvement without the benefit of an interim report. Practice at both sites has benefited from regular quality assurance mechanisms (the Quality Assurance and Improvement Framework (QAIF)).[2]

Efficiencies of the ISR model

Findings from this evaluation suggest the ISR model is delivering on many of its core aims, and therefore is well placed to achieve better outcomes for families.

Some of the most important achievements resulting from the implementation of the ISR model have been:

- **improved information sharing, risk assessment and safety planning** – the SAM table has enabled more complete information to be shared, thereby enabling more accurate risk assessments and enhanced safety planning. This has led to more efficient dissemination of information to frontline workers, including the introduction of previously unavailable information (eg, from ACC).
- **a wider awareness and responsiveness to family violence particularly among government agencies** – resulting in more collaborative, coordinated and efficient responses.
- **working with the source of the problem** – the nature of responses for perpetrators has changed and their reach and intensity have significantly increased. Perpetrators are now considered in every safety plan with specialist perpetrator positions being funded to provide one-on-one support.[3]
- **more families offered and accepting assistance** – with ISR there is a response to every family harm episode referred via Police and Corrections – three times as many families are now taking up the offers of support.
- **more efficient case management** – has been facilitated through a custom-built case management database, the CMS, which provides a platform for sharing information as well as monitoring progress on the delivery of safety plans.
- **better understanding of capacity issues and mobilisation of resources in response** – provided through multi-agency national and local governance and management groups, together with dedicated ISR directors and operations managers. Together these groups identify issues, then develop and implement solutions to effectively support the personnel delivering the ISR response.

2 The QAIF reviews are ongoing internal monitoring and evaluation activities designed to support the successful implementation of the pilot. The QAIFs are six-weekly reviews of the management of ISR cases (eg, initial decision making and recording of risk, quality of safety plans and information recorded in CMS) carried out by a mixed working group.

3 These positions are the Perpetrator Outreach Service (POS) and/or Independent Perpetrator Specialists (IPS). The ISR model refers specifically to POS, and was intended for low or medium-risk perpetrators who did not have access to other support. Christchurch elected to fund an IPS position to work just with high-risk perpetrators alongside the Independent Victim Specialists (IVS).

Effectiveness of ISR for families

While evidence is readily available on improved processes resulting from the ISR model, linking these to improved outcomes for families is more challenging. However collective evidence supports the view that under ISR, adult victims and children are better protected and safer; perpetrators are better supported to stop their violent behaviour; and families and whānau (including families from diverse backgrounds) are supported to live in non-violent homes. Key findings included:

- more intensive and collaborative efforts afforded by ISR have seen increases in engagement by those offered support responses, and overall high rates of engagement.
- descriptive statistical analysis of Police reports of family harm episodes found that for two-thirds of 'predominant aggressors', either there were no further reported family harm episodes or the subsequent episodes were less frequent and/or less serious than those in the six months before contact with ISR.
- all victims interviewed reported feeling safer, with many noticing improvements in their overall wellbeing and, where applicable, that of their children.
- sixty-three percent of a small sample of 'high risk' victims reported a complete cessation of abuse following their ISR involvement, some of this was due to the relationship having ended or their partner being in custody).
- interviews with a small sample of perpetrators suggested that, given access to an Independent Perpetrator Specialist (IPS) with the right qualities, they could be supported to change their behaviour. All those interviewed had recognised the importance of taking responsibility for themselves and their actions, and felt confident they would not use violence in the home in the future (although this was untested as most of those interviewed were in prison). Most were also confident they could form or maintain respectful relationships, with some already noticing improvements.

Effectiveness of ISR for Māori whānau

There have been some key developments in the implementation of the ISR model with respect to Māori: that is, the relocation of the ICM meetings in Christchurch to Ngā Hau e Whā marae, and increased funding to support the participation of Kaupapa Māori services in ISR. On the horizon is the potential for further resourcing to embed Kaupapa Māori and whānau-centered services into the ISR model. There has been a renewed commitment by Tū Pono in Christchurch to support Māori whānau through ISR, and a collaboration has been formed between three Māori providers to respond to all ISR referrals.[4] This is a significant turnaround from the position in October 2016 when key Māori groups were considering withdrawing from ISR. However, still more work is needed to ensure that the Tū Pono concept and the opportunity it presents is fully understood, and that the whānau-centric approach to working with Māori is fully realised and integrated into the existing ISR model.

4 In Christchurch the interests of local iwi are represented by Tū Pono: Te Mana Kaha o Te Whānau. Tū Pono is a collective of Māori organisations that have come together in Canterbury to enable a stronger Māori response to family violence, through asserting whānau voice as a fundamental key to reducing and eliminating harm (see chapter 6 for more details).

Opportunities for further development

The ISR model and all its components are operating well and achieving many of its core objectives. However, no matter how efficient a system is, it cannot change the lives of families on its own – this is achieved by the families themselves, with support from those working alongside them in the community. While the SAM and ICM tables appear to be working well (and have been the main focus to date), there is still important work to be done. Attention now needs to shift to the work that is done away from the tables: this includes better co-ordination of tasks, more ownership of plans, more training and opportunities for practice development, and overall increased partnership between NGO and government sectors in the community.

More clarity is still needed around the aims and scope of the ISR model, particularly in terms of whether the focus is primarily on immediate safety, and when and how to pass cases on to other services to support the longer-term safety and wellbeing of families and whānau. While there is a growing consensus that ISR should be concerned with ensuring immediate safety, how this translates into practice is less clear. For a model to be operating optimally, those involved must clearly understand their roles and what they are aiming to achieve. A better understanding of how ISR fits into the wider system of family violence responses may help to sharpen understanding of ISR roles and to develop contracts to better fit these roles. The wider family violence response system needs also to consider prevention activities alongside crisis responses, and to keep in focus that ISR only responds to the 24% of family harm episodes that are reported to Police.

In addition to gaining clarity around the goals of the ISR model, a refinement that deserves consideration is how the information arising from the face-to-face meetings with families can be woven into ISR family safety plans.

Concluding remarks

Ministers have recently announced the continued funding of the pilots for another two years. This provides space for all involved to take stock of evaluation findings, to reflect on aspects of the ISR model that have been successful in order to further embed them in practice, and to review identified problem areas and find solutions, before any wider roll-out of the model. As one NGO practitioner put it:

> *I don't see how we can go back to the old way, truly. I don't know how to say it any other way. Simply as a person working within the sector, why would we not be pursuing this? (NGO)*

Contents

Disclaimer 1
Acknowledgments 1

Executive summary 2
Aim and key features of Integrated Safety Response 2
Implementation of ISR model and evidence of continual improvement 3
Efficiencies of the ISR model 4
Effectiveness of ISR for families 5
Opportunities for further development 6
Concluding remarks 6

01 Introduction 12
1.1 Background 13
1.2 The Integrated Safety Response (ISR) model 15
1.3 Evaluation objectives 17
1.4 Methodological approach 17
1.4.1 Sources of data 17
1.4.2 Details of fieldwork 18
1.4.3 Quantitative data collection 19
1.4.4 Analysis 22

02 Characteristics of ISR pilot 23
A note on the CMS sample 24
2.1 Volumes and characteristics of ISR episodes 25
2.1.1 Risk levels assigned to episodes 27
2.1.2 Other characteristics of episodes 29
2.2 Characteristics of ISR people 31
2.2.1 CMS person roles 32
2.2.2 Role of children in episodes 32
2.2.3 Demographic characteristics 33
2.2.4 Repeat episodes 35
2.3 ISR plans, tasks and interventions 36
2.3.1 Family Safety Plans 37
2.3.2 Tasks 39
2.3.3 Content analysis of tasks 40
2.3.4 Interventions 42
2.4 Summary 43

03 Implementation of the ISR model 45

3.1 Comparison of Christchurch and Waikato pilot sites 47
3.1.1 The Christchurch ISR and the Waikato ISR compared 47
3.1.2 The FSN and ISR in Waikato compared 51
3.1.3 Views on transferability of ISR 52
3.2 Recap of interim report findings 53
3.3 Update on implementation and evidence of continual improvement 54
3.3.1 Increased resourcing 55
3.3.2 Intensive Case Management 55
3.3.3 Development and operationalisation of Tū Pono (Christchurch) 56
3.3.4 Review of all cases at SAM (Christchurch) 56
3.3.5 Local governance 57
3.3.6 Improved risk assessment 57
3.3.7 Closing of plans (Waikato) 57
3.3.8 Referral pathways 57
3.4 Summary 58

04 Effectiveness of the ISR model 60

4.1 Shared understanding and collective working 63
4.1.1 Increased awareness and understanding of ISR 63
4.1.2 Enhanced relationships 65
4.1.3 Effective collaboration and collective working 66
4.2 Information sharing, risk assessment and safety planning 68
4.2.1 Benefits of enhanced sharing of information 68
4.2.2 Quicker, more efficient dissemination of information 71
4.3 Implementation of plans 71
4.3.1 Response to every episode 72
4.3.2 Increased response for perpetrators 72
4.3.3 Improved engagement and retention 73
4.3.4 Faster responses and easier access 76
4.4 Ability to address complex needs 77
4.5 Co-ordinated responses 78
4.6 Improved support and oversight 79
4.7 Efficient case management 80
4.7.1 Increasing accountability with CMS 80
4.7.2 Reduced burden on families to repeat their experiences 81
4.8 Unintended consequences 81
4.9 Summary 83

05 Effectiveness of ISR for families 84

5.1 Quantitative data on recidivism and re-victimisation 86
5.1.1 Descriptive statistical analysis of Police reports of family harm 86
5.1.2 Victims' self-reported experiences of family harm 91
5.2 Victims 92
5.2.1 Initial engagement 92
5.2.2 What they found helpful 94
5.2.3 Impacts of IVS support on victims 96
5.2.4 Impacts of IVS support on victims' children 98
5.2.5 Victims' views on the impact of ISR on the perpetrators 99
5.2.6 Suggestions for improving support from IVS 99
5.2.7 Key stakeholders' views of emerging outcomes for victims 101
5.3 Perpetrators 103
5.3.1 Perpetrators' views 104
5.3.2 Impacts of IPS support on perpetrators 106
5.3.3 Key stakeholders' views of emerging outcomes for perpetrators 108
5.4 Key stakeholders' views of emerging outcomes for families and whānau 109
5.5 Summary 111

06 Māori and whānau experiences of ISR 113

6.1 Overview and profile of Māori 114
6.1.1 Person roles broken down by age for Māori 114
6.2 Descriptive statistical analysis of Police reports of family harm 115
6.2.1 Reported recidivism of predominant aggressors 117
6.3 Implementation of the ISR model 118
6.3.1 Relocation of the Intensive Case Management meetings 118
6.3.2 Justice sector funding provided to Kaupapa Māori services in Christchurch 119
6.3.3 Potential of additional investment in Kaupapa Māori and whānau-centred services in Christchurch and Waikato 119
6.3.4 Misunderstandings related to the Tū Pono approach 120
6.3.5 Tensions and challenges that have arisen 123
6.4 Emerging evidence of outcomes 126
6.4.1 Outcomes for whānau 126
6.4.2 Experience of IVS support 126
6.5 Summary 131

07 Opportunities to further improve ISR 132

7.1 Clarity around aims and scope of ISR 133
7.1.1 Clarity around roles 134
7.1.2 Understanding how ISR fits into wider family violence responses 136
7.1.3 Refinements to the model 137
7.2 Engagement and partnership with NGO sector 138
7.3 Improved integrated response beyond the tables 141
7.3.1 Increased ownership and leadership of plans 141
7.3.2 Improved co-ordination and completion of tasks 144
7.4 Family and whānau-centred working, and focus on children 146
7.4.1 Family and whānau-centred working 146
7.4.2 Addressing the needs of children 148
7.5 Ensuring privacy of information 149
7.6 The Case Management System (CMS) 151
7.7 Other issues 153
7.8 Summary 154

08 Concluding remarks 155

Appendices 160

Glossary of common abbreviations 161
Appendix 1: Family violence investigations since 2005 in the ISR pilot sites 162
Appendix 2: Details of participants and recruitment guidelines for fieldwork 163
Appendix 3: Details of analysis of family harm episodes six months before and after first contact with ISR 166
Appendix 4: Details of pre-post survey data 173
Appendix 5: ISR Quick Guide (Risk Assessment) 177
Appendix 6: Definition of CMS person roles 179
Appendix 7: Breakdown of agencies/NGOs that tasks are assigned to 180

Tables

Table 2.1 Total numbers of family harm episodes, safety plans and people 25
Table 2.2 Proportion of cases in each risk category (based on current status) 28
Table 2.3 Changes in recorded risk status (initial compared to current) 28
Table 2.4 Demographic details of all individuals entered into CMS as of 23 May 2017 34
Table 2.5 People involved in one or more reported repeat episodes of family harm 35
Table 3.1 Characteristics of the FSN and ISR in Waikato and ISR in Christchurch 48
Table 5.1 Levels of seriousness and frequency of reported family harm for predominant agressors in the six months before and after first contact with ISR (n=1601) 90
Table 6.1 Characteristics of Māori entered into CMS (all roles) 114

Table 6.2	Levels of seriousness and frequency of reported family harm for Māori predominant agressors in the six months before and after first contact with ISR (n=408)	117
Table A3.1	Demographic details of ISR sample (n=3820)	166
Table A3.2	Comparison of family harm episodes in the six months before and after first contact with ISR, with and without those who had spent time in custody	167
Table A3.3	Number and type of offence codes included as 'family violence offences'	168

Figures

Figure 1.1	Police reports of family harm episodes since 2005	14
Figure 1.2	Key features of the ISR model	16
Figure 2.1	Weekly volumes of episodes and plans in Christchurch (46 weeks)	26
Figure 2.2	Weekly volumes of episodes and plans in Waikato (30 weeks)	26
Figure 2.3	Nature of family harm in ISR episodes, Christchurch compared with Waikato	29
Figure 2.4	Nature of relationship in ISR episodes, Christchurch compared with Waikato	30
Figure 2.5	Distribution of designated CMS roles for individuals	32
Figure 2.6	Distribution of people across CMS assigned roles	32
Figure 2.7	Frequency of repeat episodes in families with children	36
Figure 2.8	Distribution of plans by lead agency in Christchurch	37
Figure 2.9	Distribution of plans by lead agency in Waikato	38
Figure 2.10	Type of tasks assigned from SAM table, Christchurch compared to Waikato (sample of 1,000)	41
Figure 3.1	ISR design features	46
Figure 4.1	ISR programme logic (high-level components)	62
Figure 4.2	Engagement outcomes for Christchurch closed plans	75
Figure 5.1	Prevalence and type of family harm behaviour in the six months before and after first contact with ISR (n=3820)	88
Figure 5.2	Self-reported changes in abuse experienced by a sample of high-risk clients	91
Figure 5.3	Self-reported fear for safety before and after IVS support	96
Figure 6.1	Māori person roles broken down by age	115
Figure 6.2	Prevalence and type of family harm episodes for Māori in the six months before and after first contact with ISR (n=854)	116
Figure 6.3	Tū Pono approach	121
Figure A4.1	Relationship status at intake	175
Figure A4.2	Self-reported changes in abuse experienced for a matched sample of high-risk clients (n=19)	175
Figure A4.3	Self-reported fear for safety before and after IVS support for a matched sample of high-risk clients (n=19)	176
Figure A7.1	Breakdown of agencies/NGOs that tasks are assigned to – Christchurch	180
Figure A7.2	Breakdown of agencies/NGOs that tasks are assigned to – Waikato	181

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01

Introduction

The family violence Integrated Safety Response (ISR) pilot was officially launched in Christchurch on 4 July 2016.[5] A second pilot site in Waikato came into operation on the 25 October 2016.[6] The pilot is one element of a larger cross-agency work programme overseen by the Ministerial Group on Family Violence and Sexual Violence.

Government ministers asked the Social Policy Evaluation and Research Unit (Superu) to commission a supplier to carry out an evaluation of the ISR pilot. In June 2016, following a tender process, Superu selected a consortium of three independent evaluators:

- Dr Elaine Mossman (sole trader)
- Judy Paulin (Artemis Research NZ Ltd)
- Nan Wehipeihana (Research Evaluation Consultancy Ltd).

The evaluation team was tasked with producing two reports:

1. an interim report, focused on the early implementation of the ISR model in the first pilot site, Christchurch (the report was completed in November 2016)
2. a final report that considers emerging evidence about the effectiveness of the ISR model and accompanying practice changes, including the extent to which the implementation of the model has taken account of early findings from the evaluation (ie, evidence of continuous improvement).

This is the final report. While it relies mainly on Christchurch data, data from Waikato is included where applicable, especially to evidence the ability of the ISR model to be generalised to other sites, and to evaluate the impacts of local variations to the model.

1.1 Background

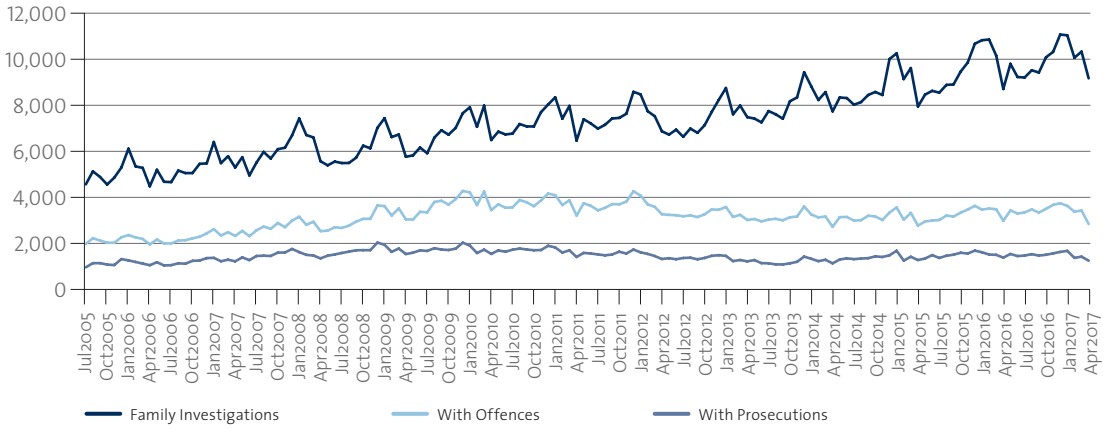
'Family violence' is defined as a pattern of abusive behaviour used by an individual, and between individuals, that can have multiple victims – both children and adults – in the past, present and the future.[7]

New Zealand is in the unenviable position of reporting a rate of violence against women by their intimate partners that is higher than in 14 comparable OECD countries.[8] There have been 312 deaths (women, men and children) in this country at the hands of a family member over the last 10 years. Recent analysis has found that family violence also has one of the highest re-victimisation rates across offence types – surveys indicate that 1% of New Zealand adults suffer 62% of all family violence acts.[9]

5 The Christchurch pilot covers three territorial authorities: Christchurch City; Selwyn District, which includes Lincoln and Rolleston; and Waimakariri District, which includes Rangiora and Kaiapoi.
6 Waikato covers Hamilton City and five rural districts: Thames, Matamata, Cambridge, Huntly, and Te Kūiti.
7 From the Family Violence Death Review Committee's media statement and accompanying fifth annual report: http://www.hqsc.govt.nz/our-programmes/mrc/fvdrc/news-and-events/media/2453/ Family violence statistics are also sourced from this report.
8 Turquet, L, Seck, P, Azcona, G, Menon, R, Boyce, C, Pierron, N, & Harbour, E (2011) *Progress of the World's Women 2011–2012: In pursuit of justice*. New York, NY UN Women.
9 From Hon Amy Adams speech 'Social Investment in the Criminal Justice System'. https://www.beehive.govt.nz/speech/social-investment-criminal-justice-system

A steady rise in recorded family violence in New Zealand is reflected in Figure 1.1, which plots Police reports of family harm episodes since 2005 nationally (equivalent data for the two pilot sites appears in Appendix 1). It is unclear to what extent this increase in investigations is due to more people being willing to report family harm events, or to a true increase in the family harm being perpetrated in the community, or to both.

Figure 1.1 _ Police reports of family harm episodes since 2005



Note:National data sourced from New Zealand Police, 22 May 2017.

A total of 118,915 family violence investigations were reported in 2016. Best estimates suggest this is only a fraction of actual family harm episodes, with some studies suggesting that only 24% of episodes are reported to Police.[10]

The costs to New Zealand from failing to adequately address family violence are extremely high. In a report commissioned by the Glenn Inquiry, Kahui and Snively (2014) estimated the economic cost of intimate partner violence and child abuse as between $4.1 and $7 billion per year. Of most concern, these authors estimated that, if nothing is done, the cumulative cost over the next 10 years could approach $80 billion.[11]

Many reviews have found that current approaches to addressing family violence in New Zealand are in need of change.[12] Of particular importance is achieving a more integrated response, rather than an array of independent and unco-ordinated responses from agencies and services.

10 New Zealand Crime and Safety Survey (2014) http://www.justice.govt.nz/assets/Documents/Publications/NZCASS-201602-Main-Findings-Report-Updated.pdf

11 Kahui, S & Snively, S (2014) *Measuring the Economic Costs of Child Abuse and Intimate Partner Violence to New Zealand.* Wellington, NZ, More Media Enterprises.

12 For example, Craig Colquhoun's 2014 FVIARS (Family Violence Interagency Response System) Practice Review across Auckland.

The ISR pilot tests a new multi-agency integrated approach to addressing family violence. In line with the Government's social investment approach to family violence, the new model aims to identify early on family members experiencing family violence and assess their needs, and then to provide both effective support to high-risk victims (including children) and earlier intervention services for perpetrators of family violence. The ultimate goal is to prevent further violence, and to disrupt inter-generational patterns of offending.

1.2 The Integrated Safety Response (ISR) model

The ISR model is based on international evidence on effective multi-agency responses, together with lessons learnt from responses trialled here in New Zealand:

- The model entails family violence specialists working with high-risk victims. This component of the model is based on the UK Multi Agency Risk Assessment Conferences (MARAC) and their Independent Domestic Violence Advocates (IDVA). An evaluation there found that three out of five victims (57%) who engaged with the dedicated victim support provided by IDVAs experienced a complete or near-complete cessation of abuse following that support.[13]
- ISR also has features of the Waikato-based Family Safe Network, including a 'family-focused' approach, collaboration and accountability among agencies, daily Safety Assessment Meetings (SAMs), and dedicated service roles (director, co-ordinators, and administrators).[14]
- Finally, the model includes enhanced early intervention services for perpetrators of family violence (an Independent Perpetrator Specialist (IPS) or Perpetrator Outreach Service (POS) offering one-on-one support at the point of crisis), following the successful evaluation of this type of intervention in Canterbury (Aviva ReachOut).[15]

The central principle of ISR is to get all relevant agencies and social service providers literally working together in the same room. At these collaborative meetings, engaged personnel identify risks and issues, problem-solve, and plan co-ordinated responses for victims, children and perpetrators. This joined-up response is delivered as soon as possible after a family violence episode has been reported to Police or after services have been notified by the Department of Corrections of the imminent release of a high-risk offender. The new operating model is thus a co-ordinated process involving timely decision making, focused actions, and ongoing reviews.

Key features of the ISR model are presented in Figure 1.2.

13 See Howarth et al (2009) *Safety in numbers: a multi-site evaluation of Independent Domestic Advisor Services*, The Henry Smith Charity http://www.henrysmithcharity.org.uk/documents/SafetyinNumbersFullReportNov09.pdf

14 Payne, P and Robertson, N (2015) *A Formative Evaluation of the Waikato Family Safe Network Pilot*. School of Psychology, Waikato University.

15 Campbell, L (April 2014) *ReachOut Men's Community Outreach Service: Connections and Conversations with a Purpose. An Evaluation of the Pilot*. The earlier intervention approach of ReachOut was found to be effective, as it offered perpetrators an opportunity to engage with an intervention service at a point of crisis when they were most likely to be open to change efforts.

Figure 1.2 _ Key features of the ISR model

Structured governance	The model is underpinned by multi-agency national and local governance and management structures
Response to every episode	Every referral to ISR (from Police or Corrections) receives a response. The response is shaped by the level of assessed risk, and by the needs of those involved
Safety Assessment Meetings (SAM)	Safety Assessment Meetings (SAM) are held at least every week day to assess risk and develop a response (Family Safety Plan). Meetings are attended by Police, MVCOT (CYF), DHB representatives, Department of Corrections, an Iwi representative and NGO coordinator and/or advocate
Evidence-based risk assessment	Assignment of cases into low, medium and high risk categories on the basis of an evidence based risk assessment framework
Case management system (CMS)	An electronic CMS database record details of family harm episodes and associated family safety plans, and monitors progress with assigned tasks
Independent Victim Specialists (IVS) and Perpetrator Outreach Services (POS)	Independent Victim Specialists (IVS) and a Perpetrator Outreach Service (POS) support victims, help keep them safe and provide essential services to perpetrators in high risk cases, particularly in areas where service gaps have been identified
Intensive Case Management (ICM)	Cases identified as high risk move into the ICM process. This involves intensive support and engagement of the IVS and the POS that is coordinated through weekly ICM meetings. These are attended by SAM participants in addition to others such as Justice, Work and Income, ACC and Education on an as needed basis
Dedicated ISR roles	Provision of full time ISR roles - including a director, operations manager, NGO coordinator and administrator provide support, coordination and oversight.
Joint training and ongoing professional development	Purpose designed joint training packages and on-going professional development for those delivering ISR
Monitoring and evaluation	A programme of monitoring and evaluation of ISR assists with continuous improvement.

16 In Christchurch, the interests of local Iwi are represented by Tū Pono, a collective of Māori organisations that have come together in Canterbury to enable a stronger Māori response to family violence by asserting whānau voice as a fundamental key to reduce and eliminate harm (see section 5.3.1)

17 'Advocate' is the term commonly used to describe those who work in Specialist Family Violence services or Women's Refuges and who support and advocate for victims of family violence.

18 The term 'family harm episode' has been adopted by Police to encompass the broad range of harm than can arise as consequence of family violence or can be linked to family violence (eg, inter-generational violence and criminal behaviours, drug and alcohol abuse and other social and health impacts). It also more accurately captures that family violence is not a series of isolated incidents affecting an individual, but a pattern of abusive behaviour overtime that can encompass multiple victims.

19 In Christchurch, there is an Independent Perpetrator Specialist (IPS) in addition to POS services providing intensive case management for high-risk perpetrators.

Additional practice principles of the ISR model are set out in the ISR guidelines.[20] The main ones include putting families and whānau at the centre of the system, using evidence-based assessments of risk and needs, and timely and accurate information sharing. Others include prevention through behavioural change of perpetrators,[21] improving collective understanding of family violence, having the 'right service at the right time', and acknowledging and respecting the diverse cultures, communities and populations that are affected by family violence.

1.3_ Evaluation objectives

The aim of the evaluation was primarily to answer three questions:

1. To what extent has the Integrated Safety Response model been implemented as intended in the pilot sites (and what have been the barriers and enablers for successful implementation)?
2. What evidence is emerging about the effectiveness of the Integrated Safety Response model, including as a result of practice changes?
3. To what extent has the implementation of the model taken into account early findings from the evaluation (ie, is there evidence of continuous improvement)?

The November 2016 interim evaluation report addressed the first question. This final report focuses on the next two questions, while also updating information relevant to Question 1.

1.4_ Methodological approach

The evaluation has adopted a mixed-method evaluation design that includes interviews, observation, reviews of relevant reports, and analysis of administrative data.

1.4.1 _ Sources of data

The following key data sources have been utilised for this report:

- in-depth interviews with victims and perpetrators (Christchurch only) and key informants[22]
- direct observations of SAM and ICM processes
- data extracted from the ISR CMS database
- New Zealand Police family harm episode data (Christchurch only)
- pre-post survey data of high-risk participants (Christchurch only)
- Quality Assurance and Improvement Framework (QAIF) review reports
- other relevant ISR documents and reports (eg, Practice Guidelines, directors' weekly reporting).

20 *Integrated Safety Response. People and the process: ISR Guidelines* (version 1.0, 30 June 2015). These guidelines were developed by a Christchurch working group in conjunction with Wellington officials.
21 IPS/POS responses also play an important role in enhancing the effectiveness of risk assessment and safety planning for families by providing intelligence about the movements, motivations and behaviours of perpetrators.
22 Quotes presented that originate from Waikato are labelled as such, all others will be from Christchurch

The QAIF reviews involve ongoing internal monitoring and evaluation activities designed to support the successful implementation of the pilot. The QAIFs are six-weekly and undertaken by a mixed working group to assess the management of ISR cases (eg, initial decision making and recording of risk, quality of safety plans and information recorded in CMS). The QAIF reviews involve extraction and analysis of data from CMS, interviews with members of the ISR team and SAM table, and observations and questionnaires.

1.4.2 _ Details of fieldwork

In addition to a number of brief visits to the pilot sites, the evaluation was based on three main periods of fieldwork. The first two rounds of fieldwork focused on the SAM, ICM and local governance groups. The final fieldwork prioritised those who worked most closely with the families and included more NGOs. Government agencies and NGOs from all ISR key roles were identified and at least one individual from each group was invited to participate. Further details on the agencies and NGOs that participated appear in Appendix 2. Each fieldwork visit also included observations of SAM and ICM tables. These were the three periods of fieldwork:

- **26 September to 4 October 2016 (Christchurch)** – 31 interviews were completed with 43 key informants representing 18 agencies/NGOs (four interviews were group interviews, and the remainder were one-on-one). Interviews focused on their views on overall progress of the implementation of the ISR pilot, with particular attention given to barriers and enablers to successful implementation.
- **6 to 9 March 2017 (Waikato)** – 19 interviews were completed with 20 key informants representing 10 agencies/NGOs (all but four were conducted face-to-face). Fieldwork focused on implementation progress and identifying site differences.
- **1 to 18 May 2017 (Christchurch)**
  - 18 interviews with ISR victims and perpetrators 18 years or older (12 victims and six perpetrators). Participants were mainly high risk and were recruited via the lead agency supporting them. Seven of the 18 identified as Māori (40%). The reason for interviewing mainly high-risk ISR participants was to enable an examination of the complete ISR model, including the ICM process and support provided by IVS/IPS/POS. Four Specialist Family Violence agencies assisted in recruiting participants; two were Māori organisations.[23]
  - A further 23 interviews with 42 key informants representing 18 agencies/NGOs. Key informants included both government agencies and NGOs, but the focus for this fieldwork was gaining the perspectives of those closest to the frontline, in relation to the impact of ISR on the families they were working with.

23 See Appendix 2 for guidelines given to agencies on the recruitment of ISR participants (victims and perpetrators).

Methods and principles associated with fieldwork interviews were as follows:

- In-depth semi-structured interviews were conducted face-to-face (unless availability or preference dictated a phone interview). Interviews ranged from 40–60 minutes.
- Signed informed consent was obtained from all participants who were interviewed face-to-face, and informed consent was obtained verbally (and recorded) from participants interviewed over the phone.
- The interviewees' permission was sought for their interviews to be digitally recorded and transcribed for analysis.
- Māori evaluation participants were interviewed by our Māori evaluation team member.
- An iterative process was used where interviewers checked back with interview participants at the end of the interview to ensure that their interpretations and analyses accurately reflected the interviewees' views and experiences.

1.4.3 _ Quantitative data collection

Quantitative data was utilised in the evaluation in three distinct ways.

Descriptive analysis of ISR pilot

This consisted of data extracted from the ISR's Case Management System (CMS) database for both pilot sites, including:

- volume and details of family harm episodes referred to ISR
- characteristics of the individuals involved in episodes
- details of the ISR plans, tasks and interventions.

This database provided valuable data on the ISR pilots. However, it was designed as a tool for case management, not as a tool for true data analysis. As such there are limitations on how data was able to be used. For example, data in the system is constantly being updated, which means that point-in-time counts of variables will yield different results, depending on the day and time when data was extracted. Further, analysis of the risk level of plans is problematic; risk status is dynamic and changes over time. This also means that numbers vary depending on whether the count is of 'current' risk status or 'initial' risk status (the two options available at present). Plans initially assessed as high risk can subsequently be re-assessed as medium or low risk, especially after supports are in place. Conversely some cases initially assessed as low or medium risk may be re-assessed as high risk if there are further episodes of violence.

This was one of the first opportunities to review data extracted from CMS, and careful attention was given to highlighting where limitations of the CMS database affect its utility as an analysis tool. The CMS database has been developed over the course of the first year, and it was hoped a critical review and presentation of the data may assist in the further development of this database over the next two years of the pilot.

Family harm episodes six months before and after first contact with ISR

A key aim of ISR is to reduce the levels of re-victimisation and re-offending among those referred to it. Timeframes within which the evaluation needed to be undertaken meant that conclusively answering questions about reduced re-victimisation was not possible. However, descriptive analysis was carried out on frequency and severity of reported offending and victimisation in the six months before and after an ISR referral, which has relevance to this question. Findings of this type are of course indicative only; the current pre-post design does not allow attribution of observed changes in family violence behaviour to ISR, given the absence of a valid comparison group. Other limitations include difficulties in fully accounting for time in custody (and therefore opportunity to offend),[24] and also the extent of bias due to the 'before' period almost invariably including the index event.[25] The results do, however, provide a useful descriptive picture of family harm behaviour for those processed through ISR, as well as participants' responses in terms of further family violence behaviour.

A sample was compiled of 3,820 individuals who had been referred to the ISR pilot in Christchurch in its first four months of operation (4 July to 31 October 2017) and who were confirmed as having a Police report of a family harm episode (see Appendix 3 for more details).[26] The sample excluded those identified as informants, witnesses or children (under 15 years) living in the home and not identified as the primary victim. All other victims, offenders or subjects as per CMS role were included (see section 2.2 and Appendix 6 for definitions of CMS person roles). This sample included all risk categories (low, medium and high).

Police-reported family harm episodes were examined for the sample in the six months before their initial referral to ISR (including the event that lead to the referral), and the six months following. Thus each individual's six month 'before' period was dated from their first referral to ISR (taken as the recorded 'date reported', or the 'date of the occurrence' if this was earlier); the six months follow-up period was taken from the day after the 'reported date'.

A range of family harm indicators were considered, including:

- episodes coded '1D' (a non-offence family harm episode)
- episodes where a Police Safety Order (PSO) was issued (where the role was 'Bound Person')
- all offences flagged as family violence (where the role was 'Offender')[27]

24 Note there was an increase 'days spent in custody' in the follow-up period. Analyses were repeated with all those known to have been in custody (before or after ISR referral) removed, and did not change main results found (see Appendix 3 for more details).

25 The family harm episode (index event) that resulted in the individuals being referred to ISR is included in the six-months before period. It is not known for what proportion of the sample this occurrence would have been their first and last involvement with police, and hence also unknown is the proportion who would have had no further family violence episodes regardless of the ISR intervention.

26 Due to the delayed start of the Waikato pilot, and in order to maximise the length of the available pre and post comparison period, only the Christchurch site was used for this particular form of analysis.

27 All offences in any one family harm episode are flagged as family violence. In some cases this includes offences that are not related to the family violence. For example, if an individual is apprehended for a Male Assaults Female charge and for possession of drugs, both offences are flagged as family violence. For the purpose of this analysis only offence categories considered to be family violence-related were included (ie, Violence, Sexual Violence and Property Damage). See Appendix 3 for more details.

- all cases of victimisation (as above, except where the role is identified as 'Victim')
- records of Protection Orders issued (coded '7P')
- apprehensions for breaches of Protection Orders (recorded offence).

These indicators were analysed for the whole sample regardless of their CMS 'person role' at referral (victim, perpetrator or subject).

Police National Headquarters extracted all occurrence records from the National Intelligence Application (NIA) for the identified sample from 1 January 2016 to 17 May 2017. The Lifetime Offender Seriousness Tool (LOST) was used to identify and summarise the family harm indicators.[28] As time spent in custody could potentially impact on results, analysis was run with and without those who had spent more than one day in custody in either the six months before or after ISR (see Appendix 3).

Pre-post survey data from a sample of high-risk ISR participants

In addition to Police reports of family harm, a small sample (n=60) of high-risk ISR victims and perpetrators completed self-reported assessments of experiences of family harm, at intake and, where possible, at exit. This was based on a similar approach used in the successful multi-site evaluation of the similar UK-based Independent Domestic Violence Advocate (IDVA) programme.[29] The Independent Victim Specialists (IVS) from ISR assisted their clients to complete a pre-post assessment at intake and at case closure, capturing data on:[30]

- victims' self-reported experiences of family harm in the three months before ISR referral and in the last three months (see Appendix 4)
- changes in victims' self-reported feelings of safety and levels of trust in community organisations, Police and other government agencies
- IVS perceptions of changes in risk and progress, and changes in knowledge, wellbeing, coping and support, at exit.

For details of the sample included in this aspect of the evaluation, see also Appendix 4.

28 LOST is a Microsoft Excel-based tool, developed by New Zealand Police with assistance from the Ministry of Social Development, that provides an automated process for summarising a person's offending history for specified periods of time.

29 See http://www.henrysmithcharity.org.uk/documents/SafetyinNumbersFullReportNov09.pdf

30 The IPS also collected pre-post data for a small sample of perpetrators (n=21). However, that data has not been presented in this evaluation because the majority of these clients were in prison (and therefore assessments of abusive behaviour were not applicable), and also because of the small amount of exit data that could be collected (eg, no data could be collected if prisoners were transferred without notice).

1.4.4 _ Analysis

Data from all sources was synthesised to formulate key findings and conclusions.

Qualitative data analysis: Interviews were coded for key themes around factors impacting on the successful implementation of the ISR pilot. The identification of themes was undertaken in an iterative way and through a combination of individual analysis (including by our Māori team member) and collective analysis. In this report, quotes are included where they represent a frequently held view, or a unique perspective. Key informants who are quoted have been linked to their organisation, where permission for this was given.

Quantitative data analysis: Quantitative data was carefully screened for any inconsistencies or inaccuracies, and presented in the report in tabular and graphical form. All numbers in the tables are rounded to the nearest whole number unless otherwise stated. Percentages may not add up to 100 due to rounding.

02

Characteristics of ISR pilot

This chapter presents a descriptive analysis of the ISR pilot in Christchurch and Waikato providing an insight into the ISR response and of those who are now processed through ISR. The analysis presents data extracted from the pilot CMS database, including volume and characteristics of family harm episodes referred to ISR, characteristics of the individuals involved in episodes, and details of plans, tasks and interventions. As already noted the data is subject to limitations, as the CMS database is designed for case management and not for research and analysis.

Data presented covers the period from when each site went live (Christchurch on 4 July 2016, Waikato 25 October 2016) up until a final data extract on 23 May 2017.

The CMS was designed specifically for ISR and has been subject to further development over the course of the pilot. Careful attention has been given to highlighting where limitations of the CMS database still exist and impact on its utility as an analysis tool. It is hoped this may assist in the further development of this database over the next two years of the pilot.

A note on the CMS sample

The CMS database records details of all individuals processed through ISR. These individuals are those associated with all episodes of family harm reported to Police and the small number associated with high-risk prison releases. Most of the initial details recorded in CMS, such as demographics and characteristics of the family harm episode, are sourced directly from the Police Family Violence Investigation Report (FVIR/POL). As such, the CMS data presented in this chapter essentially describes and compares those individuals associated with Police reports of family harm in Christchurch and Waikato since ISR began.

There is a key difference in the ISR responses that individuals and families received in Christchurch compared with Waikato, and this needs to be highlighted. It concerns the cases reviewed at the respective SAM tables (see chapter 3 for other variations).

The Waikato SAM table has reviewed all reported episodes of family harm since the pilot began. However, in order to manage the high volumes dealt with in Christchurch, between 18 July 2016 and 6 June 2017 the Christchurch SAM table reviewed and discussed only those cases that were initially conservatively triaged as high or medium risk (from 6 June 2017 all cases have been reviewed). Those episodes not discussed at the SAM table have been forwarded to a specialist family violence NGO for processing. These low-risk cases are still reviewed daily by multiple agencies (including Police, MVCOT, ACC, Corrections and key NGOs), and any escalated risk identified by these groups results in episodes initially triaged as low risk being re-directed to the SAM table and re-assessed. Regardless of whether a case was discussed at the SAM table, in all cases a family safety plan was developed, tasks were assigned (including the allocation of a lead agency), and progress towards completion of the plan was monitored through CMS.

This difference in the cases reviewed at the respective SAM tables has little impact on data presented in this chapter, as the data relates to all cases entered into CMS regardless of whether they were reviewed at the SAM table. Cases where it does impact on interpretation are noted.

2.1_ Volumes and characteristics of ISR episodes

Since the pilot began, a total of 14,789 episodes of family harm have been processed through ISR and entered into CMS. This equates to around 340 episodes per week across the two sites. The referral source for both sites is almost entirely Police Family Violence Investigation Reports (FVIRs, or 'POLs'; 98.5%), with an additional 1.5% coming from Corrections.

A total of 9,698 family safety plans have been developed, involving just under 30,000 individuals. The breakdown of total numbers of episodes, family safety plans and people for each site appears in Table 2.1.

TABLE 2.1

Total numbers of family harm episodes, safety plans and people

	Christchurch (approx. 11 months)	Waikato (approx. 7 months)	Totals
Episodes of family harm	8440	6349	14789
Family safety plans	5783	3915	9698
People	16244	13742	29986

Figures 2.1 and 2.2 below plot the weekly volumes of total episodes and the number of new family safety plans developed (dotted line). Where a safety plan for a family is already open and a repeat episode of family harm occurs, the existing plan is updated. Where a safety plan has been closed, a new report of family harm requires that a new safety plan be developed.[31]

Overall, 66% of family harm episodes processed each week are new cases requiring a new plan to be developed. As the pilot has progressed and case information in CMS has built up, the proportion of cases requiring a new plan has decreased. In Christchurch, the rate has fallen from 84% in the first four weeks, down to 60% in the last six weeks. In Waikato, new cases fell from 75% in the first four weeks to 53% in the last six weeks.[32] While there are fluctuations (see Figures 2.1 and 2.2), the proportion requiring new plans appears now to have stabilised. Further details on the number of families represented in repeat episodes are discussed in section 2.2.4.

The proportion of repeat episodes has an operational implication for the SAM table. The time taken to review repeat episodes and update an existing plan was found to be longer than that required to develop a new plan. This reflects the additional demands of reviewing and summarising all previous episodes, formulating additional safety planning, and updating required tasks.

31 The majority of safety plans represent new reports of family harm, but as time goes on there are also families who had previously had a safety plan that has been closed, and in their cases a new episode of family harm requires a new plan. It is currently not possible to re-open a plan once closed.

32 It is unclear why Waikato had a greater proportion of repeats early on, but there is some suggestion this might have involved incorporating pre-ISR records in the first few weeks.

Total volumes of family harm episodes are higher in Waikato, averaging 209 per week compared to 183 in Christchurch. To manage the load, Waikato has two SAM tables operating five days a week, with an extra table run on Mondays (11 per week in total). One table focuses on city-based referrals and the other on referrals from surrounding towns and rural areas (referrals have split as 57% city-based and 43% rural, or around 118 and 90 episodes each week). Christchurch has one SAM table operating six days a week to process referrals (although since the writing of this report it has now moved to operating seven days a week). Both sites review around 20 family harm episodes per table each day (see section 3.1.1 for more details on cases reviewed).

Figure 2.1 _ Weekly volumes of episodes and plans in Christchurch (46 weeks)

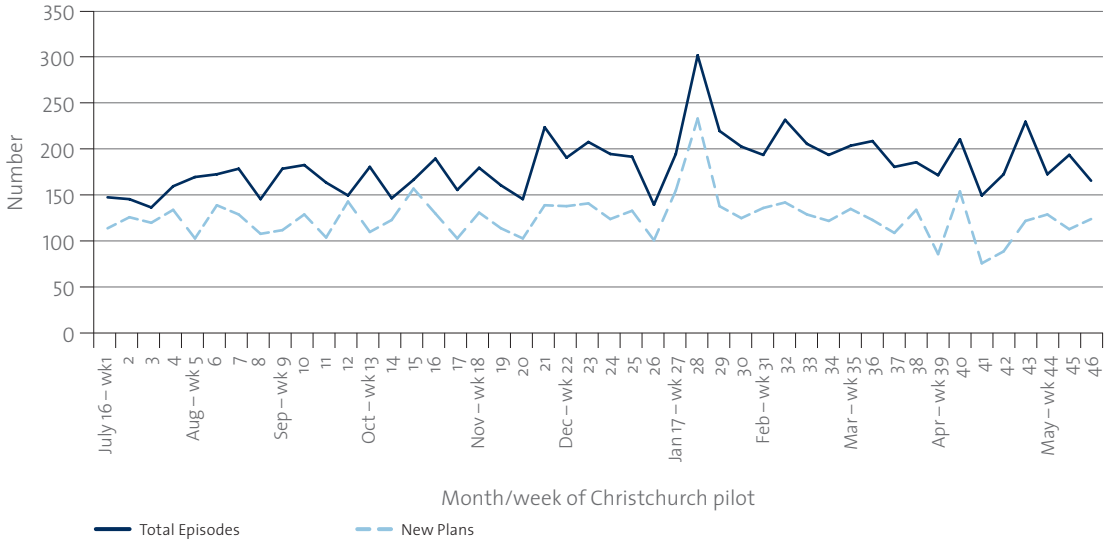


Figure 2.2 _ Weekly volumes of episodes and plans in Waikato (30 weeks)

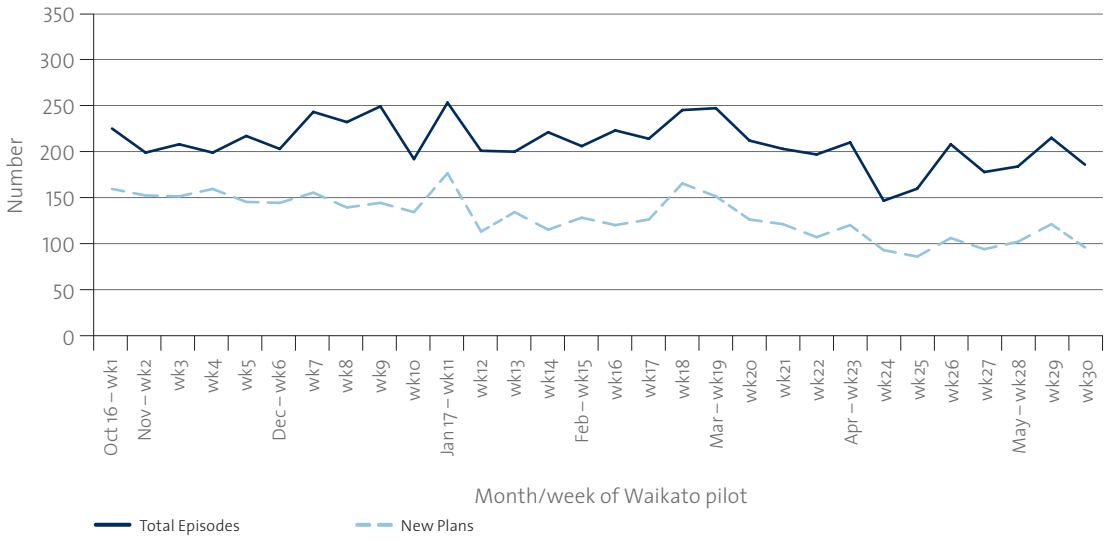


Figure 1.1 in chapter 1 showed the cyclical pattern of family violence episodes in New Zealand, with higher reports typically observed over the Christmas / New Year period. Both pilot sites experienced an increase in volumes over this time, with volumes thereafter slowly trending down (see Figure 2.1).[33]

2.1.1 _ Risk levels assigned to episodes

Assessing risk is a central aspect of the ISR model. The ISR model prescribes a different level of service according to level of risk, with only high risk clients at imminent risk of serious physical injury, or serious emotional or psychological trauma, or death, receiving intensive case management.

Following every report of a family harm episode, relevant information is shared and SAM members agree on the risk level to be assigned to the family, for whom a family safety plan is also developed. As noted earlier, to manage the high volumes of family harm Christchurch has an initial triage as well as risk level assessed by SAM members, however, the approach used to assess risk applies to all risk assessment decisions.

Assessing the level of risk within the ISR model is based on consideration of both 'concern' and 'harm':

- the level of 'concern' that violence will re-occur in the future (as well as how soon it is likely to occur); and
- the likely level of 'harm' resulting from further violence.

A number of guides and tools have been developed and made available to assist SAM members to collectively decide the level of risk for each case that they review. The primary tool is the comprehensive 'Risk Assessment Management' framework developed specifically for ISR by Corrections.[34] As its title implies, the framework is intended as a guide to assist with decision making, and not a tool that calculates risk.[35]

The ISR risk framework describes the overall approach to risk assessment and management within ISR. It includes a two-page 'ISR Quick Guide' that is designed to assist SAM members in collating information before the meeting. Criteria are set out for categorising cases as high, medium or low risk (see Appendix 5).

The risk status associated with a plan is dynamic, changing as the level of assessed risk changes – for example if a new episode occurs or when a high-risk family safety plan is completed and reviewed at the ICM table. This means proportions of high, medium and low-risk plans vary, depending on whether the count is of 'current' risk status or of 'initial' risk status.

33 The significant peak in early January in Christchurch likely reflects those responsible for the manual entering of reported episodes into CMS catching up after the Christmas holidays. The usual practice is for reported episodes to be entered into CMS on the day the FVIR/POLs are received.

34 *Integrated Safety Response. People and the process: ISR Guidelines* (version 1.0, 30 June 2015).

35 Note that the ISR risk framework is separate from the Risk Assessment and Management Framework currently being completed for the Ministerial Group on Family Violence and Sexual Violence.

Table 2.2 below presents the proportions of cases classified as high, medium or low risk in Christchurch and Waikato based on the 'current' recorded risk status. Overall, across the two sites 4% of plans (391) are classified as high risk, 44% as medium risk, and 52% as low risk.

TABLE 2.2

Proportion of cases in each risk category (based on current status)

	Christchurch (n=5783)	Waikato (n=3882)	Totals (n=9664)
Low risk	57%	44%	52%
Medium risk	38%	53%	44%
High risk	5%	3%	4%

Note: The risk tiers in this table are based on the current risk status of plans. This obscures the dynamic status of risk – for example where high-risk cases have subsequently transitioned to medium or low risk, or low risk has transitioned to high risk.

The proportion of high-risk cases is slightly higher in Christchurch (5% compared to 3% in Waikato); the proportion of low risk is also higher (57% compared to 44%); Waikato has a higher proportion assessed as medium risk (53% compared to 38% in Christchurch). Of note is the fact that all Waikato episodes are assessed and categorised at the SAM table, while Christchurch has a triage system in place, such that the SAM table reviews only those initially identified as medium or high risk.[36]

The CMS system records when risk status is revised. In practice this only tends to occur when a new episode of family harm has occurred and is reviewed at SAM, when new information is presented at the ICM table or when a high risk case is reviewed at ICM following the completion of safety planning. Table 2.3 below shows risk status as recorded in CMS changes very little.

TABLE 2.3

Changes in recorded risk status (initial compared to current)

	Initial risk level			
Current risk level	1 (Low)	2 (Medium)	3 (High)	Row total (current)
1 (Low)	54%	0.4%	0.1%	54%
2 (Medium)	4%	36%	1%	42%
3 (High)	0.2%	1%	2%	4%
Column total (initial)	**59%**	**38%**	**4%**	**100%**

Note: Data for this table was extracted at a later date than that presented in the rest of the chapter. The overall percentages for current risk levels are based on an additional 1,309 plans and they therefore vary slightly from those presented in Table 2.2.

36 Police carry out an initial screening, with those selected as low risk being reviewed 'virtually' by all agencies, with the option of a case being brought to the SAM table for review if agencies had additional information that suggested elevated risk. Around 14% of those initially triaged as high or medium risk are downgraded to low risk when they are reviewed at the SAM table (around 17 cases per week).

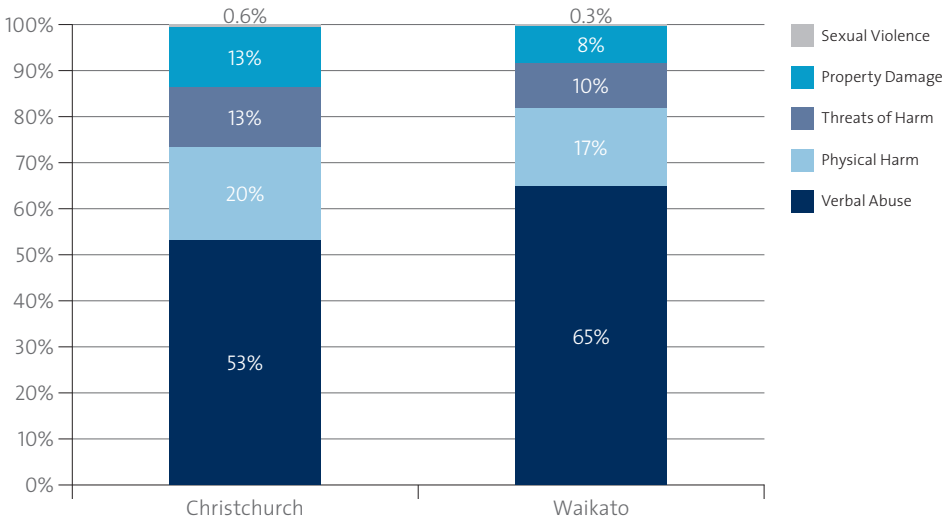
Overall, 92% of all plans had no change in recorded risk status. The shaded area in Table 2.3 highlights the proportion of plans where risk was escalated (just 5% of all plans). The greatest proportion of these plans were low-risk cases being escalated to medium risk, likely following repeat episodes of family harm. The small proportion of cases where recorded risk status has changed likely reflects opportunities within ISR to re-assess risk, rather than a true reflection of change in risk status. Many of the medium-risk cases are not re-assessed once their plan has been completed, unless there is a subsequent episode reported.

2.1.2 _ Other characteristics of episodes

Family violence is best captured in terms of 'episodes', since it rarely comprises a one-off incident. Much more frequently, it is part of a series of events of varying nature and intensity.[37] This section briefly reviews some of the characteristics of episodes recorded in CMS.

The 'Nature of harm' is an important characteristic providing information on the type of harm being experienced (ie, verbal abuse, physical abuse, threats of harm, property abuse or sexual abuse). Figure 2.3 presents available data on the nature of harm as recorded in CMS. Unfortunately, this data is somewhat unreliable. It is taken from information recorded on the FVIR/POL based on the attending officers' assessment of an episode's characteristics. It is not a mandatory field for officers to complete. It is also possible to record more than one characteristic per episode (eg, verbal abuse and property damage).[38]

Figure 2.3 _ Nature of family harm in ISR episodes, Christchurch compared with Waikato



37 Wilson, D., Smith, R., Tolmie, J., and de Haan, I. 'Becoming Better Helpers'. *Policy Quarterly*, (2)1, February 2015, pp 25-31.

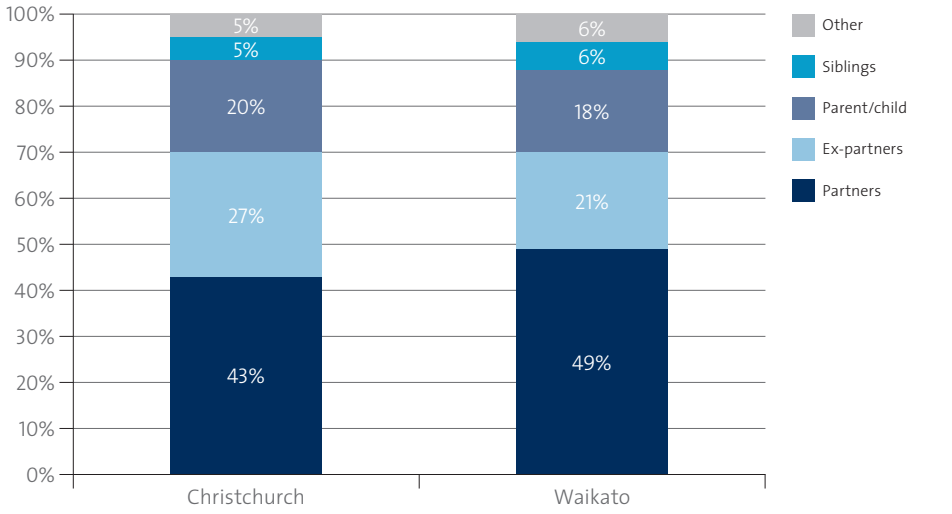
38 Recent analysis found one or more harms were recorded for 77% of all episodes.

Verbal abuse is the most common type recorded across both sites (59%) (Waikato has a higher proportion of verbal abuse, at 65% compared to 53% in Christchurch). At the other end of the spectrum there have been 43 cases of sexual violence recorded in Christchurch (0.6%) and 22 in Waikato (0.3%).

A more reliable method of recording this important variable should be developed.

Figure 2.4 plots the relationship characteristics of the family harm cases. This information is also taken from the Police FVIR/POL) and where missing it is included by ISR administrators. It is a mandatory field in CMS and therefore available for all episodes. Overall, intimate partner violence, either from a current partner or former partner, is most common (around 70% in both sites). Waikato appears to have slightly more current partners than ex-partners recorded. 'Parent/child' includes either abuse of a parent by a child, or abuse of a child by a parent.

Figure 2.4 _ Nature of relationship in ISR episodes, Christchurch compared with Waikato



2.2_ Characteristics of ISR people

All individuals associated with a Police-reported episode are entered into CMS, along with their role in the episode.[39] As Table 2.1 reveals, details of just under 30,000 individuals have been recorded in CMS. This included 16,244 people associated with 8,440 episodes in Christchurch, and 13,742 people associated with 6,349 episodes in Waikato.

Recording of person roles in CMS

The 'person role' describes the role of each individual associated with the episode (one role per person per episode). The available person roles in CMS are based on those recorded for Police purposes and include 'suspect', 'informant' and 'witness', as well as 'victim' and 'perpetrator'. In addition, the role of 'subject' is recorded; this has traditionally been used by Police for both parties involved in a non-offence occurrence such as a verbal dispute (coded as a '1D'), and these occurrences make up the majority of family harm episodes. The use of roles in CMS is slightly different and is described below (a table defining roles and highlighting these differences can also be found in Appendix 6).

From 18 July 2016, following discussion with Wellington project team members, Christchurch changed its method of recording roles within CMS to enable better understanding of the patterns of abuse over time. It was deemed more useful to identify the predominant aggressor in a non-offence occurrence, record them as the 'perpetrator' and primary victim as the 'victim'. They also refined criteria to better understand the role of a child.

- the Christchurch ISR administrator uses information recorded on the FVIR/POL and information emerging from SAM discussions to determine which party is the predominant aggressor in a '1D' episode and which is the primary victim. Where it is not possible to identify this, both parties continue to be entered as 'subject'.
- children recorded in the FVIR/POL as present in the house at the time of the episode are categorised as a 'witness' (regardless of whether they actually witnessed the family harm episode). Other children associated with the family that were not in the house at the time are categorised as 'subject'. Children who are victims of an offence continue to be recorded as 'victims', in accordance with Police recording practice (similarly, young offenders are recorded as 'perpetrators').

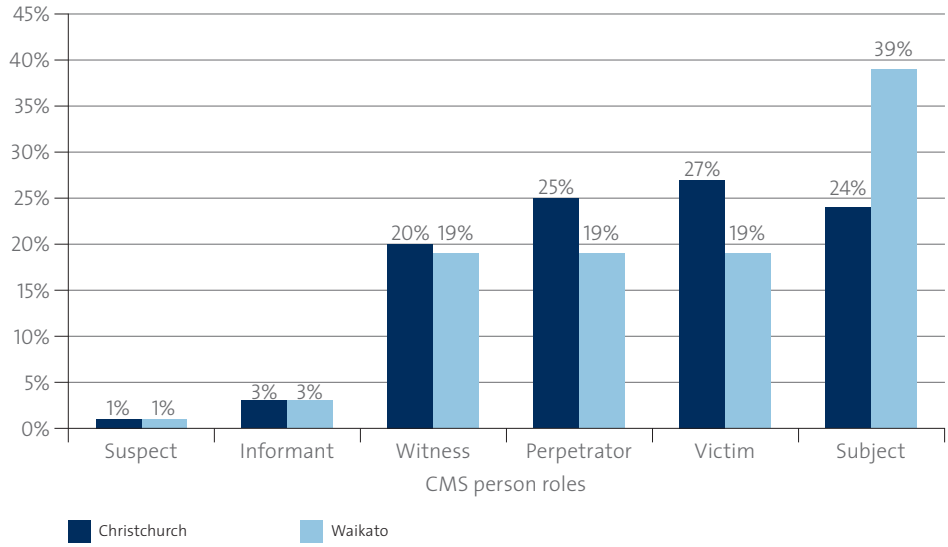
Waikato also adopted these recording practices from 23 January 2017. Before this change, 50% of all people recorded in CMS in Waikato were recorded as 'subjects': that has now dropped to 39%. The CMS database does not allow analysis of data across discrete time periods, but it is likely that data analysed for more recent periods capturing the new recording practices would show the relative proportions of roles across the two sites to be more similar.

39 Also included are referrals from Corrections when a high-risk perpetrator of family harm is about to be released.

2.2.1 _ CMS person roles

Figure 2.5 provides a breakdown of the roles of all people as recorded in CMS. There are more people in Waikato recorded as 'subjects', and fewer as 'victims' and 'perpetrators', compared with Christchurch. These dissimilarities apparently reflect simple differences in recording practices as described above, which have since been amended. The majority of those recorded as 'witnesses' are children living in the home (see also Figure 2.6).

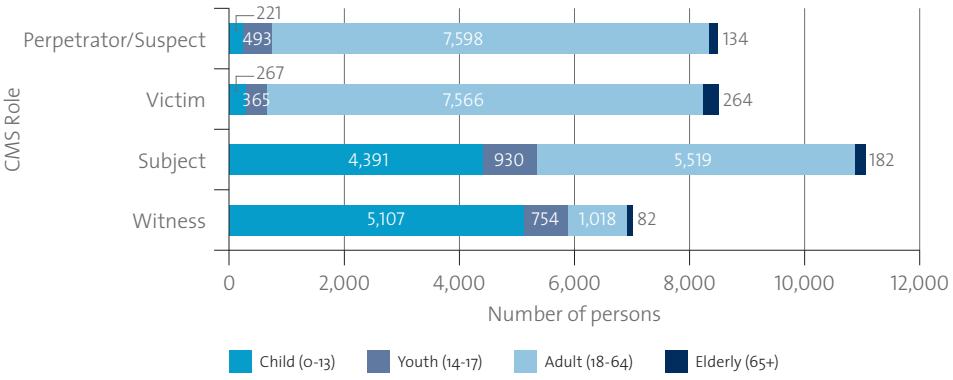
Figure 2.5 _ Distribution of designated CMS roles for individuals



2.2.2 _ Role of children in episodes

Figure 2.6 provides a breakdown of designated roles and age groups using the ISR recording described above. This offers insights into the role of children (those 13 years and under and predominantly recorded as 'subjects' or 'witnesses') in the family harm episodes.

Figure 2.6 _ Distribution of people across CMS assigned roles



Children aged under 13 make up just under 30% (n=10,022) of all people entered into CMS (see also Table 2.4). Figure 2.6 reveals that nearly all (95%) of these children are identified either as 'witnesses' (51%), meaning they were in the house at the time of the episode and may or may not have actually witnessed the violence, or as 'subjects' (44%), meaning they were associated with the family but not in the house at the time of the episode. Small proportions are recorded as either primary 'victim' (3%) or 'perpetrator' (2%). Those recorded as a 'perpetrator' are those identified as the primary aggressor (for example where a child has assaulted a parent or sibling). It is likely that some of the cases where younger children were recorded as 'perpetrators' involved recording errors (eg, the designated role or the date of birth was entered incorrectly).

2.2.3 _ Demographic characteristics

Table 2.4 gives a breakdown of demographic details of all people entered into CMS as of 23 May 2017. This data was extracted together with their person role. People who have had repeat episodes where their role changed are counted in all relevant categories.

Overall, about an equal number of males and females are entered into CMS. When categorised by role, females make up around three-quarters of all victims (72% in Christchurch, and a similar figure of 75% in Waikato). Conversely, the majority of perpetrators are male (73% in Christchurch, and 74% in Waikato).

TABLE 2.4

Demographic details of all individuals entered into CMS as of 23 May 2017

	Christchurch		Waikato		Total	
	n	%	n	%	n	%
Gender						
Female	9880	51%	8453	51%	18333	51%
Male	9635	49%	8140	49%	17775	49%
Gender Diverse	8	0.04%	16	0.1%	24	0.1%
Ethnicity						
European	11296	58%	5509	33%	16805	47%
Māori	4284	22%	9632	58%	13916	39%
Pacific Peoples	904	5%	584	4%	1488	4%
Asian	536	3%	234	1%	770	2%
Middle Eastern	140	1%	16	0.1%	156	0.4%
African	45	0.23%	28	0.2%	73	0.2%
Latin American	7	0.04%	31	0.2%	38	0.1%
Other Ethnicity	2311	12%	575	3%	2886	8%
Age						
Young Child 0-4	2046	10%	2145	13%	4191	12%
Older Child 5-13	3114	16%	2717	16%	5831	16%
Youth 14-17	1446	7%	1139	7%	2585	7%
Adult 18-24	2752	14%	2554	15%	5306	15%
Adult 25-34	3811	20%	3308	20%	7119	20%
Adult 35-64	5728	29%	4380	26%	10108	28%
Adult 65+	493	3%	264	2%	757	2%
Missing	133	1%	102	1%	235	1%
Total	**19523**	**100%**	**16609**	**100%**	**36132**	**100%**

Note: This data was extracted together with the CMS person role. People who have had repeat episodes where their role changed will have been counted more than once.

The most notable difference across sites is the proportion of individuals recorded as Māori (note only available data on ethnicity is that 'assessed and recorded' by attending Police officers, not self-reported). In Christchurch, of all people entered into CMS, 22% were Māori, whereas in Waikato Māori are the largest ethnic group, at 58%. One of the reasons for selecting Waikato as an ISR pilot was the high representation of Māori, allowing the ISR model to be tested in terms of its ability to respond appropriately and effectively for Māori whānau. These site-specific rates remain similar when person role is considered: for example, 23% of perpetrators in Christchurch are recorded as Māori, and 56% in Waikato.

In both locations, Māori are over-represented in ISR: Māori make up 19% of ISR victims and 23% of perpetrators in Christchurch, but constitute just 8% of the population of the greater Christchurch area. Similarly in Waikato, 53% of victims and 56% of perpetrators are Māori, while constituting just 21% of the population of Waikato.

2.2.4 _ Repeat episodes

Repeat episodes can be considered in three ways and the picture changes slightly depending on which method of counting is used:

1. the number of episodes reviewed each day at the SAM table where there was already an existing plan (daily rate)
2. the number of repeat episodes for each family (ie, number of repeat episodes associated with a plan)
3. the number of repeat episodes an individual has recorded against them.

Around a third of family harm episodes processed each day across both sites are repeat episodes where the family already has an existing safety plan open (see Figures 2.1 and 2.2 for total number of episodes compared to number of new plans created each week). What is unclear from looking at this daily or weekly rate is how many families these repeat episodes relate to (ie, one family with repeat episodes on multiple days in a week, or several families with just one episode). However, analysis of repeat episodes for specific plans and families provides this information.

Of the families referred to the ISR because of a family harm episode, almost a quarter (23%) have had one or more repeat episodes since the ISR has been operating (23% of all plans).[40] These families make up 46% of all family harm episodes processed.

When individuals are considered rather than families (ie, plans), the picture changes again, with some individuals involved in more than one plan. This information is presented in Table 2.5, which reports repeat episode data for each individual person entered into CMS. Since the beginning of the pilots, 34% of individuals across the two sites have been involved in more than one reported episode of family harm. This data is based on the unique identification number assigned to an individual which remains operational even when a plan is closed, and as such is a more accurate measure of repeat exposure to family harm.

TABLE 2.5

People involved in one or more reported repeat episodes of family harm

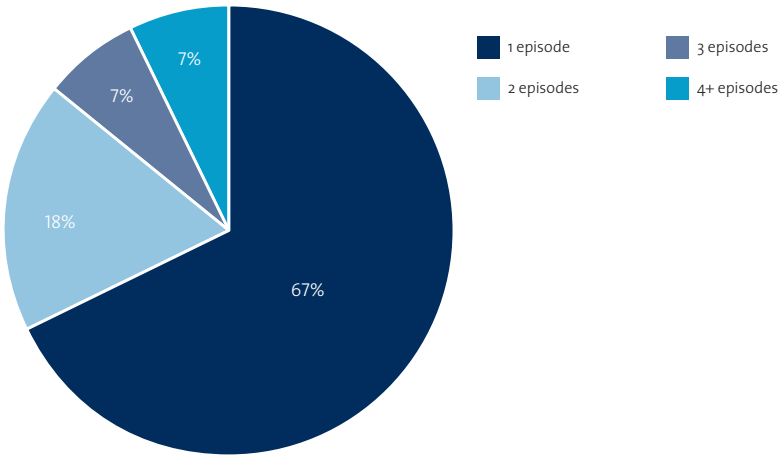
	Christchurch (46 weeks)		Waikato (30 weeks)	
Variable	**Number**	**Percentage**	**Number**	**Percentage**
Reported Episodes				
1 episode	10968	68%	8946	64%
2 episodes	2805	17%	2906	21%
3 episodes	1202	7%	1022	7%
4 episodes	561	3%	462	3%
5-9 episodes	626	4%	591	4%
10 or more	82	1%	42	0.3%
Total	**16244**	**100%**	**13969**	**100%**

40 If a family's plan was closed and there is a subsequent episode, this results in a new plan being created; this is currently not counted as a repeat episode for this family. Note that counts of repeat episodes in Table 2.5 are based on individuals, and include all repeat episodes even if a new plan has been developed.

The Christchurch pilot site has been running longer and so has had a longer period to accumulate repeat episodes. One person in Christchurch had been involved in 43 reported family harm episodes in the 46 weeks since the pilot has been operating there. In Waikato, one person was involved in 20 episodes in the first 30 weeks.

There were 10,662 individual children or youth (17 years or younger) across both sites recorded as being associated with one or more episodes. Figure 2.7 shows the number of episodes each child had been involved in, with a third of children (32%) living in a family with a repeat family harm episode.

Figure 2.7 _ Frequency of repeat episodes in families with children



2.3_ ISR plans, tasks and interventions

A single safety plan is maintained per 'family unit', and is updated following any new episodes. A plan lead (agency) is assigned to each plan to oversee it and keep it updated. Within this plan, a number of tasks are allocated. A 'task' refers to a shorter-term action that is deemed necessary (eg, a referral to a programme, or a visit to a family to obtain information). Tasks range from information sharing and information gathering, to engaging with the family or individuals, further assessments of need, enforcement of perpetrator restrictions, or the reporting of concerns about children.

Following more detailed assessment, members of the family unit can then be referred to an 'intervention'. An 'intervention' is a longer-term response, typically one delivered to family members by individuals or an organisation to address an identified need (eg, a perpetrator attending a stopping violence course). Details of these interventions are also recorded and updated in CMS.

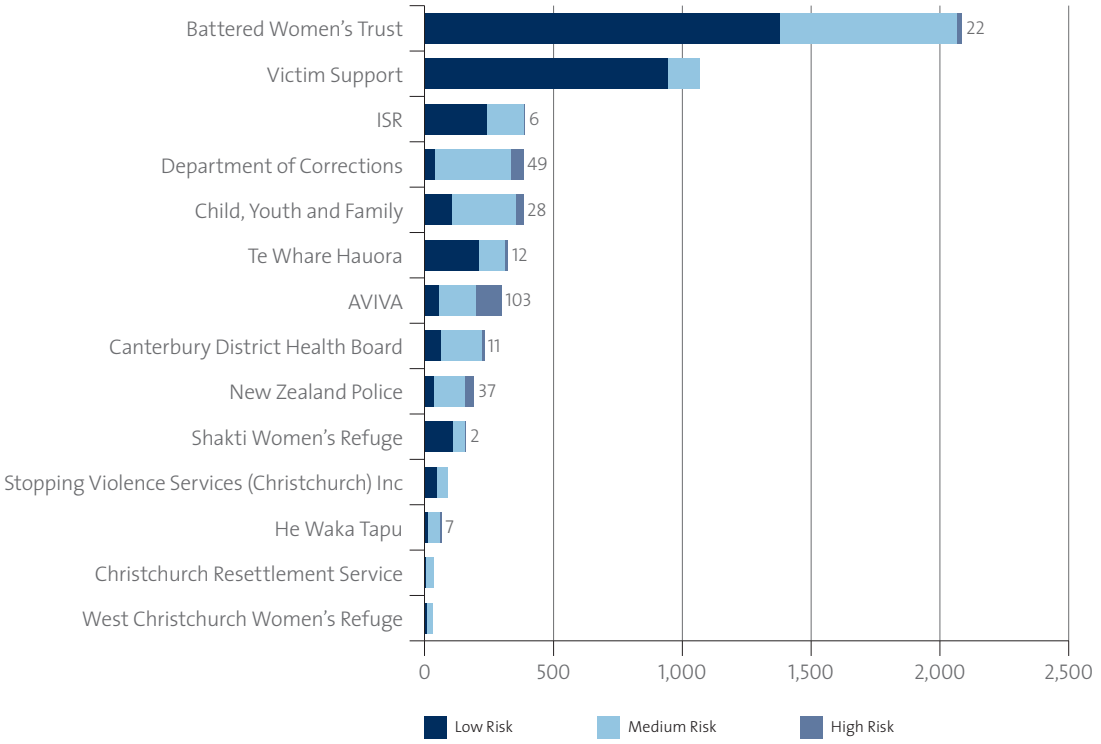
2.3.1 _ Family Safety Plans

As of 23 May 2017, nearly 10,000 family safety plans (FSPs) were recorded in CMS. Figures 2.8 and 2.9 present the distribution of agencies and NGOs assigned to lead these plans at each site. The number of plans designated as high-risk is represented by the dark-shaded segment at the right-hand end of each bar along with the number of high risk plans allocated (based on current status).[41]

In Christchurch, the highest number of plans (2,086) were assigned to the NGO Battered Women's Trust (BWT). At the commencement of ISR, BWT was funded for four dedicated advocates to respond primarily to low and medium-risk referrals.[42] High-risk plans were mainly allocated to NGO Aviva, which was allocated 103 high-risk plans (up until April 2017 Aviva was the only organisation in Christchurch with IVS positions, one of whom was seconded from He Waka Tapu to be part of the co-located team of IVS and IPS).

The majority of plans in Waikato are assigned to the ISR team itself (57%). In part this reflects the initial few months where Waikato ISR personnel took the lead on all plans; however, they now assign leads to other SAM agencies. There are few NGOs with sufficient capability (ie, have CMS access and sufficient training on the role of a plan leads) to be assigned as plan lead. Hence, ISR still take the lead role for their plans.

Figure 2.8 _ Distribution of plans by lead agency in Christchurch

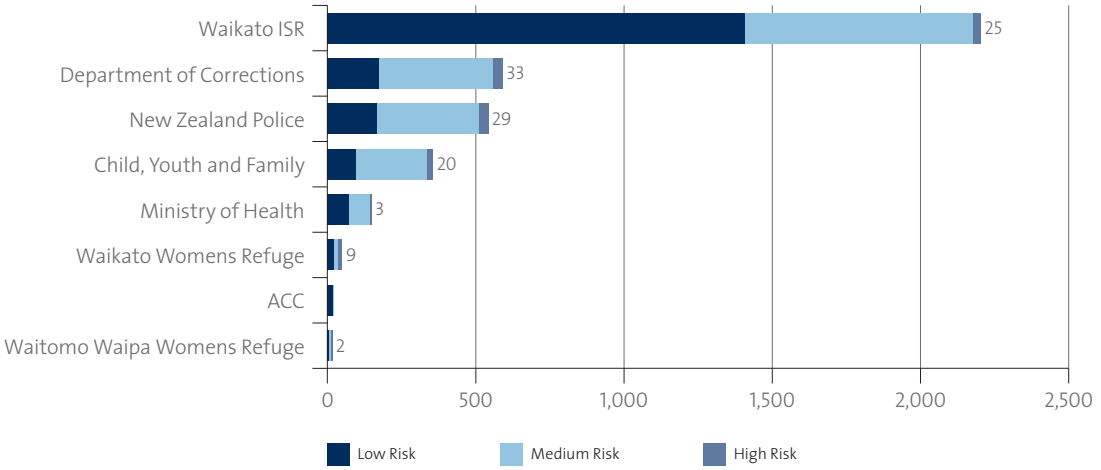


Notes: Figures reported at the end of each bar are the number of high-risk plans allocated. Only those agencies/NGOs that were assigned more than 30 plans appear in Figure 2.8; agencies with smaller numbers of plans (all low or medium risk) include Ngā Maata Waka (n=14), Barnardos (n=10), Children's Team (n=2), Ministry of Justice (n=2), and Ministry of Education (n=2).

41 Risk tiers are based on the current risk status of plans. This obscures high-risk cases that have subsequently transitioned to medium or low risk.

42 An additional seven ISR advocates have subsequently been funded across several NGOs in Christchurch.

Figure 2.9 _ Distribution of plans by lead agency in Waikato



Notes: Figures reported at the end of each bar are the number of high-risk plans allocated. Only those agencies/NGOs that were assigned more than 10 plans appear in Figure 2.9; agencies with smaller numbers of plans (all low risk) include Work and Income (n=1) and Te Whariki Manawāhine O Hauraki (n=1).

Completed Family Safety Plans

The end point of ISR is for the FSP to be closed (see Figure 3.1). This is when all safety tasks have been satisfactorily completed and sustainable safety has been achieved (see Section 7.1 for discussion around the extent ISR is responsible for achieving sustainable safety in addition to immediate safety).

It is the responsibility of the lead provider to review the completion of safety tasks, to review the plan and if satisfied with the outcomes achieved, to update CMS accordingly and record the plan as completed and subsequently closed.[43]

Of the nearly 10,000 FSPs created since ISR began:

- 48% are currently recorded as 'complete' (safety tasks completed, no change in risk or circumstance)
- 47% are 'in progress'
- 4% are 'inactive' (plans are on hold while longer-term services are provided).

43 The ISR model describes two end stages where a plan is 'completed' and then 'closed' following review by the ISR coordinator. In practice with the high volumes of plans developed, it is the lead provider that both completes and closes the plan.

2.3.2 _ Tasks

To date around 33,000 individual safety planning tasks have been assigned, in nearly 10,000 plans. As to be expected the number of tasks increases with risk level. Across both sites, on average:

- high-risk plans contain 12 tasks
- medium-risk plans contain 5 tasks
- low-risk plans contain 1 or 2 tasks.

These are however just the initial tasks assigned at the SAM table, and do not include additional tasks assigned as a plan is updated. Plans for more complex cases can contain as many as 60 tasks.

Once a task has been assigned, the government agency or NGO to which it is allocated is required to regularly update the status of the task. Two people are involved in each task: an 'owner', responsible for ensuring the task is done, reviewing it, and closing it when satisfied it has been completed appropriately; and an 'assignee', who is responsible for actually carrying out the actions involved in the task. The 'assignee' also records the task as completed when all actions have been undertaken (the time taken to 'complete' a task reflects the actual time taken in discharging all relevant actions; the 'closing' of the task is more of an administrative action). The 'closing' of tasks within CMS has proven to be a time-consuming process, particularly for owners of large numbers of tasks.

ISR guidelines state tasks must be 'acknowledged' within 24 hours (12 hours if the task has come from the ICM table). A due date for completion is entered for each task to enable monitoring of task progress. The due date is selected based on the urgency of the task, the nature of the task, and the expected time for completion (ie, some tasks are expected to take longer).

As of 23 May 2017, 78% of all tasks had been 'closed', with a further 10% completed and awaiting closure. Four percent were 'acknowledged' (ie, the assignee acknowledges receipt of the task, and the task is in progress), 8% remained 'allocated' (the task is allocated to an assignee, but s/he is yet to acknowledge it), and 0.1% were recorded as 'new' (a task not yet assigned to anyone).

The number of tasks assigned to different government agencies and NGOs appears in Appendix 7. Waikato is recorded in CMS as having nearly twice the number of agencies accepting tasks as Christchurch (reflecting in part the larger geographical area covered by agencies in Waikato).

- Christchurch – total tasks 20,435 (on average 444 a week)
  - 20 agencies/NGOs in total, of which of which 8 are government agencies (ACC, Corrections, DHB, MVCOT, Police, MOE, MOJ, MSD) and 12 are NGOs
- Waikato – total tasks 12,500 (on average 414 a week)
  - 38 agencies/NGOs in total, of which 7 are government agencies and 31 are NGOs.[44]

44 When data was extracted, some details were missing for assignees more recently loaded into CMS.

2.3.3 _ Content analysis of tasks

To get a better understanding of the nature of the tasks allocated from the SAM table, a content analysis was carried out on a random sample of 1,000 tasks (500 from Christchurch and 500 from Waikato). These were the initial tasks from the SAM table, excluding updates, and included all risk categories.

Where possible, whom the task was primarily directed at (ie, victim, child, or perpetrator) was also coded. This revealed some site differences in the focus of tasks generally:

- 42% of sampled tasks in Christchurch and 24% in Waikato were victim-focused
- 25% of sampled tasks in Christchurch and 29% in Waikato were perpetrator-focused
- 18% of sampled tasks in Christchurch and 13% in Waikato were focused on a child or young person
- 6% of sampled tasks in Christchurch and 18% in Waikato were focused on the family or couple.[45]

As noted above, Waikato has a greater number of NGOs available to take on tasks than does Christchurch, and more of these agencies worked actively with the family as a whole. This perhaps explains why Waikato tends more frequently to create one task involving referral of the entire family (or couple) or whānau to one provider, while in Christchurch it was more common for individual family members to be referred to different providers.

Figure 2.10 compares the type of task and whether it was assigned to a government agency or NGO across sites. Caution is needed in reviewing this data as categorising the tasks based on recorded information was not always straightforward, and terminology varied across the two regions.

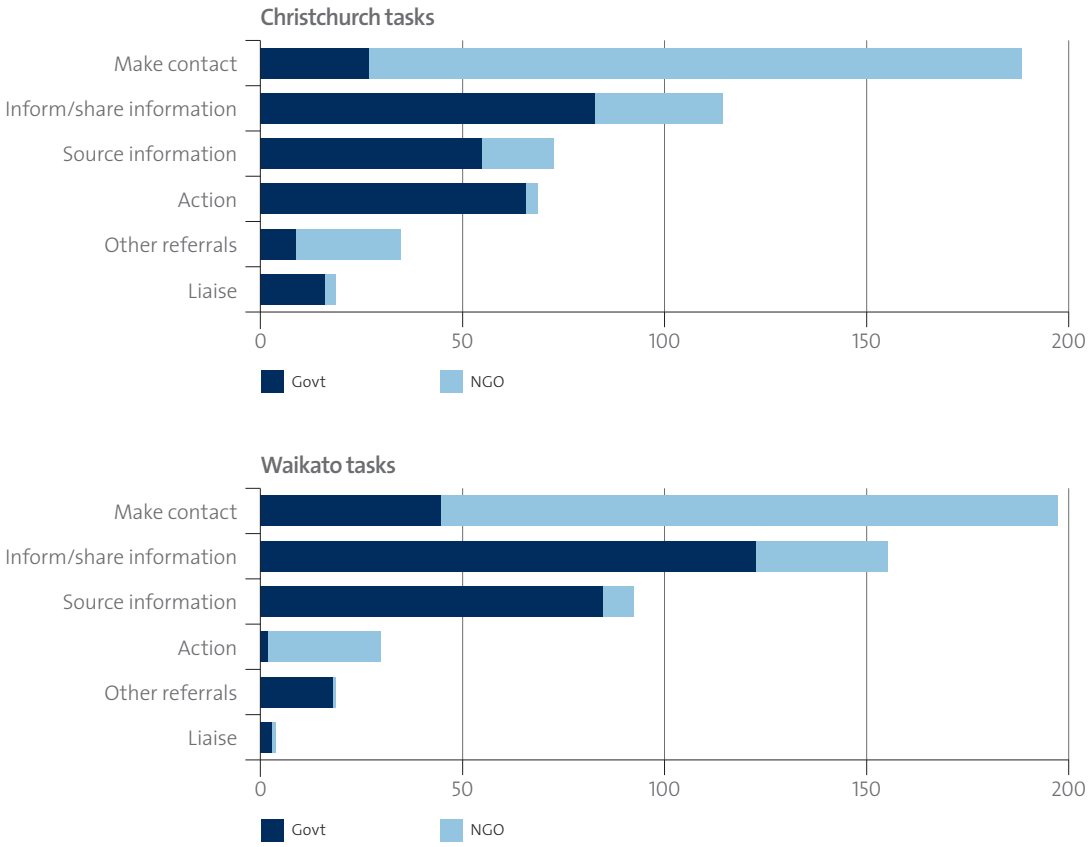
Type of tasks

Make contact: The most common task in either site was to 'make contact' (around 40% of all tasks) and was most commonly assigned to an NGO. In Christchurch this was typically recorded as 'engage and assess support needs'. In Waikato a wider range of terms was used, including 'to engage', 'assess safety needs', 'to follow up, to visit or to phone', and often included additional specific instructions (eg, ascertain child safety, discuss Protection Order, discuss alternative accommodation). In some tasks it was noted the agency/NGO should 'make attempts to contact again' / 'to re-engage'. Some tasks involved arranging a joint visit to a family by two groups (eg, Police and SFV).

In Christchurch, the task of making contact with the victim applied in 80% of cases; with the perpetrator in 13% of cases; and with a couple or family in 2% (of the remainder it was unclear whom the task was directed at). In Waikato, the task was to make contact with the victim in 43% of cases, and with the perpetrator in 19%, while a greater proportion of tasks were directed at the whānau, family or couple (24%). Insufficient information was available to identify who the remaining 13% was directed at.

45 Note that percentages do not add up to 100, as for 9% of cases in Christchurch and 16% of cases in Waikato there was insufficient information to identify whom the task was directed at.

Figure 2.10 _ Type of tasks assigned from SAM table, Christchurch compared to Waikato (sample of 1,000)



Inform/share information: A key aim of ISR is to facilitate effective information sharing among government agencies and service providers. This task typically related to those meeting around the SAM table, informing those already in contact with the family about a new family harm episode (those already engaged with a family might include the probation officer, MVCOT social worker, health professional, school teacher, or NGO personnel). This was the second most common task for Christchurch at a quarter of all tasks (23%), but recorded significantly less often in Waikato, at only 4% of all tasks.

Source information: The flip side of information sharing, was identifying information gaps and using a task to source this information so that the plan could be updated accordingly. Common information seeking examples included:

- recent outcome of court proceedings
- clarification of bail / parole / sentence conditions
- status of recent attempts to engage, or outcomes of assessments, reports of concern (ROCs), referrals, investigations
- feedback following an assessment (eg, a mental health assessment)
- current contact details (victims, perpetrators, children)
- availability of support options
- current location of all parties (victims, perpetrators, children).

Sourcing information was the second most common type of task in Waikato, making up a third of all tasks (31%). It was the third most common in Christchurch (15%).

Action: A common task in both sites was some form of safety action (14% of tasks in Christchurch and 19% in Waikato), with the vast majority of safety actions being tasked to government agencies. Actions included:

- Police actions – typically, make an arrest, serve a Police Safety Order (PSO), serve a trespass notice, conduct a welfare check, locate an offender, check on a person's immigration status, conduct a bail or PSO check, or take action about a breach of conditions
- Corrections/MOJ/Police – consider altering specific conditions (eg, an address may no longer be appropriate)
- MVCOT – conduct a Report of Concern for a child
- Health – place an Emergency Department alert on a health patient's files, arrange for a health assessment
- other support actions – eg, allocate an IVS/POS, send a letter, check entitlements through WINZ.

Liaise: This was not a common task (4% in Waikato and 1% in Christchurch), but was sometimes used to make sure people were discussing cases with the right people and co-ordinating actions together.

Other referrals: In addition to 'make contact'-type referrals, on occasions there were also additional types of referrals to specific programmes or services (eg, referrals to Plunket, Barnardos, Parentline, Family Start, culture-specific services, health social workers, youth programmes, or the Children's Team). Given that the focus of the SAM is on ensuring immediate safety, it might be expected that these types of referrals would be more common as the FSP progresses. Within CMS it was intended that these type of tasks would be captured as interventions; however, as seen in the next section (2.3.4), this does not seem to have been the case.

2.3.4 _ Interventions

Interventions (eg, engagement of parties with remedial or rehabilitative services) are critical to the ISR's aim of addressing a family's full range of needs and improving their long-term outcomes, especially safety. CMS has the ability to record the type of intervention, who was targeted, and the status (ie, in progress or completed).

However, given the number of family safety plans (n=9,698), it was surprising that relatively few formal interventions were recorded in CMS. At the time of writing, there were just 133 interventions recorded in Christchurch and 78 in Waikato (around 2% of all plans).

Lack of recorded interventions has been noted previously as a concern and there have been some efforts to increase their use and/or recording of them. Comments from some key informants suggested a general lack of understanding of what an intervention was, pointing to a need for more training. Some might consider allocation of an IVS or IPS an intervention in and of itself. It is possible that agencies/NGOs are making referrals to interventions but not updating plans. However, it is also possible that referrals are simply not being made. This is clearly an area requiring further attention.

2.4 Summary

The purpose-built ISR CMS system is capturing a range of data on the nature and extent of family violence, providing significant advances on what was previously available. From an evaluation perspective, further development of CMS would improve the recording, analysis and interpretation of its data (these suggestions have been listed in section 7.6 along with other practice-related suggestions for improvement).

Key statistics as of 23 May 2017 include:

- since commencement of the pilot a total of 14,789 episodes of family harm have been processed through ISR and entered into CMS. Total volumes of family harm episodes are higher in Waikato, averaging 209 per week compared to 183 in Christchurch.
- the referral source for both sites is almost entirely Police FVIR/POLs (98.5%), with an additional 1.5% coming from Corrections.
- multi-agency safety plans have been developed for nearly 10,000 families involving just under 30,000 individuals.
- just under a quarter (23%) of families across both sites have more than one episode. However, these 23% of families make up 46% of all episodes being processed.
- risk status is dynamic: it can be lowered following effective safety planning, or elevated following repeat episodes. In practice, risk status is changed for very few plans (8%). Using the current status of plans recorded in CMS, 4% of plans were high risk, 44% were medium risk, and 52% low risk. Christchurch has a higher proportion of plans identified as low risk (57%, compared to 44% in Waikato).
- three-quarters of perpetrators were male (73%), while three-quarters of victims were female (73%).
- the most notable difference across sites is the proportion of individuals recorded as Māori (of all those entered into CMS, 22% in Christchurch, and 58% in Waikato). In both sites, Māori were over-represented in recorded episodes for that region.
- a third of children or youth (under 17 years) were living in a family with more than one recorded family harm episode.
- intimate partner violence, either from a partner or ex-partner, was the most common type of violence (70% of all cases).

- verbal abuse was the most common type of harm recorded across sites (59%), followed by physical harm (18%), then threats of harm (11%), property damage (10%), and sexual violence (0.4%).
- to date around 33,000 individual safety planning tasks have been assigned in nearly 10,000 plans. This equates to 444 safety actions being tasked per week in Christchurch and 414 in Waikato. The number of initial tasks increases with risk level, with 12 tasks on average for high-risk plans, five for medium risk, and between one and two for low risk.
- the most common task in either site was to 'make contact' with the victim, perpetrator or family and assess safety needs (around 40% of all tasks), most commonly assigned to an NGO. This was followed by 'sharing information', most typically information of an episode shared with a social worker or probation officer (around 24% of all tasks).
- very few recorded interventions (ie, longer-term rehabilitation services) have been recorded in CMS. The lack of interventions has been noted previously, and efforts to increase their use made; however, little progress appears to have been made. It remains unclear if agencies/NGOs are making referrals but not updating plans, or if referrals for interventions are simply not being made.

03

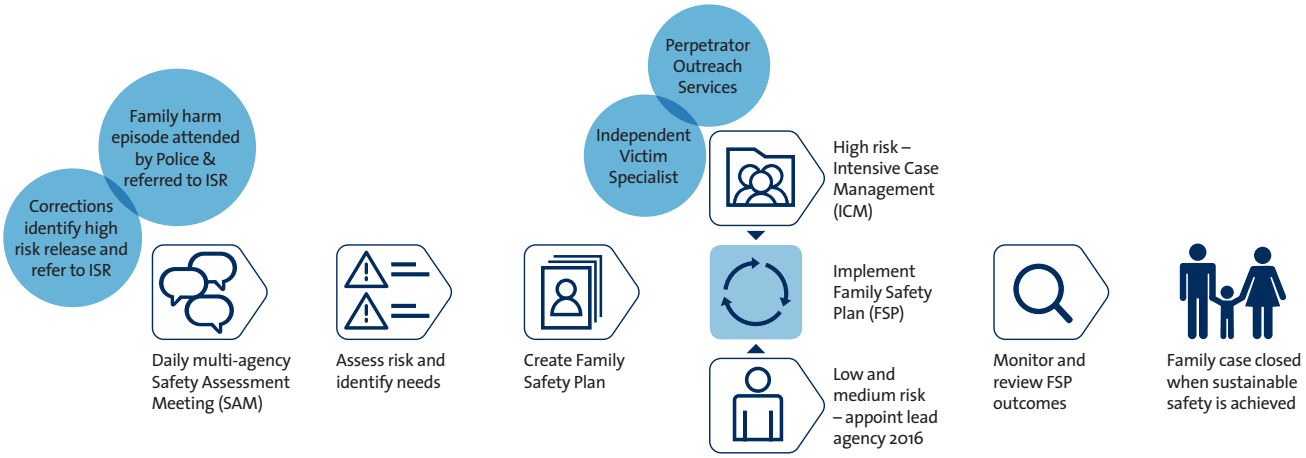
Implementation of the ISR model

A key question for the evaluation team was the extent to which the ISR model had been implemented 'as intended' in the pilot sites.

For the purposes of this report, 'implementation' is considered the extent to which the component parts of the model are evidently 'in place' and allowing the model to operate as planned. The evaluation of the actual 'operation' of model is the focus of later chapters where emerging evidence of effectiveness is presented.

The ISR model is multi-faceted, involving a range of government agencies and NGOs. Individuals from these groups are required to perform distinct roles, including participating in governance and operational managers' meetings, the ISR team, and the SAM or ICM table, and provision of specialist victim and perpetrator support (see Figures 1.1 and 2.1). Implementing, training, resourcing, mobilising and continuing to maintain engagement of all the key players required for ISR to operate is no small feat.

Figure 3.1 _ ISR design features



The extent to which this had been achieved was the focus of a detailed interim report completed in November 2016 after the Christchurch pilot had been operating for just three months. Since that time the Waikato pilot commenced and the Christchurch pilot has continued to develop and establish itself.

This section of the report (1) compares the implementation of the model across the two sites, then (2) reviews the findings from the interim report, and (3) updates progress, with particular attention to evidence of continual improvement.

3.1_ Comparison of Christchurch and Waikato pilot sites

From an evaluation perspective, the addition of a second pilot site in Waikato provides an opportunity to assess how well the ISR model works across a diverse population that includes a higher proportion of rural and Māori communities. It also enables the impact of local variations to the model to be understood. However, it is necessary first to identify the differences across sites. It is also useful to consider how ISR in Waikato differs from the Family Safe Network (FSN) pilot that was operating prior to ISR.

Table 3.1 sets out details of the ISR as implemented in Waikato and Christchurch, plus some of the characteristics of the FSN initiative in Waikato. Key differences are highlighted in section 3.1.1.

3.1.1 _ The Christchurch ISR and the Waikato ISR compared

The SAM table in Christchurch operates six days a week (six tables in total). The Waikato ISR operates two SAM tables concurrently five days a week, which requires double the number of staff resources each day. In addition, on Mondays a third table is now operating in Waikato to cope with high volumes of referrals after weekends (11 tables in total). Despite the 'city' and 'rural' labels, the SAM tables are run in the same premises in town, at the offices of MSD.

Both sites are currently in the process of securing new premises, having outgrown their current ones, and both aim to be located in the community in a multi-agency facility.

Representation at SAM and ICM tables are generally similar across sites. However, Waikato includes a Refuge representative, and just one health representative (for both mental health and general health), but has no specific representation from iwi at the SAM table. Christchurch on the other hand has an NGO co-ordinator responsible for liaising with NGOs and providing feedback on their behalf, including Refuges and specialist family violence organisations.

Waikato has 7.5 Independent Victim Specialist (IVS) positions (the 0.5 position is a supervisory role). Four NGO SFVs collaborated to co-host IVS with ISR (ie, they spend some of their time with their specific SFV and the rest co-located with the ISR team.) Depending on their SFV co-host, these IVS either work with city-based clients or rural-based clients from across the whole district. Waikato has 4.5 perpetrator outreach service (POS) positions (the 0.5 position is a supervisory role) who work with medium and high-risk perpetrators, with a similar set up to the IVS positions. Waikato has also received funding for programmes to support the POS work (for 20 high-risk placements on a 26-week programme, and 40 medium-risk placements on a 13-week programme).

Christchurch has a similar number of IVS and IPS/POS but has a slightly different set-up, with positions mostly allocated to specific NGOs working predominantly with clients referred to them.[46] These include four IVS positions, nine victim advocate positions who work with medium-risk victims, and 4.5 POS/IPS positions who work with high-risk perpetrators. Some agencies in Christchurch have created supervisory roles to manage ISR referrals, but these are not specifically funded positions as in Waikato. The IVS and IPS responses are co-located at one agency, with the aim of providing a more integrated response to high-risk families. There are an additional two IVS, three victim advocates, and five Whānau Ora navigators who work across three Māori providers. Similar to Waikato there is also ISR funding for stopping violence programmes (supporting approximately 96 places per annum).

TABLE 3.1

Characteristics of the FSN and ISR in Waikato and ISR in Christchurch

	Christchurch	Waikato	
Characteristic	**ISR**	**ISR**	**FSN**
Began operating	4 July 2016	25 October 2016	April 2015
Location	Central Police station Note: both sites currently looking for new premises	Co-located with HAIP	Co-located with HAIP
Specifically funded ISR positions (full-time)	**ISR team** • 1 director • 1 operations manager • 3 co-ordinators /facilitators including an NGO co-ordinator • 4 administrators **Victim/perpetrator specialists** • 6 IVS for high risk victims & children (2 of which are allocated across Māori providers) • 4.5 IPS/POS for high risk perpetrators • 12 advocates for medium risk victims & children (of which 3 are allocated across Māori providers) • 5 Whānau Ora navigators allocated across Māori providers. **SVS programme** • 96 places	**ISR team** • 1 director • 1 operations manager • 3 co-ordinators/ facilitators • 3 administrators **Victim/perpetrator specialists** • 7.5 IVS (recruited across 5 NGOs), 0.5 FTE in a supervisor role • 4.5 POS, 0.5 FTE in a supervisor role (all levels of risk) **SVS programme** • 20 high risk places, 40 medium risk	**FSN team** • 1 director • 2 facilitators (1 city and 1 rural) • 2 administrators (1 city and 1 rural)
Director's reporting	To National Manager (Prevention), Police NHQ	Same as Christchurch	To District Commander

46 Christchurch began by allocating all IVS/IPS positions to form a co-located team operated by one NGO. This co-located team included staff from He Waka Tapu and Christchurch Resettlement Service.

	Christchurch	Waikato	
Characteristic(s)	**ISR**	**ISR**	**FSN**
Additional staffing	NGO and government agency staff operating as 'business as usual'	Same as Christchurch	NGO and government agency staff operating as 'business as usual'
Local governance structures	• Local governance group • Operational managers meetings	Same as Christchurch	• Local governance group • Operational managers meetings
IT infrastructure	• ISR CMS	Same as Christchurch	• FSN database • HAIP 23 year historical database of family violence cases
Referrals	• Police report of family violence (FVIR/POL1310) or a Corrections referral prior to release of a high-risk prisoner • POLs sent out to all ISR participating agencies/ NGOs to assist with reviewing of their own databases to determine prior involvement	• Referral sources the same as Christchurch • ISR team prepares and sends out a list of names to service partners to identify service history (POLs not sent)	• Same as ISR • FSN sent out a list of names to service partners to identify service history
Referral volumes	• Average 183/week	• Average overall 209/week • City average 118/ week and rural average 90/week	• Hamilton city averaged 100-130 cases/week • Rural hubs averaged 80-100 cases/week
Safety Assessment Meetings (SAMs) – format	• 1 table (currently scoping the need for an additional table on certain days) • 6 per week in total • Located in Central Police Station	• 2 tables – 1 city, 1 rural – run concurrently in the city, with a third table now run on Mondays • 11 per week in total • Hosted by MSD and/or Corrections • Rural SAM once a month in rural areas in conjunction with NGO network meeting	• 1 Hamilton City hub meeting, chaired by facilitator, supported by administrator • 1 rural hub meeting operating the same as the City SAM but teleconferencing in rural Refuge representatives
SAM frequency	6 days a week (Sun-Fri), with plans to move to 7 days mid-2017	5 days a week (Mon-Fri)	5 days a week (Mon-Fri). NB: 6 days a week was trialled but abandoned because 6-day NGO coverage couldn't be secured

	Christchurch	Waikato	
Characteristic(s)	**ISR**	**ISR**	**FSN**
SAM representation	NZP, MVCOT (CYF), Corrections, two CDHB (mental health and general health), Iwi representation and ISR NGO co-ordinator	Same as Christchurch except only one Health representative, no iwi representation and a representative from a Refuge replaces the NGO coordinator role	Police, CYF, Corrections, Refuge (Health fed information through)
Cases reviewed at SAM	• Around 20 per table (based on ISR directors weekly reporting May/June 2017) • Cases reviewed by SAM table – those initially triaged as medium and high risk (note a one-month trial reviewing all cases at SAM is currently underway).	• 19 per table • Cases reviewed by SAM table – all referred	
Risk assessment	ISR Quick Guide – Assessed on a 3-point scale into low, medium and high risk on the basis of an evidence-based risk assessment framework	Same as Christchurch	Assessed on a 5-point scale ranging from tier 1 'crisis-urgent intervention' to tier 5 'zero to low risk – no further action required'
Risk classification	• 5% high risk (based on current status) • 38% medium risk • 57% low risk	• 3% high risk (based on current status) • 53% medium risk • 44% low risk	• <1% crisis-urgent, 5% escalating to crisis, 34% chronic/ escalating risk, high demand and/or complex needs
Responsibility for case closure	Plan lead is responsible for review of FSPs and plan closures	ISR coordinators are responsible for review of FSPs and all plan closures	FSN coordinators
ICM meetings	• 1 table once a week (on occasions an extra table is run to meet demand – 5 in last 12 weeks) – additional meeting once a month dedicated to reviews • Located on local marae (Ngā Hae e Whā) • Facilitated by operations manager or ISR coordinator • Averaging 17 plans per week discussed (new cases and reviews) Note: 5 out of 12 weeks required two ICM meetings	• 1 table once a week • Hosted by ACC • Facilitated alternately by 'city' and 'rural' coordinators. • Averaging 11 plans per week to be discussed (new cases and reviews)	• No formal meetings, but informal network meetings held to discuss high risk cases (once a fortnight in the city, and once every three weeks in rural centres)
ICM representation	• Same as SAM with addition of ACC, WINZ, MOE, MOJ, IVS, IPS, Tū Pono and other key NGOs involved with high-risk cases	• Similar to Christchurch but the IVS and POS supervisors rather than the IVS/POS's themselves attend	• Not applicable

It appears Waikato has a greater number of NGOs available to take referrals from the SAM tables, with a large number being family-centred organisations (see section 2.3.2). Waikato ISR also holds NGO network meetings in the city and in non-urban locations (such as Thames). This provides an opportunity for practitioners to come together and discuss issues they are encountering when responding to ISR tasks.

Waikato's referral volumes are higher than those of Christchurch, currently averaging 209 per week in Waikato compared with 183 per week in Christchurch. At this early stage, the 11 Waikato ISR SAM tables are managing to assess and develop FSPs for all cases referred within its five days per week operation (with Monday being the longest meeting day). This equates to around 19 cases being reviewed each time a SAM table meets. Since 1 October 2016, Christchurch has moved to operating SAMs six days a week (Sunday through to Friday) and reviews only those cases that are initially triaged as medium or high risk. Using the weekly directors' reports in May/June 2017 the Christchurch SAM tables review a similar 20 cases daily.[47] At the time of this evaluation, Christchurch was in the process of moving to seven days a week and was trialling a return to reviewing all cases at the SAM table; it was also considering adding a second table if required (this has now occurred since the writing of this report).

Another difference emerging between the sites is the proportion of cases assessed as high, medium or low risk. While both sites use the standardised ISR risk framework, Waikato has relatively fewer high-risk cases (3%, compared to 5% in Christchurch) and low-risk cases (44%, compared to 57% in Christchurch). In the early stages of the pilot there was also a difference in the types of cases discussed at the ICM meeting. In Waikato the focus at the ICM meetings was on the more 'entrenched' cases with a long history of violence and with multiple flags, rather than those presenting currently with a high risk of harm as in Christchurch. However, the focus in Waikato appears now to be more similar to Christchurch's.

3.1.2 _ The FSN and ISR in Waikato compared

The development of the ISR model was based in part on lessons learned from the Family Safe Network (FSN) initiative in Waikato, which preceded ISR. Unsurprisingly some characteristics of the Waikato ISR initiative bear a close resemblance to the former FSN initiative. The Waikato ISR is in fact led by the former director of FSN, and dedicated co-ordinator and administration positions remain.[48] The ISR team started off in the same premises, co-located at Hamilton Abuse Intervention Project (HAIP) along with other key agencies such as the Police Family Harm Team (FHT).[49] Similarly to the former FSN, the SAMs run daily (Monday to Friday) and referral volumes are reasonably similar. FSN also involved an operations managers group and a governance group, although the reporting structure and representation has changed under ISR.

47 Some cases initially triaged as medium or high risk are subsequently assessed at the SAM as low risk. Using director's weekly reporting for May/June 2017, on average 120 cases were reviewed weekly at Christchurch SAM tables, around 16 of these were subsequently re-assessed as low risk.

48 The FSN team re-applied for ISR positions in an external application process.

49 ISR has outgrown these premises and is currently looking to move. Demand for space meant the FHT had to move out earlier in the year.

The most significant changes involved in the transition to ISR include the introduction of the ICM table, the funding of specialist positions to work with victims and children (IVS) and with perpetrators (POS), and replacement of the HAIP database with the CMS system. ISR training is more intensive (12 modules over five weeks) and there are detailed manuals setting out practice guidelines and minimum standards.[50]

Waikato ISR has also evolved its former city and rural hub structures into city and rural SAM tables. The rural group previously involved teleconferencing with representatives from the rural Refuges when required (Thames and Waipa/Waitomo) but all are now physically present at the two tables (city and rural) running in adjacent rooms. Membership of the SAM tables has been extended to include relevant information supplied by ACC. There is daily attendance from a DHB person capable of understanding both mental and physical health issues. Previously, health information was supplied to FSN co-ordinators, but no health representative attended meetings. Finally, risk categorisation has changed, from FSN's 5-point scale to the simpler 3-point scale, with low, medium and high-risk tiers.

3.1.3 _ Views on transferability of ISR

The consensus among key stakeholders was that the ISR model is transferable to other locations. *'Taking it and putting it somewhere else would absolutely work.'* Choice of ISR staff and others connected with the model was thought to be critical. They needed to be passionate about it. *'People are important ... having the right person in the right spot is really important.'* The model was thought to be more likely to succeed in areas with strong established relationships among sufficient service providers who want to make it work. *'You'd have to have the buy-in ... It's the relationship building, understanding, identifying passionate people. You'll always have organisations that hang back.'*

There was some support for the view that the SAM table is best located as close as possible to the community it serves. The location of the Waikato ISR in Hamilton meant that those around the SAM table were not necessarily as well connected with rurally-based service providers as was the case under FSN, which had the equivalent of rural SAM tables based in Cambridge/Te Awamutu and Coromandel/Thames.

50 For example, high-risk victims, children or perpetrators must receive a face-to-face visit no later than 24 hours after notification of the reported episode. Medium-risk cases must receive a face-to-face visit within 72 hours (excluding weekends), preceded by a phone call. Low-risk cases are contacted by phone only. It appears these standards have translated into improved engagement across the board.

3.2_ Recap of interim report findings

The interim report provided a detailed description of the intended operation of the ISR model based on the 2015 ISR guidelines.[51] This intended operation was compared to that implemented on the ground in Christchurch in the early stages (after just the first three months of operation).

The interim report concluded the ISR model had largely been implemented as intended in Christchurch, which was a major achievement considering the short timeframe. Identified modifications and revisions were viewed as either adaptions to the local context (eg, unexpectedly high volumes of family harm referrals) or reflective of a commitment to continued improvement of processes.

The main departures from the model, mostly related to a lack of capacity to meet the high volumes of cases referred, were:

- **not all cases being reviewed at SAM** – the ISR model intended that all cases be reviewed at the SAM; however, only medium and high risk cases were subjected to multi-agency review at the SAM table
- **limited allocation of IVS/POS** – a key component of the ISR model is that all high risk victims should be assigned an IVS advocate, and all perpetrators have access to a POS unless already engaged with a perpetrator service – however, not all high risk victims or perpetrators were allocated an IVS or IPS/POS due to lack of capacity
- **inability to deliver culturally appropriate responses for all high risk clients** – it was noted that some of the specifics of the model (eg, IVS allocated to all high-risk victims) were not always easily combined with delivery of the most culturally appropriate response; Māori whānau were not always able to make their own decisions and choices of service provider
- **lack of review of FSPs** – guidelines suggested ICM family safety plans should be reviewed after 15 days, when a plan is complete, when there was a change of risk or if agreed actions were unable to be carried out. However, there was limited evidence of this occurring.
- **role of local governance** – local governance groups felt the need to meet fortnightly rather than every two months as per guidelines and tended to focus more on operational and implementation issues, rather than the strategic focus intended.

In general, while the various components of the model were found largely to have been implemented as intended, the interim report identified that the demands of resourcing the model were imposing considerable strain across both government agencies and NGOs, a situation that probably was not sustainable in the medium to long term. Two areas of ISR created the greatest strain:

51 *Integrated Safety Response. People and the process: ISR Guidelines* (version 1.0, 30 June 2015).

1. lengthy duration of the SAM tables, which regularly met for periods twice as long as initially anticipated, requiring members to sustain focused attention and discussion for up to six hours at a stretch, thereafter followed by further hours expended in associated ISR work
2. insufficient capacity in the NGO sector to cope with the volume of cases being referred, compounded by the minimum standards of response demanded by the ISR model.

Due to the later start date Waikato was not in scope for the interim report. However, from later visits and field work it appears their start-up period (and transition from FSN) has gone relatively smoothly. This transition has been eased where requirements of ISR were similar to FSN, but possibly have created more challenges where new ways of working were required by ISR. ISR has however required a greater input from government agencies and NGOs to respond to the higher volumes and provide coverage to a wider geographical area. The Waikato director has highlighted capacity issues similar to Christchurch, in particular:

- lack of capacity from NGOs in rural areas to carry out tasks arising from the SAM and ICM
- insufficient numbers of victim advocates (a particular concern in rural areas)
- large numbers of high-risk cases unable to be processed at ICM and a lack of IVS capacity to work with the increased workload
- case reviews not being completed in a timely manner due to workload
- a large number of tasks not being closed at SAM; a number of these were due to a lack of NGO capacity in rural areas, but around half were due to lead providers (which are mainly SAM members) not having capacity to review and close tasks.

These issues remain current in Waikato at the time of writing this report.

3.3_ Update on implementation and evidence of continual improvement

Assessing the extent to which the model's implementation has taken on board early findings from the evaluation (ie, evidence of continuous improvement) was itself an important evaluation objective. Since the interim report was completed, numerous examples of continuous improvement have been identified. These have occurred in response to specific recommendations contained in the interim report, and in response also to the six-weekly QAIF reviews, a number of subsequent workshops and hui facilitated by Police National Headquarters and also needs identified by the ISR teams themselves at both sites. In fact, almost all implementation issues outlined above and in the interim report appear to have either been remedied or improved in Christchurch (with the exception of recording of interventions). Waikato has also shown a commitment to continual improvement without the benefit of focused investigation of their implementation process. The more significant examples of continued improvement are described below and provide an update on many of the earlier implementation issues.

3.3.1 _ Increased resourcing

Perhaps the most significant improvement, particularly in Christchurch, has been an increase in resourcing to support the implementation of ISR. Funding for ISR positions comes from the MOJ's Justice Sector Fund, with MSD's Community Investment teams acting as the commissioning agency.[52] This has resulted in more dedicated ISR positions (operations manager, co-ordinators, administrators, IVS, advocates and IPS/POS positions at both sites), but also increased resourcing allocated by government agencies to better support participation at the SAM and ICM tables. Based on interviews conducted in Christchurch in May 2017, this appears to have considerably eased workload pressures, particularly among government agency staff participating at SAMs.

The Christchurch team has settled on 3–4 FTEs to staff the six-days-a-week SAM table and the once-a-week ICM table. The positive response from the government agencies involved has significantly eased the pressure on those representing their agencies in the relevant roles. Backfilling of positions is now possible (when someone is sick or on leave) and there is generally a better balance achieved between time at the tables, completing ISR administrative tasks, and doing the work generated from the table. While pressure has eased, working effectively with such high volumes remains an ongoing challenge (eg, the ability of SAMs to review all cases, including low-risk ones, and the ability of NGOs to manage high volumes of referrals and carry high caseloads).

Waikato agencies, however, appear to still be struggling to fully resource their ISR commitments:

> *I think it's probably not [adequate]. We probably underestimated the amount of time and effort required. No-one knew the workload or number of referrals. We might have two people at that SAM meeting, but actually it will take more like six people to have two people there when you think of annual or sick leave, training cover etc. We haven't got that built in from the beginning, so we're scrambling when someone is sick or taking a holiday. It hasn't been well-organised. (ICM member – Waikato)*

Waikato appears to be at a similar place to where Christchurch was at the time of the interim evaluation. This may be due to the shorter duration of the pilot in Waikato, or it could be that demands on resources are also higher in Waikato, which has higher volumes (currently requiring 11 SAM tables to review all cases) and a far wider geographical area to cover.

3.3.2 _ Intensive Case Management

There have been significant efforts to improve the operation of the ICM table in Christchurch. Process improvements include:

52 In late 2016 there was an increase in funding for 3.5 IPS/POS responses and also for SVS programmes. Then in early 2017 a second lot of funding significantly increased the number of IVS and ISR advocates and in Christchurch this included nine dedicated Māori ISR positions (two IVS, three ISR advocates, and four Whānau Ora navigators).

- a new process whereby cases are reviewed at ICM only after the IVS has been able to meet the client face-to-face to conduct an initial assessment.
- the location of the meeting has been moved to the Ngā Hau e Whā marae in Aranui. This has provided more spacious meeting areas, enabling the SAM table to operate for a full day rather than finishing early to enable the ICM meeting to begin, and much improved parking facilities.
- separate ICM meetings are now held to review outcomes and status of all high-risk plans, in addition to responding to new high-risk referrals.
- additional training and guidance had been provided to those participating in ICM, including workshops on the practical elements of ICM.
- there has been clearer messaging put out to agencies at all levels about what ISR is here to achieve, why ICM is important, and clearer expectations of participating agencies and organisations in terms of their role in ICM
- Waikato has also worked on deepening ICM members' understanding of the model's purpose, and on the need to be better prepared for meetings.

3.3.3 _ Development and operationalisation of Tū Pono (Christchurch)[53]

Another significant improvement, initiated by some Māori organisations (but supported by ISR), has been the development and operationalisation of Tū Pono. There are now three Māori providers that have formed a collaboration to respond to all ISR referrals. Funding has been provided for dedicated Māori ISR positions. This renewed commitment to supporting Māori whānau through ISR is a significant turnaround from the position in October 2016 when key Māori groups were considering whether to withdraw from ISR.

3.3.4 _ Review of all cases at SAM (Christchurch)

In late May 2017 a month-long trial began where all cases (including those initially screened as low risk) are again reviewed at the SAM table (and has now become permanent practice).

Other improvements related to the SAM review process include:

- a process has been created for when cases need to be brought back to SAM – this has been sent out to operations managers following a consultation period
- a process has also been created to manage the review of repeat cases to SAM in the following order (1) prioritised cases; (2) current plans (ie, repeats); and (3) new plans. When there is a repeat episode, the ISR co-ordinators have also taken responsibility for reviewing and summarising existing plans to speed up the updating process.

53 In Christchurch the interests of local iwi are represented by Tū Pono, a collective of Māori organisations that have come together in Canterbury to enable a stronger Māori response to family violence by asserting whānau voice as a fundamental key to reducing and eliminating harm (see chapter 6 for more details).

3.3.5 _ Local governance

In late March 2017 the local governance group in Christchurch was restructured. A smaller group with regional managers from core agencies now meets, with a larger group of representatives available to support initiatives as required. One NGO representative nominated by the sector attends (initially it was two invited NGO representatives).

In Waikato, membership of the local governance group has also been evolving with the ISR Director and Operational Manager now attending. They are also making plans towards a joint governance meeting of Waikato ISR and Waikato Children's Teams.

3.3.6 _ Improved risk assessment

In response to QAIF recommendations, both sites, and Waikato in particular, have improved their processes around the SAM table of identifying and recording risk and protective factors.

3.3.7 _ Closing of plans (Waikato)

Also in response to QAIF observations, Waikato ISR has now assigned government agencies/NGOs other than itself as the lead for plans and tasks. Initially the ISR team took sole responsibility for this final activity. Sharing the load, makes the task of closing the high volumes of plans more achievable, although it has also required further training and support for those now responsible.

3.3.8 _ Referral pathways

Both sites have continued to develop partnerships and increase the number and variety of referral pathways. A few recent examples include:

- Christchurch's Co-ordination Service (sitting across around 10 NGOs providing alcohol and drug services) is now receiving the daily lists and has agreed to accept 5–8 referrals each week. When tasked with contacting a person it will do so within 24 hours, regardless of the risk level, and will seek a face-to-face meeting immediately.
- MOJ staff in Christchurch secured funding to 30 June 2017 to have an ISR-specific FTE work on practice guidance and appropriate contributions to ICM from the three court business areas/jurisdictions.
- In Waikato, the Matamata NGOs are now taking ISR referrals. This has come at the end of meetings undertaken by local providers (existing ISR partners), the ISR director and co-ordinator, and Community Investment (MSD). The direct outcome is that substantial service gaps have now been closed in an area that previously had extremely limited options. These partner agencies have now realigned their services to fit with the funding they receive that falls within the criteria of the ISR model of practice.

One area still requiring attention at both sites is the recording of interventions that a family has been referred on to.

3.4 Summary

The ISR model is up and running in two pilot sites with varying characteristics. This indicates the model is sufficiently robust yet flexible enough to be transferred and implemented to meet local conditions. Key variations across the two pilot sites include:

- **ethnic make-up** – far greater representation of Māori in Waikato
- **geographical characteristics** – Waikato covers five rural districts in addition to Hamilton City
- **volume of family harm episodes** – Waikato having higher volumes (averaging around 210 per week compared to Christchurch's 180)
- **family violence response prior to ISR** – Christchurch was operating a FVIARS model, whereas Waikato was trialling the Family Safety Network (FSN).

Key differences in the way ISR has been implemented across the two sites include:

- **number of SAM tables** – Waikato operates two SAM tables (a 'rural' table and a 'city' table) five days a week (with a third table operating on Mondays to help cope with high volumes of referrals after the weekend). Christchurch operates just one table, but six days a week (Monday to Saturday).
- **SAM review of low risk** – Waikato's SAM tables review all episodes of family harm, while only those initially triaged as medium and high risk have been reviewed by the Christchurch SAM table (although since the writing of the report Christchurch are now reviewing all cases).
- **set-up of IVS, IPS, POS** – The IVS, IPS and POS positions in Christchurch are predominantly co-located and operated by one NGO, and work with clients referred to this NGO. In Waikato the positions have been spread across NGOs and are co-hosted by ISR and these NGOs.
- **NGO representation at SAM table** – Christchurch has an NGO co-ordinator responsible for liaising with NGOs and providing feedback on their behalf. In Waikato a representative from one of the Refuges takes on this role.
- **referral options** – Waikato appears to have a greater number of NGOs available to take referrals, with a large number being family-centred organisations.

Operating the ISR model is resource-intensive, and has been challenging for both sites. There has been an increase in resourcing allocated by government agencies and additional funding provided by the Government for the ISR pilot. In Christchurch this appears to have eased workload demands, particularly for government agencies, making participation at SAMs and ICM far more sustainable. While pressure has eased, working effectively with such high volumes remains an ongoing challenge (eg, the ability of SAMs to review all cases, including low-risk cases, and the ability of NGOs to manage high volumes of referrals and carry high caseloads).

Waikato agencies appear to still be struggling to fully resource their ISR commitments. This may be due to the shorter duration of the pilot in Waikato, or it could be that demands on resources are also higher in Waikato, which has higher volumes (currently requiring 11 SAM tables to review all cases) and a far wider geographical area to cover.

There has been clear evidence of continued improvement in how the model operates across both sites – to the point that it has been hard for the evaluation to keep up with the many changes. Christchurch has either improved or remedied all implementation issues identified in the interim report (except for recording of interventions). Waikato has also shown a commitment to continual improvement without the benefit of a focused investigation into their implementation process.

04

Effectiveness of the ISR model

The relatively short time span of the pilot, and limited availability of relevant data able to be generated over this period, means that the current evaluation could not conclusively assess actual outcomes for families and whānau. Instead, the objective has been to review emerging evidence of effectiveness and to document relevant practice elements and practice developments. A key source of data for this was the interviews with key informants and ISR participants (victims and perpetrators). Data from these interviews, supplemented by descriptive quantitative data, is presented in the next three chapters. These chapters successively address emerging evidence for the effectiveness:

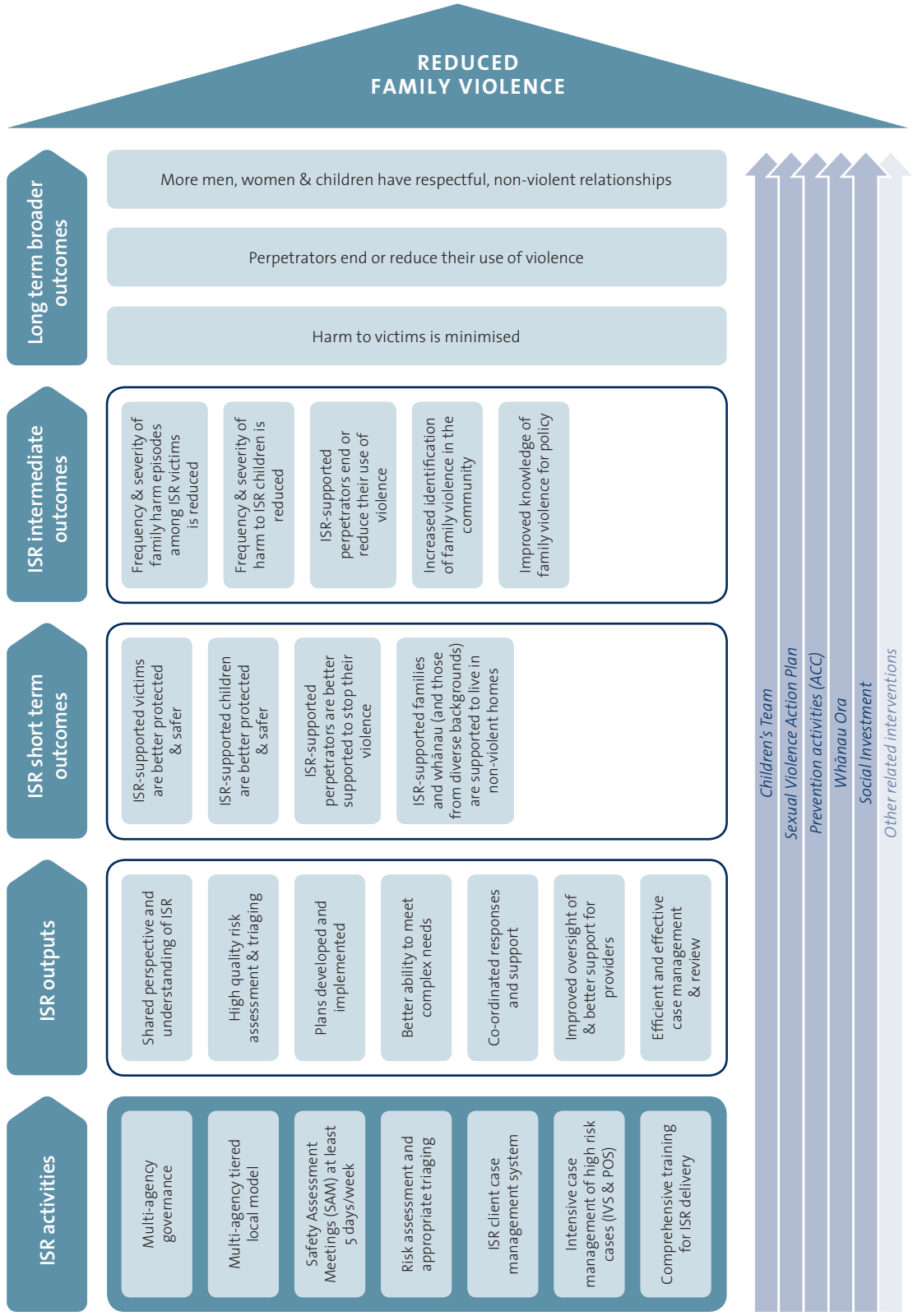
- of the ISR model itself;
  - for families; and
  - for Māori and their whānau

This aligns with the programme logic that was developed at the beginning of the pilot (see Figure 4.1 for high-level elements of the logic).

The current chapter considers the extent to which outputs expected from the ISR model itself have been achieved. The chapter looks closely at the intended aims of the ISR, which if achieved should result in better outcomes for families according to the programme logic. Many of these outputs were aspects of the model that were identified as 'working well' in the interim report. They are reviewed in less detail in this report and have been framed to focus on what has been achieved through efficient processes.

While the main focus is on what has been achieved through the ISR model (ie, improved processes), evidence of areas requiring further improvement are flagged and discussed in more detail in chapter 7. Unintended consequences will be reviewed in this current chapter (see section 4.8).

Figure 4.1_ ISR programme logic (high-level components)



4.1_ Shared understanding and collective working

A key driver behind the development of ISR was the perceived need to bring government agencies and NGOs together to share relevant information, work collectively, and improve access to services. A 2016 report of the Family Violence Death Review Committee (FVDRC) specifically called for this type of approach, highlighting the need to shift from a fragmented assortment of services, referred to as 'islands of practice', to a more integrated system.[54] For this collective style to be effective, it was important that those involved had a shared understanding of what the model entails, its intended aims, and the roles and responsibilities of those involved. ISR practice guidelines and training that accompanied the implementation of the pilot further assisted achievement of this goal.

The ISR model requires a range of government and non-government agencies to come together and work collectively on several levels. This includes at the national level (eg, the ISR Project Board) and the local level (eg, fortnightly governance group and operations managers' meetings, and weekly ICM and daily SAM tables).

Clear evidence has emerged of ISR working in this way, and this is recognised by many as one of its most important achievements:

> *Oh, I just think the fact we're all working together and talking together is probably one of the most positive things, and everybody is committed to making a difference for families. (ISR)*

One of the positive outcomes of collective working is the opportunity for enhanced information sharing. Below are examples of how an awareness and understanding of ISR is extending beyond those directly involved at the ISR tables into the agencies they represent; these examples show the enhanced relationships that have resulted, and how these have translated into effective collaboration.

While overall this has been an area of success, there are still areas where more collaboration and a shared understanding is desirable (chapter 7 discusses co-located teams and partnerships between NGOs and the government sector).

4.1.1 _ Increased awareness and understanding of ISR

The interim report described the shared understanding of ISR among those directly involved in ISR, particularly SAM participants. Seven months later, several representatives of the core agencies commented on how an awareness of ISR had now extended beyond those directly involved to also include their frontline colleagues. A representative from MVCOT spoke of an increased awareness in the surrounding site offices:

54 Family Violence Death Review Committee. (2016). *Fifth Annual Report: January 2014 to December 2015*. Wellington, Health Quality and Safety Commission. Retrieved June 2014 http://www.hqsc.govt.nz/assets/FVDRC/Publications/FVDRC-5th-report-Feb-2016.pdf

> *Having been responsible for family violence in the 18 months prior to this pilot, that [FVIARS] process was largely invisible to the wider staff in Christchurch. Now, family violence response is visible throughout all the sites. ... it's given me a vehicle to push that further. It was an isolated role ... now it's gone from invisible to highly visible. It's a work in progress ... but it's given a good opportunity for family violence practice to be high in the agenda in terms of our role, Oranga Tamariki's role, and collective response. (MVCOT)*

This increased awareness also appeared to translate into increased acceptance of the tasks. In the interim report SAM members spoke of often experiencing 'pushback' from their colleagues who had been tasked with completing an action: *"Who are these people to tell me how to manage my client?"*. However, this attitude was now much less evident:

> *I think it was picked up in the last evaluation, the frontline staff in various big agencies feeling affronted or puzzled that a group was making decisions or operational calls or offering advice about the management of their cases.... I've heard far less about that. So I think a sort of outcome is, there's been an acceptance and adjustment to the importance of the ISR and the SAM table, and the legitimacy of that table to make calls that as a practitioner you ought to listen to – because they've got seven multi-agency people really scrutinising what's best for the whānau – I think that's a good thing. (Corrections)*

This greater awareness and understanding appears to have developed via a number of mechanisms, including:

- resourcing that enables SAM and ICM members to spend more time working alongside their colleagues, communicating the goals and practices of ISR.
- greater numbers of agency staff now sitting on the SAM/ICM tables, which raises the profile of ISR within their agency. In some cases a core group of three to four staff are now recognised as 'the ISR team' and are increasingly visible. In other agencies, rather than a dedicated team the SAM/ICM roles are rotated through a larger number of staff, similarly increasing knowledge and awareness of ISR.
- positive outcomes and interactions resulting from those tasked with completing ISR safety actions.

As will be seen later, this increased awareness has resulted in staff being more receptive and responsive to requests for help.

Another intended outcome of a shared understanding is around more consistent messaging. When organisations work in isolation, they are less likely to be giving consistent messages to families. It appears ISR can assist with this goal as illustrated in the example below:

> *For victims, perpetrators and children, what's important for ISR is that the messaging is the same. Regardless of which organisation they're talking to. That was a good example for this man. He was getting all these messages from [the IPS] before our meeting, we came in without having spoken to [IPS] previously about what we're going to say, and we [social workers] started to give him the same messages. And the IVS was also working with his partner, who was also getting those same messages at that end. So when we pulled those people together, we're all collectively there, giving the same messages. (SAM)*

4.1.2 _ Enhanced relationships

Alongside an increased awareness and understanding of ISR, there appears to be increased understanding of and respect for the work of those involved:

> *I think also, like now obviously we're nearly at the end of the first year of the pilot, ISR is starting to be known amongst these professionals now and so they're sort of starting to take on board. We say we're from the ISR and things like that, probably a bit of respect coming from that way now, starting to build, people are being aware of what it's about and what it means for them and the families. (NGO)*

> *I definitely like the relationships with other professionals, that would be the key. Probably the biggest positive gain out of all of it, in particular Corrections. … also even with Oranga Tamariki, you know I think that they, the more we're working with them, I think the more trust they have in us. (NGO)*

An outcome of this can be more effective working relationships:

> *I've got two clients staying in motels that Work and Income are paying for. … because they go to SAM, they hear the conversations of these clients, so they are a bit more receptive/responsive, compared to if they didn't come to the table before. They … might have just taken my word and maybe done it, but now they get the bigger picture. (NGO)*

Positive relationships between ISR and other community partners have also been seen to provide positive results while supporting continuity of care.

Case 4.1 This case involving Shakti illustrates positive outcomes through positive relationships with community partners. (Shakti is a specialist provider of culturally competent support services for women, children and families of Asian, African and Middle Eastern origin.)

Following years of unreported sexual abuse and violence, a victim entered Shakti's safe house with her young children and a baby due soon. Shakti quickly gained a strong rapport with her and supported her to gain a Protection Order. Her partner breached the Protection Order twice, leading to a referral to ISR, where the case was rated as high risk. Shakti have supported the victim to rent a new Housing New Zealand property and she has attended their MOJ-funded safety education programme.

Shakti kept ISR updated regularly on progress and came to the weekly high-risk meeting to talk about this plan.

Support from other ISR partners included:

- Canterbury DHB maternity services supported a safe birth plan for the victim.
- The partner is well-engaged in a programme with Stopping Violence Services.
- Work and Income are checking the victim's full entitlement to income support.
- Police are working very closely with Shakti to support the victim when she is ready to make a statement about the abuse she has experienced.

4.1.3 _ Effective collaboration and collective working

There were many positive examples of collective working in the interim report, and this clearly continues to be a key area of success for ISR on several levels. The SAM table itself best embodies the collective working approach. Observations were made regarding SAM representatives' frequent use of the term 'we' in discussions, illustrating 'joined up' thinking, and shared decision making.

In line with the wider awareness of ISR described above, in this later round of fieldwork, numerous examples were given of how a more collective approach to working with families had been achieved. One individual commented:

> *One of the real benefits that I've seen, is it is not just the NGO trying to struggle away, but they can pick up the phone and ring ACC and ask for that, pick up the phone and ring WINZ. So that network ... agencies are calling on their contacts to help and support them and to work alongside them. And that can only be possible, I think, because it's about everyone working with that person as best they can. That is definitely a positive. (ISR)*

This was appreciated by the advocates too:

> *... but also the engagement, the time to engage and able to like sort of tap into, like go and meet with them at a Corrections meeting, or go with Police or if they're going to WINZ or CYFS, you know like just being able to obviously get on board via other people that are already engaged with them, whereas previously we never had that at all. We were very much on our own, so that's probably where some of that integrated stuff comes into play. (IVS)*

This collaboration included accessing information to facilitate engagement with family members as a crucial but often challenging first step in implementing a safety plan:

> *I had one recently. I had trouble getting in contact, the phone was going straight to voicemail. And generally when that happens, we think it's not the right number. We did a home visit but no-one was home. I got in touch with WINZ, and they were able to confirm I did have the right phone number, but the lady worked during the day. So I tried her on an evening call and got hold of her. (NGO)*

There were also examples of more elaborate problem solving to achieve the same end. In the case of a high risk victim who was not willing to talk to anyone, WINZ would make an appointment for them to come and discuss their entitlements and at this appointment ask whether the victim would be prepared to speak with Police. If so, this provided the opportunity for Police to discuss with her their concerns for the victim's safety.

> *So we did one of these last week. I'll introduce myself to her and explain my role and ask if I can speak to her after the appointment and then I'll ask her if she would speak to the Police officer. Because what they want to do is tell her how much risk she's at. So that was an 'outside the square' thing at the ICM table, with how can we get in front of these people and it was a question for Work and Income, "Is this something that you could do?". Well there's been no problem with our organisation about doing that because it is about safety. So that would never have happened before. (WINZ)*

The improved relationships and collaboration also assisted in smoothing referral pathways:

> *Another really good positive out of this that we'd never had before was putting names through for counselling, ACC counselling. Then ACC hunting down the counsellor and then contacting our client.... we've never had that at fingertips before ... I mean it's been sitting there but not ever tapped into because no-one knew that we could. So, marvellous. Again good response, people that they've put forward are very easy to deal with and try really hard to make it work for our clients. It's great. (NGO)*

In part these collaborative efforts stemmed from a better understanding of services provided by other agencies:

> *We're getting more familiar with what other services provide and them with us as well, about what our processes are. ... I think we're getting a really, really solid understanding of the other agencies. Not just the ones that sit round the table but also broader within Christchurch or within Canterbury. (ICM)*

> *It's the fact that they've got a lot of policy and legislation that can help us with achieving safety that we've never had access or knowledge of prior. Just some of the things, some of the conditions they can put on the offenders and things like that. So that's something we've never really had access to before. It's like they've been over there doing their thing and we've been over here – you know, that silo working. So I guess ISR has pulled that together a little bit. (IVS)*

The whole-of-family approach of ISR provides increased opportunities also for those supporting the victim or perpetrator to work together and also to have a better understanding of each other's work:

> *Like for instance I'm working with a young girl who's 18 and pregnant. I'm working with her, [IPS] is working with the partner. ... now, because I have all this inside information on this boy, you know I would really be on the back foot and probably a little bit intimidated perhaps or a little bit nervous. Not one bit, because [IPS] and I are talking about this couple so much so, and straight away like when we were there the other day he couldn't get to probation. Right, "Jump in the car, I'll take you." Those sorts of things would never have happened in the past. You know so I feel hey, we're doing the right thing for this little family, we've got an IVS working with the mother, and an IPS working with the perpetrator, and they're trying to make it work too. Yeah exactly. It's just working really well. (IVS)*

4.2_ Information sharing, risk assessment and safety planning

Under ISR, government agencies and NGO service providers review their own databases on a daily basis against new reports of family violence, and identify any prior involvement and any other information of relevance. This information is then shared or brought to the SAM table. SAM members then jointly make an assessment of risk (low, medium or high) on the basis of this information, and then proceed to develop a safety plan. More complete information means more accurate risk assessments and much improved and better targeted safety planning. This dynamic is clearly evident within the operation of ISR.

The value of this information sharing at the SAM table was a strong theme to emerge in the interim report and, for many of those interviewed more recently, it remained perhaps the most positive outcome of ISR:

> *The biggest [positive] difference between the ISR and the FSN is the increase in the information sharing and the options available to put into plans from the partners at the table and partner agencies. (SAM member – Waikato)*

Sharing information enables a more complete picture of the family to be considered – for example, identifying children who are part of the family:

> *And especially with these vulnerable children that are linked to perpetrators or to the victims, either of them. So if they're not noted on the POLS or episodes then we put a note in there that goes back saying that there's vulnerable children, these are the ages, these are the names, and that kind of stuff. So that just highlights something to talk about at the table. (ICM/WINZ)*

Other benefits of this enhanced information sharing are reviewed below. One area of information that remains lacking from assessments however is that provided by the family themselves. This is discussed further in chapter 7 (see section 7.1.3).

4.2.1 _ Benefits of enhanced sharing of information

Benefits of increased sharing of information can be identified at a number of stages.

More accurate risk assessment

Perhaps the clearest example of the benefit of this increased information sharing is with risk assessment. This is particularly so in cases where there have not been previous reports of violence to Police, and/or no or only minor criminal history. Such cases would typically have been assessed as low risk. However, health information shared in cases has, for example, indicated frequent visits to emergency departments for assault-related injuries, or ACC information has noted multiple claims for injuries. This previously unavailable information has served to significantly improve the assessment of risk level:

A shining example for ACC – we had a family that came through, it was their first domestic, and the information we had was really minor. It was "My brother assaulted me, hurt my hand." Then we got ACC's info, the lady that went and recorded the episode was 17 years old. We got ACC's info, which indicated that her brother has been assaulting her since she was one. And serious/extensive assaults she has been subjected to for 16 years. And no-one else around the table had any info on that. If we didn't have ACC info, this would have been rated lighter, but as a result of the ACC info, it escalated higher. (ISR – Waikato)

Another illustration of how information shared can result in better risk assessment and safety planning was provided through a 'good news' story provided by Waikato.

Case 4.2 This case demonstrates how the immediate risks to the primary adult victim and her baby were addressed more quickly due to the information shared at the SAM table.

The couple have a baby and the woman (the primary victim) is pregnant. The index family harm episode was of a relatively minor nature.

Information shared at the SAM table included that the woman:

- had, following the Police call out for the family harm episode, called the Crisis Mental Health Services to say she'd killed her baby. She'd then hung up. (The Police made a welfare check and ascertained the baby was safe.)
- had recently attempted suicide
- had previously presented with bruising
- lived in an overcrowded house with the man's family.

The SAM table assessed the case as 'high risk'. Police was tasked with conducting a second welfare check immediately and ascertaining the woman's needs.

The woman is being supported by emergency housing and mental health services. With the support of Women's Refuge, she wants to exit the relationship with the man (primary aggressor).

Enhanced safety planning

In other cases information sharing has enhanced safety planning. For example, information on a couple's relationship status has been supplied that indicates the need for the perpetrator's bail or parole conditions to be revised (eg, a non-association order added or a more appropriate address considered). Increased access to relevant information to support safety actions can also continue after the initial SAM meeting – for example when agencies are responding to tasks:

I have an example of last week, how I think it's working really well in that we had a bloke who came through as a PSO and a brief intervention, which we didn't know about, but through ISR we joined the dots. We updated the ISR system, highlighting mental health issues. The next day, he got served with a Protection Order, and as a result of that, Police – really on the basis that we had put that into ISR strongly – accessed the mental health services and got a 5 day section. That wouldn't have happened before ISR. That's the beauty of it. (NGO)

CMS. Having a place where we can all find the info, especially our NGOs. If I was a social worker in an NGO and I needed to find info, having CMS there, directing them there and have them know what it is, I think that helps the process much better. (NGO – Waikato)

Case 4.3 This case shows the value of information sharing at the SAM table and the difference that ACC's contribution made.

The case was a new referral to the SAM table via a Police call-out for a family harm episode. Those around the table had virtually nothing to share about the family except the ACC representative, who spoke of one of the parties to the episode having an extensive history of severe self-harm. This vital piece of information informed the risk assessment and planned response to the family. The family was living in a rural area with no access to the appropriate services locally, so an agency from outside its usual service delivery area was brought in to support them.

More effective work with families

Quite clearly, for those tasked with working with the families, this increased information and increased ease with which they can access the information helps them to work more effectively.

From my side – the info we get from that meeting. We go in with more info ie, criminal history, the role of Corrections. The people sitting at the table gives us more trigger points in terms of what we need to consider from the beginning. That's helpful. We know if there's going to be a Refuge response in terms of who to link in with. It gives us a good platform – we didn't have that before. (SAM)

Also when you get some background info, and when they are basically downplaying the incident... you have a fuller picture. Especially if they're young, it's their first relationship and they're pregnant.... It's like, you can see there's a history. You ask more questions. (NGO)

4.2.2 _ Quicker, more efficient dissemination of information

In addition to more information being shared, through ISR the information also appears to be being disseminated more quickly:

> *We have good systems for info at the table to go straight to social workers. If there's concerns, that's all recorded right from the beginning. (SAM)*

> *Kind of like to see that the probation officers need the information as early as they can, particularly if the guys are reporting or the girls are reporting on the next day. It gives them a little bit of a chance to have a look at what the safety assessment meeting spoke about and some of the information available from the other agencies. It'll help them with their reporting and stuff. (Corrections)*

4.3_ Implementation of plans

The existence of ISR has heightened awareness of the sheer volume of family harm occurring in the two regions (similar findings will doubtless occur if ISR is expanded nationally). Each and every new report of family violence resulting from a Police call-out to an episode (or high-risk prison release) is now being referred to ISR and an FSP developed and implemented.

The quality of these plans is continually improving, supported by the six-weekly QAIF reviews:

> *Yeah. So, the other thing that's changed is that the expectation of the quality of the plans has gone up consistently through the QAIFs. … The expectation has gone up. So, with expectations going up, time per case has gone up. … which is good because the quality is better. So the QAIF, I find, has a pretty high expectation from day dot. (ISR)*

Once developed, implementation of the plans is another of ISRs most significant achievements. Through ISR:

- the level of the response has increased – now there is a meaningful response to every episode
- responses have been extended to encompass perpetrators in addition to victims
- there has been increased engagement and uptake of plans
- responses are more rapid and more efficient.

4.3.1 _ Response to every episode

The demand for ISR response has been huge. As seen in chapter 3, across the two pilots there have been nearly 10,000 family safety plans developed involving nearly 30,000 individuals. A core aim of ISR is to provide a response to every episode. In Christchurch, prior to ISR, there were some cases assessed as low risk that drew no response;[55] most others would have been reviewed by three agencies and likely referred to a single agency/NGO, and only the most serious cases were reviewed by a larger multi-agency group. Post-ISR all episodes are reviewed daily by five agencies (eg Police, MVCOT, Corrections, Canterbury DHB, and ACC) together with a large number of NGOs, and all episodes have FSPs developed.

The difference in level of response post-ISR was highlighted by an NGO that receives low and medium-risk referrals. In the year prior to ISR it had received 50 family violence referrals, but since ISR it had been assigned the lead on over 1,000 plans.

4.3.2 _ Increased response for perpetrators

Reducing the incidence of family violence requires that effective work is done with perpetrators to change their propensity for violence. While the safety of a victim may be achieved by supporting them to leave a relationship, this will not necessarily keep a perpetrator's future partners safe from victimisation; nor does it recognise that many victims are unwilling or feel unable to leave the relationship. Many of those interviewed pointed to the work with perpetrators, particularly the new focus around supporting them to change their behaviour, as a stand-out achievement of ISR:

> *Yeah, you can tell victims to hide under their bed and build bigger fences around their houses and stuff, but we need to deal with perpetrators and it's starting. (Police)*

> *So we've been for a long time happy for people to go round and assault and bash their partners and do nothing about it, you know. They've got a custodial sentence. ... but now we've got a system that targets perpetrators about their behaviour and actually – it doesn't get them all because we haven't got the resource for all and some don't want it. ... But it's starting to seriously address what perpetrators – how they – you know, why they are offending and so on from there. (Police)*

> *This is a good thing for Hamilton/our community/our people. ... this [ISR] is going to be a force to be reckoned with. To anyone who is going to show abusive behaviour, there's going to be support people there, not just for victims but also perpetrators. If I can work with a perpetrator to a position where he's no longer abusive, there's the flow-on effect of that – it's something you can't quantify because that continues for generations. So breaking that cycle. (NGO – Waikato)*

55 Recorded as 'NFA' (No Further Action Required).

While there has always been a range of mostly mandated interventions for perpetrators (eg, stopping violence programmes delivered by the courts, Corrections and community organisations), the nature, reach and intensity of responses has changed and significantly increased as a result of ISR.[56] Every perpetrator is now considered integral to the FSP, and ISR also provides for one-on-one support for perpetrators through the IPS and POS, especially when the individual lacks access to other support services.

A particular success noted in Christchurch was the collaborative efforts that have resulted in the IPS, POS and other stopping violence services reaching perpetrators (and victims) inside prison, including both those on remand as well as those serving sentences (see also chapter 5). This was seen as an effective opportunity to intervene that had been less utilised prior to ISR:

> *My focus is, within this organisation around engaging with fathers/perpetrators of violence.... there has been great engagement gains here, that would have never existed before [ISR], that's going out and seeing men in prison. That was a gap for us. Often, it would be convenient for men to be in prison, because safety is achieved, and we don't have to do much work on that/move on. Or, we ignore that, all this other work to do with the other side of the family, then we panic because he's getting released and we've had no engagement with him. (ICM)*

> *... they're resigned to [the] fact that it's come – yeah, it's come to a head. But, you know, in three months' time they start thinking, "Oh, I'm angry about being here now" and, you know and that's not always a great time. (Police)*

4.3.3 _ Improved engagement and retention

From the outset ISR has had high expectations around the level of engagement expected. The ISR guidelines set out minimum standards for responses to families and whānau. For example, high-risk victims, children or perpetrators must receive a face-to-face visit no later than 24 hours after notification of the reported episode. Medium-risk cases must receive a face-to-face visit within 72 hours (excluding weekends), preceded by a phone call. Low-risk cases are contacted by phone only. It appears these have translated into improved engagement across the board.

In Christchurch, NGOs estimated that before ISR their engagement rates with clients (mainly victims) ranged between 23% and 34%. These rates were significantly increased with ISR. In Christchurch the NGO receiving most taskings for high-risk victims has engagement rates of between 75% and 90% across the IVS (where engagement is defined as four or more activities with the client). The NGO that receives the greatest number of medium and low risk victims is averaging monthly engagement rates of 69-85%, where engagement is defined as victims receiving safety planning either via phone, or face to face.[57]

56 POS has been designed as an earlier, crisis intervention model; it is non-mandated and highly individualised. Its first aim is to enhance risk assessment and safety planning by improving information sourced from the perpetrator. As an earlier intervention model, POS aims to shift the burden of responsibility from victims for taking action to become safe, and to build readiness for behaviour change programmes.

57 Figures supplied by agencies using their own agency records prior to and after ISR.

IVS explained how they could now allocate more time to attempt engagement, thus improving engagement rates:

> *Yeah, engagement, because we've got more time to put into it. ... It's gone through the roof. ... I think, like as I said to you, a client that we were talking about how time's used up. You know I've texted, I've phoned, I've emailed. You know that probably in the scheme of things before, I wouldn't have been able to do anything more than that but now I'm going to start now cold calling and I'm going to have a walk around. (NGO)*

> *Some of them swear at us, tell us to go. But we say: "Just think about it and what you may need. We'll come back and see if we can support you." If we keep going back, then next minute, they invite us through the door to engage. Some of them, they're Mongrel Mob or whatever, and once we explain who we are, and why we're there ... sometimes they invite us round the back, then we go and they completely change, ask us why we're there, what we can do, and they open up. (NGO – Waikato)*

ISR advocates also pointed to successes with medium and low-risk cases, as a consequence of their new process of follow-up phone calls:

> *... and if they don't want to engage further than a phone call, we do follow-up calls around two weeks after, and then again about six weeks after the incident, so.... And we often find, it was quite interesting when it first started, we found that people did end up wanting to engage at those follow-up times because they might have felt like it was just a one-off, or they hadn't identified what the risk was to them or the fact that they were, you know, being abused, and then realised it was continuing on, and because they'd had that little bit of education and that support. (NGO)*

Engaging perpetrators is perhaps the harder task. Overall rates of engagement for the IPS response were lower at 48%. However, engagement and retention levels with the most high-risk perpetrators inside prison appear higher:

> *... it's all voluntary, that are putting their hands up to want help. They can walk out and leave at any time so they actually – all the guys want to be there which is quite – which is significant, you know.... I think [IPS] has got about [a] 100-percent strike rate out here. He's – I don't – I can't remember any other guys that have said, "No, I don't want to work with him", and they'll at least do a couple of sessions before they'll go, "Oh, this is not for me".... You know what males are like. They don't like talking about their problems ... but he's had a really good rate. (Corrections)*

> *Some of the guys have had, you know, double-digit sessions without one miss, for instance, you know. (IPS)*

Christchurch ISR use the 'Outcome' field in CMS to monitor engagement rates. All those closing plans used the following criteria for selecting the three CMS outcome options, 'Negative', 'Neutral' or 'Positive'. These are defined as follows:

Positive:

- engagement with both parties to the episode leading to interventions and/or ongoing engagement
- engagement with one party but not the other, leading to ongoing engagement.

Neutral:

- receptive to phone call and willing to engage in conversation
- open to support but not willing to commit to anything at this point.

Negative:

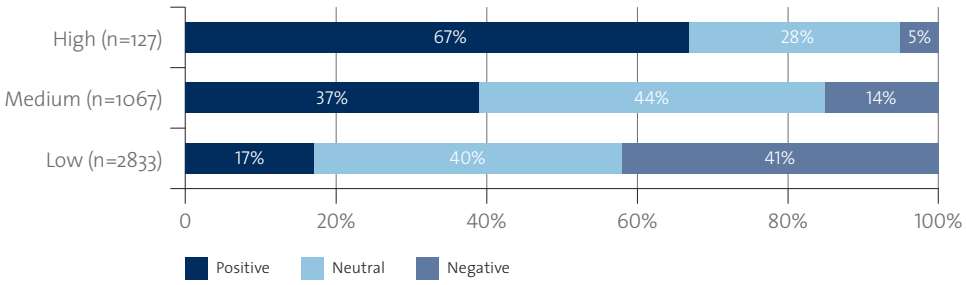
- unable to be contacted
- unwilling to acknowledge the issue or consider support
- immediately cut off when attempt made to engage.

Engagement outcomes for closed Christchurch plans by risk tier appear in Figure 4.2. Two-thirds of all referrals had received contact and been offered support (positive or neutral outcomes). Considering the high volumes dealt with, this appears a very positive outcome. Engagement rates increased based on the intensity of the response received, with high-risk plans achieving the highest rates, followed by medium and low risk.

Success in achieving these high rates appears to be through:

- more intense efforts possible (ie, IVS and IPS)
- differences in caseload levels by risk tier
- more collaborative efforts among agencies/NGOs (see section 4.1.3)
- more opportunities for engagement, including better access to prisoners.

Figure 4.2 _ Engagement outcomes for Christchurch closed plans



Case 4.4 The following case highlights an IVS succeeding in making safe a woman with a long history of intimate partner violence and a history of non-engagement with family violence prevention and AOD (Alcohol and Other Drug) services.

The man and woman had been in a relationship and living together for two years. The woman (the primary victim) has a long history of being victimised during family harm episodes, including by the man (the primary aggressor). She also has mental health and alcohol addiction issues.

They had been referred to ISR four times in less than a year. Each time that the Police had been called out because of a family harm episode, both parties had been intoxicated.

The man had breached Police Safety Orders, and once during a breach had stabbed the woman in the neck with a pen.

The woman had been reluctant to talk with Police and disclose the full extent of the intimate partner violence. She believed she "deserved" it.

Neither the victim nor the perpetrator had previously engaged with family violence prevention or AOD services.

The table assessed the case as high risk and an IVS was assigned to work with the woman. As a result of this engagement alongside the Family Protection Team, who have been closely monitoring the perpetrator, the victim is looking to move addresses, has started attending a women's group, has started taking her medication for depression, and now contacts Police promptly when she is concerned for her safety.

4.3.4 _ Faster responses and easier access

ISR has increased the speed at which responses can now be delivered, mostly through the shared understanding and collective working described in section 4.1.

For example, an IVS describes the speed of access, in this case for Work and Income services, when a WINZ representative sits on the ICM table:

> *To be able to cut through a hell of a lot of red tape and address, just so much quicker than what, you know that frees up time. We're always under real time constraints because of the workload. I mean, back in the old days you know, trying to get anything done could take days and days and days. (NGO)*

> *... normally when we're approaching we have to do the advocacy and explain the impacts of family violence and how it's led to our client being in the predicament she's in. We basically, excuse the term, cut through the bullshit now, and get straight to actually what assistance we actually need from her, and because she's got that awareness she's onto it just like that. (NGO)*

The ease with which support can be accessed was also noted:

> *Look, the major benefits now is that victims don't have to go and shop for help. It's all being thrown on their lap so – and, look, without doubt that's a plus. And we – look, we've seen victims who would never engage with us [and] are now hearing through friends and other people in the same situation who are now engaging with us as well because they don't have to go and, you know, go and look around. "Well, I've been – the Police can't help me because he isn't – they can't prove the offence and WINZ isn't listening to me because of this". And "ACC won't help me because the Police can't prove that I've been assaulted". And so victims were running into closed doors all over the place and now none of that happens, you know, because, like, if you're a victim of family harm, you're pretty much going to be shown – the red carpet's going to get rolled out for you. (Police)*

4.4 Ability to address complex needs

The ISR multi-agency approach seeks to have the right people around the table to enable identification of the wider or underlying risks and needs for the presenting family. While it is clear that much better information is now available, and the number of services accepting referrals continues to increase, it is less clear whether there is sufficient time at the SAM table to problem solve beyond planning for immediate safety. There are questions around whether addressing complex needs through longer interventions is a realistic goal for ISR (see section 7.1)

The multi-agency members of the SAM table appear primarily focused on immediate safety needs. They identify the best referral pathway to achieve immediate safety, but do not always identify the steps that could achieve long-term safety. The ICM table has a better representation of government agencies and NGOs who can offer targeted solutions; but again, with high-risk families the ICM focus is also more that of ensuring immediate safety. Once engaged, the intensity of support provided by IVS, IPS and POS place them in a better position to identify and explore how to address the complex needs of many of their families. However, ISR guidelines recommend around 12 weeks of engagement, which may not be sufficiently long to permit complex needs to be addressed and resolved.

The challenge of addressing complex needs was raised by an ICM member:

> *It's difficult to change family violence within a family with all that going on. It makes the collaboration and integration of agencies even more important for those situations. Sometimes it can be a huge amount of responsibility on the IVS to manage those dynamics. They need to be supported. But these are the most challenging families in our communities, and if we haven't dealt with them previously, we're not going to magically deal with them now. (SAM)*

More work is needed to understand what works in addressing complex needs within families. It may also be necessary to review the scope of ISR – specifically, whether it can realistically address complex needs within a 12-week timeframe.

Whilst recognising the challenges for ISR to address more complex needs, the case study below provides an example of ISR working effectively within a complex family environment.

Case 4.5 This case shows how ISR is helping to break the cycle of family violence across generations.

> The children grew up in a violent home. The case came to the ISR's attention when the Police were called to an episode in which one of the children had used a blunt instrument to assault his mother, herself a victim of sexual, physical and psychological violence.
>
> The resulting FSP included immediate support to the whānau in terms of safety planning, and also service referrals for needs such as food parcels and school uniforms.
>
> Truancy services were tasked with meeting with the young person on a daily basis. The young person is also supported by a school counsellor, and a service centre has helped the young person apply for tertiary training options as well as a youth benefit from Work and Income. The young person has also developed some new pro-social relationships with peers. Their truancy has reduced and they are no longer presenting with any behavioural concerns at school.
>
> The mother has engaged with two local support agencies to address her needs, including for counselling.

4.5_ Co-ordinated responses

An aim of the Integrated Safety Response model is for ISR-supported clients to receive connected supports and services that address their needs, and for overlaps or gaps in delivery of support services to be reduced through increased information sharing and the Case Management System. Many of those interviewed referred to a co-ordinated response as 'one car up the driveway'.

This was an area with mixed results. While there were some examples of co-ordinated delivery of safety plans, maintaining this co-ordination of tasks once they left the SAM table, emerged as an area for improvement (see section 7.3). Progress is perhaps summed up by this quote:

> *Yeah, one other point about when the politicians were here. You know, their initial intent was they had seven cars up the drive. But they only wanted one; less messaging. We're down to three cars. (Police)*

Examples of consistent messages were given in section 4.1, and below is an example of collaboration and co-ordination achieving positive results.

Case 4.6 Example of achievements gained through co-ordination.

MVCOT were tasked with reviewing the safety needs of children following an assault on the mother of the children, which required them to meet with the father who was remanded in custody. However, he declined to meet with them – his case manager described how he "wouldn't have a bar of" them' and that he had said "the only way I'll talk to these guys [is] through my lawyer." However, MVCOT co-ordinated their efforts with the IPS, who had already been tasked with engaging with the father. The IPS made good progress with the father, and following five or more one-on-one sessions asked him again if he was willing to meet with social workers, at which point he agreed. The social workers met with him for about an hour and had a very productive conversation around safety concerns, enabling them to plan for all concerned on his release.

Another example of improved co-ordination was around the initial referrals. With increased information available on prior engagement with services, more consistency could be achieved around who would be best as the primary engager. A SFV also described how the right referrals were arriving more directly:

> *Previously all family harm POLS were sent to Refuge for contact. Under ISR, youth or mental health services are being directed to more appropriate help. (NGO)*

4.6 Improved support and oversight

National and local ISR governance, and local operational management, are all integral parts of the model, something that sets ISR apart from previous multi-agency responses. There is also a dedicated ISR director and operations manager. One of the aims of these groups and positions is to have oversight of capacity issues, identify pressure points, and have the capability to effectively support providers in their work.

The high volumes of family harm episodes and consequent gaps in capacity of providers to meet demand has been made more visible through ISR. This is seen as a positive attribute of ISR, and enables problem solving to address the true extent of need:

> *I think it definitely is healthy... that it has exposed the issues in the sector. It's exposed the capacity issues. It's exposed the need I feel for there to be more alignment in terms of government, how we fund family violence. (ISR)*

At the time of the interim report, the challenges posed by the high volumes had many feeling that the sector was almost at 'breaking point'. However, seven months later (in Christchurch at least) a much more sustainable picture is emerging, following significant mobilisation of resources and support (see section 3.3.1). This is evidence of what can be achieved with good oversight, management and support.

The partnership of ISR with Māori providers was also very precarious in October 2016, but has also experienced a significant turnaround (see chapter 6). The commitment of Māori providers to address family violence among their whānau was supported through hui facilitated by the National ISR team and the local ISR team. Most importantly, significant additional funding was sourced for dedicated Māori ISR positions.

> *... to see Te Whare Hauora and Te Puna and He Waka Tapu in a collaboration together, and to have these 10 [new] workers amongst them, feels really good for Māori. It's all focused on family violence. That's a good outcome because this has been the biggest injection of Māori workers to this system. Statistically, we still sit high in the system. (NGO)*

Providers who are tasked with working face-to-face with families report feeling supported by colleagues who sit around the ICM/SAM tables (as described in sections 4.1.3, 4.2.1 and 4.3.2). However, NGOs felt less supported by higher levels of ISR management. There was a sense of being expected to shoulder most of the work being generated by ISR, but with insufficient appreciation or respect. This is discussed further in section 7.2.

4.7_ Efficient case management

The inability of previous systems to monitor and keep individuals and agencies/NGOs accountable for actions has been a long standing problem. In response, ISR developed a custom-built database, the Case Management System (CMS), as a platform to share information around risks and safety planning among those involved in family harm cases (based on approved access rights). CMS also enables tasks assigned to individuals to be monitored with respect to both progress and outcome.

While there are still issues with the system (see section 7.6), it appears to have its strengths. As one NGO summarised:

> *It's definitely a good thing, it just needs some tweaking. It has a lot of potential. (NGO)*

4.7.1 _ Increasing accountability with CMS

Several agencies/NGOs spoke of improvements in individuals' performance due to the transparency created through the CMS system:

> *There's more transparency in your practice. There's more eyes on you internally and externally, looking at your tasks/updates. There's nowhere to hide if you're not doing the job. (NGO)*

The accountability ... it shows if you're doing a poor job, it's very visible. That forces people to up their game. What we would have gotten in FSN was 'NAH' – not at home. In the beginning, we started just getting NAH. We had conversations with them that this is a national database, the ministers are looking over this, plus they're monitoring what you're putting in there. Their feedback has significantly changed. And for me, under FSN, they just said, "Live with it, deal with it." With ISR, you can challenge and say, "We need more." We've got a framework to say that. (ISR – Waikato)

Finally, while time consuming, the ability of CMS to ensure people don't fall through the gaps was also recognised:

It's more time [now], you have to make sure you go into the system and you copy the lead person in, to make sure it's all going in there to create that picture. The system is designed so that people don't fall through the cracks. I think that's a good thing. But it has been more intensive, time-wise. (NGO)

4.7.2 _ Reduced burden on families to repeat their experiences

Increased safety planning created through information shared in CMS was discussed in section 4.2.1. Another efficiency raised by an ICM member was for the families themselves, reducing the number of times they have to repeat their story:

Yeah, and it's an absolutely huge amount of work because you can imagine there are a lot of people that either want to be shifted internally within Housing New Zealand or people that are applying – have arrived down here and they're applying or they're applying in Christchurch for the first time. But the good thing about that is we can get the information off the ISR database and we can get it to our housing case managers so the client doesn't have to repeat their story to everyone. (ICM)

4.8_ Unintended consequences

Possible unintended consequences of ISR were uncovered during fieldwork – some positive and some not. They tend to be sourced from individual comments and perspectives, rather than emerging as a main theme:

- **previous systems were now broken** – A few agencies/NGOs were concerned that while ISR was in fact just a pilot, in the meantime other systems and processes that were relied upon had fallen into disuse. Examples included a 'round table' of agencies/NGOs in North Canterbury, which had a deep knowledge of local families there (knowledge now allegedly lost), as well as the roster system among SFVs for allocating referrals:

  I don't know if I'd be disappointed [if the pilot discontinued] but I'd worry, the old system we had has been broken down. So it would be a scramble to [regain] what it would look like. It would go quickly back to a recovery mode, which could be what we knew best back, which wasn't the greatest, but we still had a system we were accountable to.

- **funding leading to competition among NGOs** – Significantly increased funding has been essential to enable NGOs to better manage the high volumes of referrals generated by ISR. In Christchurch, this increased funding has reportedly increased competition between NGOs, with an accompanying decline in willingness to collaborate.
- **reduced capacity for non-ISR work** – When additional ISR funding is provided, some NGOs rapidly redeploy existing staff into new ISR roles and then have to backfill vacated roles in order to maintain capacity to meet non-ISR contract volumes. Alternatively, experienced staff are recruited directly from other agencies to fill these roles. The result has been considerable strain on the NGO sector, with a reduced workforce to carry out other non-ISR work. NGOs are aware that MSD continues to expect them to meet non-ISR contract volumes, in spite of the inevitable reduction in non-ISR capacity due to higher priority attached to ISR.
- **less energy for prevention work** – One NGO raised concerns that the demands on agencies from delivering ISR might mean there is less time and energy for preventative work in the sector:

  > *... we've tried to take an across-the-spectrum approach so we do a lot of prevention, we do staff learning and development. But what would be quite interesting is seeing the sector as a whole has less energy to put into other collaborative work now, because everything's getting sucked into ISR, I would say. (NGO)*

- **increases in self-referrals** – There were anecdotal reports from several sources of increased self-referrals (to men to stopping violence programmes, and also to Refuges); however, these self-referrals did not receive funding through ISR, and created pressures on existing resources:

  > *Our self-referrals jumped through the roof. ... ISR is resulting in increasing workloads for HAIP [Hamilton Abuse Intervention Project]. There are flow-on effects for HAIP of the POS [Perpetrator Outreach Service] successfully engaging with perpetrators of ISR cases. More men are self-referring to their group programmes, which in turn require more facilitator and support person resource. (NGO – Waikato)*

This increase was thought to be a result of previous positive ISR responses (to themselves or someone they knew), meaning more families knew who to contact and more became willing to do so if they needed help. There was also a feeling that ISR had generally increased public awareness of family violence.

4.9 Summary

Findings from this evaluation suggest the ISR model is delivering on many of its core aims, and therefore, according to the programme logic, is well-placed to achieve better outcomes for families.

Some of the biggest achievements resulting from the implementation of the ISR model have been:

- **improved information sharing, risk assessment and safety planning** – the SAM table has enabled more complete information to be shared, thereby enabling more accurate risk assessments and enhanced safety planning. This has led to more efficient dissemination of information to frontline workers, including the introduction of previously unavailable information (eg, from ACC).
- **a wider awareness and responsiveness to family violence particularly among government agencies** – resulting in more collaborative, co-ordinated and efficient responses.
- **working with the source of the problem** – the nature of responses for perpetrators has changed and their reach and intensity have significantly increased. Perpetrators are now considered in every safety plan, with specialist perpetrator positions funded to provide one-on-one support.
- **more families offered and accepting assistance** – with ISR there is a meaningful response to every family harm episode, and three times as many families are now taking up the offers of support.
- **more efficient case management** – has been facilitated through a custom-built database (CMS). The CMS provides a platform for sharing information as well as for monitoring progress on the delivery of safety plans.
- **better understanding of capacity issues and mobilisation of resources in response** – provided through multi-agency national and local governance and management groups, together with dedicated ISR directors and operations managers. Together these groups identify issues, then develop and action solutions to effectively support the personnel delivering the ISR response.

05

Effectiveness of ISR for families

This chapter explores some specific emerging impacts of ISR for families and whānau. Expectations are that, where ISR interventions occur and support is offered:

- adult victims will be better protected and safer
- children will be better protected and safer
- perpetrators will be better supported to stop their violent behaviour
- families and whānau (including families from diverse backgrounds) will be supported to live in non-violent homes (see Figure 4.1).

Gathering evidence on the extent to which these outcomes are achieved, and how ISR has contributed towards them, is challenging. While evidence is readily available on perceived efficiencies resulting from the ISR model, linking these to improved outcomes for families is more difficult.

Data is presented from three sources, each with its own strengths and limitations. Again, it is important to acknowledge that it is not possible to directly attribute reported or observed outcomes to ISR on the basis of this data.

The primary source of the available data was interviews with selected ISR participants (12 victims and six perpetrators). While there are limits to the extent these views represent ISR participants more generally, this information allows the voice of participants to be included in this evaluation. These individuals provided feedback on their experiences of the ISR components (eg, working with IVS or IPS) and what they felt had been achieved through this support. Findings overall were positive.

Police data on family harm episodes allowed consideration of a larger sample of ISR victims and perpetrators, including more data on the frequency and severity of reported offending and victimisation in the six months before and six months after an ISR referral. This data provides a descriptive picture of participants' responses in terms of further family violence behaviour.

The final source of data includes unreported family violence. This came from a small sample of high risk victims and their self-reported experiences of family harm, before and after ISR.

Data from these three sources is presented in the following sections, beginning with administrative and other quantitative data on the family violence behaviour of ISR participants (victims and perpetrators).

5.1_ Quantitative data on recidivism and re-victimisation

5.1.1 _ Descriptive statistical analysis of Police reports of family harm

This first section looks at Police reports of family harm of ISR participants in the six months leading up to and including the ISR referral, and the six months following. This provides insights into the type of family harm occurring in families processed through ISR. Obviously, this data excludes any family harm event that has not come to Police attention; findings from the 2014 New Zealand Crime and Safety Survey (NZCASS) suggest that as much as 74% of family harm is not reported to Police.

A sample of 3,820 individuals were identified who had been referred to Christchurch ISR in its first four months of operation (4 July to 31 October 2016). The sample discussed here excludes those identified as informants, witnesses or children (under 15 years – unless they were identified as the primary victim). Included were 'primary victims' (42%), 'predominant aggressors' (42%), and 'subjects' (16%) ('subjects' are family members involved in a non-offence family harm episode where it is not possible to identify who the predominant aggressor or primary victim was). Analysis was carried out for the complete sample (see Figure 5.1) but also for just those identified as predominant aggressors (see Table 5.1). The sample included cases in all risk categories (low, medium and high; see section 1.4.4 for further details of the methodology, and Appendix 3 for characteristics of the sample).

> The family harm episode (index event) that resulted in the individuals being referred to ISR is included in the six-months-before period. It is not known for what proportion of the sample this occurrence would have been their first and last involvement with Police, and hence also unknown is the proportion who would have had no further family violence episodes regardless of the ISR intervention.

The following family violence indicators were analysed to provide a picture of the type of family violence behaviour occurring for those referred to ISR:[58]

- **1Ds** – episodes identified as family harm but where no offence had occurred (eg, a verbal dispute). These are the most common type of family violence episodes recorded and are recorded against all parties involved in the episode.

58 Data on the number of family harm episodes for the six months before and after their first contact with ISR were extracted from the Police National Intelligence Application (NIA) database. Data is based on occurrences records, and offence-related data relates to apprehensions not convictions.

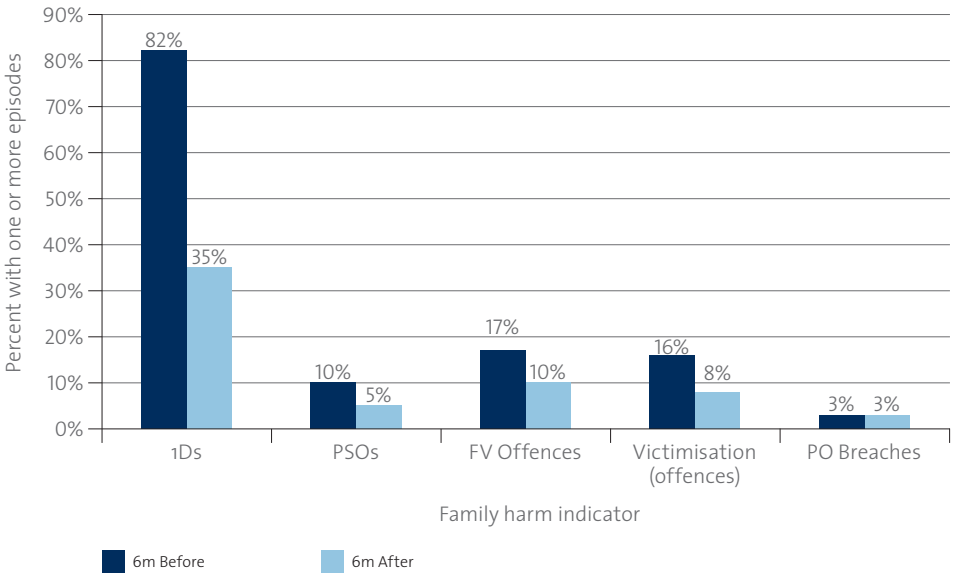
- **PSOs** – episodes where a Police Safety Order (PSO) was issued to the predominant aggressor (bound person). PSOs can only be issued where there is no evidence of an offence being committed but where Police have concerns for a victim's safety; as such they represent an escalation in seriousness compared to a 1D where no PSO was issued.
- **FV offences** – all recorded apprehensions for an offence where an offender is identified and the episode was flagged as family violence[59]
- **Victimisation (offences)** – all cases of victimisations (recorded offences as above except where the person's role is identified as 'Victim')
- **PO breaches** – apprehensions for breaches of Protection Orders (these are recorded offences).

Figure 5.1 presents the proportions from the participant sample who had one or more of these family harm episodes occurring in the six months leading up to their referral to ISR and in the six months following. This provides a perspective on the prevalence of these family violence indicators for those processed through ISR.

Note that the data presented relates to individuals regardless of their role at referral (ie, primary victims, predominant aggressors, or subjects), and not households. The nature of family violence is such that while a predominant aggressor and primary victim in a relationship can usually be identified if there is sufficient information, the family harm committed in any single episode can be committed by either party, as the primary victim may retaliate or act in self-defence.

59 All offences in any one family harm episode are flagged as family violence. In some cases this includes offences that are not related to the family violence. For example, if an individual is apprehended for a Male Assaults Female charge and for possession of drugs, both offences are flagged as family violence. For the purpose of this analysis only offence categories deemed to be family violence-related were included (ie, Violence, Sexual Violence and Property Damage). See Appendix 3 for more details.

Figure 5.1 _ Prevalence and type of family harm behaviour in the six months before and after first contact with ISR (n=3820)



The most common type of episode was a non-offence family harm episode (a '1D' – for example, a verbal dispute between a couple). Eighty-two percent of the sample (n=3137) had one or more 1Ds in the six months leading up to their ISR referral (the highest number being 13). This dropped to just 35% (n=1333) of the sample with one or more further 1Ds in the six months following.

Less than 10% (n=367) of the sample had been issued with one or more Police Safety Orders in the six months leading up to their referral, and this dropped to just under 5% (n=183) in the subsequent six months. These figures relate to the party identified during the episode as the predominant aggressor (the 'bound person'). This person can be ordered to leave the property and have no further contact with the primary victim for up to five days.

Seventeen percent (n=663) of the ISR sample had been apprehended as perpetrator for one or more family violence-related offences in the six months before referral to ISR (including their first ISR referral). The highest number of offences over this six-month period was 12. This dropped to 10% (n=392) of the sample in the following six months. As noted earlier, family harm is not always limited to one party, and in some cases the recorded offending was committed by the individual identified as the primary victim at the time of the referral to ISR (59, or 9%, of those with a recorded offence in the six months prior were recorded at ISR referral as the primary victim, and 55 or 14% of those with recorded offending once or more in the six months following – note these are not necessarily the same people).

The proportion of the sample who had been identified as a victim of one or more family violence-related offences dropped by half, from 16% (n=626) to 8% (n=312). The highest number of episodes of victimisation was 11 in the six months leading up to and including the referral. Of the victimisations occurring in the six months prior this included 52 individuals recorded at ISR referral as the predominant aggressor, and 48 of those recorded as being victimised one or more times in the six months following.

Recorded breaches of Protection Orders increased very slightly from 3.1% to 3.3%. However, the number of Protection Orders issued had also increased, with 19 issued in the six months leading up to ISR compared with 62 in the subsequent six months.[60] While numbers of Protection Orders issued are small, if ISR referral had assisted victims to apply for these orders this would be considered a positive outcome of ISR. Similarly if an applicant for a Protection Order was more willing to report a breach, this would also be considered a positive outcome.

Reported recidivism of predominant aggressors

A key question of interest is whether referral to ISR and subsequent tasks and referral activities result in a reduction in the frequency or seriousness of family harm experienced. However, this is difficult to answer, particularly when relying on Police data from reported episodes of family harm. From this data, if a decrease in reported family harm episodes is observed, it is not known if this reflects a decrease in family harm perpetrated (a positive outcome), or if the violence has continued but the victim's willingness to report the family harm to Police has decreased (a negative outcome).

With this important limitation in mind, Table 5.1 presents descriptive data on seriousness and overall frequency of reported family harm in the six months before and after first contact with ISR for those identified as the predominant aggressor at referral (n=1601).

- **seriousness** is based on a rating for the highest level of reported harm where a 1D=1, PSO=2, and family violence offence=3, regardless of how many occurrences. For example, if an individual has one of each type, they still score a 3, as this is their most serious type of family harm episode.
- **frequency** is based on the number of family harm episodes regardless of type (1Ds, PSOs or offences) and, in the case of offences, regardless of the number of offences at any one event. This equates to Police call-outs for family harm-related episodes.

Data for each predominant aggressor has been matched to show changes in frequency and severity of reported family harm for individuals. Data in rows reflects initial family harm behaviour for groups of predominant aggressors, and data in columns reflects reported recidivism in the six months following for each of these groups. For example, the first column presents those with no reports of family harm in the six months following ISR, with each row showing their pre-ISR frequency. Hence, looking at the second row, first column, you can see that 686 predominant aggressors had one reported episode in the six months before ISR but none in the six months following (relating to 43% of all predominant aggressors).

60 Counts of new Protection Orders issued were based on Police occurrence records of Protection Orders issued (coded '7P').

The shaded areas in Table 5.1 highlight where there were decreases in reported frequency and/or seriousness of family harm episodes for perpetrators compared with their pre-ISR records.

For two-thirds (67%) of predominant aggressors, either there were no further reports of family harm episodes (58%) or any subsequent episodes were less frequent and/or less serious than those in the six months prior (9%).[61] There had been an escalation in reported seriousness for 208 perpetrators (13%).

TABLE 5.1

Levels of seriousness and frequency of reported family harm for predominant aggressors in the six months before and after first contact with ISR (n=1601)

	Frequency of episodes in six months after ISR				
Frequency – 6m before and including ISR	0	1	2 – 4	5 plus	Total
0	23	11	9	1	44
1	686	195	132	23	1036
2 – 4	210	114	123	31	478
5 plus	7	9	19	8	43
Total	**926 (58%)**	**329 (21%)**	**283 (18%)**	**63 (4%)**	**1601**
	Most serious episode in six months after ISR				
Seriousness – 6m before and including ISR	None	1D	PSO	FV Offence	Total
None	23	12	1	8	44
1D	495	179	41	103	818
PSO	107	33	13	43	196
FV Offence	301	98	20	124	543
Total	**926 (58%)**	**322 (20%)**	**75 (5%)**	**278 (17%)**	**1601**

Note: Those with no family harm episodes in the six months leading up to referral are either high-risk prison releases where the offender had been in custody for the six months prior to referral, or a family violence occurrence for an incident or offence that was not considered to be a family violence occurrence for the evaluation (eg, property theft, breach of bail, or suicide attempt). See Appendix 3 for more details.

Overall results look relatively positive, and should allay any fears of a potential for the frequency or seriousness of episodes to escalate following contact with ISR. However, again it must be stressed that the degree to which the picture has been distorted by including the index event is not quantifiable.

61 Where there had been further episodes of reported family harm these were less frequent for 9% (n=142) of perpetrators and also less serious for 9% (n=151).

5.1.2 _ Victims' self-reported experiences of family harm

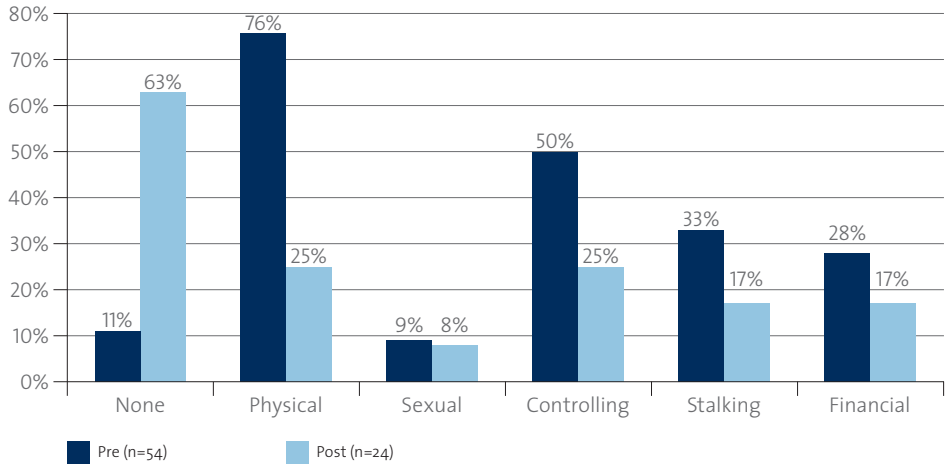
A small sample of high-risk victims (n=60) were assisted by IVS to complete self-reported assessments of experiences of family harm at intake and at exit, regardless of whether the experience was reported to Police. This included participants' self-reported experiences of five types of family harm (physical, sexual, controlling, stalking and financial) in the three months before ISR referral, and in the last three months. The average number of days for IVS support is 99 days (see section 1.4.4 and Appendix 4 for more details).

Unfortunately, pre and post assessments could only be matched for 19 cases. In some cases, clients had not yet exited, in others clients had discontinued contact and were unavailable, and in five cases they had completed an exit assessment but had no entry assessment (because they entered before the collection of self-report data began). Analysis was carried out on the complete sample and also on just the matched sample, with similar results being found. The findings below relate to the complete sample; results for the matched sample are given in Appendix 4.

Figure 5.2 presents self-reported changes in abuse experience for the complete sample. They reported decreases in all five types of abuse at exit, with the greatest decrease being in physical abuse (76% had experienced this in the three months leading up to their referral, and this reduced to 25% at exit). Of note in all cases where abuse was still being experienced (all types) it was reported to have reduced in frequency and severity.

Sixty-three percent of high-risk victims reported experiencing no abuse at exit. While for many this was because the relationship had ended or because their partner was in custody, it is nevertheless a positive outcome. Eleven percent had reported experiencing no violence at intake; these were invariably ISR referrals made in relation to high-risk prison releases, where the partner (current or ex-) had been in custody in the three months leading up to ISR referral.

Figure 5.2 _ Self-reported changes in abuse experienced by a sample of high-risk clients



5.2_ Victims

The views of victims and key stakeholders were sought about the services and support that victims and their children received under ISR, and the difference they thought this made to victims' lives. The views of victims themselves present direct evidence, while the views of other key stakeholders is indirect evidence.

In total, 12 female victims were interviewed: 11 who had been assessed by Christchurch ISR as 'high risk' and one assessed as 'medium risk'.[62]

Due to capacity issues, it was not always possible for high-risk victims to be allocated an IVS. The victims who were interviewed had been supported by support workers from three different organisations, two of which had IVS positions. All received intensive support in line with ISR guidelines for high-risk clients. The term IVS has been used throughout regardless of their official title, to protect identities of victims and advocates when a victim refers to their support worker by name.

Although the interviews were focused on the experiences and impact of ISR, only two of the 12 women had known that the IVS was in fact part of the Integrated Safety Response pilot. It tended to be the case that only through ongoing engagement (and evaluation interviews) did women became aware of the link between the support they received and ISR.

While victims were not necessarily aware of what ISR entailed, the response they received would have been different from that delivered prior to ISR. Those interviewed would have received more intensive one-on-one support from their support workers (IVS or IPS), would have had a multi-agency review of their case at ICM, and would have been initially identified as high risk following a different risk assessment process (SAM).

5.2.1 _ Initial engagement

Overall, those acting in the IVS capacity were seen by victims as highly accessible, and as providing timely and responsive support. The IVS's were described as good listeners, as able to build rapport, and as empathetic and caring.

Typically, these women first met with their IVS within a couple of days of the family violence episode to which the Police had been called.[63]

The women reported mixed feelings initially – relief, nervousness, happiness, not wanting to talk – when first contacted by the IVS. However, their fears and apprehensions soon dissipated once they had met up. For example:

62 Victims were recruited with assistance from three organisations to whom high-risk victims had been referred.
63 One reported it had been two weeks later.

So when I first met [IVS] what made me feel comfortable was just her ability to be empathetic and very supportive and ensuring that I had a safety plan. She really instilled in me having safety tools or a plan for my own wellbeing. … She made me feel respected because she actually thought about me, looking after me.

It was like talking to an auntie. [IVS] is very passionate about what she does.

Along with all of the help, you know the practical stuff [IVS] has done for me, she's authentic … I truly believe she cares about me, about my children, my family. … She's passionate and committed … [and] I know I'm not, we're not another statistic….

[IVS] let me talk about things in my own time and in my own way … [and] she really listened and seemed to be able to relate to what I was saying. I really felt that she got it – got me, you know?

Following the initial visit, the IVS visited them at home every couple of days, then moved to regular but less frequent contact (weekly or fortnightly) by a range of modes (face-to-face, phone, text etc). This continued for as long as the women expressed the need for it.[64] For example:

[IVS] definitely gave me what I needed at the time. She home-visited several times and always got back to me. We'd talk on the phone or text, whatever worked for me at the time.

Several women valued being able to maintain contact after the initial engagement, making contact with her through text or email, by phone, or by visiting in person:

We'd text each other and later on catch up weekly because I joined the women's group.

[IVS] helped me over the worst stuff…. This place has got really good vibes and I like that it's okay to drop in for a cup of tea…. That feeling encouraged me to join the women's programme and I'm really enjoying that and I get to say hello to [IVS].

They took a lot of comfort from the fact that the IVS was at the end of the phone if they wanted them. For example:

[IVS] being there. … Knowing I can text or ring [IVS] whenever and I'll get a response.

It was good to know someone was there whom I could contact if there was a breach of a Protection Order.

Many of the IVS had experience (both personal and professional) of personal harm and family violence. Sharing this experience with victims or just making it known to them made it easier for victims to relate to their IVS – it helped them to trust them, and to share their stories, fears, needs and goals. For example:

64 Some of these women had needed IVS support for more than the 12 weeks provided for under ISR.

[IVS] was amazing. The key was she wasn't a Fendalton lady. She had lived experience, was pragmatic, practical. She's great, she's awesome.

[IVS] was open and honest and shared about her own journeys, bringing up children and the hardships of being a mother. [And] she's genuine ... shared her own faults, the human side of her.... So I could see, sense her genuineness ... and it made it easier for me to talk with her, and to open up to her.

5.2.2 _ What they found helpful

Overall, the women interviewed had found the support provided by IVS to be helpful. On a 7-point scale, from 1 = 'Not helpful', to 7 = 'Very helpful', 10 of the 12 women interviewed rated the support they had received from their IVS as 'very helpful'.

Keep up the good work. Violence isn't right. Women are equal.

[IVS] is great. It's very important to have the service.

When asked what they had found helpful, many of the women talked of practical assistance, of emotional support, of being listened to and being allowed to move at their own pace.

IVS were seen as responsive in that they provided practical assistance in a timely way around the realities of family life, children and work commitments. For example:

I felt [IVS] was really on board and went out of her way to make things workable for me.... She worked around my needs, having to pick up and drop children off, and she didn't get phased by my busy-ness.

There was so much going on: moving to a new house, getting the kids sorted in school and college – and they were playing up and not easy to deal with – and just getting myself sorted: my health, my head, safety plan, work.... She just rolled with the flow and was on to it.... I'm not sure how she kept it all sorted but she really went out of her way, what with everything that was going on for me and my kids.

The women participants also valued the emotional support they received from IVS, such as attending appointments with them as well as reassurance and encouragement to try new things. For example:

What was helpful was [IVS] came with me to the WINZ appointment – and then she wanted to put in a complaint to WINZ because the case worker I had on the day was really distressing.

It sounds silly but just having someone to go with me to Work and Income, sitting with me. Normally I'm a pretty confident person and able to go to bat for myself. But when you experience that level of violence it knocks you back and you lose your confidence.

[IVS] helped me to stay on a positive vibe ... [and] they made me realise I can still achieve what I want to achieve.... She really picked me up, just sort of brought out a stronger person in me.

Also valued was the IVS taking the time to listen to women, being non-judgemental and allowing the women to tell their own story and share their experience at their own time and pace. For example:

[IVS] let me know what I was feeling was normal. ... It's nice to see [IVS] every week. She knows my history, is 100 percent on my side. She listens to me.

[IVS] is very understanding. Amazing. She took her time, moved at my pace.

He beat me up pretty badly and my family just want me to be shot of him. They think I'm crazy to have anything to do with him, even talking to him.... I'm moving to a new place and moving out of the area and not mixing with any of his mates. But it's confusing because he rings up and I miss him ... [and] it's hard to turn off the emotions.... [IVS] helps me to understand my feelings, and works things through with me. She doesn't judge me or cut me off.

Similarly, one woman appreciated the non-judgmental attitude of her IVS and said how important that was for their relationship:

I was already blaming myself for putting my children in harm's way, not doing something sooner, and [IVS] would say something like "Well, you've done something now, you doing something now." ... Not blaming me, not judging me. That was a big thing for me ... [and] for our relationship.

They appreciated being provided with tools and resources to help themselves, and being referred to additional programmes or services. Women participants talked about how their IVS had tried to link them and/or their children with other people or agencies including Police, emergency housing, ACC, Victim Support, Court Victims Advisors, and family violence prevention programmes. While a few women reported not wanting to be referred to other programmes and services, saying they only wanted the support of the IVS, most appreciated being referred. For example:

One of the pluses was linking me up to other services. Not straight away but later on.

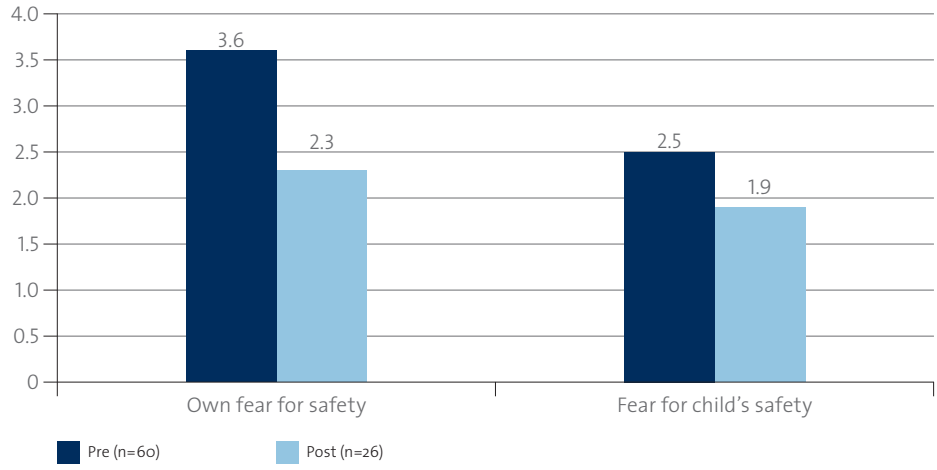
I started with the women's group and I'm loving that ... [and] that's been the stepping stone confidence-wise and with encouragement from the women to enrol on a literacy course at Polytech. That was a big step for me and I wouldn't have thought about it, or known about it, if I hadn't agreed to join the women's group.

5.2.3 _ Impacts of IVS support on victims

Impacts of IVS support on victims' safety

The high-risk victims who participated in the pre-post survey were asked to rate their fear for their own safety and that of their child at intake and exit (where 1 = 'No fear/ unconcerned', and 7 = 'Extreme fear'). Of note was that around a third of this group reported no fear for themselves at intake; for some this was simply because a partner was in custody, but for some there appeared to be a degree of 'denial' about the level of risk they were under. Despite this, as a group their fear at exit for themselves significantly reduced (see Figure 5.3).[65] Overall, they had less fear for their children's safety at intake, which reduced further at exit, though this was not a statistically significant shift.[66]

Figure 5.3 _ Self-reported fear for safety before and after IVS support[67]



Similarly, all 12 of the women interviewed said they now felt safer. All had safety plans in place; some commented on how their plans were evolving over time as their needs changed.[68]

For example, one woman who had recently sold her house spoke of the assistance she anticipated she would get from her IVS in relation to safety at her new house. The IVS had also provided practical advice.

65 Mann-Whitney U, Z=2.39, p=0.017 (p<0.05).
66 Mann-Whitney U, Z=1.39, p=0.164.
67 Note that the sample size varies slightly from that presented in Figure 5.2, as more victims completed this self-report measure.
68 On a 7-point scale where '1'= 'No fear' and '7' is 'Extreme fear', most of these women rated their current fear of the perpetrator as a '4' or a '5'. On the same scale, one woman rated her current fear for her children from the perpetrator as a '7' and one woman rated it as a '5'.

Another spoke of her and her IVS's plans to review her safety plan three months prior to her ex-partner's release from prison. She explained it as follows:

> *If we look at realism, my ex-partner is released from prison in [X] month. He's determined to take my life, so do we feel safe? No. Have we had enough time to integrate services we need? Yes. So [IVS] in her wisdom has said that three months prior to release, we will come back together in that regular time and we will start preparing for what released safety looks like.*

Four mentioned having had Police-monitored alarms installed at their homes. Two had subsequently had these taken out, but they still felt safer than they otherwise would have before ISR.

Three of the women mentioned they had been assisted by an IVS to obtain a Protection Order.

Impacts of IVS support on victims' wellbeing

Of victims participating in the pre-post survey, their allocated IVS rated their progress on several outcomes. In relation to wellbeing and confidence, IVS reported for 80% of clients that this had improved at exit.

Not all of the interviewed women could identify specific ways in which the ISR/IVS had affected their wellbeing. One woman simply said that she was not stressing nearly as much as she used to; another said that she was "totally less stressed" and "way better now"; and a third said that she "feels a lot better".

One woman mentioned that her stress levels had not really changed, but were "just different". She explained how she'd never been out of any relationship before. Until very recently, her ex-partner had always been in the picture. She now had two children to care for on her own and was in her second year of study, so there were different things to worry about.

Impacts of IVS support on victims' ability to cope with day-to-day life and challenges

Of the victims participating in the pre-post survey, their IVS rated 79% of them as overall having improved coping skills at exit.

Of those interviewed, some linked the support from IVS with an improved ability to cope with day-to-day life and challenges. One woman relayed that with the support of the IVS she was now feeling much stronger than three months ago and was thinking more clearly than she had in years. Another mentioned how the IVS had provided a good listening ear when she had had problems with her flatmates (which had since been resolved).

Impacts of IVS support on victims' relationships with family and friends

For those women who mentioned the impacts of IVS support on their relationships with family and friends, almost uniformly these impacts were favourable. One woman mentioned how she was now able to "open up more" with her family. Another commented that she now had a stronger relationship with her mother and brother as a result of the events following referral to ISR.

Impacts on trust and the likelihood of reporting family violence

High-risk victims who completed the 'post' survey (n=24) were asked how their trust in Police, other government agencies, and community organisations had changed since contact with ISR/IVS. Improvements in trust were most notable in relation to community agencies:

- 76% reported 'more' or 'complete' trust in community organisations
- 48% reported 'more' or 'complete' trust in Police
- 24% reported 'more' or 'complete' trust in other government agencies.

The women who were interviewed were asked a similar question, and all rated their current level of trust in community support agencies as a '7'. Some specifically mentioned the organisation that had supported them. Their trust in Police varied from a '4' (the mid-point) to a '7' (high trust).

Two women implied they would not now hesitate to call the Police, or to press charges, if they were involved in other family violence episodes.

Speaking about wider ISR-linked support, one woman said:

> *The relationships have encouraged me enough to stay on this waka [referring to ISR].*

5.2.4 _ Impacts of IVS support on victims' children

All but three of the women interviewed were caring for babies or children. All thought that their children were safer now. One spoke of her four-year-old son now being "bubblier" and having "come out of his shell". She thought he was now more outspoken, argumentative in a good way, and feeling more secure. Another reported that her son used to be scared and jumpy if he saw a male passing the house, fearing it was his father, but no longer was like that; her daughter was happier and back to her "sassy self". One mentioned that her five-year-old son was attending a tamariki programme, which had been "wonderful".

Three of the women had left what had been long-term relationships. They spoke of the negative impact of the split on their adult children. Two noted that their adult children had taken up counselling to help them cope.

One woman spoke of her daughter not coping well. The IVS had given her the name of an Aviva staff member, but her daughter had yet to take this up. Nonetheless, it was a comfort to her mother to know the service was available.

One said her children had been shocked that things had escalated to a point where she and her husband had separated (the violence had largely been hidden from the children.) Her son was now more protective.

Another said she was hoping that in time she would be able to restore her relationship with her daughter.

5.2.5 _ Victims' views on the impact of ISR on the perpetrators

Of the 12 women interviewed, all had ended the relationship with the person who had perpetrated the violence against them. Three of the perpetrators were currently in prison.

Six women who offered observations regarding possible changes to their perpetrator's behaviour believed that the person probably had not changed. This belief was often based on whom the perpetrator was mixing with (eg, friends and associates who were drug users or dealers); where the perpetrator was living (ie, close to the same friends and associates); or the belief that the perpetrator did not want, nor feel the need, to change his behaviour.

> *He was inside for a short time, but he's out now. He's living with [a relative] but I hear he's still taking 'P'.*
>
> *He's a bully and has a domineering personality. He's highly educated, articulate and has a good job. He's not going to change. No, he doesn't believe he needs to change.*

5.2.6 _ Suggestions for improving support from IVS

Overall the women interviewed were very satisfied with the support they had received from their IVS.[69] All 12 women thought their needs had been met, or mostly met, by the IVS (and by implication by ISR). They spoke glowingly of the support the IVS had given them, saying for example:

> *I would be lost without [IVS]. She is an anchor, a voice of reason.*[70]
>
> *[IVS] goes above and beyond. I think she's wonderful.*
>
> *She's professional, involved, knowledgeable.... If she doesn't have the info she goes and gets it. She knows process.... [She's] exceptional.*
>
> *[IVS] ... put me at the top of the list. It made me feel very special.*

69 Nine of the 12 reporting being 'very satisfied' with the support their IVS had provided.
70 A detective also rings her quite regularly.

These women were asked for suggestions as to how the support they had received from their IVS could have been improved for others like themselves. Overall, they were very positive about the support they received from their IVS and offered few suggestions.

Two of the 12 mentioned counselling, suggesting they still had some level of unmet need. One mentioned she would have liked one-to-one counselling earlier. Another said she would have liked more communication with her IVS and another that she had found the slow pace of the court process frustrating.

One woman hoped that the different services could work better together:

> *It's really sad. It's competition. You can work with us [NGO 1] but not with [NGO 2]. You can work with [NGO 2] but you can't stay at the safe house.... I needed a safe home but also extended services for me and my children, and us moving forward with our safety plan. That was the breakdown.*

Facilitating more collaborative work by agencies is recognised as an area requiring attention in Christchurch. Contracting arrangements and competition for funding have worked against a more collaborative environment.

One woman mentioned that victims should be able to stay in the environment they want and be supported there, rather than have to move to a safe house. Another thought organisations needed to better advertise their services, as she wouldn't have known that the service supporting her had existed if they hadn't reached out to her.

Two women would have liked more support around accommodation. For one Māori woman this related to having to move into temporary accommodation, as she needed to move out of the house because the perpetrator and his associates live in the neighbourhood. In order to "move on with her life" – which included her daughter returning to her fulltime care – she felt she needed permanent as opposed to temporary accommodation. She acknowledged that her IVS had advocated strongly on her behalf with Housing New Zealand, but the woman had not been successful in securing permanent accommodation (at the time of the interview):

> *I want to start my new life. I have a sense of urgency. I don't have a sense of belonging or a foundation and I need this to move forward.... so moving into temporary accommodation is like having to put things on hold ... and I need a house to get my daughter back ... and I feel weak in my addiction ... and not having my own place means it's going to be too easy to go back to taking drugs.*

Similarly, another woman felt temporary housing was unhelpful when what she most wanted was to make a clean start and get her life back on track. Moving to permanent accommodation would have made this more real:

> *I needed to get out of this house, out of this area, so they told me to give notice to my landlord. I did that and now I've got nowhere to go. I've been offered temporary accommodation but I don't want to have to move twice.... I want to get my life back on track so I can get my daughter back.*

One woman would have liked access to a Kaupapa Māori and whānau-centred approach as part of the support she received (this point is discussed in more detail in chapter 6).

A Māori woman had consciously made a choice to attend a non-Māori service for reasons of privacy and confidentiality. She also appreciated the professionalism offered by this service and was extremely happy with the service she received. She did however feel the service could be further improved with the inclusion of more tikanga Māori such as karakia as part of a programme. The service was open to and supportive of her taking on this cultural leadership, but she would have preferred to have been a participant only:

> *The group was half and half Māori and non-Māori and I felt they really appreciated the taha Māori [Māori aspect] that I brought to the group. There wasn't a karakia as part of the process and it [karakia] is something that I just naturally do and could bring to the group.... And I thought f**k here I go again running a programme, I'm supposed to be participating; and it's up to me to maintain the taha wairua [spiritual protocols]. That's where I thought when it comes to taha wairua the service really needs training and support because they [programme/organisational staff] are so willing....*

5.2.7 _ Key stakeholders' views of emerging outcomes for victims

Key stakeholders gave numerous examples in support of their views that adult victims and their children were better protected and safer as a result of ISR than they otherwise would have been.

As noted in the introduction to this chapter, it is not always easy to isolate the extent to which ISR contributed to observed outcomes and how responses differed from pre-ISR. However, the response received by those featured in case studies would have been different. All cases would have initially been triaged following a multi-agency review, a family safety plan developed and monitored through CMS and where applicable an independent victim or perpetrator specialist assigned. Also different, but hard to isolate, is the impact of improved efficiencies resulting from ISR, such as enhanced information sharing and collective working among those involved in delivering ISR.

The following three case examples were extracted from ISR weekly reports ('good news stories') and have been selected to illustrate positive outcomes for families processed through ISR.

Case 5.1 In this case, a woman was made more aware through ISR of the safety risk her male partner posed to her and her children. She left the abusive relationship to live in a safer environment with the children.

The woman (the primary victim) was living with her male partner (the primary aggressor) and children. The Police were called to their home for a family harm episode and the case was referred to ISR.

The case was discussed at the SAM table, and a family safety plan developed.

An advocate was tasked with making contact with the woman. It came out that the woman had not realised she'd been living in a violent relationship for 10 years, since her partner had not physically assaulted her or her children. He had punched holes in the walls and had threatened to kill her and their children (because they were "too expensive") and to kill himself.

The advocate supported the woman and encouraged her to report the ongoing abuse to the Police. The Police issued him with a PSO and removed his weapons.

The woman is no longer in a relationship with the man. She continued to be supported by the advocate until she was safe and going great and her (other) family were back in her life.

Case 5.2 Here the risks to a child were quickly responded to following an ISR referral and the child was made safer and longer-term supports were put in place.

Police had been called out to a family harm episode. The man (the primary aggressor) was arrested for assaulting his new partner's six-year-old son.

The boy had a history of being assaulted by other adult carers.

His biological father had died about a year before the child's latest assault (that is, the latest assault that had come to Police attention). At the time of his father's death the boy had been referred to Oranga Tamariki but had not met the agency's threshold for receiving care and protection.

A phone call from the SAM table to a partner NGO meant that a worker from that NGO was able to respond immediately to the boy and his mother.

The boy promptly received individual counselling through the NGO and has since been referred to an appropriate children's programme.

The NGO also supported the boy's mother. The NGO's prompt actions have contributed to the mother's and son's safety in the longer term.

Case 5.3 This case (from the Police) is another example of how the risk to a child was quickly responded to and the child made safer once the case was referred to ISR.

An Asian couple had married despite being mismatched according to their respective caste statuses. They had an infant child.

The couple applied to Immigration for refugee status on the basis that they feared death if they returned to their home country, but their application was declined. Both adults threatened suicide and to take the child's life.

The case was discussed at SAM. The family safety plan included a meeting of professionals to address safety issues. MVCOT was tasked with obtaining an order to uplift the child. The order was successfully executed by Police staff in the Family Protection Team, and through ISR the child has been made safe.

5.3_ Perpetrators

ISR represents a significant shift in responses for perpetrators of family harm. In the past there have been a range of mostly mandated safety measures that target perpetrators, such as stopping violence programmes delivered by Corrections and community organisations. However, the nature of responses has changed and their reach and intensity significantly increased through ISR; for the first time in ISR sites every perpetrator in every family harm episode is now considered and included as part of an ISR family safety plan. Also, dedicated independent specialist positions (IPS/POS) have been created to work one-on-one with perpetrators.

Through ISR, agencies/NGOs are assigned to work with perpetrators to minimise the risk of further violence. For example, a justice sector partner may be tasked with locating an offender and arresting and placing them in custody, or optimising their bail or parole conditions. Meanwhile, an NGO is tasked with engaging with the perpetrator to offer them support to change their behaviour and stop their use of violence.

ISR always planned to respond to high-risk prisoners near the time of their release, and therefore the work inside prisons has been a positive development. The majority of high-risk perpetrators are sentenced to imprisonment, and this presents an opportunity to begin work on behaviour change. In Christchurch access has been granted for the IPS and POS to work with both remanded and sentenced prisoners.

5.3.1 _ Perpetrators' views

The focus of interviews with a small sample of perpetrators was on the support they had received and its impact on their behaviour.

Five male 'high risk' perpetrators were interviewed who were being supported by an Independent Perpetrator Specialist (IPS) as part of Christchurch ISR. All had voluntarily engaged with the IPS.

One female perpetrator was interviewed in the community. While no formal risk assessment information was provided, assessment as low risk seemed likely, based on the information shared by the perpetrator. This was a first-time incident, with verbal abuse, anger and aggression, and with low-level application of force and physical restraint. The victim moved out of the family home for a short period of time (and moved back after a few weeks). Both the perpetrator and the victim received counselling and support in relation to anger and behaviour management. The perpetrator has been encouraged to enrol in community continuing education courses and the victim is able to contact the organisation for any reason, if she feels it is needed. There are minimal concerns about a repeat episode.

Of the male perpetrators interviewed, one was serving time in prison and near the end of his sentence, three were on remand in prison awaiting sentence, and one was serving a community-based sentence. None was aware of the fact that their IPS support was part of the wider Integrated Safety Response.

The four in prison had met with the IPS once a week at first, and then moved to fortnightly. The amount of face-to-face contact they had had with the IPS had varied from two to more than 20 sessions. The man serving the community-based sentence had met with the IPS every fortnight.

Of the five, two said the relationship with the person they had perpetrated violence against had ended, and three said they were still in contact and hoping to maintain a relationship with the person.

The men reported mixed feelings – including curiosity and suspicion – when they had first met with the IPS.[71] All had continued to engage in subsequent therapy sessions despite initial doubts:

> *I thought "What does this f ****er want? ... I'll go and see what he's up to."*

> *I was hesitant at the start. I thought: "Is this guy all there?"*

> *The first few sessions were a bit iffy, but the last 12 to 15 have been brilliant.*

The personal qualities of the IPS – especially his ability to "get alongside" the men in a gentle way – was what mostly kept the men coming back. They liked his use of simple language, and they came to trust him:

71 Case managers first sound out whether they might be interested in accessing IPS support.

He's a good fella. He uses layman terms and keeps it simple. He spoke to me, not at me.

He's not forceful. He sits beside you. He gets what's going on. It's not "You must …." He role-plays how you should treat people.

We've got things in common and – music, kids and we joke around. He says: 'I'm better than you at playing guitar." I say: "But at least I can sing!" He is someone I trust.

The most recent of the recruits, though, acknowledged a self-serving motive for engaging:

It looks good to the judge to be doing stuff.

Responses from the men on remand in prison awaiting sentence suggest that being offered support from an IPS, at such a time when not much else is on offer, can be particularly beneficial:

I wanted to look at things and understand why I was here…. It was a good time.

Word about IPS support had spread to other prisoners, who had asked how they might get referred for it.[72]

On a 7-point scale where 1 = 'Not helpful', to 7 = 'Very helpful', all five who were interviewed rated the support they had received from the IPS as 'very helpful'. And on a similar scale, all were also 'very satisfied' with that support.

What was helpful?

The men we interviewed mentioned several aspects of IPS support they had found helpful. Much of it came back to the IPS himself – his personal attributes, his methods, and his messages:

You can relate to him. He says: "Can I tell you a story?" and boom! you get something out of it.

He got me to open up. [I'd] been a long time all locked up…. My heart felt better.

[The IPS's] thing is prevention is better than cure. He's at the top of the cliff with you so you don't go over the edge. That's what you want.

He would go over stuff a lot explaining it to me…. After he went over it a few times I got it and it finally stuck in. … Then it's just practising it when you get out.

72 A key stakeholder relayed how some prisoners had been approaching him saying: *'Hey, mister, when can I see this [IPS's name] character?'*

Feedback from the men spoken with was that the support they had received from the IPS was much better than any similar support they had been offered before. For example:

> *I'm 50 and have tried heaps of counselling. This is hugely, a hundred times, a thousand times better. He gives you a coping mechanism.*

Among other related aspects that the men identified were that the sessions had:

- helped them understand the need to take responsibility for themselves and their actions

  > *You have to own up for what you've done. I used to play the blame game, but now I say "It wasn't you, it was me."*
  >
  > *I've got trust issues [with my partner] but I know now I have to trust myself before I can trust other people.*

- given them strategies to help them better deal with future situations. Strategies they mentioned included:

  > *If I'm angry take 5, get up, and walk away.*
  >
  > *If something major happens, realise it is just part of the cycle and cope with it. Don't go on a linear path downward [mood-wise].*

What else might be helpful?

Most were initially stumped by the question of what other supports, assistance or advice (besides ISR) might be helpful. One simply said: *"It's just me. I need to sort my shit out before I can help my family."* On reflection, three of the four prisoners mentioned it would help them if they could continue to access the IPS on the outside.

5.3.2 _ Impacts of IPS support on perpetrators

Other positive impacts of IPS support related to wellbeing and relationships.

Impacts of IPS support on perpetrators' wellbeing

Three of the men mentioned feeling better or knowing how to improve their sense of wellbeing.[73] For example:

> *I'm happier and dealing with things better.... I'm better at problem solving now ... It's hard to explain but I'm looking out for myself now.... I'm more confident now than I was in the past. I get that it's about me and fixing me.*
>
> *I'm in a way better place now. [IPS] brought my spirits up.*
>
> *I know now it's my choice to keep myself well, to look after myself, do more exercise, eat healthy, take time to look after myself.*

73 We also obtained some other indirect evidence of these prisoners looking happier and walking away from trouble and fights.

One of the ways in which perpetrators' wellbeing is better supported under ISR in Christchurch is through the provision of a new service for perpetrators with mental health issues who may have previously struggled to get assistance because of 'behavioural' issues. Stopping Violence Services (SVS) is providing the service, which includes mental health assessments and interventions aimed at ending violent behaviour.

Impacts of IPS support on perpetrators' relationships

On a 7-point scale where 1 = 'Very unconfident' and 7 = 'Very confident', four rated their confidence to form or maintain respectful relationships at a '5' or higher. One rated his confidence at '3', adding "it needs more work".

A couple of men mentioned that accessing IPS support had made a positive difference to their relationships. Two specifically mentioned they wanted to repair or improve relationships with their children.

> *[Since the restorative justice meeting] I'm getting on with my partner now. My children are in their 20s. We're getting there, but there's ... a way to go yet.*
>
> *Relationships are better.*

Those on the inside were well aware of the challenges they would face on release, with all wanting to maintain contact with the IPS. One explained the situation like this:

> *I've done work in here but it is going to be about putting it in place when I get out. I can only test it on the outside when I get out.*

He thought continued contact with the IPS on the outside would help support him in making positive behavioural changes.

The self-reported behaviour of the sole man interviewed on the outside, who had been supported by the IPS while in prison, suggested that the content of the sessions with the IPS translated well beyond the prison walls:

> *I'm walking the talk now ... I get to practise what I learned ... I'm putting it into action all the time, like hearing what people have to say, like if someone is challenging you or something ... I listen now and respond better. It used to be just about my way, what I wanted.*

Impacts of IPS support on perpetrators' understanding of what causes violence and its consequences

The following quotes suggest there is greater understanding among perpetrators about the causes of violence and its consequences. The second one illustrates how greater understanding can be applied to achieve positive behavioural change:

> *I didn't really understand what happens with me when things came up. I reacted the wrong way. Now I understand my thoughts and feelings better.*
>
> *He [IPS] has shown me some tricks and I've used them a few times. They stopped me from hitting someone in here.*

On a 7-point scale where 1 = 'Very unconfident' and 7 = 'Very confident', the five men spoken to rated their confidence that they would not use violence in the home at a '5' or higher.

Impacts of IPS support on perpetrators' knowledge of services

None mentioned increased knowledge of services that are available and knowing who to contact (other than the IPS) for help. This may have been because four of the five were in prison.

5.3.3 _ Key stakeholders' views of emerging outcomes for perpetrators

Practitioners and justice-sector representatives who were spoken with were universally supportive of the view that perpetrators are better supported under ISR.

The IPS told of the feedback he had been receiving from the perpetrators that they weren't getting pulled so much into the negative prison culture and were feeling stronger in themselves and more able to make positive choices in that environment: *"They know they can do it differently.... They're basing their choices on their wellbeing, basing their choices on respectfulness to themselves."*

Another provider spoke of being able to support some perpetrators and how this service would never have reached them without ISR:

> *Through ISR we're seeing a number of people in prison who've been issued a Protection Order and aren't far from coming out or ones we may not have caught up with before. That is bound to help increase safety. (NGO)*

A Corrections representative was aware that word about the good work of the IPS service had spread among prisoners, who were increasingly asking how they might access it. Case managers had also observed positive changes in the prisoners accessing it. While the Corrections representative thought some of the perpetrators may have had an ulterior motive for engaging with the IPS based on a judge looking more favourably on them when it came to court, he thought this was only for a minority of prisoners – and in any case their motivation could change the more engagement they had. He thought the work was essential and should continue even if the ISR pilot didn't.

These key stakeholders also gave numerous examples to support the view that, through ISR, perpetrators are better supported to stop their violent behaviour than they otherwise would be.

The following example was extracted from an ISR weekly report.

Case 5.4 In this case a perpetrator was supported to stop violent behaviour that was associated with his mental health issues.

Police were called out to a family harm episode. The man (the primary aggressor) was found to be in breach of his intensive supervision sentence. (The sentence came with an order not to associate with the adult woman (the primary victim) whom he had previously assaulted with intent to injure.) The man had mental health issues and had been known to not always take his medication.

Through the case coming to the SAM table, the man was admitted to a residential care unit. Six months after the episode, he was reported to be doing well, his medication had stabilised his condition, and he was fully engaged in the programme.

5.4 Key stakeholders' views of emerging outcomes for families and whānau

While some practitioners and providers had been working in a family/whānau-centred way for years prior to ISR, the sense was that ISR had helped strengthen this approach:

> *What HAIP's done over the years is that every man that comes, whether self-referred or MOJ/Corrections, part of the process in engaging them into the programme is to get their partner's details so our women can make contact with them for help. ... We're trying to do this good practice stuff. We're working with him. Getting the partner's details. Even if she's an ex we'll contact her to see if we can support her. ... Our staff are doing work, wanting to work with families. ... It's not about ticking boxes, it's about making a difference. (NGO – Waikato)*

> *We're not working in isolation, so we can work with both parties in the family, as opposed to just this person. It's more immediate, faster. There's more info out there. We're having couples come in and be able to do sessions together and have safety planning at no cost. Cost has been a barrier previously. (NGO)*

They also gave numerous examples to support the view that, through ISR, families and whānau are better supported to live in non-violent homes than they otherwise would be.

Case 5.5 In this case a young couple with a new-born baby are supported through ISR to live in a non-violent home.

Police had been called out to a family harm episode at their home. The couple had been very co-operative. The man (the primary aggressor) had said he was trying to turn his life around and was no longer offending to support his drug habit.

The couple had asked Police how they might access relationship counselling and a Women's Refuge. Police had explained how they might do this and given them a Hamilton Police Family Harm Prevention Card, which contained the information they wanted.

The SAM table established that the man had not come to the attention of the criminal justice system for some time, and it deduced that he was genuinely trying to make some positive change.

A plan was developed to support the young couple to achieve a non-violent relationship.

Case 5.6 In this case a mother and her children are supported through integrated support and services to leave the children's father in order to live in a non-violent home.

The case was referred to ISR through a Police call-out related to a breach of a Protection Order. The mother (the primary victim) had suffered years of sexual abuse and violence from the father of their children (the primary aggressor). The mother had not reported this until recently. Shakti had supported the mother to apply for a Protection Order.

The SAM table assessed the case as high risk, and developed a plan through which ISR-connected agencies supported the family members. The pregnant mother and her children are being supported in the following ways:

- Housing New Zealand is renting a new house to the mother and her children
- MOJ is funding a safety education programme that the mother is attending
- Canterbury DHB maternity services increased the pregnant mother's safety through the development of a safe birth plan
- Work and Income is clarifying the mother's entitlements for income support
- Police are working with Shakti so that when the mother is ready she will be supported to make a statement about the abuse perpetrated against her by her former partner
- Stopping Violence Services is supporting the children's father through providing programmes.

5.5_ Summary

This chapter explored some emerging impacts of ISR for families and whānau.

Under ISR, the expectations are that: adult victims and children will be better protected and safer; perpetrators will be better supported to stop their violent behaviour; and families and whānau (including families from diverse backgrounds) will be supported to live in non-violent homes.

Together, the available evidence supports the view that the experiences of those referred to ISR matched all three of those expectations.

The data used came from three sources: interviews; self-report data from a small sample of 'high risk' victims and perpetrators; and Police data on family harm episodes. It was not possible to directly attribute change to ISR alone on the basis of any of these data sources.

The inclusion of the index event in the 'before' data is a limitation of the findings using the Police data. Nevertheless, the results are in a positive direction for ISR. For example, two-thirds of predominant aggressors either had no further reported family harm episodes or subsequent episodes were less frequent and/or less serious than those in the six months prior.

Key findings in relation to victims and children include:

- All 12 of the 'high risk' women victims interviewed said they now felt safer after having received IVS support. All had ended the relationship with the person who had perpetrated the violence against them. Three of their perpetrators were currently in prison.
- All 12 women were very satisfied with the support they had received from the IVS, and all 12 women thought their needs had been met, or mostly met, by the IVS. All these women had safety plans in place, with some mentioning having evolving plans that reflected their changing needs.
- Some linked support from IVS with an improved ability to cope with day-to-day life and challenges. A minority commented that the IVS support had helped reduce their stress levels or had helped mend relationships with family or friends.
- All of the women victims interviewed who were caring for babies or pre-school children reported that their children were safer and doing better since receiving IVS support.
- Sixty-three percent of a small sample of 'high risk' victims reported a complete cessation of abuse following their ISR involvement, with some of this due to the relationship having ended or their partner being in custody. These 'high risk victims' reported decreases in all five types of family harm (physical, sexual, controlling, stalking, and financial) at exit from IVS support compared with the three months leading up to their referral to an IVS. The greatest self-reported decrease was in physical abuse (from 76% down to 25% at exit). In all cases where abuse was still being experienced, it was reported to be reducing in frequency and severity.

- Key stakeholders also lent support to the view that adult victims and their children are better protected and safer when they are supported by ISR than they otherwise would be.

For perpetrators, the key findings included:

- Of the five male 'high risk' perpetrators interviewed who were being supported by an IPS, all five rated the support they had received from the IPS as 'very helpful'. The men interviewed mentioned several aspects of IPS support they had found helpful. Much of it came back to the IPS himself – his personal attributes, his methods, and his messages. And on a similar scale, all were also very satisfied with that support.
- Feedback from these men was that the support they'd received from the IPS was overwhelmingly better than any similar support they'd been offered previously.
- In terms of impacts of the support:
  - Three of the men mentioned feeling better or knowing how to improve their sense of wellbeing.
  - Four out of five were confident that in the future they could form or maintain respectful relationships, with one rated his confidence on a 7-point scale as at '3', adding it needs more work. Two men were already aware of positive differences in their relationships with others.
  - All five men rated their confidence that they would not use violence in the home as high ('5' or higher on the 7-point scale).
- Those on the inside were well aware of the challenges they would face on release, with all wanting to maintain contact with the IPS. The self-reported behaviour of the sole man spoken with on the outside who had been supported by the IPS whilst in prison suggested that the content of the sessions with the IPS translated well beyond the prison walls.
- Practitioners and justice-sector representatives who were spoken with were universally supportive of the view that perpetrators are better supported under ISR.

While some practitioners and providers had been working in a family/whānau-centred way for years prior to ISR, the sense was that ISR had helped strengthen this approach.

06

Māori and whānau experiences of ISR

This chapter first provides an overview and profile of Māori accessing ISR. It then goes on to discuss aspects of implementation of the ISR model with respect to Māori participants and then discusses Māori participants' experiences of ISR in Christchurch.

6.1_ Overview and profile of Māori

Māori make up 39% of all those entered into CMS; 22% of those entered in Christchurch and 58% of all those entered in Waikato. (It is important to note that this is not self-identified ethnicity, rather it is ethnicity as assessed and recorded by attending Police officers; historically, data relating to ethnicity is under-reported.)

In both locations, Māori are over-represented in ISR: Māori make up 19% of ISR victims and 23% of perpetrators in Christchurch, but constitute just 8% of the population of the greater Christchurch area. Similarly in Waikato, 53% of victims and 56% of perpetrators are Māori, while Māori constitute just 21% of the population of Waikato.

TABLE 6.1

Characteristics of Māori entered into CMS (all roles)

	Christchurch		Waikato		Total	
	n	%	n	%	n	%
Gender						
Female	2152	50%	4928	51%	7080	51%
Male	2128	50%	4697	49%	6825	49%
Gender diverse	4	0.09%	7	0.09%	11	0.1%
Age						
Young child 0-4	623	15%	1406	15%	2029	15%
Older child 5-13	768	18%	1786	19%	2554	18%
Youth 14-17	314	7%	712	7%	1026	7%
Adult 18-24	636	15%	1511	16%	2147	15%
Adult 25-34	885	21%	1882	20%	2767	20%
Adult 35-64	1013	24%	2197	23%	3210	23%
Adult 65+	39	1%	82	1%	121	1%
Missing	6	0.1%	56	1%	62	0.4%
Total	**4284**	**100%**	**9632**	**100%**	**13916**	**100%**

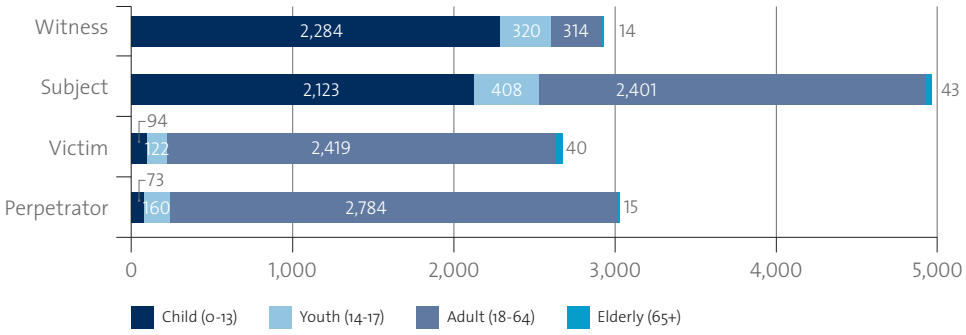
Note: This data was extracted together with their CMS 'person role'. If a person has had repeat episodes where their role changed, they will be counted more than once.

6.1.1 _ Person roles broken down by age for Māori

Figure 6.1 provides a breakdown of designated roles and age groups using the ISR recording described above. Thirty-seven percent of Māori have a person role recorded as 'subject', with 43% of these representing children (see Appendix 6 for descriptions of person roles).

This enables an insight into the recorded role of children (those 13 years and under) in the family harm episodes. Thirty-three percent of Māori recorded in CMS are children under 13 years old; this is higher than for non-Māori, where children make up 24%.

Figure 6.1 _ Māori person roles broken down by age



6.2_ Descriptive statistical analysis of Police reports of family harm

A sample of 3820 individuals were identified who had been referred to ISR in Christchurch in its first four months of operation (4 July to 31 October 2016) and who were confirmed as having a Police report of a family harm episode (see sections 1.4.4 and 5.1.1 for more details on methodology). Of these, 854 (22%) were recorded in CMS as being Māori. An analysis of their family harm episodes in the six months before and after their first contact with ISR is presented below. This analysis enables insights into the type of family harm occurring for Māori processed through ISR (note that the analysis excludes the estimated 76% of family harm that has not come to Police attention).

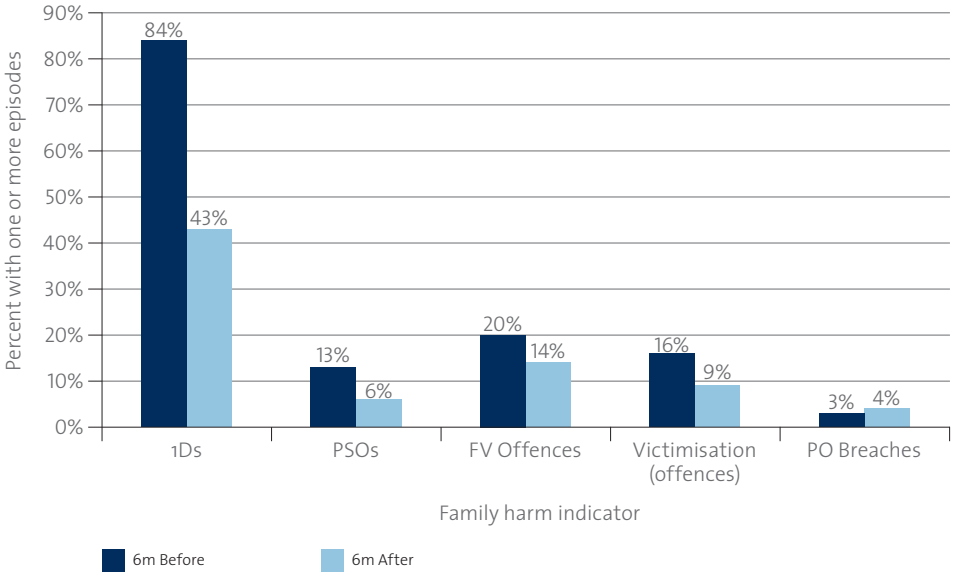
Data on the number and type of family harm episodes for the six months before and after their first contact with ISR were extracted from occurrence records in the Police National Intelligence Application (NIA) database.

> The family harm episode (index event) that resulted in the individuals being referred to ISR is included in the six-months-before period. It is not known for what proportion of the sample this occurrence would have been their first and last involvement with Police, and hence also unknown is the proportion who would have had no further family violence episodes regardless of the ISR intervention.

Figure 6.2 presents the percent of the sample with one or more of five types of family harm reported in the six months leading up to their referral to ISR and in the six months following.

Note that the data presented relates to individuals regardless of their role at referral (ie, primary victims, predominant aggressors, or subjects), and not households. The nature of family violence is such that while a predominant aggressor and primary victim in a relationship can usually be identified with sufficient information, the family harm committed in any single episode can be committed by either party, as the primary victim may retaliate or act in self-defence.

Figure 6.2 _ Prevalence and type of family harm episodes for Māori in the six months before and after first contact with ISR (n=854)



As with the complete sample (see section 5.1.1), the most common type of family harm episode for Māori was a non-offence episode (to which Police assign the code '1D' – for example, a verbal dispute between a couple). A similar 84% Māori (n=721) had one or more 1Ds in the six months leading up to their ISR referral (the highest number being 13). This dropped to just 43% (n=363) of the sample with one or more further 1Ds in the six months following. This reduction is less than it was for the whole sample, which dropped to 35% in the six months following ISR referral.

Māori had slightly higher rates of PSOs (13%, compared to 10% for the whole sample) and family harm offences (20%, compared to 17% for the whole sample). In the six months following ISR referral, the prevalence of PSOs for Māori dropped by a rate similar to the drop for the whole sample (46%, compared to 50% for the whole sample), and family harm offences dropped by a slightly greater rate (70%, compared to 60% for the whole sample).

Recorded breaches of Protection Orders increased very slightly, from 3.4% to 4.1%. However, the number of Protection Orders issued had also increased, from two issued in the six months leading up to ISR, to 12 in the subsequent six months. While the numbers of Protection Orders issued are small, if ISR referral had assisted victims to apply for these orders this would be considered a positive outcome of ISR. Similarly if an applicant for a Protection Order was more willing to report a breach, this would be considered a positive outcome.

6.2.1 _ Reported recidivism of predominant aggressors

In chapter five, analysis was conducted on seriousness and overall frequency of reported family harm in the six months before and after first contact with ISR, for those identified as the predominant aggressor at referral (n=1601). Of this group of predominant aggressors, 408 were identified as Māori, and results of a similar analysis appear in Table 6.2 below. As noted earlier, a key limitation of this data is that where a decrease in reported family harm episodes is observed, it is unknown if this reflects a decrease in family harm perpetrated (a positive outcome) or if the violence has continued but the victim's willingness to report the family harm to Police has decreased (a negative outcome). See section 5.1.1 for more details on analysis and procedures.

TABLE 6.2

Levels of seriousness and frequency of reported family harm for Māori predominant aggressors in the six months before and after first contact with ISR (n=408)

	Frequency of episodes in six months after ISR				
Frequency – 6m before and including ISR	0	1	2 – 4	5 plus	Total
0	6	2	3	0	11
1	150	53	36	10	249
2 – 4	55	34	36	10	135
5 plus	3	2	6	2	13
Total	**214 (52%)**	**91 (22%)**	**81 (20%)**	**22 (5%)**	**408**
	Most serious episode in six months after ISR				
Seriousness – 6m before and including ISR	None	1D	PSO	FV Offence	Total
None	6	3	0	2	11
1D	113	58	9	29	209
PSO	26	13	3	15	57
FV Offence	69	21	4	37	131
Total	**214 (52%)**	**95 (23%)**	**16 (4%)**	**83 (20%)**	**408**

Notes:

- **Seriousness** is based on a rating for the highest level of reported harm where a 1D = 1, PSO = 2, and family violence offence = 3, regardless of how many occurrences. For example, if an individual has one of each type, they still score a 3, as this is their most serious type of family harm episode.
- **Frequency** is based on the number of family harm episodes, regardless of type (1Ds, PSOs or offences) or, in the case of offences, regardless of the number of offences at any one event. This equates to Police call-outs for family harm-related episodes.
- Those perpetrators with no family harm episodes in the six months before and leading up to referral are either high-risk prison releases where the offender had been in custody for the six months prior to referral, or a family violence occurrence for an incident or offence that was not considered to be a family violence occurrence for the evaluation (eg, property theft, breach of bail, or suicide attempt). See Appendix 3 for more details.

The shaded areas in Table 6.2 highlight where there were decreases in reported frequency and/or seriousness of family harm episodes for Māori perpetrators compared to their pre-ISR records.

For just over half of Māori predominant aggressors there were no further reports of family harm episodes (52%, n=214). Where there were further reported episodes, for around one-in-ten of these perpetrators their occurrence was less frequent (10%, n=42) or less serious (9%, n=38) than in the six months leading up to ISR referral. There had been an escalation in reported seriousness for 58 (14%) of perpetrators.

Overall results look similarly positive to the whole sample, and should allay possible fears of potential for escalation in frequency or seriousness of episodes following contact with ISR. However, again it must be stressed that the degree to which the picture has been distorted by inclusion of the index event is not quantifiable.

6.3_ Implementation of the ISR model

There have been two key changes to the implementation of the model with respect to Māori: the relocation of the ICM meetings to Ngā Hau e Whā marae; and the additional resourcing provided to Kaupapa Māori services in Christchurch.

6.3.1 _ Relocation of the Intensive Case Management meetings

The ICM meeting was previously held at Christchurch Central Police Station on a Thursday afternoon. A decision was made by the ISR team to change the meeting time to combat typically low energy levels (particularly for some participants coming from the SAMs table), and to change the meeting day to earlier in the week. This allows more preparation time, and has resulted in a different mix of attendees – ie, new attendees as opposed to SAM participants staying on for the ICM meeting.

A key benefit identified in moving to Ngā Hau e Whā marae was a greater capacity to connect with Māori – with whānau, hapū and iwi and with Kaupapa Māori services.

> *The marae's a great place to have it ... [because we're] not doing enough in the Māori space. (Police)*

At the same time, the movement of the ICM meeting to Ngā Hau e Whā marae was viewed positively by some Māori stakeholders and responds in part to criticism that ISR was too far removed from Māori: the Māori community, the reality of Māori whānau, and Te Ao Māori (Māori cultural perspectives and values). However, while it is a positive step, and signals a desire to better engage with Māori, it does not go far enough for some Māori stakeholders in embedding a whānau-centred approach in the ISR model:

> *How can we embed a Māori response into the ISR trial, because that hasn't really been considered... There's a key difference between Māori organisations taking a referral, and having a model, a way of working, that's driven by Kaupapa Māori and takes a whānau-centred approach. (Māori NGO)*

6.3.2 _ Justice sector funding provided to Kaupapa Māori services in Christchurch

At the outset of the ISR pilot in Christchurch, the additional resourcing made available to Māori organisations was limited.[74] In the main, Māori providers were contributing to the SAM table, taking taskings, and accepting referrals without being resourced for this work. While they did this because of a commitment to whānau and whānau wellbeing (ie, reducing family violence and strengthening whānau), it placed considerable financial and human resource pressure on these organisations. It was also felt to be inequitable, as other organisations were being funded for the services they provided as part of the ISR pilot.

In April 2017, additional justice sector funding was made available to Māori organisations (with MSD Community Investment operating as the commissioning agency). The funding provided for:

- two Independent Victim Specialists (IVS) (this was reconfigured to be three positions)
- three advocates
- five Whānau Ora navigators.

6.3.3 _ Potential of additional investment in Kaupapa Māori and whānau-centred services in Christchurch and Waikato

The ISR Christchurch pilot was largely developed based on evidence emerging from the UK's MARAC model and on features of the Waikato-based Family Safe Network and Canterbury's Aviva ReachOut. However, also relevant is the growing body of evidence that whānau-centred responses to addressing violence can achieve positive results and that cultural values can influence the effectiveness and quality of a service.[75]

In recognition of these factors and some of the challenges raised in the interim evaluation report of the Christchurch ISR pilot in November 2016, particularly for Kaupapa Māori services, additional investment in Kaupapa Māori and whānau-centred services for Christchurch and Waikato was considered.

As noted in the previous section, additional funding was injected into the pilot in March 2017 to support more frontline services, including Kaupapa Māori services.

It is envisaged that the additional funding will respond to the issues identified in the evaluation for Kaupapa Māori services. These included:

- an urgent need for Kaupapa Māori providers to help the pilot fully implement a whānau-centred approach
- the need for a case management approach that is based on integrated plans with whānau at the centre

74 Initially there was funding for an IVS position through a partnership arrangement between Aviva and He Waka Tapu.

75 Te Puni Kōkiri (2013) *Measuring Performance and Effectiveness for Māori: Key Themes from the Literature.*

- the need for high-risk whānau victims to be given more choice between mainstream or Kaupapa Māori services
- demand for Kaupapa Māori services (including perpetrator services) exceeding supply, and the agreed need for urgent resourcing for Kaupapa Māori services.

At this stage the Christchurch ISR investment priorities being explored include:

1. investing in creating a 'whānau first' response (eg, accompany Police when they go to a family harm episode, including outside business hours) to de-escalate family violence situations and link whānau into follow-up whānau-centred services that can preclude the need for further involvement in the system
2. investing in Māori providers to participate in the daily Safety Assessment Meeting (SAM) and weekly Intensive Case Management (ICM) meetings and to influence the triaging of all cases involving whānau Māori for seven days per week
3. investing in enabling Kaupapa Māori providers to support the whole whānau, including tamariki, witnesses and perpetrators
4. investing in supporting whānau to plan to make themselves safe and to achieve their nurturing, cohesiveness and resilience aspirations (long-term wellbeing and advancement in Te Ao Māori). It is important to note that this is not necessarily NGO or provider-led: this is potentially an opportunity for a whānau-led response.
5. supporting the collection of whānau-centred evidence and data on what works for whānau, and building the evidence base.

At this stage the Waikato ISR investment priorities being explored include:

1. investing in whānau responders to assist whānau within 24 hours of a family harm call-out by Police
2. enabling whānau-centred Kaupapa Māori providers to participate in the daily SAM and weekly ICM meetings and to have responsibility for triaging all cases involving whānau Māori
3. enabling whānau-centred Kaupapa Māori providers to operate as a direct partner with the ISR governance structure
4. investing in the whānau-centred Kaupapa Māori family violence workforce
5. enabling whānau-centred Kaupapa Māori providers to support the whole whānau
6. supporting whānau to plan to make themselves safe in low to medium-risk cases
7. supporting the collection of whānau-centred evidence and data on what works for whānau, and building the evidence base.

6.3.4 _ Misunderstandings related to the Tū Pono approach

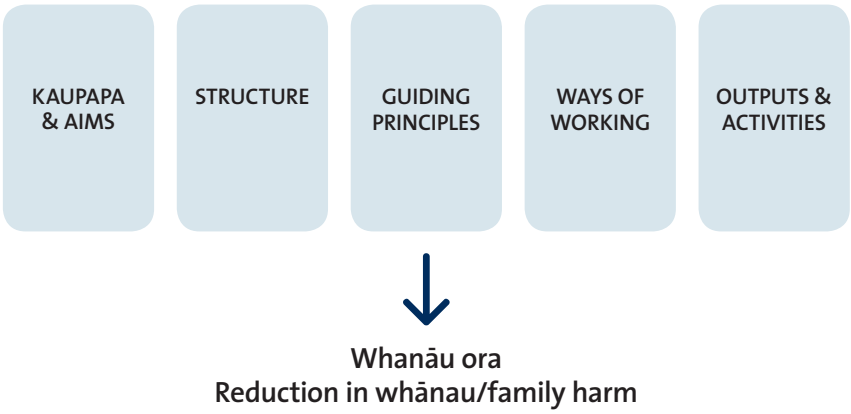
According to key Māori providers in Christchurch, although the ISR leadership has a genuine desire to engage more fully and effectively with Māori, signalled by the movement of the ICM table and additional funding, fundamentally the ISR leadership lacks a deep understanding of what a whānau-centred and whānau-led approach looks like and how it might be applied in practice. As a consequence the Christchurch ISR model fails to accommodate or fully facilitate a whānau-centred approach.

Tū Pono is the mechanism by which Māori NGOs and providers seek to give effect to whānau-centred services within ISR. However, the Tū Pono approach – its aims and objectives, and its structure, activities and ways of working – is largely not understood by those outside the Tū Pono membership. Tū Pono is more than a group of organisations coming together to provide co-ordinated services, and more than the provision of Māori advice and input at various parts of the process; although this appears to be what most ISR stakeholders and providers think Tū Pono is.

Tū Pono: Te Mana Kaha o Te Whānau is an approach as outlined in Figure 6.3.

Kaupapa and aims: Tū Pono promotes a whole-of-whānau strength-based approach at multiple levels, utilising tikanga and Kaupapa Māori principles of self-determination. It promotes primary and early intervention strategies to address the causes of family violence and to enable those at risk to access timely and culturally appropriate support and intervention.

Figure 6.3 _ Tū Pono approach



Tū Pono aims to:

- improve responses to whānau Māori engaged in the national ISR programme
- ensure the needs, aims and aspirations of whānau are central to and inform decisions, actions and interventions intended to serve their needs
- improve integration of services/responses for whānau in need/crisis
- identify challenges, constraints, gaps, needs and opportunities for improved responses and/or innovative approaches
- enable and promote whānau-led solutions reflecting the needs, strengths, aims and aspirations of whānau
- advocate on behalf of providers for appropriate resourcing to effectively deliver quality tertiary interventions at the interface with statutory organisations.

Structure: Tū Pono has a two tiered structure: collaborative members and an advisory group.

The collaborative members include:

- Te Whare Hauora (Ōtautahi Māori Women's Refuge)
- Te Puna Oranga
- He Waka Tapu
- Te Rūnanga o Ngā Maata Waka
- Te Pūtahitanga o Te Waipounamu (Whānau Ora Commissioning Agency)
- Te Rūnanga o Ngāi Tahu

The Tū Pono Advisory Group, which was established to provide guidance and support, includes representatives of these organisations, as well as Purapura Whetū (a community-based Kaupapa Māori health and social services provider); ACC; the Department of Corrections, Oranga Tamariki; Stopping Violence Services; and the Ministry of Social Development.

Guiding principles: The principles that guide and underpin the Tū Pono approach include: whole-of-whānau and strength-based; utilising tikanga; and Kaupapa Māori principles of self-determination. Other principles include: whānau as the starting point; whānau potential; enabling whānau action; whānau belief; and whānau results and frame the Tū Pono Whānau Response Model.

A whānau strength-based approach requires active and meaningful participation from whānau Māori – it requires putting whānau at the centre. It also requires timely service responses for whānau in crises after events – ie, services that respond to long-term needs, including rehabilitation, and multiple supports along a continuum of interventions.

Whānau have played a key role in the genesis of Tū Pono. In 2016 and 2017 over 600 whānau attended community conversations throughout Te Waipounamu, including in Christchurch, Morven, Invercargill, Dunedin, Hokitika and Blenheim. Some of the key themes or 'recipes for hope' that emerged from the community consultation were that 'The healing journey begins with whānau'; 'We need to give our children a voice to say no'; and 'We need zero tolerance for violence on our marae'. A key message was the need to address violence more broadly with whānau in Te Waipounamu. Thus the scope of Tū Pono, and therefore the response envisaged, is more holistic and more expansive then the current ISR model (see section 7.1 on the need for ISR to clarify its aims and scope and how it integrates into the wider system, which should include how it integrates with Tū Pono).

Ways of working: The Tū Pono Whānau Response Model sets out the following steps:

- **Whānau as the starting point** – acknowledging the hurt; time for kotahitanga, manaakitanga and whanaungatanga
- **Whānau potential** – the healing journey begins with whānau, with creating the space for whānau to articulate their dreams and aspirations
- **Whānau action** – applying strategies for change, strengthening whānau and improving the knowledge base
- **Whānau belief** – positive results help us to believe in ourselves; whānau have the capability to drive whānau leadership
- **Whānau results** – overcoming barriers and following resilient pathways
- **Whānau future outlook** – foundations for tomorrow, plans for the future.

Activities and outputs: Some of the Tū Pono activities and outputs include:

- engaging with over 600 whānau throughout Te Waipounamu to inform the Tū Pono response to whānau violence
- the Tū Pono Whānau Response Model
- the Whānau Ora Navigators Referral Process for Integrated Safety Response.

Coming together as Tū Pono has strengthened the relationships between Māori providers and NGOs.

6.3.5 _ Tensions and challenges that have arisen

This brief overview of the Tū Pono approach provides the context for understanding the frustrations and tensions on the part of Māori providers, NGOs and stakeholders, including whānau and iwi. Some of the frustrations and tensions are outlined below:

1. Invitations have been extended to the ISR community – but have not really been taken up:

   And I think that's the sadness ... that we have explained Tū Pono, we have invited ISR to our meetings, we've sent the invitation far and wide. The Police attended the hui, that was when she [the Police ISR project executive] was there, she brought down a couple of Police with her. They thought it was fantastic, but since then we've had nobody who's been interested in what this is. So we're operating in parallel worlds.

2. The principle is one of mahitahi (working together) but the flow of information and the opportunity to share information and input into decisions has diminished. The changes to the governance group membership mean reduced Māori and NGO representation. This has created a vacuum in terms of flow of information – both ways.

And you know, to be honest, since we have been removed, or withdrawn, or no longer on [the] governance board we've have virtually no communication from the ISR governance group. We don't get minutes, we've had one meeting with the ISR director ... but that's the only feedback we've had from the governance group. So we don't actually know what's happening with ISR other than what we get fed from those of us who are at the coalface. My information comes from the Māori providers and Māori networks. That's not to say those organisations are not doing a great job – they might be, but we don't know because we haven't seen any reports to tell us since basically December last year. So we're not getting information from the top, but the governance group itself.

3. The principle is whānau voice, whānau-led, and this is misinterpreted as being self-serving or organisationally driven:

   What Tū Pono has given us is a lever by which the voice of whānau gets to the table and it doesn't get blocked by others. [However,] the mainstream organisation thinking is, "Oh, that's just [Māori provider] or [Māori NGO] looking after their own purse strings." And what we've been able to do under Tū Pono is say, "Forget about the names of our organisations – this is an approach to responding to the needs of whānau, which actually ISR isn't doing."

4. The principle is whole-of-whānau, whānau wellbeing, and a long-term perspective, but the ISR response is limited to immediate safety:

   ISR refers the case on and you might get that immediate follow-up, but you don't get the whole whānau wellbeing.

   There is a philosophical clash between the whānau-centred, whole-of-whānau approach of Tū Pono, and the ISR approach of 'make safe' with some but less emphasis on the whole whānau and long-term perspective:

   We all know you can't bring somebody who's got difficulties and just fix it overnight. We take the model on board to fix the immediate problem, the presenting one. The biggest problem is bringing in the whole whānau. Because it's not just that one person that has a problem – the whole whānau has the problem and that's how we deal with it.

   You won't make a community safe by just fixing the one problem, because he or she is probably not the sole architect of the problem. It's probably happened in the whānau.

   You have a greater chance of success by working with the whānau, the bigger community, rather than just the individual. Sooner or later the individual is going to come out and mix with other people and you're going to need whānau, so we might as well go straight there from the beginning. Why wait around, let them make a few more mistakes before they realise it.

5. When you take a whole-whānau approach it takes more time and resources to trace, track and work with whānau members. This work is important for the immediate and longer term response as well as a preventative focus on building family strengths and resilience. The current ISR model does not appear to value the importance of whānau tracing and therefore it is not explicitly resourced:

That point about whānau contact tracing [is that] in sexual health for example we used to get funding as part of our contract for tracing of sexual partners for gonorrhoea, syphilis. So you'd have [a] contact tracing schedule put in place, who's been in contact with that family, 200 people, we'll go and make sure that it's happened. I've always thought with issues to do with whānau, whether it be Oranga Tamariki, whether it be whānau violence, you actually need to value the contact tracing, that we're not just dealing with a perpetrator in isolation. He has to, or she has to, commit violence against somebody and somebody is watching and somebody is hearing. So the tracing and contacts are important. Well surely violence or the care of our whānau is a serious problem [where] we would value those contacts that are around the victim, the perpetrator, the witness.

6. In a real sense, the breadth of work being undertaken by Tū Pono is largely invisible to the ISR community and therefore to the wider ISR regional and national stakeholders, with the exception of the direct engagement in core parts of the model (taskings, whānau support activities, etc). And if Tū Pono is largely not understood and invisible then it's not going to be valued; or the value of what it offers is lost to the wider network and communities:

   Amazing leadership of those kuia and koroua who were at that hui yesterday. It was phenomenal and that's exciting. But ISR governance group wouldn't have any idea that there's a revolution happening.... I just wish the ISR pilot knew that this is one of their greatest resources....

   My view a year down the track is that it feels like we're operating in parallel worlds. There is this amazing transformation happening with whānau saying we want to identify violence, we want to ring up, we want to talk to you, we're going to challenge this, we're going to deal to this as a whānau. We're going to stand up. What's powerful about this is whānau taking the lead. This is not about providers going in and telling whānau what to do. This is whānau saying, "Let us determine how we are going to deal with family violence within our whānau and help us to do this."

In summary, participants describe the current ISR context as "operating in two different worlds and at times in parallel worlds". How those worlds come together is the key challenge going forward:

... they still don't get the concept of Tū Pono. We're not visible; we're not on their radar. We're there as providers, you know, providers of service and maybe providing some advice, but they don't seem to have grasped the full concept of Tū Pono. And because they don't understand Tū Pono they don't see the potential, the opportunity of Tū Pono. It's almost like we're not relevant. It's like they only see the operational implementation side as opposed to Tū Pono as an approach, a philosophy, a commitment to a principle – being whānau-centred, of elevating whānau voice as the mechanism by which you begin to think about how you might engage with whānau. So we've kind of got, it's like parallel worlds....

6.4_ Emerging evidence of outcomes

6.4.1 _ Outcomes for whānau

It is too early in the life of the Integrated Safety Response programme to be able to discuss outcomes for whānau. Indeed the timing of this evaluation one year into the pilot, along with the focus of this evaluation report on the emerging evidence of the model's effectiveness, and the evaluation design and methodology, precludes valid analysis and legitimate reporting of outcomes for whānau. Further, only seven of the 18 interviews were with Māori (five females and two males). While their data and feedback is an authentic reflection of their experience, it is insufficient to provide robust and generalisable feedback on outcomes. Later in this section we provide two case examples that point to the impacts and emerging outcomes.

This section provides an overview of Māori victims' experience of ISR. The views of Māori women, with a few exceptions, were largely the same as non-Māori women. While we have re-stated the same or similar points, for reasons of conciseness we have not repeated the quotes (which can be read in section 5.2).

Overall, the five Māori women interviewed for this evaluation were highly positive about the engagement with their IVS – and by implication ISR, as this was the most impactful and memorable experience of their ISR journey. IVS were variously described as good at building rapport, as good listeners, and as allowing women to share information or carry out activities at a time and pace that worked for them. IVS had good networks with NGOs and government agencies, and this helped to get things started or completed more easily and quickly.

6.4.2 _ Experience of IVS support

Overall, Māori who were interviewed were highly positive about their engagement with their IVS (or equivalent).[76] A key strength was the ability of the IVS to build rapport and create a safe space where women felt comfortable sharing information.

They described their IVS as good listeners, as letting them share their story in their own time and in their own way. This combination of empathetic listening and rapport-building skills meant that women truly felt heard and understood.

The sharing of personal history and professional experience in relation to violence made it easier for women to relate to and build a relationship with their IVS. The knowledge that they had lived experience of violence and were also open to sharing something about themselves made it easier for Māori women to share information and talk to their IVS.

76 The victims who were interviewed had been supported by support workers from three different organisations, two of which had IVS positions. All received intensive support in line with ISR guidelines for high-risk clients. The term 'IVS' has been used throughout regardless of their official title, to protect identities of victims and advocates.

IVS assisted women in very practical and important ways. This ranged from helping them find accommodation (or assisting them to return home); developing safety plans; going with them to various appointments, such as WINZ or ACC; helping them apply for assistance (eg, to the Mayoral Fund) to cover existing debts such as power, or new costs such as a bond; and at times providing transport to appointments:

> *I think one of the first things she did was help with a Protection Order. And later on she helped me pay my power bill. She also put in place a counselling arrangement that I could go to when I was ready, and got me on a new drug and alcohol course and a domestic violence course.*

The women commented that the IVS were highly networked with providers, NGOs and government agencies. This made contacting organisations, filling out forms, and attending interviews faster and easier because they knew who to contact and often what was needed:

> *She knew everyone … she did seem to know a lot of people, who to contact and what to do and what forms to fill out. It was obvious that she had worked with some of them before because often all it took was a quick phone call and that saved time, or it helped to get things underway more quickly.*

The women who were interviewed were highly appreciative of this support, as the assault or violence episode disrupted existing arrangements, resulting in new tasks. For example a change in accommodation could mean a change of schools for children, or having to find temporary transport or after-school care because of the movement away from whānau and other support networks. At times it resulted in losing support from the perpetrator's whānau, again complicating day-to-day tasks as well as creating a new set of whānau relational dynamics.

> *When I first moved into my new house I had nothing and was starting afresh. And I'm from up north, so have no whānau here who might help me out … and these ladies here they got things lined up for my whare and helped me move in. And even at the Refuge they got a lot of stuff donated for my house. So when I eventually moved in I didn't have to take my babies to a cold house with no beds or blankets, and I didn't end up with big debt just to get started again.*

> *Initially I was going to attend a domestic violence and drug alcohol course with [provider]. But that didn't work out as some of [the perpetrator's whānau] were on the course or worked for the organisation running the course. So [IVS] had to do it all again and look for other courses or options for me … and you know it wasn't a bother to her because she got it that it didn't feel safe or okay for me to go those courses.*

Those interviewed valued the way their IVS made time for them, seeming to be available at all hours and at the drop of a hat. This was particularly important in the early engagement period. Women also found it reassuring to know that there was someone they could contact if they needed. Māori women also appreciated being able to stay in touch once their formal time together had come to an end or they had moved onto other programmes or services:

> *I know I can give her a call or send [IVS] a text. I know she's there. I haven't had to, but I know I can do. It's just good to know she's there.*

What they found helpful

When asked what they had found helpful, the women's comments included a mix of practical support and emotional support. Referrals to other services were also important.

Practical support from IVS included helping the women get through the many tasks or activities they needed to get done. IVS were seen as responsive in that they provided practical assistance in a timely way around the realities of family life, children and work commitments.

These women also valued the emotional support the IVS provided, such as giving encouragement and reassurance, or at times just showing they cared. The IVS also helped them work through conflicting emotions, such as still having feelings for the perpetrator who inflicted the violence. The women also liked that IVS recognised their need for support by accompanying them to meetings or appointments.

Being linked with other educational or support programmes was also appreciated. For one young Māori woman, once a safety plan had been put in place and she had moved into new accommodation it was suggested to her that she might attend programmes at another Kaupapa Māori organisation. She agreed and since then has participated in a parenting course, a women's group, and a budgeting course. She found these activities beneficial, and she values the relationships she has formed with staff at the new organisation, as well as with the women on the courses:

> *They referred me here and said this would be a really good place to start and to get more support from. They described what the course was about and I thought yes, that was something that could boost my little self-esteem [because] as I told you I was ready to pack it all in.... So I came and I just got really good vibes ... [and] it's been awesome. There's been a lot of support and you can come here and be yourself, and there's no judging.... I'm just loving it at the moment.*

Another Māori woman appreciated being given tools and support through a personal reflection process to identify her problem list (needs and goals). Once this was completed she was able to look at a range of options, both internal and external to the current organisation, and make choices and select other personal development and wellbeing options:

> *[IVS's] other huge strength and helpfulness, once I'd made my problem list, was linking me with resources to nut out where I was and how I wanted to move forward ... [and] this resulted in me doing the women's group and negotiating time off work to that every week.*

The following case study reflects the ISR journey and the impacts and outcomes for whānau as shared by women in their evaluation interviews in May 2017.

Case 6.1 This case demonstrates an integrated response involving Police, Te Whare Hauora and Te Puna Oranga. For Mere,[77] the support was seamless. Mere does not know the formal roles or titles of the people who supported her and her whānau, nor that she was part of an intervention called ISR (until this evaluation interview). What she does know are the names of the organisations, the names of the people who helped her, and that she and her children have been supported on each step of their journey to date.

Mere (the primary victim) is a young mother in her early 20s with three children (5, 6 and 7) living with her male partner John (the primary aggressor), who is the father of two of her children.[78] The children witnessed the episode.

Mere had moved back to Christchurch in late December 2016 so that she and her children would be closer to John. In January 2017, the Police were called and a Refuge was contacted. Once she got out of hospital (she thinks she was hospitalised overnight or for a couple of days but is not sure) Mere and her children moved into the Refuge. She later found out that John had been charged, placed in custody, and then released on bail.

Mere and the children had been staying with John but Mere had lodged an application with Housing New Zealand. Around the time of the episode, Mere had been told that a house had become available but that there was a four to five-week waiting period. Mere and the two children stayed in the Refuge until they could move into their new home.

During this time Mere worked with a Refuge kaimahi (worker) (she's not sure of their actual title), developing a safety plan and a budget, and making arrangements to move into the house. Mere recalls being taken to a lot of appointments (hospital, doctors and school) as she didn't have a car. Te Whare Hauora and Te Puna Oranga helped furnish the house from donations and helped with the move.

Mere has left the abusive relationship and her children are settled in their new home. Mere is participating in a women's group and is looking at some education and training options, most likely in the New Year. Mere has stayed connected to Te Puna Oranga through the women's group and through informal contact. The option of counselling is being explored, as behavioural issues have surfaced with one of the children.

John is out on bail and awaiting his court date. So far the children have not seen their father and they miss him. Mere plans to explore contact options for the children, depending on the outcome of the court case. She believes John is not a danger to the children.

77 Not her real name – a pseudonym has been used for this case study.
78 Not his real name – a pseudonym has been used for this case study.

Suggestions for improvement

Increased training and support to provide stronger cultural or tikanga practice: Two of the Māori women interviewed purposefully chose to access a non-Māori service. They did so for a number of reasons. These included:

- They saw the service they chose as the best organisation to meet their needs and the needs of their children. A key factor here was the other services they provided, particularly in relation to the ability to support and to access support and services for children.
- The service had highly skilled staff, who work from a strong, well-evidenced practice base.
- They were well known in the Māori health and social services sector and felt there would be greater degrees of privacy and confidentiality by not engaging with a Māori provider where they might formally or informally come into contact with whānau and past or present workmates.

As stated earlier, both Māori women were highly positive about their IVS experience, citing many of the attributes reported earlier – including relational and interpersonal skills, and being responsive, committed and caring.

> *[IVS's] ability always to draw back to what framework we're in, and for me she wove these three important areas together – my safety, my whānau and from a Te Ao Māori or Kaupapa Māori way – and she wove these into her response and the best way to work with me and my whānau.*

However, both women suggested aspects of the support and services could have been strengthened or enhanced if a strong cultural or tikanga practice had been embedded in the programme and the organisation. Given that they experienced an openness and willingness on the part of staff to the tikanga they facilitated, they saw this as an organisational capacity and training need:

> *Well ideally it would be great if [service] had a Māori equivalent to [IVS], who's awesome, or someone who was Māori that would walk alongside their whānau.... To me every organisation needs to have that Māori seat to make it safe for everybody. I'm not saying that they control or facilitate every Māori who comes through the door, but just that they are available.... There is also a need for training and support because the staff are so willing to [do] what is needed. So it just needs to be enabled.*

Māori providers as the 'default' referral allocation for Māori whānau: As discussed in the interim evaluation report in November 2016, the current ISR operating model means that whānau/victims assessed as high risk are automatically assigned to the one designated service; and are not able to choose an alternative service. These interviews suggest that women are accessing alternative services, albeit in this instance they are choosing a non-Māori organisation. To be fair, these women were sufficiently knowledgeable about the system to advocate for their preferred service.

The suggestion put forward by Māori providers and NGOs is that the default position for allocation of Māori should be to Māori organisations – articulating a kaupapa of by Māori and for Māori in the first instance, as well as the view that Māori organisations are best positioned to deliver support and services in a whānau-centred way. If Māori whānau would like to access a different service they would be supported to do this.

6.5 Summary

Māori are over-represented in family violence statistics (as both victims and perpetrators), and this is evident in both pilot sites. Hence it is important that ISR is responsive to, and effective for Māori whānau.

It is too early in the life of the programme to be able to discuss outcomes for whānau. Indeed the timing of this evaluation one year into the pilot and the evaluation design and methodology preclude valid analysis and legitimate reporting of outcomes for whānau. However, collective emerging evidence supports the view that Māori whānau, similar to other ISR participants, are better protected and safer.

There have been some key developments in the implementation of the ISR model with respect to Māori. The relocation of the ICM meetings to Ngā Hau e Whā marae, and increased funding to support the participation of Kaupapa Māori services in ISR. On the horizon is the potential for further resourcing to embed Kaupapa Māori and whānau-centred services into the ISR model, and supporting whānau to plan to make themselves safe.

However, despite a genuine desire to engage more fully and effectively with Māori, fundamentally the ISR leadership lacks a deep understanding of what a whānau-centred and whānau-led approach looks like and how it might be applied in practice. As a consequence, the Christchurch ISR model fails to accommodate or fully facilitate a whānau-centred approach. However, both sides are entirely motivated to achieving the best outcomes for whānau; hence, with some progress already made, it is likely that more can be achieved over the next two years of the pilot, providing conversations continue.

07

Opportunities to further improve ISR

The ISR model constitutes a significant change in the ways in which family harm is responded to at two sites in New Zealand. At the time of writing this report, ministers announced funding for the ISR pilots for a further two years. It is important therefore to identify any problems and use these two years to find solutions before any possible wider roll-out of the model. The interim report in November 2016 detailed a number of challenges and areas requiring improvement, most notably reducing the workload pressures required to operate the ISR model.

Since that report there have been significant improvements in how the ISR model is operating (see section 3.3 for more details). The SAM tables are running smoothly, with the Christchurch table described in the February QAIF report as "high functioning and well-structured with excellent information sharing and robust discussion as to risk tier evident". Recent attention on the ICM tables has been reflected in improved purpose, efficiency and outcomes. It appears attention now needs to shift to the work that is done away from the tables – this includes better co-ordination of tasks, more ownership of plans, and overall increased partnership between the NGO and government sectors in the community.

This chapter examines areas for improvement, including: clarity around aims and scope; engagement and partnership with the NGO sector; improving the implementation of integrated responses; and whānau and family-centred working, with a focus on children.

7.1_ Clarity around aims and scope of ISR

In the early stages of the pilot there was confusion around whether the ISR was aiming to achieve 'sustainable safety' in addition to 'immediate safety'. In particular this relates to the extent to which ISR can be responsible for achieving sustained, long-term safety, when that would likely require in-depth work to address the pervasive factors co-existing with the violence, such as addiction and mental health issues, or financial difficulties.

There appears now to be growing acceptance that ISR is just one part of a larger system and that it should focus on what is more realistic for ISR to achieve, which is the crisis response of securing immediate safety:

> *You've got a model that deals with – they come across the [SAM] table, the table makes decisions, they never see them again. It's not like we bring them back to assess it in any way or do anything like that. We just can't do that. So the suggestion that we manage sustainable safety is not realistic really. (Police)*

> *So for me it kind of works in terms of you have – very clearly this is what ISR is here to do, this is what it's here to achieve. So everyone's quite clear on what it is ISR is – that it is a short intervention to help the person's immediate safety needs, get them onto that road to being safe, and then transitioning over to the longer term, more sustainable working through some of those more long-term issues. (ISR)*

However, how this translates into practice is less clear, particularly in relation to realistic timeframes for the work tasked from the SAM table. It also relates to the appropriate point at which an FSP should be closed.

Family violence is complex and no two cases are the same. Engagement can be immediate for some, take months for others, and, for some, not happen at all. Some relationships have ended, others are 'on again off again', and others remain largely intact. When working with families their different make-up and cultural influences need to be taken into account. Clearly, the specifics of the model, including timeframes, need to be sufficiently flexible to meet these differing needs.

7.1.1 _ Clarity around roles

What 'immediate' safety means in practice is more challenging for certain ISR roles, particularly for IVS, IPS/POS, advocates and navigators.

> *It's still not clear whether it's about immediate safety or whether it's about longer-term prevention of reoffending. ... I think – well, I think they need to decide what it is, because if it's about – I think it's really about immediate safety, but recently they have put more resource into working with offenders. So I think that's good because that's more, you know, prevention. (NGO)*

For those struggling to cope with the high volumes of referrals, working in the prevention area was seen as important in order to reduce these volumes.

Most of the ISR NGO support worker roles begin with a task, 'engage and assess'; however, for some clients this process can take many weeks, particularly for some of the more vulnerable and higher-risk clients. An IVS described one case where it took 12 to 16 weeks to get the client to engage, and then another 12 to 16 weeks to then begin to carry out the work that was needed:

> *I had policemen telling me, "You'll never get her to leave, you'll never get her to leave. We've been trying." She'd been with this guy for nine years and just through my perseverance and not giving up and just being at the same place, in order to try and engage with her because she was so controlled, I was going to the school on a weekly basis and just waiting for her and if she wanted to talk she could and if she didn't she didn't. Did that for three months and then also built a relationship with her mother. Just through those actions and building that relationship with her mother, when it did come to crisis point she actually was finally at a place where she was ready to trust us and follow that process with us. And now they are in their own home, she's doing really well health-wise. The doctors and that are just so blown away by her health and how much that's improved not living in that stressful situation. She's really positive, she's got really good insight into what's happening for her daughter and identifying that and actually talking about that. (NGO)*

While not necessarily a common scenario, this example does illustrate the dilemma for deciding start and end points for ISR-funded intervention. This example clearly doesn't fit with the intended 12-week timeframe for an IVS allocation (or with any reasonable expectation of number of hours to be allocated to a case in a week). However, it clearly achieved positive and significant outcomes.

Previous chapters also detail the good work being completed by the IPS in Christchurch, where remanded perpetrators, when offered help at the right time, made a commitment to work on themselves and start making better life choices. However, this does not happen straight away, but develops in tandem with the therapeutic relationship over several sessions. Again, this fits awkwardly with the intended 12-week timeframe. But the value of this work is significant, as recognised by Corrections staff:

> *The need for an IPS or someone of that nature needs to be ongoing. Even if the pilot was to end on 1 July, there's still the need for these guys. I don't know how that works funding-wise, that's out of my department, but there is still a need – because the family violence and family harm is not going to go away. (Corrections)*

Achieving long-term positive outcomes for the most high-risk individuals is clearly something that needs to be funded. The challenge is working out whether or how this fits into the ISR model.

When the development of a trusting relationship has been a significant achievement in and of itself, a particular challenge is how to then transition a client to a new service after the immediate safety work has been completed.

Some NGOs seem better set up to begin initial work, but then may refer on to other parts of their organisation or to another organisation for longer-term work. In Waikato, where ISR covers rural districts, a process of 'handing over' clients to local providers had been worked out through necessity:

> *When I deal with rural cases, it involves touching base with local agencies and asking how they'd feel about re-engaging with them [ISR referrals]. So it's around walking them into those services and supporting them through that. Letting them know I'm there and these are the services I can provide, but also encouraging them to take on board what supports they have in their own communities, and also respecting those community agencies and the services they provide as well. Logistically, me driving to the countryside wouldn't work too well. That's the sort of model we're trying to put together in terms of the POS position and the work involved with it. (POS – Waikato)*

Working out the best approach and timing for a handover is the challenge, and it is not helped by the lack of research evidence on what is most effective to support these decisions. Current options include specialised navigators, short-term specialised teams (see section 7.1.3), or sufficient flexibility in the model to allow current ISR specialist roles to work with a family until they are ready to be transitioned.

Similar issues can arise around the role and purpose of the ICM table. As noted in section 4.4, one of the aims of multi-agency membership of ICM was to bring the right people around tables to be able to identify the wider or underlying risks and needs of the families presenting. While most accept that immediate safety is the primary role, some still question if it could also extend to fostering longer-term change:

> *It's still unclear what the ICM purpose is. There's different opinions on whether it's following up on immediate safety or if it's about long-term change, but no-one's really sorted that out. There needs to be an opportunity for ICM participants to meet outside of ICM to have those discussions about ICM. I really enjoy those meetings. (ICM)*

Part of the confusion may arise when underlying or related issues need to be addressed before the violence and safety concerns can be targeted. The ISR team gave an example of how a serious assault had been reported involving a couple living rough on the street. With this couple, their housing needs needed to be addressed before a support worker could begin to engage or start working on violence issues.

The overlap between the goals of immediate safety and achieving longer-term sustainable safety was also pointed out by a SAM representative:

> *Family violence is so complicated. It [ISR] is absolutely [about] immediate safety. But how we approach immediate safety can lead to better outcomes. How we engage, what confidence we give victims/perpetrators and what we say we are gonna do. How well we are resourced in the initial stage, because we're getting good outcomes in terms of perpetrator response. That's because we got in there quick. It has to be immediate safety done well ... that leads into long-term change. So, not following the old school of relationship break-up, Protection Order, PSO, or he's locked up. It has to be around, yes immediate safety, but who is going to work with this and how will we know if it's not working? (SAM)*

Separating immediate safety and sustainable safety is not always going to be easy. There are times when complex solutions are required to ensure immediate safety, and where some more resistant families may need both intensive and long-term interventions.

7.1.2 _ Understanding how ISR fits into wider family violence responses

To better clarify the role and scope of ISR, a useful exercise would be to map out how ISR fits into the wider system of responses. It is important to recognise ISR only responds to the 24% of family harm episodes that are reported to Police. The wider family violence response system also needs to consider prevention activities alongside crisis responses.

One way to approach this, suggested by an ISR team member, was to understand better what is currently being funded by whom, and for what purpose.

> *... if I use the word "government" I mean so ISR provides funding, MOJ provides funding, Corrections provide funding, and Community Investment, and now it will be Oranga Tamariki and it will be MSD because it's split off, so we've added another field. ... So all of these government agencies provide opportunities to the sector to provide services in many shapes and forms for family violence, which is great. But there's no alignment. ... So actually a mapping out of what we cover so that we look at it as a collective and we could look at it and go, "Okay, so where are our gaps?" Or, "So ISR funds this component, so why is MOJ also funding it?" Because what I'm seeing there is we're all in some way directly or indirectly crossing over each other and funding the same families. (ISR)*

This exercise may help to provide a more seamless 'all of government' approach, while also gaining better clarity around the limits of ISR, and which bit of the system ISR should be funding. This would also assist in defining the roles of ISR positions and developing contracts to fit these roles:

> *That's the first thing we need to be very, very clear on, what ISR is here to achieve and then from there it is about – so because from there what we can then understand what it is we need to do in order to achieve that. So what services do we need to purchase? What do your contracts need to look like? And what does our training and development need to do in order to support that? (ISR)*

This is perhaps no easy exercise. Family violence is rightly receiving a lot of attention at present and the landscape in which ISR operates is constantly changing (eg, the Workforce Capability Framework).

If the scope of ISR is clearer, it may improve thinking around when a plan should be closed, and up to what point an agency/organisation is required to update CMS. This perhaps will also assist in the operationalisation and use of the 'intervention' field within CMS.

7.1.3 _ Refinements to the model

In addition to gaining clarity around the goals of the ISR model, another aspect that deserves consideration is how the information arising from the face-to-face meeting with families can be woven into ISR FSPs.

> *What you have right now in ISR is the daily triage meeting, SAM, and at the daily triage meeting in ISR, you collate multi-agency info, determine a risk level, and they attempt to do problem solving at the table. The weakness in the problem solving at the table is that you don't get a whānau voice there at the table. (Police)*

One NGO pointed out how the lack of this voice potentially contradicted an intended aim of the model:

> *They might call it client-centred, but they are not there. Their voice is not there. (NGO)*

> *The family aren't involved in the taskings. People are making plans for people they don't even know/engage with. There's a disconnect with that – as far as social work goes, that's a step backwards. We're making plans for people, not with people, which apparently never works. (NGO)*

An example was given of how this had been resolved in another non-ISR district:

> *In Counties, with the support of the rapid deployment team, you're not actually doing problem solving at the table, you're doing risk assessment, gathering of information first, risk assessment and anticipated pathway. For your low risk, you will determine a pathway and it goes off to a single agency response. Then you get your rapid deployment team to get in there with med/high risk, get the voice to the whānau as part of the plan, either confirms or says we need to get this to somebody else, or confirms to build engagement. Then you get the safety stuff happening. (Police)*

In the UK's MARAC model, the multi-agency risk assessment committee reviews cases only after a face-to-face meeting with the victim and the victim specialist (Independent Domestic Violence Advocate – IDVA). The information gained by the IDVA forms the basis for risk categorisation and discussions. Included in the ISR Guidelines is a seven-page 'Risk Checklist' that is available for advocates to use when meeting face-to-face with victims (adapted from the UK's DASH validated assessment). It is unclear to what extent this is currently being used to update risk assessments, but it could be a mechanism for updating risk assessment after meeting with a family (for high-risk clients at least).

Incorporating assessments based on information gained from meeting with a family may also address concerns of an NGO around cultural assessments. They felt the current system did not allow for an appropriate cultural lens to be applied to plans. They felt strongly that for an assessment to be valid, someone with appropriate religious and cultural knowledge needed to meet with the family first; then only after this had occurred would plans be developed and tasks sent out.

7.2_ Engagement and partnership with NGO sector

The interim report identified a considerable commitment among the NGO sector to see the pilot work in order to achieve better outcomes for families, despite huge workloads being generated by the ISR. Seven months on, while NGOs continue to value the relationships and collaboration with other frontline workers (see section 4.1), commitment to ISR is showing signs of waning for a significant number of NGOs (in Christchurch at least). Despite a major increase in funding and resources for several NGOs, the sense conveyed was one of feeling over-worked and under-valued.

The SAM and ICM tables struggle to review the high volumes of family harm episodes that come across the tables daily, yet each case potentially results in considerable work for those then tasked. As seen in the content analysis of tasks (section 2.3.3), the NGO sector shoulders most of this work:

> *At the end of the day, as a NGO, if you look at all NGOs involved, we are the ones doing most of the work – the face-to-face stuff. (NGO)*

> *Because the services are what, in the end, makes the difference. The client isn't in at the system part [ISR]. They're not involved in that. A system can't change their lives on its own, can it? It's the two. (NGO)*

And yet to many of those NGO representatives who were interviewed, the work they did and their expertise felt under-valued:

> *Yeah, they're just Refuge workers. You know I guess just sort of bottom of the – I don't know, I don't think they realise, we're not just Refuge workers and we've been doing this work probably a lot longer than 90 percent of you and have a better understanding than 99 percent of you. (NGO)*

We need to assess and engage. It sounds like a pedantic thing ... but sometimes you can assess not to engage. We have to assess what risks are involved in engaging. ... Not doing home visits isn't the answer, but people recognising that we have the ability to assess and decide what's appropriate. There's pressure on us to be chasing this woman around Christchurch engaging for her safety, but actually, that can make it worse. Having to explain yourself around that all the time is difficult. (NGO)

... the biggest gap is that it needs equity. Let the specialists of family violence lead it. That's NGOs. We're alongside it, we follow along, but we're not leading it, and we need to. It's incorrect. (NGO – Waikato)

This is perhaps not a new scenario, but ISR is built around collaboration, and requires a true sense of partnership between the NGO and government sectors. It is unclear to what extent this is more of a site-specific issue for Christchurch, or to what extent it extends to Māori organisations in Christchurch who have been given the space within ISR to develop their role within the model.

While not necessarily intended, there appeared to be several contributing factors:

- **Lack of consultation and voice** – NGOs felt they had not been invited to participate in the development and/or ongoing development of the model:

  So there has been NGO involvement, but it's been quite limited and it has been – I don't want to use the word 'dictated' but it has been set. It has not been a truly collaborative – and I think that shows in the thinking of the implementation, which is basically here we have this idea, this is the way it's going to go and, you know, you've all got contracts, so you're going to come along. So I'd tell them that's not the best way to go. (NGO)

  If we think about how we are set up in ISR, we had nobody come to us and ask us, or tell us this is what/how we're doing. There was no consultation. They said there was but I don't know where that came from. We are a large provider, and had no input whatsoever. We were just invited to the trial/training. (NGO)

  In Christchurch there was also limited or no opportunity for the NGO sector to come together as practitioners and discuss issues they were experiencing with implementing ISR. In Waikato, regular NGO network meetings are held for this specific purpose, which seems a positive difference.

- **Lack of representation** – In Christchurch the lack of NGO representation at the SAM table was commented on by several, and also the recent (but temporary) removal of NGO representation at the governance level:[79]

  They kept SAM a very government table. The core workers who are getting stuck in to do the work are NGOs. They have a representative who doesn't have any training around family violence. ... How can you represent us if you are not from us? ... All of the NGOs are looking, going "What?" ... that's got to change. ... At a governance level too. There's no NGO representatives sitting at Governance. I've been told that they didn't want NGOs sitting up there because they didn't trust them. (NGO)

79 Two NGO representatives were originally invited to be part of the local governance group but, with the re-structuring of the group, representation by these two was discontinued and replaced by a single NGO representative, to be nominated by the NGO sector. This has now occurred.

This lack of representation means NGOs don't have a voice and input into decision making that impacts on them greatly, considering they are shouldering so much of the work generated by ISR. Concerns were also raised over a general lack of specialist family violence expertise at the SAM table and in other ISR management roles.

This was however another difference across the pilot sites, with Waikato having elected to retain the representation of Women's Refuge at their SAM table (a practice that had continued on from FSN).

- **How tasks are delivered through CMS** – For many NGOs their sole link with ISR is through the CMS system when they receive a task. While not intended, some sense that they are being "controlled" and "told what to do":

  The word 'referral' is better language, but that's not the system – the system is about being in control, it's about directing what's going to be done. (NGO)

  How it works is that the people who run that table, well they believe that they have this amazing amount of power to be able to tell us, and other agencies as well, what they will do and how they will do it ... if you perhaps suggest something that they don't like the idea of, they will shut it down, tell you it won't be done that way. ... Like, it's like we're not allowed to challenge, we just need to shut up, listen to what they're saying and be dictated to. That's how it feels at times. (NGO)

It could be argued that some of these sentiments are misconceptions, but regardless of their validity it is important to acknowledge that this is how many in the NGO sector are feeling.

Others felt relationships with NGOs had suffered as a result of the high volume of referrals and the early focus on ensuring that all aspects of the ISR model were operational:

No, I think it's a tunnel vision, I think they're so focused on the SAM and the ICM table and they're so caught up in that process, on how that works, that anything that goes on around that gets a bit sidelined. (NGO)

With ICM, I feel disconnected from my agencies – the rural agencies. We were just so busy with implementation that there was a disconnect with the agencies because I didn't have the time to manage that relationship, and get my head around ISR as well. (ISR – Waikato)

There is awareness that this is an area requiring attention, with actions underway to improve things. The need to reframe how tasks are communicated to agencies in a way that is less dictatorial and more of an invitation for collaboration has already been discussed:

It is re-framing it. It is totally re-framing it. ... And I think that will create more of a working together ... I think that is some of the feedback we've had from the NGOs and the work that I've been doing for Māori NGOs, so is actually that ability to say, rather than telling us what you want us to do, saying to us, "Here's the family I want you to work with. Here's some of the things that we are seeing", and then for them to come back and say, "Right, I've met with them and here's what we need to do." So that some of the concept changes we want to look at. (ISR)

This approach puts into perspective the value but also the limits of what can be achieved at the SAM table without input from the family themselves.

Part of the solution may also lie in creating a team culture through co-location where the NGO ISR positions are an integral part:

> *So the work I think we need to do … is actually building the knowledge and building the confidence in our NGOs who we rely on heavily to do that work, to knowing and feel that they are part of a team. And this is where I think this virtual team sort of team concept helps. That they are part of a team that can call on their other colleagues that work within the ISR model to be able to support them as needed. (ISR)*

> *The NGO sector – the whole way their services are contracted needs to change so they're actually part of this team. I want to mash them altogether into a co-located hub to enculture change. We need to change how people are behaving so they understand they're all trying to achieve the same purpose. (Police)*

7.3_ Improved integrated response beyond the tables

Most of those interviewed felt the SAM and ICM components of ISR were working well, and that it was the ISR elements subsequent to the tables where improvements could be made. This included better management of plans, better co-ordination of tasks, and generally a more integrated response in the community. This was summarised by an ISR team member from Waikato:

> *The SAM to me is only supposed to be a small bit of the workload. Addressing and making a plan is important, but what's more important is executing that plan. That is the part where we still have to work with the agencies around the table and the NGOs to get them to a level that is acceptable for ISR. FSN has done lots of groundwork for us, but we still have a lot of work to do. (ISR – Waikato)*

7.3.1 _ Increased ownership and leadership of plans

For each FSP a lead organisation is assigned. However, the extent to which these organisations were able to actively manage plans appeared variable. Traditionally the idea of being the lead on a case would suggest full ownership and responsibility for overseeing and directing work as needed. A typical first step would be holding a professionals meeting to understand who was involved and why, and to make a collaborative plan from there. However, high volumes worked against this more traditional lead role occurring within ISR.

Challenges posed by high volumes

Some agencies and NGOs found it difficult to take on the role of 'plan lead' because of the sheer volume of plans. Instances were identified where individuals had literally hundreds of plans assigned to them:

I'd be the lead for plans at the moment that I couldn't even name. I've got maybe 80 to 100 plans. Police would have huge numbers too. It becomes difficult to manage. (SAM)

... the volume might get in the way of leads of plans being able to go, "Oh look, this hasn't happened." If someone closes the task, there's no notification. Unless you're the lead and you've gone in and looked at that, it might not be until months later till you've had a look, and you've lost the opportunity then. They've bolted, and POS are still trying to engage two months after an episode.... (NGO)

Perhaps one of the more critical roles of the lead on an ISR plan is the closing of the plan. This involves a full review of the plan, checking on each task, and deciding if it has been completed satisfactorily. This review provides the opportunity to ensure that all appropriate safety planning has been completed. This is a critically important role and yet, due to volumes, often difficult to fulfil:

Closing them seems to be what happens last when people get busy and that's across the board. That's the last thing they do. (ISR)

They do the plan, and yet, those plan closures, from a practitioner's view, is that if you're looking to close it, you've got to do a review of it. That gets missed. If no-one's closing them, no one's getting to the point where they're doing that. (NGO)

A couple of NGOs expressed concerns over the degree to which they could be held responsible if a plan was closed and a serious episode subsequently occurred:

The bottom line responsibilities of the lead: what are they? What's our liability? That's the scary bit. (NGO)

Concerns around plans not being reviewed and closed were identified early on, and there have been significant improvements in the rate at which plans are now closed. However, it appears there are still issues around the ability of leads to fulfil this role effectively.

Barriers to active leadership

In addition to high volumes, the role of the SAM table in developing the plan and subsequent oversight through CMS appeared to reduce the confidence and/or ownership of some lead agencies to actively manage the plans:

It's very exposing and accountable, so that probably makes people quite nervous. They'll be needing to make the right decision in their mind. There's definitely a nervousness around some decisions. Some not. And it varies across the agencies. (ISR)

Rather than a lack of confidence, some NGOs described it more as a lack of receptiveness to suggestions that discouraged active management:

... if you perhaps suggest something that they don't like the idea of, they will shut it down, tell you it won't be done that way. ... So sometimes you might have an idea of how you want to do your piece of work but it doesn't even feel safe to put that forward to the table. (NGO)

The perceived inability to challenge a decision at the SAM or ICM table was raised in the previous section, where advocates felt their expertise was not respected. It appears a better balance is needed in respecting the multi-agency collective decision making at the SAM table and also that of those tasked to work with the family.

For some the barrier was more around different understandings of what satisfactory completion of a task is:

> *Not everyone is at the same level when it comes to taking responsibility for your work or service delivery or minimising risk. One agency will close a plan purely because the victim/perpetrator is committed to doing something. Another will wait until they started with the programme. Me, I wait until they finish the programme, until they say that they've done what they have to do. (ISR – Waikato)*

Role of plan lead

Given the barriers many faced to actively leading their plans, this left some questioning if the role should be better defined. One NGO relayed a conversation they had had with another organisation, who commented that:

> *"Being lead doesn't really mean anything, does it?" (NGO)*

It was felt the role was more of an administrative one, rather than the active management of a plan.

A couple of those interviewed suggested that an alternative title of 'ISR plan manager' might better capture the role:

> *I don't think that 'plan lead' is the right definition for it in a way. ... It should just be the 'plan manager' because they're not a lead, because leadership suggests that you've got some decision making. ... So the decision making's been done. They are the managers of the plan coming off the table. (Police)*

However, if the role was a plan manager, without the power and expectations of decision making, that would raise the question of who then would revise a family's plan as needed if new information comes to light.

A final suggestion was to introduce a supervisory role to oversee the quality of the plan leadership, perhaps similar to the current set-up of tasks – where the 'owner' of the task effectively supervises the actions of the 'assignee' in completing the task. The need for a supervisory role has been recognised in Waikato with the allocation of two 0.5 FTE positions to supervise IVS and POS referrals. In Christchurch, individual agencies have created similar roles out of existing resourcing.

It appears more work is needed to clarify the role and responsibilities of this key position within ISR. The extent to which the role is one of primary decision maker, manager/administrator or supervisor will impact on the nature of their work and what an acceptable caseload of lead plans should be.

7.3.2 _ Improved co-ordination and completion of tasks

In section 4.5 it was noted that there had been progress towards achieving more co-ordinated and integrated responses, but that there was still more to do to consistently achieve this:

> *... there are still far too many 'cars up the drive' – people working with families or individual agencies – not a joined-up approach. (NGO)*

> *... there are also times where I think that what is captured at SAM isn't implemented as intended. You can read a POL – share info – discuss the situation at SAM, come up with a plan.... But how that's implemented outside of the table can still be disjointed, siloed. ...it's collaborative in terms of who you speak to ... but integration would be, we are doing this piece of work together. (SAM)*

Problems one victim encountered in getting the support she needed when organisations were not prepared to work together were made clear in section 5.2.1.

For some context it should be noted that since the beginning of ISR there have been close to 33,000 individual safety planning tasks allocated across the two sites, so co-ordinating and integrating this level of response is inevitably going to be challenging.

An NGO commented that, despite good intentions, high volumes impacted on their ability to respond in a more co-ordinated way:

> *... they're tasking out to five different organisations: Barnardos being one, Child, Youth and Family being one, Mental Health and Aviva. So then it's quite – you've got four individuals now phoning that one client.... That's a huge problem, and we've tried to work collaboratively in the past and it just is unrealistic, so we had to give up on that. ... So, initially we thought we'll do joint visits with a court family violence agency. But because they're so busy and rushed off their feet and, for good reason, it just got so – yeah, imagine trying to schedule the visit. So in the end we just had to go ahead and then sort of feed back to them. So, yes, ultimately people might be seeing more workers sometimes than they need to. (NGO)*

There were also concerns raised over high volumes impacting on the quality of the work being completed. Many spoke of the pressure for tasks to be completed:

> *It's the ongoing capacity issue that worries me in terms of people not just ticking boxes but having the time to do everything they are required to under the taskings properly. That's where the risk is, as opposed to anything else. I like it – it's a better system. I keep on top of it, but it's not easy with other things I do. (NGO)*

We miss opportunities. I've seen plans where an agency might be tasked with the primary aggressor, they try to phone twice and don't get through so they close. They don't go, 'Oh look, OT have had contact, I'm gonna contact the social worker to see if they've had engagement." They close off the task. Some of that is volume, but we are missing valuable opportunities to think outside the box. If you think, "I haven't had any luck with my phone call, but look, someone else has had contact – how can I try [to] get a response so I know that primary aggressor is going to get service, and change what happens next time they have an argument?". That's the biggest disappointment for me. (ICM)

Several agencies raised specific concerns over the negative impact of high caseloads. High volumes of referrals coming to the SAM table resulted in pressure to 'push' referrals out to NGOs so that the SAM table can receive the next wave of referrals. However, there is an inevitable conflict between quantity and quality. Agencies urged that there was a need to understand better what a maximum caseload should be, to ensure that practice is both safe and effective.

The quality of task completion was not helped by some agencies not having access to CMS and so being unaware of how their task related to the safety plan.

Other issues raised by the quality of the co-ordination and/or completion of tasks included:

- **Duplication of work** – The concerns raised were around providers ending up attempting to perform a similar role for cases, which as one NGO noted can create safety issues:

  The other thing we've experienced is that other agencies aren't actually looking at the CMS to see who is the lead and who is doing what. That gets a bit mucky, because it duplicates a service. (NGO)

  If you've got two agencies trying to do the same thing when it comes to safety planning, a gap gets created. The client gets confused. (NGO)

- **Multiple agencies tasked, creating complexity** – When multiple providers are tasked from the SAM table to work with individual family members, this requires more communication and co-ordination among agencies (and for the 'plan lead'). If there were more agencies available to work with the whole family, this might simplify the task of co-ordination.

- **CMS not capturing work done** – Because of the need for tasks to be closed, many NGOs would close a task such as 'engage and assess' after initial contact, but then keep working with the client:

  And because it's by the tasks, everyone closes the task, and then everyone thinks everyone's gone. But actually, that's not the case. That's why the languaging is always on re-engage. They're thinking we've closed, because the system says we have. But we haven't. For me, I know we're still open. (NGO)

  That's why sometimes the taskings say, stay engaged or reconnect. It's like – we haven't been anywhere! (NGO)

The issue with this is the creation of information gaps. This ongoing work might be more visible if agencies and NGOs were using the 'intervention' field within CMS.

- **Perceived relevance of tasks and/or appropriateness of provider to whom the tasks were allocated** – Some tasks don't appear relevant and/or achievable:

  ... it feels like some taskings that come from there are just like, "We don't know what to do with this, we just need to give it to someone." I think it needs to change, but I don't know how. (NGO)

  ... but we continually get taskings for women that we can't engage with. It's like they're not recognising that and maybe they haven't got other options, but they're just like, try again, re-engage. (NGO)

If tasks do not feel relevant, they are less likely to be acted on with efficiency. This is perhaps an example of why closer communication and networking are needed between those assigning tasks and those receiving them.

7.4_ Family and whānau-centred working, and focus on children

Questions were raised in the interim report around the extent ISR was able to deliver a family/whānau-centred approach and its ability to address the needs of children.

7.4.1 _ Family and whānau-centred working

Some still felt ISR had more to do in regards to working in a truly family and whānau-centred way:

So rather than actually really understanding that it's safe, and with some work that family unit could be okay, it seems like we just work with the victim and we look to help them get out of the situation, rather than necessarily sort it out as a family. ... Because there's no coming together of who's working with perpetrator and who's working with the victim. There's no meshing together. It's just very siloed, walking alongside each other rather than merging in at a point that's safe. (ISR team)

Others were more interested in understanding better what working in a family or whānau centred way meant:

Yes. And just in the sense of – when we say family-centred, it's really people's understanding of what family-centred work is. There's limited knowledge around what that looks like/how it's practised. (NGO)

Three different views emerged on which approach is best, and in what circumstances. These are set out below.

Working collectively with different members of the family and whānau

For some, working in a whānau-centred way meant all those involved with the whānau coming together in a professional meeting and collectively planning for the family. An NGO and several government agencies described this as their understanding:

> *For me [it is], if we were tasked or the lead, I believe we'd be having a collaborative professionals meeting. You would know who is involved/why/how. (NGO)*

> *But you have IPS, IVS, Oranga Tamariki, all working on the same thing. You had a focus on all parts of the family, which is what the whole idea is. (SAM)*

> *So you get to do your initial piece of work from the SAM, but then you get to come together again quickly, off the table, as the people that are there actually working with the family. That's how it continues to be co-ordinated, so the plan lead could take responsibility for gathering the practitioners together after the initial bits of the work has been done. (ICM member)*

Some Māori victims were of the view that some non-Māori NGOs shy away from working with whānau because of perceived time and resource implications and importantly, not seeing whānau as being part of the solution.

> *You can put them the perpetrators over there and us being the victims over here. Where's the whānau in that? ... So we need services like this to take a whānau perspective and actually integrate whānau therapy as part of the recovery. ... I think taking a whānau lens is a struggle for mainstream services as they see a long-winded process working with whānau. ... I know for my ex, he's a very hard nut to crack around taking responsibility, but we seem to be able to do that as a whānau unit. (Māori victim)*

Supporting a family or couple to stay safely together

For others, the key aspect was accepting that the family wanted to stay together and working in a way that enabled this to happen safely:

> *I think a different mind-set that ISR's brought is that there's acknowledgement that some of these family harm things, we have to fix while the perpetrator and the victim reside in the same house ... because that's what they want. So before [ISR] we just kind of go, "Oh, like, they're mental. Why would we do that?" But now there's a bit of a cultural change in there that we can actually start working with them in terms of resolving their problems. ... They actually want to stay together. They just don't want to have the violence in their life. ... So we are seeing some progress in terms of that. So the IVS's are working with them as a couple, you know, and getting them moving on that road as well. (Police)*

This echoed the wishes clearly articulated by one victim:

> *We don't want whānau broken, we want the behaviours broken.*

Some NGOs appear better set up to work in this way than others. For example, a Refuge with a safe house arguably is focused on keeping the family apart. On the other hand, a Māori social service generally will work with the whole family. Waikato more often tasked NGOs to work with a couple or a family, and had more NGOs set up to receive these types of referrals (see section 2.3.3).

A Christchurch NGO described how they used the Te Whare Tapa Whā model, which meant that in order to support the victim they needed to assess all their needs – physical, financial and spiritual – but also the family or wider whānau needs. In short, to help the victim required them often to work with other members of the family and whānau:

> *We're likely to be tasked with the victim but there is that interface between the couple. It's about assessing initially what is actually going on in the family, so we can be working with the victim and the victim is saying, "I'm really struggling with his drinking and his outbursts", and so the partner may be referred off to either Alcoholics Anonymous or Familial Trust or some other agency to work with partners, family members of addicts. As part of that process it may be, "Have you thought about this and this and this for your partner?", or the example that comes to mind is teenage boys, you know, "Have you thought about the Enabling Youth programme?" and things like that, that they could perhaps go into. (NGO)*

Supporting whānau and whakapapa

For Māori, being whānau-centred means working with the wider whānau regardless of the status of the relationship. For example, a victim may have left her husband/partner, but if he is the father of her children, it is important that relationships with wider whānau are maintained in order for the children to stay connected to their father's whānau and to their whakapapa (see chapter 6):

> *You want a relationship because he's your children's father, he's always going to be their dad. And you want to stay connected to his brothers and sisters, your children's aunties, uncles and cousins. ... we've just finished our first counselling session together around what it is we want to do as a whānau, whatever that looks like, intimate or just friends.... (Māori victim)*

> *In Māoridom, I can't break whakapapa. I can't. If I look at my whakapapa, I can say, where my mum/dad comes from and connect it to all these areas. ... So if we look at whānau violence, my children – the system, restorative justice, we were offered that. What are we restoring? I don't want to restore my relationship with my ex-partner. But in Māoridom, I can't break whakapapa. My two sons have a mother and a father. Right now, I choose not to host my son's father. I can't do that, we've tried. So I can't break this; I have to acknowledge it. (Māori victim)*

7.4.2 _ Addressing the needs of children

Children still seem less visible in ISR than the adult victims or perpetrators. This is despite the existence of child-specific agencies (MVCOT and the Children's Teams) and organisations whose services include those for children (such as Barnardos, and children's programmes offered by Parentline and Women's Refuges and other Specialist Family Violence NGOs).

While several 'good news' stories have emerged illustrating outcomes that can be achieved (see for example cases 5.2 and 5.3), there still appears to be more of a focus on adults in the family. Fortunately, much of the excellent work that the IVSs are doing to support high-risk adult victims also appears to be impacting in a positive way on their children (section 5.2.4). The family safety plans developed for adults are also likely to include tasks that support them to be safer and better parents, whether they are together or apart.

Those interviewed felt a contributing factor in the lack of visibility of children was the lack of referral options for children. Several child-focused agencies suggested better representation of child-focused people at the SAM table might help (eg, a child-focused NGO representative):

> *At the table, we're the only child-focused people at the table. There's scope for the Children's Team to be sitting at the SAM ... or someone child-focused who represents that NGO sector. (MVCOT)*

> *... so what concerns me is that we rely heavily on the Ministry of Vulnerable Children to deliver services for all of the children that are in the – pretty much all of the children that sit under the ISR umbrella. However, they're geared to respond to high risk only.... It's really tough, I think it's a natural consequence of some of the Māori organisations that because they have that whānau-centric approach, so they're picking up the children. I'm not specifically aware of other NGOs that are focused in that space ... it's just we think there's potentially a gap.... (ICM member)*

7.5 Ensuring privacy of information

Ensuring appropriate privacy of information has been an important consideration for ISR. As part of the ISR initial planning, information-sharing protocols appropriate for agencies and NGOs were researched and developed. These appear to be working well in relation to relevant information being shared at the SAM and ICM tables. Concerns were raised however during interviews around potential for inappropriate use and sharing of information beyond the SAM table, and the impact of the MSD's Individual Client Level Data (ICLD) policy.

Inappropriate use and sharing of information

During ICM observations in Christchurch, a serious concern was raised by the untasked action of a perpetrator worker who had contacted a previous client having seen his name on the SAM list of cases to be discussed.[80]

80 When the agency employing this individual was notified, they implemented a serious misconduct investigation and suspended the employee from clinical practice. The investigation upheld the concern of serious misconduct and, as a result, the employee no longer works for this agency.

The agency/NGO assigned as lead had met with the victim and ascertained that contacting the perpetrator would put the victim at increased risk (he was unaware of the report made to Police). In response, the support worker had contacted the provider who had been tasked to make contact with the perpetrator, and got them to immediately close their task. However, no doubt with good intentions but completely inappropriately, the POS had phoned his ex-client saying he had heard from Police there had been another episode. The victim relayed that the perpetrator had become very agitated following the phone call. This distressed the victim, who had been assured this would not happen without her knowledge or consent. She subsequently began to withdraw her engagement and became distrustful of officials.

While possibly an isolated case, it highlights the potentially serious consequences when information-sharing protocols are not adhered to, and the importance of ongoing education about and enforcement of those protocols. This is perhaps a timely reminder as the number of individuals involved with ISR increases, many of whom start without the initial ISR training.

Another concern related to the sharing of inappropriate information in CMS. Most agencies/NGOs had their own client databases they had to maintain, and updating CMS often involved entering duplicate information. To save time they would often cut and paste information across from one database to the other. However, this could result in non-relevant information being shared, which a large number of people would then have access to:

> *But because you're putting stuff in our database as well, people copy and paste. That's much faster than filtering the information you're putting on. So huge amounts of information goes on CMS. (NGO)*

> *In regards to confidentiality, ... that's a concern because there's been information uploaded onto CMS that's not relevant. We go back to the past, round table; there was only a small number of agencies involved with that. We had to sign documents around confidentiality. Now there's a huge amount of people having access to CMS and private information. (NGO)*

The sharing and appropriate recording of data in CMS are clearly areas where further or updated training is required.

Impact of Individual Client Level Data policy

Last year the Ministry of Social Development began rolling out funding contracts that required NGOs to disclose Individual Client Level Data (ICLD) about service users. This policy has recently been put on hold. The potential of the ICLD policy to have a negative impact on ISR was raised by nearly every NGO spoken to.

The policy would require them to get clients' informed consent to share their personal details before they could offer services. This would include explaining who had access to the information and how it would be used, which would mean a full description of ISR, CMS and the agencies who had access to this information. While most NGOs already had their own policies around gaining consent from clients to share information, they had control over when and how this was done.

When you're having that conversation, you need to have it in a way they understand. But the first phone call, it is confronting to be talking about something that's really private/personal. (NGO)

The main fear of NGOs is that the requirement would increase non-engagement:

I can't even imagine how I'm going to ask that question, to the clients that I'm working with in crisis. "Is it okay if I give your personal information, your details to MSD?" ... When they're already distrusting. (NGO)

I worry about when women or victims become aware of how much information is shared, how willing they would be to speak with us. That quickly becomes an issue. I've come across one woman who had some knowledge of the processes of ISR and didn't want to speak to me. She was outspoken about it. (NGO)

Current protocols allow agencies/NGOs to share information where there are concerns for safety (ie, the SAM table). This reduced barriers to providing a safety response. Concerns about this was described clearly by one NGO:

... with ISR at the moment the exchange of information around that SAM table, across agencies is based on the principle that safety trumps privacy, and there was a lot of consideration of privacy legislation before the pilot that developed assurance and therefore confidence that we could share this information for the purposes of risk assessment and safety planning. The ICLD actually completely turns that principle on its head, so it will no longer be a matter of safety trumping privacy, it will become a matter of data trumping safety because we will not be able to provide a safety intervention. SAM will still be able to do its business, but our staff will not be able to provide a safety intervention unless a client has provided that consent beforehand. (NGO)

While there appears to be a reprieve at present in relation to this policy, it is clearly something that needs careful consideration.

7.6_ The Case Management System (CMS)

The interim report highlighted a number of problems Christchurch users were experiencing with CMS. While some improvements had been made, there was a consensus at that site that CMS was still "clunky" and that improvements were urgently required. Over time, CMS has had to store increasing amounts of information on families, and managing and extracting this information from CMS has become more difficult.

Notably, during this later round of fieldwork that focused more on the frontline agencies, it became evident that for many agencies (those who did not attend the ICM) their primary contact with ISR was through the tasking they received via CMS. Hence their perceptions of ISR were greatly influenced by the performance of CMS.

The main issue that surfaced was the time taken to keep the CMS system up to date.

Feels like the database has become its own client – you have to keep it happy. Keep checking on it. (NGO)

The focus/time on database – the time it's taking away from face to face contact with client work. That's a huge shift for me. Doing data entry, responding/updating tasks, closing... It's horrendous. It's a waste of resource and my skill base to be doing data entry – for all of us. (NGO)

Even with improvements to CMS, it will be challenging to make the administrative side of ISR manageable, and many NGOs raised the idea of more administrative support.

Other improvements in CMS that were requested included:

- building in a spell-checker
- more summary screens to help organise and navigate the information (eg, a summary of the plan that could be quickly and easily read to put various tasks in context)
- the ability to archive tasks, so they are accessible but not cluttering up more immediate tasks (eg, for a series of tasks to be archived under a summary statement such as "X agency had seven tasks on this plan and the person didn't engage with them")
- making contact numbers for families more visible
- being able to re-open and edit a closed plan
- being able to correct mistakes (eg, an episode accidently linked to the wrong plan currently cannot be amended by most users)
- a glossary for abbreviations so that tasks can be understood by a plan lead
- a greater ability for the ISR team to use CMS to track ISR work (eg, to produce a list of cases for review at SAM or ICM)
- access for NGOs and others to the reporting facility within CMS
- a more efficient process for getting staff access to CMS.

Analysis of data presented in chapter 2 of this report highlighted several limitations to the current recording of data in CMS. From an evaluation perspective, several revisions to CMS would improve the analysis of its data:

- an improved ability to analyse data by risk tier – this is vital; and ideally data should be coded by 'highest ever' risk status in addition to 'current' and 'initial' status
- the ability to analyse data for distinct time periods
- a more valid measure of ethnicity (perhaps updated to be 'self-identified' after a support worker has made contact with a family)
- more reliable recording of the nature of the family harm episode – and include also if there is co-occurrence of child abuse and/or neglect
- where possible, recording the self-reported type, frequency and severity of family harm at referral and exit
- adding a field for relationship status at referral
- improved categories of person roles, to better identify the role of children

- pre-coding of tasks to enable easier analysis
- the ability to re-open a closed plan, to ensure that repeat episodes of family harm for a family are being accurately captured.

7.7_ Other issues

There were a number of other suggestions for improvement, most of which are fairly self-explanatory:

- **Training** – As also noted in the interim report, there were calls for more training to ensure all new staff are fully informed around ISR. This included more practice-focused training (guidelines on what best practice looks like to achieve the ISR aims) and training around information sharing. The other area still requiring urgent training is interventions:

  So, the Police have an idea of what an intervention looks like, BWT [Battered Women's Trust] had an idea, and Barnardos had a different idea of what an intervention is. So no-one could come to a collective agreement to know where to put that box. … I mean, that says it all, doesn't it? That just shows that the understanding of the logic of the model is not understood. (NGO)

- **Meetings for practice leaders** – There were calls for opportunities for practice leaders to get together and review and reflect on practice, raise issues, and understand how ISR is going for others:

  There's been no ongoing training, no forums for reviews as a collective…. we're also interested to hear how it's going for the likes of WINZ and Corrections and their views as well. It's just so ridiculous because there could be little niggly things going on out there that could have been, could be so quickly rectified if they would bring us all together. And identify what training some people need that we could, you know, as you say support one another. (NGO)

- **Greater representation of frontline family violence workers at the tables** – Many in Christchurch felt there was a need for more frontline family violence experience with ISR roles and the SAM table in particular (perhaps using a roster system):

  One big difference I think would make is if at the SAM table … there was actually somebody who'd worked in family violence and could provide that expertise to that table. I think it would make a huge difference and our plans would be more relevant and successful. (NGO)

- **Better access to contact details** – A continual frustration among those receiving a task to 'make contact' was not being supplied with valid contact details, requiring them to spend precious time attempting to source them. It was suggested more efficiencies could be achieved if those around the SAM table, where possible, could confirm these details before sending the task.

- **More analytic support –** It was suggested that, at the local level, there should be the ability to extract and analyse more information from CMS and other relevant sources, eg, the Police National Intelligence Application (NIA):

  > *... we need some analytical support, you know, like a performance analyst or something, sitting over the CMS system. ... But if we had an analyst looking over the lows all the time – because the gold [untapped knowledge] in the lows, ... we could see (1) potential escalations or more – you know, when, you know, the same family's propped up two or three times. ...And if you looked at the – if you had a – looked back through the homicides and the family harm, none of those would have been high before they were homicides. (Police)*

- **Establish independence of ISR –** Currently all ISR staff have Police email addresses, which makes differentiating the service from the Police an issue.

7.8_ Summary

An interim report in November 2016 detailed a number of challenges and areas requiring improvement, most notably reducing the workload pressures required to operate the ISR model. These pressures have been eased by an increase in resources allocated by government agencies and additional funding provided by the government for the ISR pilot. The SAM tables are running smoothly and recent attention on the ICM tables has been reflected in improved purpose, efficiency and outcomes.

More work is still needed to clarify the aims and scope of the ISR model. For a model to be operating efficiently, those involved must clearly understand their roles and what they are aiming to achieve. While there is a growing consensus that ISR should be concerned with ensuring immediate safety, how this translates into practice is less clear. A better understanding of how ISR fits into the bigger family violence response system would help to better define ISR roles, and help to develop contracts to better fit these roles. Another important area to consider is how assessments following face-to-face meetings with families can be incorporated into the ISR family safety plan.

Other areas for development include:

- developing a true partnership between the NGO and government sectors
- better co-ordination and delivery of tasks (consistently working together to deliver quality responses)
- more ownership and active management of plans by the plan lead
- understanding and delivery of whānau-centric responses
- more understanding and attention to how ISR is meeting the needs of children
- renewed attention to protecting privacy of information, ensuring strict adherence to information-sharing protocols.

08

Concluding remarks

The Integrated Safety Response (ISR) programme represents a significant opportunity to reduce the harm caused to families through family violence. The piloting of the ISR model in Christchurch and Waikato has brought together a multi-agency team to enable fully informed risk assessments and safety planning. Independent Victim Specialists (IVS) and Perpetrator Outreach Services (POS) are in place to provide intensive support for those identified as high risk and/or most in need, with another multi-agency Intensive Case Management (ICM) team meeting weekly to review and further address the safety planning as needed for these high-risk families. A local and national management and governance structure operates as an integral part of the model, a feature that sets ISR apart from other multi-agency interventions in New Zealand and which is key to its sustainable and effective operation. The aim of these groups is to ensure that those on the ground and around the table are resourced and supported to do this work, and also to make strategic decisions and associated policy changes to ensure ISR is operating optimally.

The ISR model constitutes a significant change to the ways in which family harm is responded to in New Zealand, and therefore the evaluation of the ISR pilot is extremely important. Ministers have recently announced the continued funding of the pilots for another two years. It is timely to now take stock of evaluation findings and reflect on the design and functioning of the ISR model. This should include considering aspects that have been successful in order to support their further development, and problem areas where solutions are required, before a wider rollout of the model.

The evaluation was tasked with answering three main questions:

- To what extent has the Integrated Safety Response model been implemented as intended in the pilot sites, including barriers and enablers to successful implementation?
- What evidence is emerging about the effectiveness of the Integrated Safety Response model, including as a result of practice changes?
- To what extent has the implementation of the model taken into account early findings from the evaluation (ie, is there evidence of continuous improvement)?

Implemented as intended

The ISR model is multi-faceted, involving a range of government and non-government agencies. The success of the ISR model requires assigning, training, resourcing and mobilising all the key players, and keeping them engaged during the course of each response – this is no small feat. Hence, it is a considerable achievement that in under a year the ISR model has been implemented, largely as intended, in two sites with varying social and geographical characteristics. This implementation in two pilot sites indicates that the model is both robust enough and flexible enough to operate successfully in varying local conditions.

Key learnings that may assist with any further roll-out of ISR include the importance of:

- consultation with all groups (NGOs and government agencies) prior to implementation
- selecting sites with strong established relationships among sufficient service providers who want to make it work
- finding facilities with sufficient space to allow a co-located ISR team

- ensuring that ISR training includes practice-oriented guidelines, reaches the wider community of organisations, and is ongoing to ensure all new staff are fully informed around ISR.

The interim report completed in November 2016 focused on the early implementation of ISR in Christchurch, and identified that the demands of resourcing the model were imposing considerable strain across both government agencies and NGOs, a situation that was not sustainable in the medium to long term.

However, just six months later the operation of ISR in Christchurch appears to be in a far better place. Since the interim report there has been an increase in resourcing allocated by government agencies and additional funding provided by the Government for related NGO service providers. This has eased workload demands, particularly for government agencies, making participation at SAM and ICM far more sustainable. While managing the high volumes is an ongoing challenge (eg, the inability for low-risk cases to be reviewed at SAM, and pressure on NGOs to carry high caseloads), the SAM tables are now running smoothly, and recent attention on the ICM table has been reflected in improved purpose, efficiency and outcomes. The area requiring attention now is the work that is done away from the tables.

Waikato has been operating for a shorter period and, while largely operating as intended, appears to be struggling with resourcing issues similar to those Christchurch was facing at three months post-implementation. Many of the government agencies are struggling to provide staff to ensure regular attendance at SAM and ICM. NGOs – particularly those in the rural areas — are not all coping with the workload being sent their way from the SAM tables. It is unclear if this is due to the shorter duration of the pilot in Waikato or because demands on resources are also higher in Waikato.

Continual improvements

What is clearly evident across both sites is the level of commitment towards continual improvement – to the point that it has been hard for the evaluation to keep up with the many innovations and changes. Christchurch has either improved or remedied all implementation issues identified in the interim report (with the exception of recording interventions in CMS). Waikato has also shown a commitment to continual improvement without the benefit of focused investigation of their implementation process. These improvements have occurred in response to: specific recommendations contained in the interim report; recommendations resulting from six-weekly quality assurance reviews (QAIFs); outcomes from a number of workshops and hui facilitated by Police National Headquarters and also needs identified by the ISR teams themselves at both sites.

Emerging evidence of effectiveness

It was made clear from the outset that the evaluation would be presenting evidence of 'emerging effectiveness', rather than any conclusive evidence on outcomes achieved as a result of ISR. This was due to the relatively short time span of the pilot, and the limited amount of relevant data that was able to be generated over this period.

Strong evidence emerged that the ISR model is effectively delivering on many of its core aims and that, according to the programme logic, it is well-placed to achieve better outcomes for families.

While evidence is readily available on improved processes resulting from the ISR model, linking these to improved outcomes for families is more challenging. However, all available data provided encouraging results:

- Clear minimum standards, and more intensive and collaborative efforts enabled by ISR, have seen increases in engagement by those offered support responses, and overall high rates of engagement.
- Descriptive statistical analysis of Police reports of family harm episodes found that for two-thirds of predominant aggressors they either had no further reported family harm episodes or any subsequent episodes were less frequent and/or less serious than those in the six months before referral to ISR.
- All victims interviewed reported feeling safer, with many noticing improvements in their overall wellbeing and, where applicable, that of their children.
- Sixty-three percent of a small sample of 'high risk' victims reported that abuse completely stopped following their ISR involvement, with some of this due to the relationship having ended or their partner being in custody.
- Interviews with a small sample of perpetrators suggested that, if given access to an IPS with the right qualities, they could be supported to change their behaviour. All those interviewed had recognised the importance of taking responsibility for themselves and their actions and felt confident they would not use violence in the home in the future, although for most this had yet to be tested. Most were also confident they could form or maintain respectful relationships, with some already noticing improvements.

Core elements of the model and areas for development

After nearly a year since the first ISR pilot site began, and with confirmation that the pilots can run for a further two years, it is time to reflect on which parts of the model must be retained and which areas need development. The two pilot sites will continue to provide an opportunity to assess how well the model works across diverse environments and populations and to compare the effectiveness of local variations to the model. There are also a number of other family violence initiatives being trialled by Police in other districts that work in a similar space to ISR (management and responses to Police reports of family harm). It is likely they too will have successful elements that could be incorporated into ISR.

Some of the biggest achievements resulting from the implementation of the ISR model have been:

- **improved information sharing, risk assessment and safety planning** – the SAM table has enabled more complete information to be shared, thereby enabling more accurate risk assessments and enhanced safety planning. This has led to more efficient dissemination of information to frontline workers, including the introduction of previously unavailable information (eg, from ACC)
- **a wider awareness and responsiveness to family violence, particularly among government agencies** – resulting in more collaborative, better co-ordinated and more efficient.
- **working with the source of the problem** – the nature, reach and intensity of responses for perpetrators has changed and significantly increased. Perpetrators are now considered in every safety plan and intervention.

- **more families offered and accepting assistance** – with ISR there is a meaningful response to every family harm episode, and three times as many families are now taking up the offers of support.
- **more efficient case management** – has been facilitated through a custom-built database (CMS). CMS provides a platform for sharing information as well as monitoring progress on the delivery of safety plans.
- **better understanding of capacity issues and mobilisation of resources in response** provided through multi-agency national and local governance and management groups, together with dedicated ISR directors and operations managers. Together these groups identify issues, then develop and implement solutions to effectively support the personnel delivering the ISR response.
- **better funding, partnership and collaboration with Māori providers** – has been achieved especially in Christchurch.

The ISR model and all its components are operating well and achieving many of its core objectives. However, no matter how efficient a system is, it cannot change the lives of families on its own. This is achieved by the families themselves, with support from those who are working alongside them in the community. While the SAM and ICM tables appear to be working well (and have been the main focus to date), it appears to be time now to focus on how initial plans and tasks are deployed from the SAM table and how community agencies can be organised and supported to work more effectively with families.

The challenges moving forward are:

- developing a true partnership between the NGO and government sectors
- incorporating the voice of the family into safety planning
- better co-ordination and delivery of quality, integrated responses
- more ownership and active management of plans by the plan lead
- understanding and delivering whānau-centric responses
- more understanding of and attention to how ISR is meeting the needs of children
- gaining clarity on the scope and aims of ISR, and working out the best approach and timing to transition clients after immediate safety work has been completed.

There is much to be gained from improving and refining the ISR model, to build on those achievements already made possible.

> *I don't see how we can go back to the old way, truly. I don't know how to say it any other way. Simply as a person working within the sector, why would we not be pursuing this? Why wouldn't we? (NGO)*

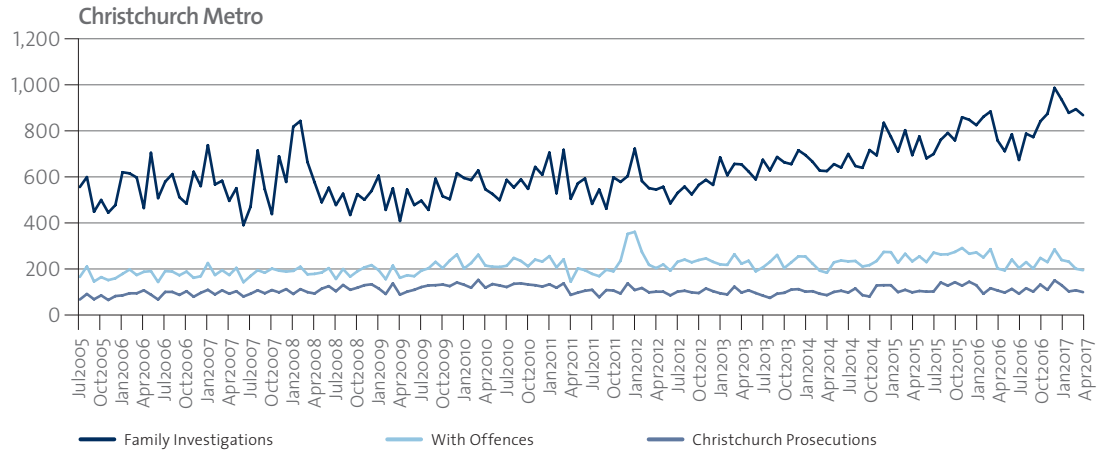
Appendices

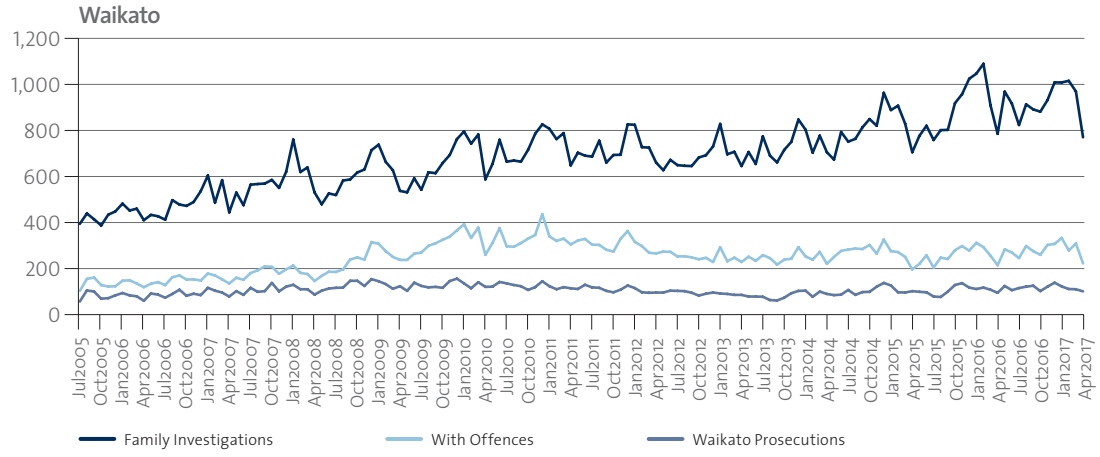
Glossary of common abbreviations

1D	A non-offence family harm episode
ACC	Accident Compensation Corporation
BWT	Battered Women's Trust
CMS	Case Management System
FSN	Family Safe Network
FSP	Family Safety Plan
FVIR/POL	Police Family Violence Investigation Report
HAIP	Hamilton Abuse Intervention Project
ICM	Intensive Case Management
ISR	Integrated Safety Response
IPS	Independent Perpetrator Specialist
IVS	Independent Victim Specialist
MOE	Ministry of Education
MOJ	Ministry of Justice
MSD	Ministry of Social Development
MVCOT (CYF)	Ministry for Vulnerable Children, Oranga Tamariki (previously Child, Youth and Family)
NGO	Non-government organisation
NZP	New Zealand Police
PO	Protection Order
POS	Perpetrator Outreach Service
PSO	Police Safety Order
ROC	Report of Concern
SAM	Safety Assessment Meeting
SFV	Specialist Family Violence agency
Tū Pono	Tū Pono: Te Mana Kaha o Te Whānau – collective response to addressing family violence from Kaupapa Māori providers, iwi and the Whānau Ora Commissioning Agency, Te Pūtahitanga o Te Waipounamu
WINZ	Work and Income New Zealand

Appendix 1:

Family violence investigations since 2005 in the ISR pilot sites





Appendix 2:

Details of participants and recruitment guidelines for fieldwork

Details of agency/ NGO representation in fieldwork

	October 2016 (Christchurch)	March 2017 (Waikato)	May 2017 (Christchurch)
ISR team members	✓	✓	✓
Government agencies			
Police	✓	✓	✓
Corrections	✓	✓	✓
MVCOT (CYF)	✓	✓	✓
District Health Board	✓	✓	✓
Accident Compensation Corp	✓	✓	✓
Ministry of Social Development	✓	✗	✓
Ministry of Justice	✓	✗	✓
Ministry of Health	✓	✗	✗
Ministry of Education	✗	✓	✗
Other (Refuges/NGOs/agencies)			
Aviva	✓	✗	✓
Battered Women's Trust (BWT)	✓	✗	✓
Te Whare Hauora	✓	✗	✓
Shakti Refuge	✓	✗	✓
West Refuge	✓	✗	✓
Canterbury FV Collaboration	✓	✗	✗
Barnardos	✓	✗	✓
Stopping Violence Services	✗	✗	✓
Victim Support	✗	✗	✓
He Waka Tapu	✗	✗	✓
Ngā Maata Waka	✗	✗	✓
Te Puna Oranga	✗	✗	✓
Parentline	✗	✓	✗
HAIP	✗	✓	✗
Waikato Women's Refuge	✗	✓	✗
Members of local governance	✓	✓	✓
Tū Pono representatives	✓	✗	✓
Members of National Project Board	✓	✗	✓

Guidelines for recruiting ISR participants for interviews

As part of the Superu's external evaluation of ISR we are keen to include the voice of the families. We would like to meet with 30 ISR participants to hear about their experiences of being involved with ISR and working with a specialist support worker (IVS or IPS). We'll ask them about what they found helpful (or not helpful), what if anything has changed for them following their ISR support and any ways they feel ISR could be improved. (We have received ethical approval for this research)

Interviews will be conducted in the **first three weeks of May** – we'll start contacting participants from the 26th of April, so if we could have identified a sample by then that would be great.

To identify this sample:

1. we need help from IVS/IPS's to select a sample of participants they feel would be appropriate, eg
   - not likely to find talking with us too stressful/uncomfortable
   - those with recent but sufficient experience of the pilot to be able to comment meaningfully on their experiences (eg recently closed case and/or 12 weeks of contact but case still open);
2. we then need help from IVS/IPS or another appropriate person to contact these individuals to see if they are willing to participate and happy for their contact details to be passed on to us. (We need help with this step as we need the participant's permission for you to release to us their contact details to us, also hopefully this will be a nicer way for us to be introduced);
3. there is a more detailed information sheet for participants which can be passed on, so they can see what will be involved. We will go through this with them again when we contact them, to make sure they are fully informed and happy to participate;
4. please let us know if anyone would prefer a Māori interviewer, as Nan will be available in the second and third week of May; and finally
5. let us know if there are any particular safety concerns we should be aware of.

We appreciate this will be a significant demand on everyone's time and are happy to work with to help out in any way we can. We feel it is really important for participant's own voices to be a significant part of the evaluation and greatly appreciate your help in achieving this.

Criteria/goals/wish list

- 30 interviews in total with high risk victims and/or perpetrators (perhaps 20 victims, 10 perpetrators)
- if possible, 50:50 Māori: NZE or other
- initially assessed high risk at SAM and were allocated an IVS or IPS
- all participants 18 years or over

Ideally we'd like to get a mix of:

- varying relationship status (from pre-post data it seems most relationships appear to have ended, but it would be nice to speak with some who have stayed together)
- different family make-up (eg couples and those with children)
- participants of different ages (young adults, older adults)
- positive and negative experiences (this is our opportunity to learn how to improve ISR as well as document the benefits)
- perpetrators – in custody and community (we'll see the appropriate permissions to visit the prison)
- those who have been supported through court

What's involved is covered in the information sheet, but in brief:

- ideally we'll meet face-to-face and at a public location they would be comfortable with, either at Aviva or a café etc. However, if they would prefer a phone interview this is absolutely fine too.
- participation voluntary, and they only tell us what they feel comfortable with
- we will give a koha of $50 in appreciation for sharing their experiences with us
- participants can elect a Māori interviewer if this is their preference

Contact details

If you have any questions about these interviews or process of recruiting, you can contact Dr Elaine Mossman on 027 7373272 / e.mossman@clear.net.nz; or Judy Paulin on 027 433 6484 / judy@artemis-research.co.nz or Nan Wehipeihana on 021 686 766 / nan.wehipeihana@gmail.com

Appendix 3:

Details of analysis of family harm episodes six months before and after first contact with ISR

Data matching

All reports of family violence should be processed through ISR (in addition to high-risk prison releases). An initial sample of 4,482 individuals were identified in CMS as having the appropriate CMS role and having their first ISR contact between 4 July and 31 October 2017, representing 2,217 episodes. However, when compared to Police records of family harm episodes in Christchurch Metro, only 3,820 of the 4,482 could be matched with Police records (85%). Some of the mismatches could be explained through recording errors in either database (eg, date reported, CMS role) or subsequent re-coding of occurrences as family violence by Police; however, it is unlikely this could account for all mismatches, and further investigation is required to fully understand the apparent differences in the two databases.

Sample characteristics

TABLE A3.1

Demographic details of ISR sample (n=3820)

	ISR sample for pre-post analysis	
	n	**%**
CMS role		
Perpetrator	1601	42%
Victim	1597	42%
Subject	622	16%
Ethnicity		
European	2337	61%
Māori	830	22%
Pacific Peoples	199	5%
Asian	94	2%
Middle Eastern	38	1%
African	11	0.3%
Latin American	3	0.1%
Other ethnicity	308	8%
Age		
Child 0-13	36	1%
Youth 14-17	199	5%
Adult 18-64	3500	92%
Adult 65+	85	2%
Total[1]	**3820**	**100%**

Impact of time in custody

If individuals had spent time in custody in the six months before or after first contact with ISR, this impacts on their opportunity to offend (or be victimised). Therefore, if a large number of the sample were in custody for long periods in the six-month post period, it could potentially skew the results. Information obtained from Corrections identified 135 individuals for the ISR sample who had spent one or more days in custody in the six months pre-ISR, and 219 in the six months after (see below).

6 months pre-ISR (n=135 out of 3.5,820) including:

- 103 perpetrators, 14 subjects and 18 victims
- 66 NZE and 56 Māori
- total days in custody = 8,227 days

6 months post-ISR (n=219 out of 3,820) including:

- 177 perpetrators, 22 subjects and 20 victims
- 112 NZE and 85 Māori
- total days in custody =16,404 days.

To investigate the potential impact of these individuals on the results, analysis of summary family violence indicators was run with and without individuals who have spent time in custody. The results appear in Table A3.2 below, and they show no difference to the main findings.

While there were slightly lower means for frequency and seriousness of reported family harm episodes when those who had spent time in custody had been removed, the Wilcoxon Signed Ranks test still found a statistically significant reduction in frequency and seriousness in the six months following ISR regardless of whether this group was included or excluded.

TABLE A3.2

Comparison of family harm episodes in the six months before and after first contact with ISR with and without those who had spent time in custody

Variable	n	6m Before	6m After	Z	sig
		Means (sd)			
Complete sample					
Overall seriousness	3820	1.3 (.87)	0.62 (.96)	-30.631	.000
Overall frequency	3820	1.18 (.62)	0.60 (.86)	-32.613	.000
Removing those who spent time in custody					
Overall seriousness	3554	1.25 (0.83)	0.56 (.88)	-31.034	.000
Overall frequency	3554	1.16 (.61)	0.57 (.83)	-32.504	.000

Number and type of family violence offences and episodes

All offences in any one family harm episode are flagged as family violence. In some cases this includes offences that are not related to the family violence. For example if an individual is apprehended for a Male Assaults Female charge but at the same time apprehended for possession of drugs or stolen items, all offences are flagged as 'family violence'. For the purpose of this analysis only offence categories deemed to be family violence-related were included (ie, Violence, Sexual Violence, and Property Damage). Those that occurred in the sample and were included appear in Table A3.3 below.

Some codes were difficult to categorise as in some cases they would have been family violence-related and other times not. For example, breach of bail (6C): if the condition breached was a family violence-related non-association order it would be relevant, but if the condition was not to consume alcohol, it would not be. Where this was unclear, these occurrences were removed.

TABLE A3.3

Number and type of offence codes included as 'family violence offences'

Code & Description	Total	Included
1112 – MURDERS (OTHER WEAPON)	1	yes
1212 – KIDNAPS (NO GAIN)	2	yes
1219 – OTHER KIDNAPPING	7	yes
1361 – AGGRAVATED ROBBERY (TOGETHER WITH ANOTHER PERSON/S)	2	yes
1413 – WOUNDS INTENT TO GBH (MANUALLY)	5	yes
1415 – WOUNDS INTENT TO INJURE (OTHER WEAPON)	2	yes
1416 – WOUNDS INTENT TO INJURE (MANUALLY)	1	yes
1417 – WOUND WITH INTENT TO GBH (STABBING/CUTTING WEAPON)	3	yes
1418 – WOUND WITH INTENT TO INJURE (STABBING/CUTTING WEAPON)	5	yes
1422 – INJURES INTENT TO GBH (OTHER WEAPON)	4	yes
1423 – INJURES INTENT TO GBH (MANUALLY)	5	yes
1425 – INJURES INTENT TO INJURE (OTHER WEAPON)	2	yes
1426 – INJURES INTENT TO INJURE (MANUALLY)	79	yes
1428 – INJURES INTENT TO INJURE (STABBING/CUTTING WEAPON)	4	yes
1454 – DANGEROUS ACT INTENT TO INJURE (FIREARM)	2	yes
1492 – ASSAULT PERSON WITH STABBING/CUTTING WEAPON	31	yes
1493 – ASSAULT PERSON WITH BLUNT INSTRUMENT	71	yes
1498 – OTHER ASSAULTS WITH WEAPON SECTION 202C	6	yes
1513 – AGGRAVATED ASSAULT (MANUALLY)	4	yes
1522 – ASSAULTS WITH INTENT TO INJURE (OTHER WEAPON)	2	yes
1523 – ASSAULTS WITH INTENT TO INJURE (MANUALLY)	139	yes
1524 – ASSAULT INTENT TO INJURE (STABBING/CUTTING WEAPON)	2	yes
1529 – OTHER ASSAULTS WITH INTENT TO INJURE	2	yes
1532 – ASSAULTS CHILD (OTHER WEAPON)	3	yes
1533 – ASSAULTS CHILD (MANUALLY)	71	yes
1539 – OTHER ASSAULT ON CHILD (UNDER 14 YEARS)	1	yes
1542 – MALE ASSAULTS FEMALE (OTHER WEAPON)	10	yes
1543 – MALE ASSAULTS FEMALE (MANUALLY)	679	yes
1553 – ASSAULT POLICE(CRIMES ACT)MANUALLY	3	yes
1582 – COM ASSLT(DOMESTIC)CR ACT(OTH WEAP)	8	yes
1583 – COM ASSLT(DOMESTIC)CR ACT(MANUALLY)	144	yes
1589 – OTHER COMMON ASSAULT(CRIMES ACT)	7	yes
1591 – COMMON ASSAULT(CRIMES ACT)FIREARM	3	yes

Code & Description	Total	Included
1592 – COMMON ASSAULT(CRIMES ACT)OTHER WPN	4	yes
1593 – COMMON ASSAULT(CRIMES ACT)MANUALLY	58	yes
1594 – COMMON ASSAULT (STABBING/CUTTING WEAPON)	2	yes
1613 – ASSAULTS POLICE (MANUALLY)	18	yes
1641 – COMMON ASSAULT (DOMESTIC) (FIREARM)	1	yes
1642 – COMMON ASSAULT (DOMESTIC) (OTHER WEAPON)	13	yes
1643 – COMMON ASSAULT (DOMESTIC) (MANUALLY)	497	yes
1649 – OTHER COMMON ASSAULT	6	yes
1652 – COMMON ASSAULT (OTHER WEAPON)	2	yes
1653 – COMMON ASSAULT (MANUALLY)	108	yes
1711 – THREATENS TO KILL/DO GBH (FIREARM)	18	yes
1712 – THREATENS TO KILL/DO GBH (OTHER WEAPON)	4	yes
1713 – THREATENS TO KILL/DO GBH (MANUALLY)	43	yes
1714 – THREATENS TO KILL/DO GBH (VERBAL)	67	yes
1715 – THREATENS TO KILL/DO GBH (STABBING/CUTTING WEAPON)	36	yes
1719 – OTHER THREATENS TO KILL/DO GBH	3	yes
1724 – THREATEN PERSON(CRIMES ACT)-VERBALLY	1	yes
1727 – THREATEN PROPERTY(CR ACT)-MANUALLY	2	yes
1728 – THREATEN PROPERTY(CR ACT)-VERBALLY	3	yes
1729 – OTHER THREAT ACT(PERS/PROP(CRIMES)	51	yes
1731 – BEHAVE THREATENINGLY (FIREARM)	6	yes
1732 – BEHAVE THREATENINGLY (OTHER WEAPON)	9	yes
1733 – BEHAVE THREATENINGLY (MANUALLY)	43	yes
1734 – SPEAKS THREATENINGLY	48	yes
1735 – BEHAVE THREATENINGLY (STABBING/CUTTING WEAPON)	2	yes
1739 – OTHER THREATENING BEHAVIOUR OF LANGUAGE	6	yes
1744 – DEMANDS TO STEAL (VERBAL/LETTER ETC)	1	yes
1747 – DEMANDS TO STEAL (STABBING/CUTTING WEAPON)	2	yes
1748 – BLACKMAIL	1	yes
1756 – POSSESS OFFENSIVE WEAPON (OTHER)	33	yes
1758 – POSSESS KNIFE IN PUBLIC PLACE (SUMM OFF)	2	yes
1765 – CAUSING HARM BY POSTING DIGITAL COMMUNICATION	22	yes
1775 – ILLTREAT/NEGLECT CHILD UNDER 18 YEARS	2	yes
1789 – OTHER MISCELLANEOUS INTIMIDATION AND THREAT	5	yes
1841 – CRIMINAL HARASSMENT	6	yes
1A – ALARM SOUNDING	1	no
1C – CAR/PERSON ACTING SUSPICIOUSLY	3	no
1D – DOMESTIC DISPUTE	8495	yes
1J – JUVENILE COMPLAINT (ACTION TAKEN UNDER CYP & F ACT)	2	no
1K – DRUNK CUSTODY/DETOX CENTRE	37	no
1M – MENTAL HEALTH	12	no
1V – VEHICLE COLLISION	15	no
1X – THREATENS/ATTEMPTS SUICIDE	50	no
1Z – OTHER INCIDENT	25	no
2631 – INDECENTLY ASSAULTS FEMALE UNDER 12	3	yes
2632 – INDECENTLY ASSAULTS FEMALE 12-16	1	yes
2633 – INDECENTLY ASSAULTS FEMALE OVER 16	4	yes
2652 – MALES RAPES FEMALE 12-16	1	yes

Code & Description	Total	Included
2653 – MALES RAPES FEMALE OVER 16	25	yes
2655 – UNLAWFUL SEXUAL CONNECTION FEMALE UNDER 12	1	yes
2657 – UNLAWFUL SEXUAL CONNECTION FEMALE OVER 16	2	yes
2659 – OTHER SEXUAL VIOLATION OFFENCES	6	yes
2677 – ASSAULT INTENT COMMIT SEXUAL CONNECTION FEMALE OVER 16	1	yes
2693 – UNLAWFUL SEXUAL CONNECTION MALE UNDER 12	1	yes
2695 – UNLAWFUL SEXUAL CONNECTION MALE OVER 16	1	yes
2817 – SEXUAL CONNECTION WITH YOUNG PERSON 12 – 16	3	yes
2991 – MADE AN INTIMATE VISUAL RECORDING	3	yes
2993 – PUBLISH/IMPORT/EXPORT/SELL AN INTIMATE VISUAL RECORDING	2	yes
2C – CIVIL DISPUTE	2	no
2I – INFORMATION	13	no
2O – COURT ORDERS	12	no
2P – PUBLIC RELATIONS	13	no
2T – WARRANT TO ARREST/FINES ENFORCEMENT	1	no
2W – FAILS TO APPEAR ON WARRANT	1	no
2Z – OTHER SERVICE REQUEST RESPONSE	19	no
3154 – PROCURE/POSSESS MORPHINE	1	no
3185 – POSSESS NEEDLE/SYRINGE ETC FOR DRUGS	3	no
3251 – PROCURE/POSSESS CANNABIS SEED	2	no
3252 – PROCURE/POSSESS CANNABIS PLANT	10	no
3271 – CULTIVATE CANNABIS	6	no
3284 – POSSESS NEEDLE/SYRINGE ETC FOR CANNABIS	7	no
3511 – OBSTRUCT/HINDER POLICE	7	no
3514 – RESIST POLICE	25	no
3531 – DISORDERLY BEHAVIOUR (LIKELY TO CAUSE VIOLENCE)	7	no
3535 – OFFENSIVE BEHAVIOUR S4 S/OFFENCES ACT	2	no
3536 – DISORDERLY BEHAVIOUR S4 S/OFFENCES ACT	17	no
3537 – DISORDERLY BEHAVIOUR PRIVATE PREMISES	1	no
3541 – OBSCENE LANGUAGE	2	no
3545 – INSULTING LANGUAGE	1	yes
3546 – THREATENING LANGUAGE	2	yes
3561 – FIGHTING IN PUBLIC PLACE	7	yes
3711 – CRUELTY TO/ILLTREAT CHILD (CRIMES ACT)	3	yes
3713 – ABANDON CHILD	1	yes
3718 – LEAVING CHILD < 14 WITHOUT REASONABLE SUPERVISION	2	yes
3851 – CONTRAVENES PROTECTION ORDER (FIREARM)	38	yes
3852 – CONTRAVENES PROTECTION ORDER (NO FIREARM)	949	yes
3857 – FAILS TO COMPLY WITH POLICE SAFETY ORDER	73	yes
3858 – DETENTION BY CONSTABLE: FAILURE TO REMAIN	2	no
3861 – CONTRAVENE PARENTING ORDER	1	no
3A – BREACH POLICE BAIL CONDITIONS	4	no
3Z – OTHER PREVENTATIVE TASK	53	no
4121 – BURGLES (OTHER PROPERTY)(OVER $5000) BY DAY	2	no
4122 – BURGLES (OTHER PROPERTY) ($500-$5000) BY DAY	4	no
4123 – BURGLES (OTHER PROPERTY)(UNDER $500) BY DAY	11	no
4125 – BURGLES (OTHER PROPERTY)($500-$5000) BY NIGHT	3	no
4126 – BURGLES (OTHER PROPERTY)(UNDER $500) BY NIGHT	2	no

Code & Description	Total	Included
4127 – REMAINED WITH INTENT	1	no
4129 – OTHER BURGLARY (OTHER PROPERTY)	9	no
4139 – OTHER BURGLARY ASSOC OFFENCE (CRMS ACT)	1	no
4156 – COMMITTING BURGLARY WITH A WEAPON (OTHER WEAPON)	1	no
4158 – REMAINED AFTER BURGLARY (OTHER WEAPON)	3	no
4211 – UNLAWFUL TAKES MOTOR VEHICLES (MOTOR CARS/TRUCKS ETC)	24	no
4213 – UNLAWFUL CONVERTS MOTOR VEHICLES (MOTOR CARS/TRUCKS ETC)	4	no
4223 – UNLAWFUL GETS INTO/UPON MOTOR VEHICLE/MOTOR CYCLE	3	no
4342 – THEFT EX CAR (UNDER $500)	4	no
4352 – THEFT EX PERSON (EST VAL UNDER $500)	2	no
4362 – THEFT EX DWELLING (EST VAL UNDER $500)	7	no
4363 – THEFT EX DWELLING ($500-$1,000)	8	no
4373 – THEFT (UNDER $500)	28	no
4387 – THEFT (OVER $1,000)	8	no
4388 – THEFT ($500-$1,000)	2	no
4538 – USED FORGED DOCUMENTS	2	no
4554 – OBTAIN BY DECEPTION ($500-$1,000)	2	no
4571 – TAKE/OBTAIN/USE DOC FOR PECUNIARY ADVANTAGE	4	no
4584 – TAKE/OBTAIN/USE CRED/BANK CRD TO PECUNIARY ADVANTAGE	26	no
4X – EXECUTE SEARCH WARRANT	1	no
5119 – OTHER ARSON	2	yes
5127 – WILFUL DAMAGE	506	yes
5142 – INTENTIONAL DAMAGE (NO INTEREST)	14	yes
5215 – ENDANGERING TRANSPORT	1	no
5858 – POSSESS NON APPROVED PSYCHOACTIVE PRODUCT	1	no
5951 – PROCURE/POSSESS METHAMPHETAMINE AND AMPHETAMINE	3	no
5955 – PROCURE/POSSESS BZP TYPE SUBSTANCES	1	no
5985 – POSSESS/USES UTENSILS METHAMPHETAMINE / AMPHETAMINE	2	no
5F – FAMILY HARM INVESTIGATION	14	yes
6111 – WILFUL TRESPASS	81	yes
6119 – OTHER OFFENCES UNDER TRESPASS ACT	1	yes
6132 – UNLAWFULLY IN BUILDING	10	yes
6136 – UNLAWFULLY IN ENCLOSED YARD OR AREA	2	yes
6391 – CRUELTY/ILL-TREATMENT OF ANIMALS	2	yes
6551 – OFFENSIVE/DISTURBING USE OF TELEPHONE	32	yes
6554 – USED OR PERMITTED TELEPHONE TO BE USED	6	yes
6555 – USED PHONE FOR FICTITIOUS PURPOSE	2	no
6563 – POSTING OF OBJECTIONABLE THING	1	yes
6851 – UNLAWFULLY CARRY/POSSESS FIREARM/RES WEAPON/EXPLOSIVES/ AMMUNITION	12	no
6856 – UNLAWFULLY POSSESS PISTOL/RESTRICTED WEAPON	1	no
6857 – UNLAWFULLY CARRY/POSSESS FIREARM/AMMUNITION/EXPLOSIVES PUBLIC PLACE	1	no
6861 – PRESENT FIREARM/RESTRICTED WEAPON AT PERSON	5	yes
6911 – BREACH COMMUNITY DETENTION	1	no
6913 – BREACH DETENTION CONDITIONS	2	no
6915 – BREACH CONDITION OF INTENSIVE SUPERVISION	1	no
6C – CHILD PROTECTION REPORT	330	no

Code & Description	Total	Included
6D – BAIL BREACH	247	no
6S – POLICE SAFETY ORDER BREACH	152	yes
7112 – PERSONATING POLICE	1	no
7123 – FALSE STATEMENT/DECLARATION ETC	1	no
7138 – ESCAPE FROM POLICE CUSTODY	2	no
7181 – BREACHES OF MEDICINES ACT 1981	1	no
7191 – FAILURE TO ANSWER DISTRICT COURT BAIL	55	no
7192 – FAILURE TO ANSWER POLICE BAIL	5	no
7945 – BREACH COURT RELEASE CONDITION PRISON	2	no
7P – DOMESTIC VIOLENCE ACT PROTECTION ORDER	3	yes
A331 – REFUSED OFFCR REQ FOR BLOOD SPECIMEN 3RD OR SUBSEQUENT	1	no
A518 – BREATH ALCOHOL LEVEL OVER 400 MCGS PER LITRE OF BREATH	3	no
A530 – DROVE WITH EXS BREATH ALCOHOL 3RD OR SUBSEQUENT	2	no
B106 – GAVE FALSE DETAILS AS TO OWN IDENTITY	1	no
B109 – FAILED TO GIVE NAME AND ADDRESS ON DEMAND	1	no
B184 – UNLICENSED DRIVER FAILED TO COMPLY WITH PROHIBITION	1	no
B203 – FAILED TO STOP OR ASCERTAIN INJURY – NON-INJURY CRASH	1	no
D101 – RECKLESS DRIVING	2	no
D201 – DRIVING IN A DANGEROUS MANNER	4	no
D502 – CARELESS DRIVING	3	no
L143 – DROVE WHILE LICENCE SUSPENDED OR REVOKED	1	no
L201 – DRIVING WHILE DISQUALIFIED	2	no
L209 – DROVE CONTRARY TO A ZERO ALCOHOL LICENCE	1	no

Appendix 4:

Details of pre-post survey data

Assessment of self-reported family harm

Instructions for IVS/IPS

Participant exposure/experiences of family harm: Please use information you have sourced directly from the client to record below the type of family harm they have been exposed to over the previous three months: tick as appropriate

Type of family harm	Is this harm occurring?	If occurring – rate severity of harm	If occurring – rate escalation over previous 3m	
			Severity	Frequency
Physical	☐ Yes → ☐ No ☐ Unknown	☐ Extreme ☐ High ☐ Moderate	☐ Worse ☐ Unchanged ☐ Reduced	☐ Worse ☐ Unchanged ☐ Reduced
Sexual	☐ Yes → ☐ No ☐ Unknown	☐ Extreme ☐ High ☐ Moderate	☐ Worse ☐ Unchanged ☐ Reduced	☐ Worse ☐ Unchanged ☐ Reduced
Jealous and controlling behaviour	☐ Yes → ☐ No ☐ Unknown	☐ Extreme ☐ High ☐ Moderate	☐ Worse ☐ Unchanged ☐ Reduced	☐ Worse ☐ Unchanged ☐ Reduced
Harassment and stalking	☐ Yes → ☐ No ☐ Unknown	☐ Extreme ☐ High ☐ Moderate	☐ Worse ☐ Unchanged ☐ Reduced	☐ Worse ☐ Unchanged ☐ Reduced
Financial abuse	☐ Yes → ☐ No ☐ Unknown	☐ Extreme ☐ High ☐ Moderate	☐ Worse ☐ Unchanged ☐ Reduced	☐ Worse ☐ Unchanged ☐ Reduced

Guidelines for rating types and extent of family harm experienced

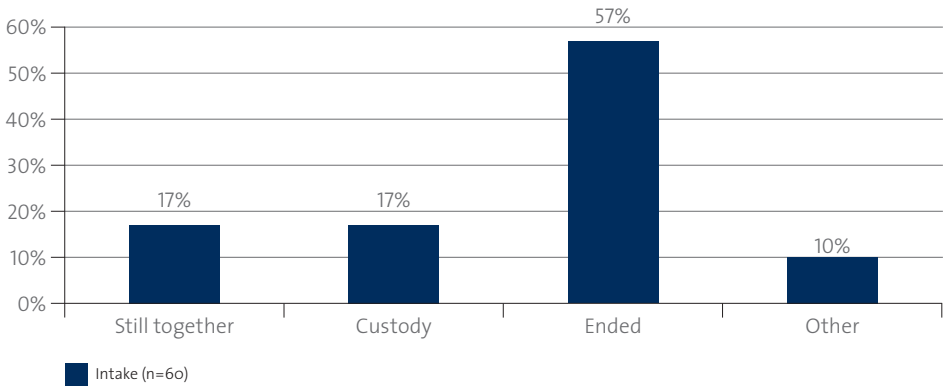
Physical abuse			
No	**Standard/moderate**	**High**	**Extreme**
Never, or not currently	Slapping, pushing; no injuries and/or lasting pain or mild, shallow bruising or cuts	Beating up, severe contusions, burns, broken bones, miscarriage, threats to kill (imprecise) Noticeable bruising, lacerations, pain	Threats to kill partner, children, relatives or pets with specific risks such as access to weapons. Strangulation, holding under water or threat to use or use of weapons; loss of consciousness, head injury, internal injury, permanent injury, miscarriage
Sexual abuse			
No	**Standard/moderate**	**High**	**Extreme**
Never, or not currently	Uses pressure or threats to obtain sex	Uses force to obtain sex, threatens to sexually abuse children	Forced sex or sexual acts on partner, violent sexual practices, deliberately inflicts pain during sex, combines sex and violence, sexually abuses children and forces spouse to watch, enforced prostitution
Jealous and controlling behaviour			
No	**Standard/moderate**	**High**	**Extreme**
Never, or not currently	Makes you account for your time, isolates you from family and friends, intercepting mail or phone calls, controls your access to money	Controls most or all of your daily activities? (eg, tells you with whom you can be friends, when you can see your family, how much money you can use, or when you can take the car)	Extreme dominance, eg, Believes absolutely entitled to partner, partner's services, obedience, loyalty no matter what. Extreme jealousy, (eg, 'If I can't have you, no-one can') with belief that abuser will act on this. Locking you up or severely restricting your movements. Threats to take the children. Suicide/ homicide threats. Extreme sexual fantasies.
Harassment and stalking			
No	**Standard/moderate**	**High**	**Extreme**
Never, or not currently	Frequent phone calls, texts, emails, drops in occasionally	Constant phone calls, texts or emails. Uninvited visits.	Calls obsessively, pursues victim after separation, stalking, threats of suicide/ homicide to you and other family members, threats of sexual violence
Financial Abuse			
No	**Standard/moderate**	**High**	**Extreme**
Never, or not currently	Tries to control how you spend your money. May use your funds/credit card without asking (smaller sums). Makes you pay more than your share of bills	Makes most or all financial decisions for you. Has control of most or all your financial assets. Has used funds/ stolen property of yours (moderate sums). May stop/ prevent you from working. Withholds funds or only gives you an "allowance"	Taken complete control of all financial assets (eg, taken over control of bank accounts, property). Fraudulent behaviour eg, falsifies signatures/identity theft. Has taken large sums of money without permission, or run up very large debts on joint accounts.

This is based on the instrument used by Howarth and colleagues in 2009 to evaluate the UK's Independent Domestic Violence Advocates (IDVA). http://www.henrysmithcharity.org.uk/documents/SafetyinNumbersFullReportNov09.pdf

Details of sample who participated in the pre-post survey

- All participants were high-risk victims
- Where ethnicity was recorded (n=38), 53% or 24 were NZE, 30% or 11 were Māori, and 5% or 2 were Pacific
- All but 9 had children (n=51, 88%)
- Total intake surveys = 60
- Total exit surveys = 26 (of which matched intake & post = 19)

Figure A4.1 _ Relationship status at intake



Victims self-reported experiences of family harm (matched sample, n=19)

Figure A4.2 _ Self-reported changes in abuse experienced for a matched sample of high-risk clients (n=19)

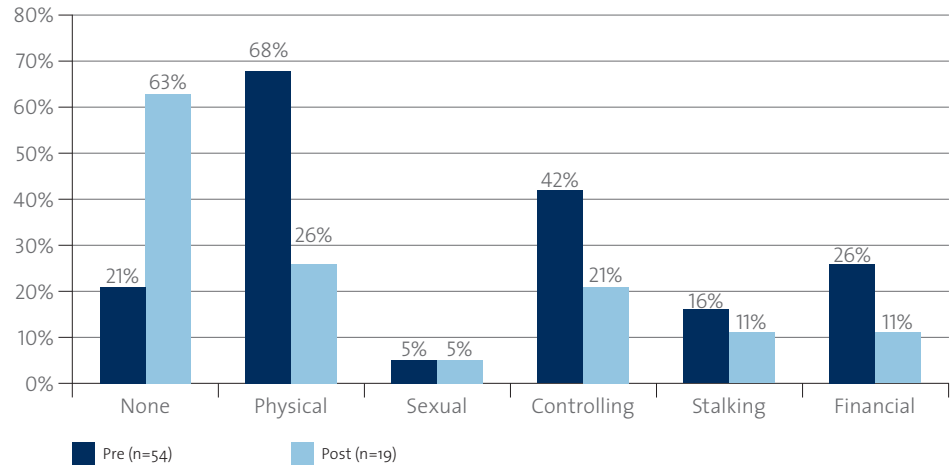
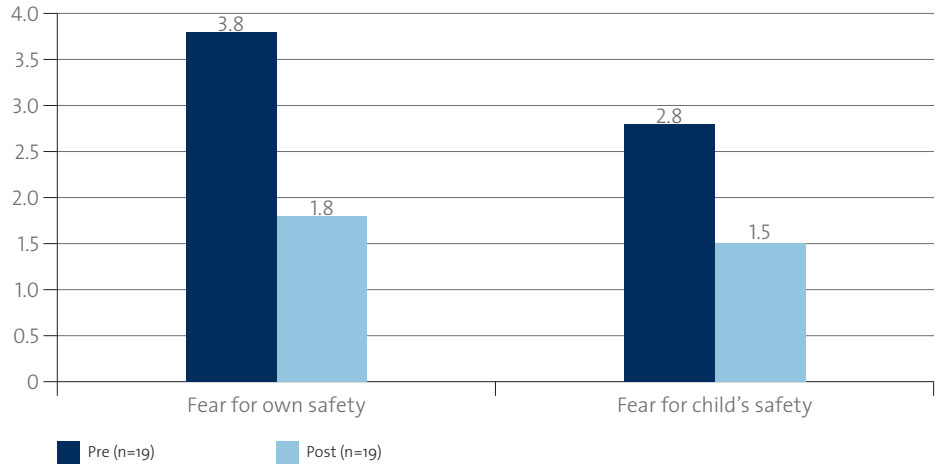


Figure A4.3 _ Self-reported fear for safety before and after IVS support for a matched sample of high-risk clients (n=19)



Appendix 5:

ISR Quick Guide (Risk Assessment)

Integrated Safety Response Quick Guide

Victim(s) Children Perpetrator(s)	CONCERN	HARM
	What is the level of concern for further violence reoccurring? The likelihood of another episode of family violence reoccurring as well as how soon it is likely to occur	**What would be the level for harm from any further violence?** The degree of harm that is likely to be caused to others, including victims and children, if further family violence were to occur

SCAN	SCAN THIS USING	
Scan the available information (current and historic) from all agencies and assess the concern for further family violence and the level of harm that would result	Number of previous episodes Number of episodes in the last 12 months Frequency of episodes Presence of risk factors/lethality indicators	Harm resulting from previous episodes Escalation in severity Yes / No Number of known victims Potential victims

ANALYSE		
Analyse the concern for further family violence and harm using the guidance on risk and supported decision framework	☐ **HIGH CONCERN** Family violence is about to reoccur imminently or is highly likely to reoccur ☐ **MEDIUM CONCERN** Family violence is likely to reoccur, but not imminent ☐ **LOW CONCERN** Family violence is unlikely to reoccur	☐ **HIGH HARM** Potential for serious physical injury, emotional or psychological trauma, or death ☐ **MEDIUM HARM** Potential for moderate physical injury, emotional or psychological trauma ☐ **LOW HARM** Potential for minimal or no physical, emotional or psychological trauma

RESPOND	TIER 1	TIER 2	TIER 3
Match the level of response to the assessed risk. Develop and action a plan that is tailored to the family to keep them safe and prevent further violence.	• Requires highly intensive and extensive responses • Intervene now if family violence or harm is imminent • Engage IVS and action ICM referral for victim(s) at high risk	• Requires medium intensity response • Assign lead agency and develop Family Safety Plan	• Requires low intensity response • Assign lead agency and develop Family Safety Plan

Integrated Safety Response Quick Guide

Victim Risks

- ☐ Pregnancy or recent birth
- ☐ Mental health issues
- ☐ Alcohol and/or drug abuse
- ☐ Suicide/self harm (threatened or attempted)
- ☐ Isolation (including social and geographical)
- ☐ Deprivation
- ☐ Non-engagement
- ☐ History of victimisation/cumulative harm
- ☐ Fear for own safety

Relationship Risks

- ☐ Recent separation/recent protection order
- ☐ Escalation in frequency and/or severity of violence
- ☐ Financial difficulties
- ☐ Previous violence in relationships
- ☐ Gang

Children/Young People Risks

- ☐ Step children/children from prior relationships
- ☐ Vulnerability (infants, under 5 years, complex needs)
- ☐ History of victimisation/cumulative harm

Perpetrator Risks

- ☐ History of violent behaviour/family violence
- ☐ Attempted to kill the victim
- ☐ Harmed/threatened to harm, intimidate the victim, forced sex
- ☐ Strangulation, suffocation, drowning, choking
- ☐ Breach of protection order
- ☐ Weapons/access to weapons
- ☐ Unemployment/loss of employment
- ☐ Stalking of the victim
- ☐ Coercive & controlling behaviours, obsessive, jealous
- ☐ Harmed/threatened to harm, intimidate children, family members, or pets
- ☐ Suicide/self harm (threatened or attempted)
- ☐ Alcohol and/or drug abuse
- ☐ Mental health issues
- ☐ Previous police involvement

Practice Considerations

- ☐ Escalation/changes in risk?
- ☐ Vulnerability?
- ☐ Previous patterns of behaviour?
- ☐ Further information required/verification?
- ☐ Key risk factors to target?
- ☐ Impact on children?
- ☐ Complex needs?
- ☐ Engaging family/whānau/key supports?
- ☐ Protective factors/strengths to build?
- ☐ Cumulative harm?
- ☐ Barriers to change?
- ☐ Other?

Agency sources of Information/ Assessments

- ☐ Previous FV incidents
- ☐ ODARA
- ☐ Roc*Rol
- ☐ ASRS
- ☐ Offending history
- ☐ Tuituia
- ☐ DRAOR/SDAC-21
- ☐ STABLE/ACUTE 2007
- ☐ Safety Screening
- ☐ Health & Risk Assessment
- ☐ Other

Appendix 6:

Definition of CMS person roles

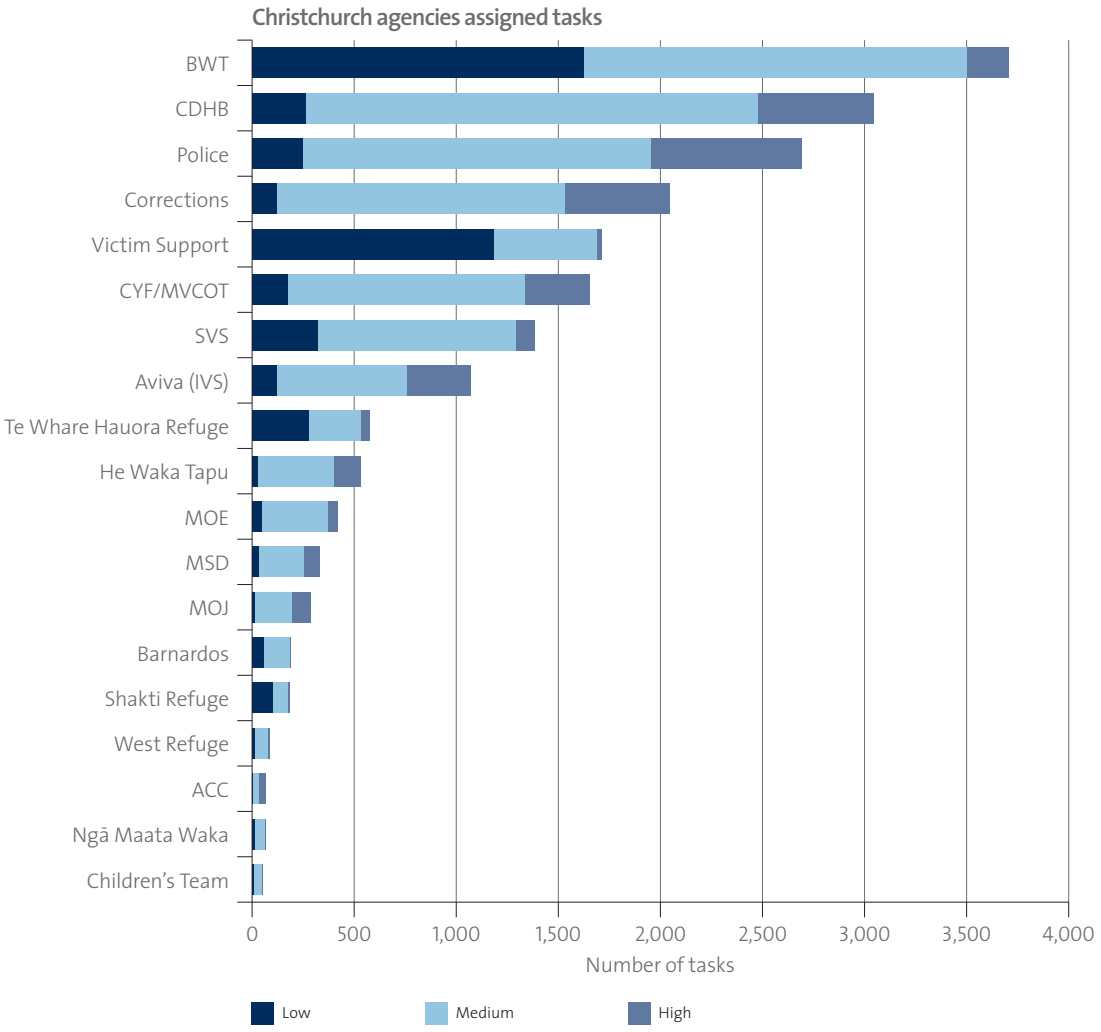
Role	Definition
Victim	NZP – A victim includes any person or organisation that has had **an offence** committed against them, or against property owned by them.
	CMS – A victim includes any person that has had an offence committed against them, or against property owned by them **OR** was identified as the 'primary victim' in a non-offence incident (i.e. 1D). This could be an adult or child.
Perpetrator	NZP (Offender) – An offender is a person or organisation whom the police have determined committed **an offence**.
	CMS – A perpetrator is a person whom the police have determined committed an offence **OR** was identified as the 'predominant aggressor' in a non-offence incident (i.e. 1D). This could be an adult or young person.
Suspect	NZP – A suspect is a person or organisation whom the police suspect may have committed **an offence**, and about whom police require further evidence in order to determine whether or not the person did commit the offence.
	CMS – As above – [for analysis purposes 'suspects' are usually combined with 'perpetrators', but Christchurch still records them in CMS as 'suspect'].
Subject	NZP – The person(s) or organisation about whom **an incident or task** primarily relates. It is inappropriate for the terms victim and offender to be used in the context of a non-offence incident.
	CMS – (1) Individuals involved in a non-offence incident (i.e. 1D) where it is not possible to identify who was the primary victim or predominant aggressor; (2) A child related to a family referred to ISR who was not in the house at the time of the episode.
Witness	NZP – A witness is a person who has seen an offence, or incident or happen, spoken to the offender, or can assist the police by providing information to corroborate a victim's statement, etc.
	CMS – (1) As above; (2) A child who was in the house or present at the time of the episode regardless of whether they actually witnessed the family harm.
Informant	NZP – An informant is a person who reported an occurrence to police.
	CMS – As above.

Appendix 7:

Breakdown of agencies/NGOs that tasks are assigned to

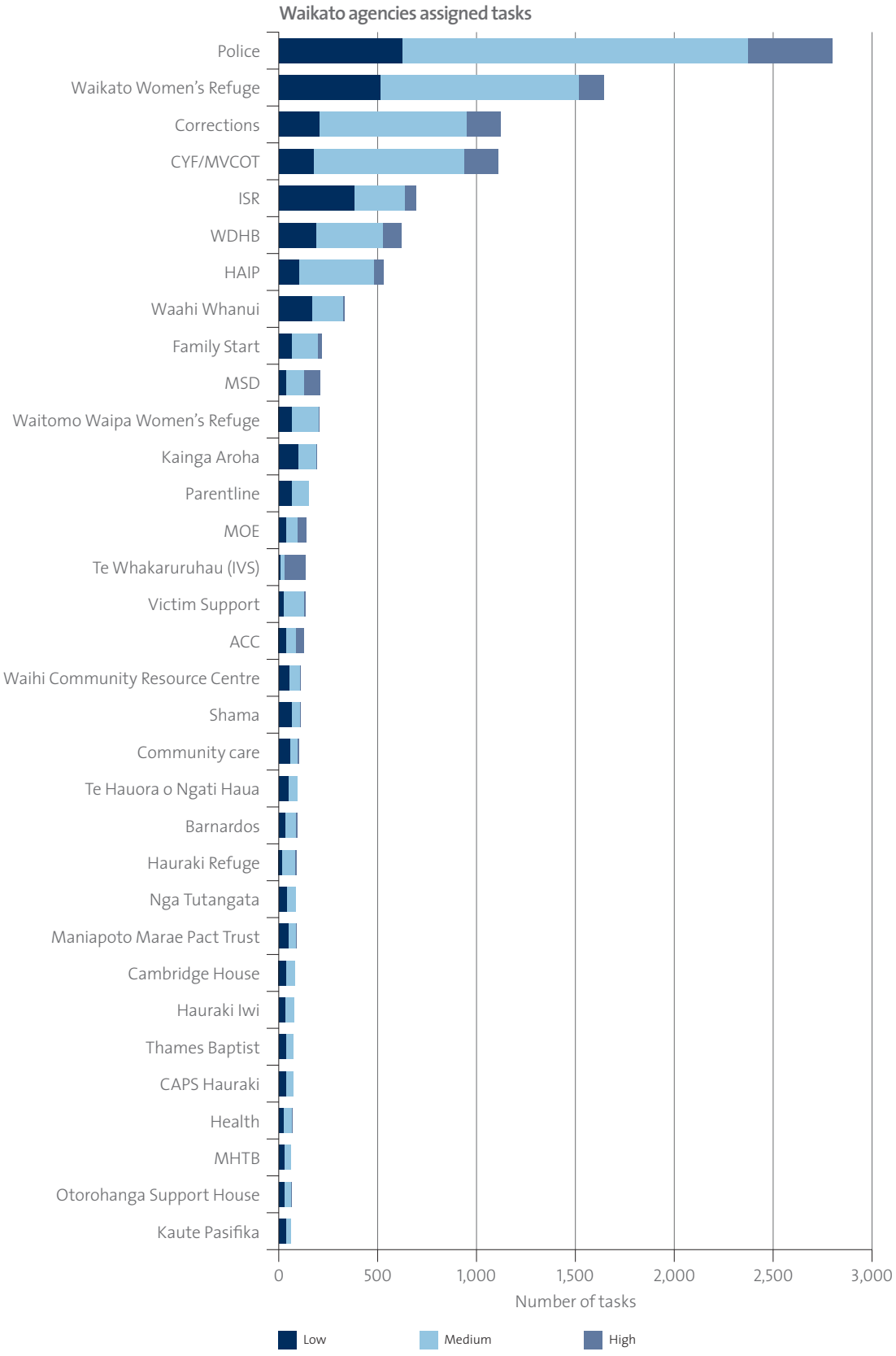
These figures are based on whom the task was 'assigned to' (ie, who was responsible for completing the task) and not the 'owner' of the task (responsible for closing the task when satisfied it has been completed appropriately). Only agencies/NGOs assigned more than 50 tasks in total are included.

Figure A7.1 _ Breakdown of agencies/NGOs that tasks are assigned to – Christchurch



Note: Risk tier is based on the current risk status of plans and thus obscures the dynamic status of risk, where for example high-risk cases have subsequently transitioned to medium or low risk, or low risk have transitioned to high risk.

Figure A7.2 _ Breakdown of agencies/NGOs that tasks are assigned to – Waikato



Note: Risk tier is based on the current risk status of plans and thus obscures the dynamic status of risk, where for example high-risk cases have subsequently transitioned to medium or low risk, or low risk have transitioned to high risk.

Families Commission Kōmihana ā Whānau

The Families Commission operates under the name Social Policy Evaluation and Research Unit (Superu)