Research for the Development of Two ‘One Stop Hubs’

Executive Summary

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Glossary

AOD	Alcohol and other drugs
CaLD	Culturally and Linguistically Diverse
CBD	Central Business District
CRS	Coordinated Response Service
DoJ	Department of Justice
DCS	Department of Corrective Services
DVAS	Domestic Violence Advocacy Service
FDV	Family and Domestic Violence
FDVRT	Family and Domestic Violence Response Teams
GPs	General Practitioners
Integrated Responses	The term used to include work being undertaken that involves a range of agencies coming together to work towards a common purpose in a specific field of practice, in this instance family and domestic violence services.
KFVS	Kimberley Family Violence Service
MDVHL	Department for Communities Men's Domestic Violence Helpline
SaH	Safe at Home
WA	Western Australia

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Executive Summary

The Government of Western Australia, as part of its commitment to improving the safety and wellbeing of women and children experiencing family and domestic violence (FDV), recently announced their intention to develop two 'One Stop Hubs'; one in the metropolitan area and one in regional WA, to complement existing services. The purpose of this report is to provide guidance on what forms of hub service design could be implemented in a metropolitan and a rural location to develop and optimise interagency and collaborative working. This includes the key features of the service designs, start-up and implementation considerations, and evidence about successes and challenges around setting up such partnerships to work in this form of service design.

The drive for coordination is also directly related to the complexity of the issue and that effective responses mostly involve a multiplicity of agencies. In the FDV context, it is also a recognised way of reducing secondary victimisation caused by agency silos and systems directly or indirectly holding victims responsible for abuse (Wilcox, 2010). Typically, the aim of service integration is to be more effective and efficient through reducing duplication of tasks, improving agencies' responsiveness and providing such responses with less burden on the service user (Fine, Pancharatnam, & Thomson, 2000).

Establishing coordinated and integrated responses to address FDV has become a well-recognised service delivery option in recognition of the need to join up services, reduce costs and improve the accessibility and experience of service users. This approach has been advocated for some time at the international and local levels (Fine et al., 2000; Gordon, Hallahan, & Henry, 2002; Ombudsman Western Australia, 2016). Unfortunately, a common driver of coordinated one stop service delivery, has been the FDV related deaths that have occurred and which may have been prevented, had the practitioners in their agencies effectively assessed escalating risk and imminent harm, shared information and worked collaboratively with all parties involved: the perpetrator, the victims and the informal supporters of those involved. It is this complexity of circumstances and the potentially large number of agencies all holding various forms of information about the families that drives the need for effective ways of working together. This would ideally involve the development

of specialised collaborative practices, all parties being FDV informed and understanding what to do with the information they hold, an alignment of purpose and strategy and agencies able to respond flexibly and efficiently.

This approach is not unique to the FDV space with service coordination and collaboration incorporated across many contexts of public service delivery including health, child development, family support and homelessness sectors. The aspect which can often make FDV more difficult is that there are potentially more individuals involved (partners, children, family members) than may be the case in other settings.

In FDV, hub service delivery models offer a centralised pathway of support to those impacted by FDV. As a result of the Victorian Government Royal Commission into Family Violence, 17 Safety and Support hubs are being implemented across Victoria to ensure a cohesive, comprehensive and accessible response to those experiencing FDV. The aim of these hubs is to provide a single entry pathway into support services so that perpetrator visibility is improved, the needs of children and adult victims remain central and accessibility to support is improved for families (State of Victoria, 2016).

The importance of a single and credible pathway to a hub service is critical to improve help seeking and ultimately increase safety. Many victimised by FDV do not seek help for a number of reasons which include: embarrassment and shame of disclosure, fear of not being believed or taken seriously, fear that it could make their circumstances worse if help is not forthcoming or unresponsive, worry about getting fathers and other family members in trouble with authorities, fear of involvement of child protection services, not knowing their rights or unable to access existing services and hope that the violence will cease and life will improve. It is therefore imperative that the hub models implemented by the WA Government offer robust, safe and reliable pathways to assess risk, promote safety and reduce further FDV.

This was of utmost importance in the collection of evidence for the proposed hub models suggested for metropolitan and regional areas of WA. Data collected included:

- A desktop review of national and internationally documented hub models of service design with an appraisal of their fit for purpose and the WA context;
- Site visits of FDV hubs in other jurisdictions;

- A review of research evidence about FDV and more general hub models of service design; and
- Consultations with a wide range of stakeholders took place to inform the design of the model. This included service providers in metropolitan and regional WA from mainstream and specialist services, policy makers from the range of portfolios involved in FDV responses and the opportunity for stakeholders to provide written feedback in response to the models.

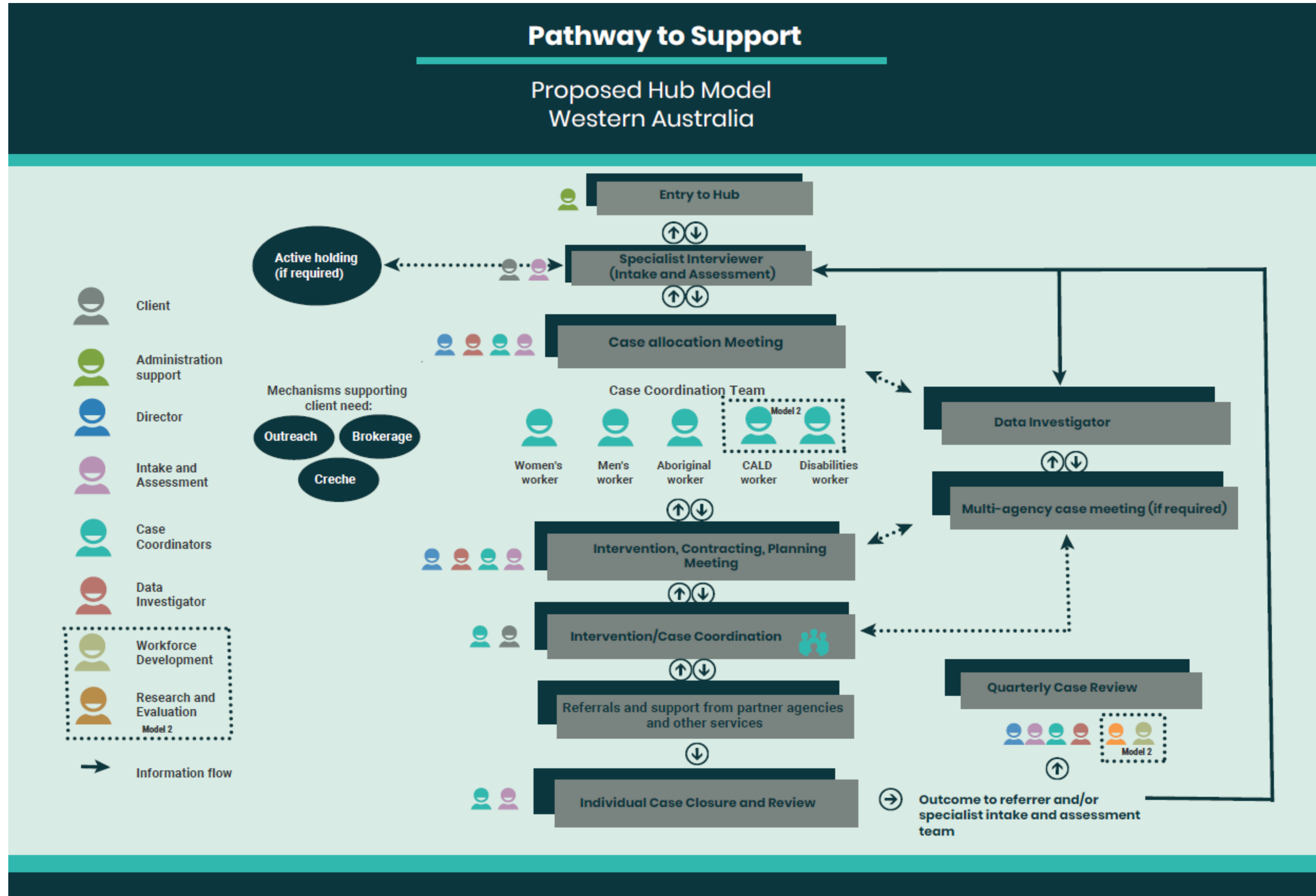
Hub models have been developed and modified according to the body of evidence and feedback about the fit within the WA context, which also varies according to locality. We have also documented potential opportunities and important implementation factors for consideration within the final composition of the hub models.

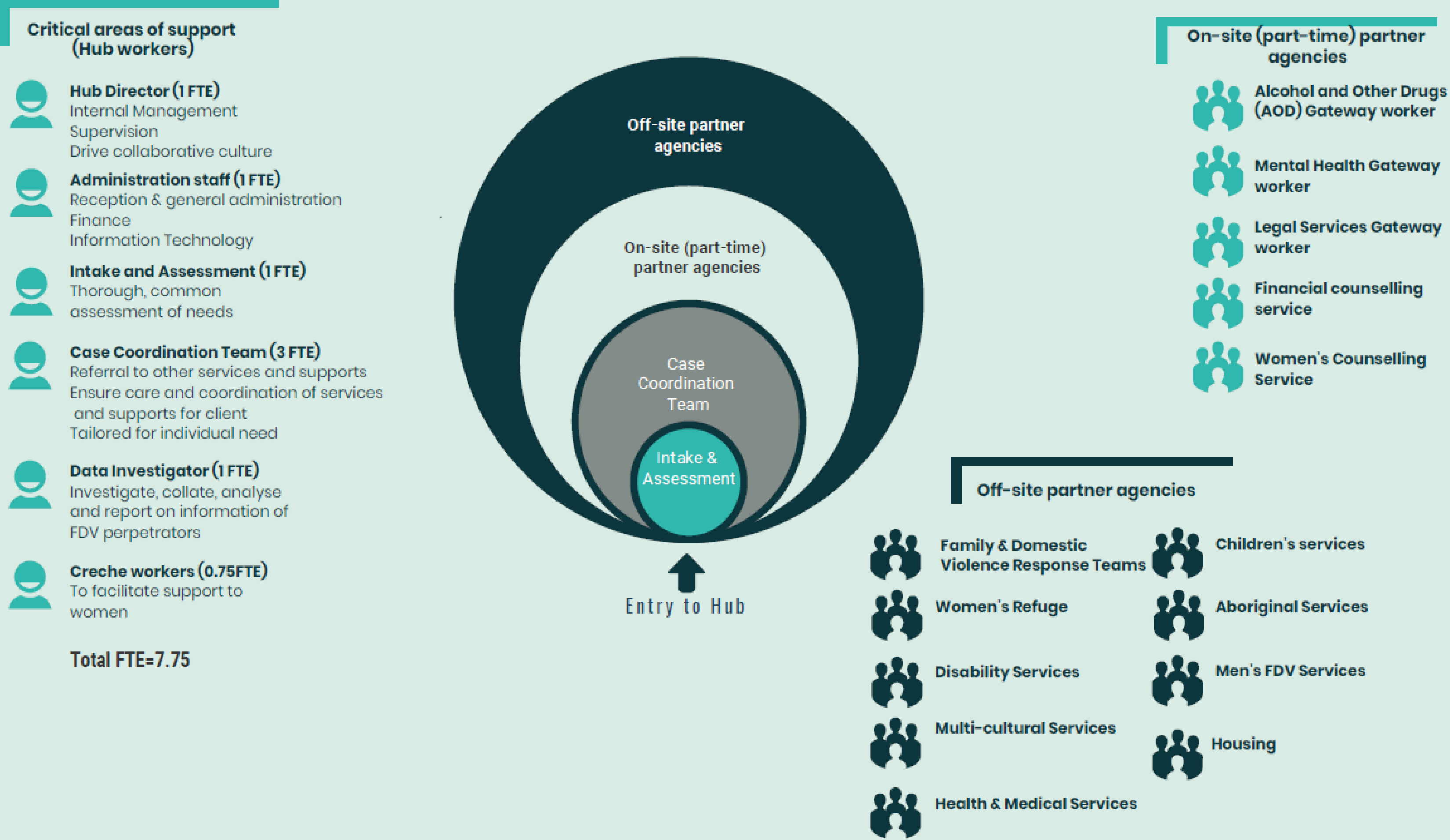
Proposed Hub Models of Service Design

Considerations underpinning the proposed models

A key implementation lesson across the evidence reviewed suggests that a 'sudden' and 'substantive' change to service delivery design can result in a sense of failure of such reforms because in the case of collaborative models, not enough attention was paid to the details of how a new approach would operate. Often described as being a case of the 'devil is in the detail'. As requested in the brief for the design of hub service delivery we have provided two models. We have designed the models as a staged implementation with Model 1 an initial development and Model 2 the next phase of development. This enables implementation issues to be addressed and solutions found to 'teething problems' whilst collaborative practices and procedures are refined for both operators of the hub and the partner agencies and the pathways for service users.

Model 1 & Model 2





Base Model (Model 1)
Proposed Hub Model
Western Australia
Critical areas of support (Hub workers)
Hub Director (1 FTE)
Internal Management
Supervision
Drive collaborative culture
Administration staff (1 FTE)
Reception & general administration
Finance
Information Technology
Intake and Assessment (1 FTE)
Thorough, common assessment of needs
Case Coordination Team (3 FTE)
Referral to other services and supports
Ensure care and coordination of services and supports for client
Tailored for individual need
Data Investigator (1 FTE)
Investigate, collate, analyse and report on information of FDV perpetrators
Creche workers (0.75FTE)
To facilitate support to women
Total FTE=7.75
Off-site partner agencies
On-site (part-time) partner agencies
Case Coordination Team
Intake & Assessment
Entry to Hub
On-site (part-time) partner agencies
Alcohol and Other Drugs (AOD) Gateway worker
Mental Health Gateway worker
Legal Services Gateway worker
Financial counselling service
Women's Counselling Service
Off-site partner agencies
Family & Domestic Violence Response Teams
Children's services
Women's Refuge
Aboriginal Services
Disability Services
Men's FDV Services
Multi-cultural Services
Housing
Health & Medical Services

Enhanced Base Model (Model 2)

Proposed Hub Model
Western Australia

Critical areas of support (Hub workers)

Hub Director (1 FTE)
Internal Management
Supervision
Drive collaborative culture

Administration staff (2 FTE)
Reception & general administration
Finance
Information Technology

Intake and Assessment (2 FTE)
Thorough, common assessment of needs

Case Coordination Team (5 FTE)
Referral to other services and supports
Ensure care and coordination of services and supports for client
Tailored for individual need

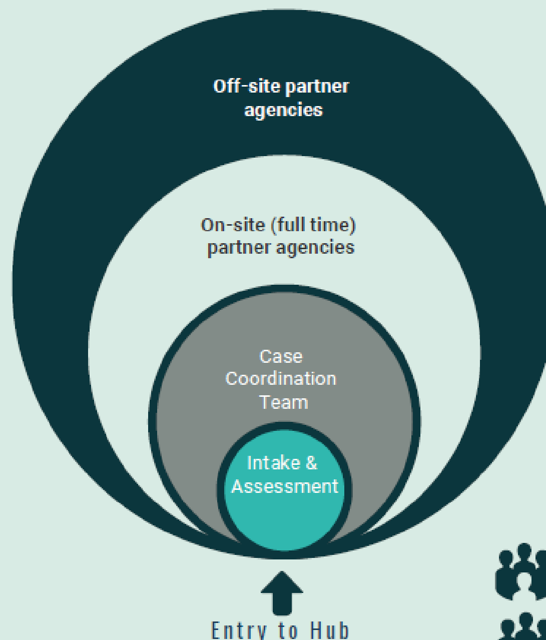
Data Investigator (1 FTE)
Investigate, collate, analyse and report on information of FDV perpetrators

Workforce development (1 FTE)
Internal/external training
Supervision
Student placements
Knowledge dissemination

Research and evaluation (1 FTE)
Support the hub as a place of learning, development and training

Creche workers (1.5 FTE)
To facilitate support to women

Total FTE=14.5



On-site (full time) partner agencies

Alcohol and Other Drugs (AOD) Gateway worker

Mental Health Gateway worker

Legal Services Gateway worker

Financial counselling service

Women's Counselling Service

Off-site partner agencies

Family & Domestic Violence Response Teams

Children's services

Women's Refuge

Aboriginal Services

Disability Services

Men's FDV Services

Multi-cultural Services

Housing

Health & Medical Services

The hub service design should offer a single pathway for access to support for all involved in situations of FDV: women, children, young people, and men. In addition, we would suggest that there is a short term response available to family and friends of those living with FDV. We make this suggestion because the research consistently indicates that these informal supporters are often the first to know about what is happening or at least suspect FDV. Family and friends often wish to support victims but are not sure how to do so without making matters worse. We recognise the importance of services' policies which require the person to contact the service directly and thus we are not suggesting that there is intervention without anyone's consent, rather that family and friends have an opportunity via short term support to seek advice and support so that they are best able to respond when necessary. This can reduce their distress and also offer tangible ways in which they can be supportive. This has not typically been a key consideration in service design, however, increasing evidence points to the need to offer safe and supportive advice to informal supports. It also has a flow on effect to raising awareness of the dynamics of FDV in the community. The piloting of a short term response to support and offer advice family and friends is incorporated within the design.

It is proposed that the service hub is operated by WA Government with partnership arrangements and agreements with government and not for profit agencies. Whilst there has been a trend to contract out the delivery of human services by governments internationally, it is recommended that the base of the hub is operated by government as it is a single pathway approach and it is important that the community do not view the hub as an operation of a specific agency. This will avoid the perception that only specific agencies services are available within the hub.

Key Features of the Hub Designs

The key features have taken account of existing evidence, local stakeholder response to the WA context, and experiences in other locations with hub services for FDV. FDV hub designs exist on a continuum ranging from:

- co-location of commonly recognised specialist FDV and key mainstream services where the focus is on the architecture of sharing the building and there is an assumption by sharing space it will be easier for those seeking help and make it easier for agencies to develop collaborative working relationships; through to

- co-location involving a clear logic and intention to develop a collaborative approach between agencies which requires a shared agreement of purpose, vision of the roles for respective agencies which in practice are interlocking and recognise the interdependence of agencies' roles in FDV responses and are focused on how that creates a pathway for those seeking support and safety.

The latter is being proposed as the aspiration for the hub design in WA, particularly as the other end of the continuum does not result in a robust or consistent service model.

The proposed design includes the involvement of agencies that in Australia have not typically played a central role in FDV coordinated system approaches. In this instance, we are proposing the inclusion of mental health services and alcohol and other drug services as on-site agency partners in the hub. The rationale is that often perpetrators and some victims are also experiencing mental ill-health and problem substance use whilst in FDV. This is not to suggest a causal FDV pathway, but rather that for individuals and families living at the intersection of all or a combination of these three, a service response which can work across these has historically been non-existent or at best patchy. This would require the two government departments to work co-operatively in co-designing a response with respective agencies. The intention would be a suitable service response that addresses the complexity, is FDV-informed and creates safety for all parties.

In some hub designs, the services for perpetrators are co-located with services for women and children on the same site. This raises the obvious safety concerns, and whilst it is recognised this may be appropriate in some situations of FDV, as this would be a single pathway it does not seem suited to trial this at this time. There would be a men's worker located in the hub, however, men who are perpetrators would be seen off-site in a local agency with which there is a partnership agreement.

The hub is likely to include Aboriginal and non-Aboriginal families seeking support, therefore it is important that Aboriginal community controlled organisations have a presence at the hub as well as strong links and access to direct individuals and families to Aboriginal community controlled organisations. The aim being to ensure that pathways are culturally safe and responsive. It is considered key that the hub service is accessible to individuals who

are in same sex relationships and heterosexual relationships. As older women do not often attend refuges and older men do not tend to be referred to perpetrator programs, it is recommended that the hub service model promote their responses as suited to a range of people across the age spectrum. It is also proposed that specialist CaLD services are available at the hub with relevant interpreter access where required.

Description of the Hub model in action

The Hub model is designed to provide a complete and thorough service response to FDV. This response begins with the first initial contact a client makes with the Hub, initiated through another agency or self-referral. The service pathway proceeds as follows.

1. At the point of initial first contact, the client is provided with a comprehensive assessment by the Specialist Interviewer (Intake and Assessment) and they are registered with the Hub. This assessment is used to inform the intervention response that follows, and also any safety concerns that require immediate action. If necessary, the Specialist Interviewer can triage an immediate safety response for very high risk situations. The assessment is documented and stored centrally, with access to such information for both on-site and off-site partner agencies being determined through the Hub Information Sharing policies which are managed by the Director.
2. Following the initial assessment, a case allocation meeting is held between the Specialist Interviewer, the Case Coordination team, the Hub Director and the Data Investigator as needed. The purpose of this meeting is to discuss active assessments and to allocate clients to Case Coordinators. The Director provides procedural oversight to this process and ensures that the process is collaborative and comprehensive. The case coordination team comprise a mix of expertise[1]. It is anticipated that all workers will be allocated cases, but this mix of expertise will be used to support the workings of the team and provides for the kinds of expertise required to address the often multiple and complex needs of women and children experiencing FDV. Depending on need, clients may be allocated to Case Coordinators in accordance with their expertise. A men's worker will provide active contact,

[1] See model diagrams – Women's Worker, Men's Worker, Aboriginal Worker in both models, with the inclusion of CALD worker and Disabilities worker in the enhanced model.

referrals, and outreach (where appropriate) to male adolescents and men identified as perpetrators of violence. The men's worker will also assist with increasing the visibility and knowledge of perpetrators and the perpetrators risk for all agencies as a way of enhancing and supporting women and children's safety. The Data Investigator contributes to this process with additional information from external sources on perpetrators (where possible) that will assist in managing risk and safety factors, and this information will provide for an additional layer of accountability. This additional information will complement the information gathered at the point of assessment, and will help with safety planning. All active referrals are discussed at this meeting, and an outcome of this meeting is that clients are allocated to Case Coordinators.

3. Once the client has been allocated to a Case Coordinator—who now has access to relevant information—the Case Coordinator works with the Data Investigator, Director and other relevant Hub partners (e.g. AOD, Mental Health, Legal, Refuge) to discuss a provisional intervention response plan for the client. This may include deciding on the scope of intervention, working out what other services need to be involved, and taking into account any risk and safety factors that need consideration. At this point, a multi-agency meeting with other partner agencies may be convened to discuss and plan other agency service responses and the scope of their involvement. The Case Coordinator works directly and collaboratively with the client to develop, contract and implement the intervention plan. This may include referral to other off-site partner services and supports (e.g. Women's Refuge, Health and Medical Services, Aboriginal Services). The Case Coordinator ensures care and coordination of services and supports for the client, and works to tailor the intervention to meet individual need. The Case Coordinator has complete oversight of the total intervention, and will coordinate the involvement of other on-site Hub partners or off-site external services (where relevant). The Case Coordinator stays actively involved with the client throughout the process, until all relevant services and responses are in place and completed as planned, and until the objectives of the intervention are achieved.
4. Once the intervention plan is completed, a case closure and review meeting is convened between the Case Coordinator and Specialist Interviewer. This meeting is

held to report on progress and to ensure that all relevant factors identified in the initial assessment and case planning meeting have been adequately addressed. If it is deemed there are unresolved matters, the situation has changed, or new information has come to light that warrants a further response, an outcome from this step may include re-assessment and the development of a further intervention plan and response.

5. A quarterly review meeting is held for all cases. The Director, Case Coordinators, Data Investigator (and in the enhanced model, Workforce Development Worker and Research and Evaluation Worker) review all cases, processes and outcomes. The purpose of this quarterly review meeting is quality assurance, evaluation and development of the Hub and best practice.

Parallel support to the Hub

In parallel to this intervention process, the Hub is supported with an on-site staffed crèche to enable women with children to access meetings and appointments with Hub workers. The crèche is there to support on-site appointments, but could be expanded as a much wider service to enable women to access off-site appointments if required.

Further support is provided by a Workforce Development worker (in the enhanced model), who will coordinate and provide internal and external training, supervision, knowledge dissemination, and to coordinate and manage student placements. The purpose of this role is to ensure that the Hub workforce receives a high level of on-going training and professional development, and that the Hub is based on the most up-to-date theoretical and empirical knowledge.

The Hub is also supported by a Research and Evaluation worker (in the enhanced model), who will coordinate and develop on-going reviews and evaluations of the Hub model and its outcomes, so that the Hub can achieve continuous review and improvement by gathering, analysing and reporting on evidence of its effectiveness in responding to FDV. The information from the research and evaluation will also support continual refinement and development of the model (including the development of operational procedures and protocols), and it will also inform the training and professional development agenda of Hub workers.

The Hub is supported by a Director, who has oversight of internal operations and standards, but this is also a key role for driving and supporting a culture of collaboration, both internal and external to the Hub. The Director needs to establish those links and relationships, which may include building relationships and agreements with the management level of other services. It is the role of the Director to build and maintain the collaborative relationships with on-site and off-site Hub partners, and promote and build the reputation of the Hub in the community. The Hub is also supported by Administration worker(s), who provides reception, administration, financial management, record keeping and IT support to the Hub and to the Director.

Implementation considerations

The consultation process resulted in key areas of consensus and divergence with regard to the development and implementation of the FDV hubs within a Western Australian context. Analysis resulted in areas that are key to consider for successful implementation:

Governance

Governance of the FDV hubs was identified as a major challenge to implementation. Based on the consultations, literature review and desktop scan any implementation plan should consider the issue of authorisation for hub activities and the interface with existing services and agencies. It is recommended that the hubs be developed under the auspice of the State Government, as their own, independent entities.

Opportunities for extended collaboration

The hubs were viewed as being an opportunity for legitimate collaboration between agencies which would assist in delivering a more comprehensive service with increased levels of perpetrator visibility. Formal agreements and a strong operating environment were seen as critical to ensure the hub is more than just sharing a space and resources, but genuinely acts as a centre for collaboration, and expertise with opportunity to improve understandings and responses to FDV at worker, service, and sector level.

Co-location of services

There was agreement that co-location would facilitate and enhance the flow of information and support, facilitate collaboration between services and clients and also improve accessibility and safety for women. Although overall seen as positive, concerns were expressed around the possibility for some agencies continuing to operate as discreet silos,

even if they were co-located together. This underscores the centrality of genuine collaboration and not merely one of co-location.

Location of Hubs

Taking into consideration feedback from the consultations the data indicates the preference is for the hubs to operate in a local context and in response to local issues which is relevant for both metropolitan and regional areas. This would involve careful selection of the site location, service boundaries to a local context, and extensive relationship building and community engagement, under the leadership of the hub Director. The research findings also suggest that the hubs should be located in an area of high risk and high need, in reasonable proximity to other relevant services, and close to public transport. Whilst there were mixed views around the visibility of the hub in the community in the metropolitan area, this is less of a concern in regional areas with often there being little choice available around anonymity.

Expertise of hub workers

The expertise and skills of the hub workers were seen as critical. In particular, this includes workers involved at the initial interview and assessment, which informs the intervention response. Interviewers and assessors need to have significant authority and expertise, and be able to work with multiple sources of data, trained in the responsible use of information sharing and collaborate well with other workers and agencies. Interviewers and assessors need to be able to triage and provide critical responses to high risk situations—they should be knowledgeable in FDV, trauma, and culturally appropriate knowledge and skills. The ability to build trust and rapport was identified as a key skill required of workers.

As noted in the research data, a highly skilled and trained workforce is recommended for the hub. This is a matter for recruitment and staff selection, but also for a program of ongoing professional development, training supervision and knowledge building. These have been factored into the hub staffing design. Consideration for enhancing and developing the current workforce through providing professional development opportunities and potentially linking in with universities to arrange student placement opportunities may be other strategies utilised to assist in the development of the workforce.

Information management and sharing

Information management and sharing was identified as crucial to supporting women and children's safety and promoting perpetrator accountability. The development of policy and processes for addressing consent, confidentiality and legal implications of sharing information with statutory services was seen as crucial to successful implementation. Benefits of "joining up" information include: more timely information sharing; active collaborative decision-making; enhancing relationships and understanding of roles and responsibilities; sharing of risk related information and assessments, which reduces the burden on service users having to repeat their stories. The hub could also act as an information repository, as a way of storing information collected through assessments or small research projects carried out via collaboration between agencies. This was viewed as potentially being a very significant benefit as currently there are no mechanisms that facilitate this.

Development of a central comprehensive assessment process and case management processes

A comprehensive assessment is also key to the case coordination process, which involve developing and coordinating an intervention plan and response. A central, comprehensive assessment was viewed positively as contributing towards collective case planning for needs, streamlining work processes, reducing the burden and traumatisation of retelling stories.

Inclusion of a crèche facility

A very strong and unanimous theme throughout the focus groups was the importance of having an on-site crèche for hub clients, which was seen as a very practical way to support women and children's needs. This has been identified as essential to facilitating care-givers engagement in services (Shelby Consulting Pty Ltd, 2017).

Incorporate evaluation framework

Evidence suggests that incorporating evaluation and review points can provide opportunity to identify areas working well as well as those needing improvement. The Refuge Service System Model Emergency Response utilised evaluation points from inception as a means for reviewing and refining processes which led to implementation issues being addressed (Chung, Chugani, & Marchant, 2016). Incorporating evaluation processes are also

consistently recognised as important for monitoring the quality of responses over time (Breckenridge, Rees, Valentine, & Murray, 2016; Herbert & Bromfield, 2017).

Consideration of the Benefits and Risks Associated with the Proposed Hub Models

ENHANCED HUB MODEL - FULLY FUNDED	BASE HUB MODEL - SMALL AMOUNT OF RESOURCING
Benefits	**Benefits**
• Is a higher intensity collaborative arrangement recognised as a more effective option for "managing complex interdependencies and clients with multiple needs" (Nylén, 2007, p. 162) which would add value to existing systems as well as address safety and accountability. • Improved opportunity for the development of effective collaborative partnerships between agencies and workers which can be sustained over the longer term. • Streamlined processes and better communication between agencies (Breckenridge et al., 2016) resulting in improved support and safety for clients, with partner agencies located on-site. • Workers co-located on-site together means that spaces for conversation, discussion, professional learning and feedback loops will be inherently built in to the model (Bronstein, 2003). • Co-location will foster development of practice alignment and learning (Edwards, 2015). • Workforce Development officer and Research and Evaluation worker will	• The smaller scale potentially means it is easier to integrate with an existing service, but also least intensive in terms of level of response (Nylén, 2007). • Easier to implement initially (but harder to develop and sustain in the future). • Lower staffing levels means cheaper to operate in terms of salaries and office accommodation

provide opportunity to ensure high level of on-going training and professional development so that the hub is based on the most up-to-date empirical knowledge. Professional development, continuous improvement and evaluation will be built in to the model with such specialised staff. • Co-location will help to minimise siloing of services, a key concern of Consultation participants. • Establishment of new roles or activities that can only be realised through collaboration; they do not simply replicate existing practice (Bronstein, 2003). • Greater opportunity for shared input into the hubs vision and operations, each stakeholder jointly responsible for its form, its success or failure (Bronstein, 2003). • Reduced risk of power imbalances, competitive relationships, and lack of common ground between perspectives, disciplines and agencies (Atwool, 2003; Breckenridge et al., 2016; Worrall-Davies & Cottrell, 2009). • Sharing of responsibility and resources (e.g. money, time, energy, risk). • Retain specialisations but improved understanding of other agency roles and responsibilities. • Improved accessibility for clients due to being able to access services in one place.	
Risks	**Risks**
• May be more difficult to implement initially, requiring greater time and effort into developing and sustaining collaborative relationships, especially across	• Is a lower intensity kind of collaborative arrangement which has potential to not meet the 'One Stop Shop' brief, resulting in criticism to Government and not

diverse organisations (McDonald et al., 2011). • More staff means higher costs in terms of salaries and office accommodation. • Agencies having differing foci for their interventions which could be difficult to navigate (Atwool, 2003). • Power imbalances, competitive relationships related to tendering, and lack of common ground between perspectives, disciplines and agencies is also a possible area requiring attention (Atwool, 2003; Breckenridge et al., 2016; Worrall-Davies & Cottrell, 2009).	effectively meeting the needs of women and children. • Perception of duplication of processes and resources requires skilled negotiation and knowledge of local conditions. • With some partner agencies locate off-site, it is anticipated it will be difficult to create and sustain collaborative relationships between agencies. Concern was expressed by Consultation participants about how this model would become a genuine model of collaboration if partner agencies remain off-site. • Concern was also expressed by Consultation participants about the availability of workers to provide assistance if they are off-site. • Increased risk of service siloing and thus no real change to current system. • Relatively small number of case coordinators limits number of clients able to coordinate and support. • Staff diversity is limited. • Greater difficulty in promoting mechanisms that support the development of effective collaboration (Hill & Laurence, 2003). • Individual (client) perceptions of cross-agency control (Breckenridge et al., 2016). • Not being co-located could lead to communication problems between and across services, which can be frustrating for clients and workers (e.g. information sharing concerns, which can lead to ineffective case management) (Atwool, 2003; Breckenridge et al., 2016; Wilcox, 2010). • Overcoming embedded siloed ways of thinking could be more difficult

	when agencies and workers are not located together (Howard, 2017).

Recommendations for model adoption

Metropolitan Hub

From the analysis of existing services, there appears to be limited opportunities from which a FDV hub could be combined with in a way that adequately supports the ethos of the proposed new service. It is therefore recommended that a new entity be created that can establish its own identity.

Regional Hub

Our research has identified the possibility for a FDV hub to be incorporated with an existing refuge service in a regional area. Women's refuges in these areas are integral avenues of support to women and children experiencing FDV, already having developed the trust and respect needed to provide effective support to their community. They are well known; provide safe and culturally appropriate support; and are well connected to other services and supports in the local area. Consideration would need to be given to the location of the hub as it is recommended it be kept separate from residential accommodation to ensure that women and children experiencing FDV are continued to be provided with a safe space for healing.

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Research for the Development of Two 'One Stop Hubs'

Full Report

Prepared by Professor Donna Chung, Dr David Hodgson, Dr Lynelle Watts, Ms Darcee Schulze, Ms Sarah Anderson & Ms Amy Warren for the Department for Communities

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Glossary

AOD	Alcohol and other drugs
CaLD	Culturally and Linguistically Diverse
CBD	Central Business District
CRS	Coordinated Response Service
DoJ	Department of Justice
DCS	Department of Corrective Services
DVAS	Domestic Violence Advocacy Service
FDV	Family and Domestic Violence
FDVRT	Family and Domestic Violence Response Teams
GPs	General Practitioners
Integrated Responses	The term used to include work being undertaken that involves a range of agencies coming together to work towards a common purpose in a specific field of practice, in this instance family and domestic violence services.
KFVS	Kimberley Family Violence Service
MDVHL	Department for Communities Men's Domestic Violence Helpline
SaH	Safe at Home
WA	Western Australia

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Executive Summary

The Government of Western Australia, as part of its commitment to improving the safety and wellbeing of women and children experiencing family and domestic violence (FDV), recently announced their intention to develop two 'One Stop Hubs'; one in the metropolitan area and one in regional WA, to complement existing services. The purpose of this report is to provide guidance on what forms of hub service design could be implemented in a metropolitan and a rural location to develop and optimise interagency and collaborative working. This includes the key features of the service designs, start-up and implementation considerations, and evidence about successes and challenges around setting up such partnerships to work in this form of service design.

The drive for coordination is also directly related to the complexity of the issue and that effective responses mostly involve a multiplicity of agencies. In the FDV context, it is also a recognised way of reducing secondary victimisation caused by agency silos and systems directly or indirectly holding victims responsible for abuse (Wilcox, 2010). Typically, the aim of service integration is to be more effective and efficient through reducing duplication of tasks, improving agencies' responsiveness and providing such responses with less burden on the service user (Fine, Pancharatnam, & Thomson, 2000).

Establishing coordinated and integrated responses to address FDV has become a well-recognised service delivery option in recognition of the need to join up services, reduce costs and improve the accessibility and experience of service users. This approach has been advocated for some time at the international and local levels (Fine et al., 2000; Gordon, Hallahan, & Henry, 2002; Ombudsman Western Australia, 2016). Unfortunately, a common driver of coordinated one stop service delivery, has been the FDV related deaths that have occurred and which may have been prevented, had the practitioners in their agencies effectively assessed escalating risk and imminent harm, shared information and worked collaboratively with all parties involved: the perpetrator, the victims and the informal supporters of those involved. It is this complexity of circumstances and the potentially large number of agencies all holding various forms of information about the families that drives the need for effective ways of working together. This would ideally involve the development of specialised collaborative practices, all parties being FDV informed and understanding

what to do with the information they hold, an alignment of purpose and strategy and agencies able to respond flexibly and efficiently.

This approach is not unique to the FDV space with service coordination and collaboration incorporated across many contexts of public service delivery including health, child development, family support and homelessness sectors. The aspect which can often make FDV more difficult is that there are potentially more individuals involved (partners, children, family members) than may be the case in other settings.

In FDV, hub service delivery models offer a centralised pathway of support to those impacted by FDV. As a result of the Victorian Government Royal Commission into Family Violence, 17 Safety and Support hubs are being implemented across Victoria to ensure a cohesive, comprehensive and accessible response to those experiencing FDV. The aim of these hubs is to provide a single entry pathway into support services so that perpetrator visibility is improved, the needs of children and adult victims remain central and accessibility to support is improved for families (State of Victoria, 2016).

The importance of a single and credible pathway to a hub service is critical to improve help seeking and ultimately increase safety. Many victimised by FDV do not seek help for a number of reasons which include: embarrassment and shame of disclosure, fear of not being believed or taken seriously, fear that it could make their circumstances worse if help is not forthcoming or unresponsive, worry about getting fathers and other family members in trouble with authorities, fear of involvement of child protection services, not knowing their rights or unable to access existing services and hope that the violence will cease and life will improve. It is therefore imperative that the hub models implemented by the WA Government offer robust, safe and reliable pathways to assess risk, promote safety and reduce further FDV.

This was of utmost importance in the collection of evidence for the proposed hub models suggested for metropolitan and regional areas of WA. Data collected included:

- A desktop review of national and internationally documented hub models of service design with an appraisal of their fit for purpose and the WA context;
- Site visits of FDV hubs in other jurisdictions;

- A review of research evidence about FDV and more general hub models of service design; and
- Consultations with a wide range of stakeholders took place to inform the design of the model. This included service providers in metropolitan and regional WA from mainstream and specialist services, policy makers from the range of portfolios involved in FDV responses and the opportunity for stakeholders to provide written feedback in response to the models.

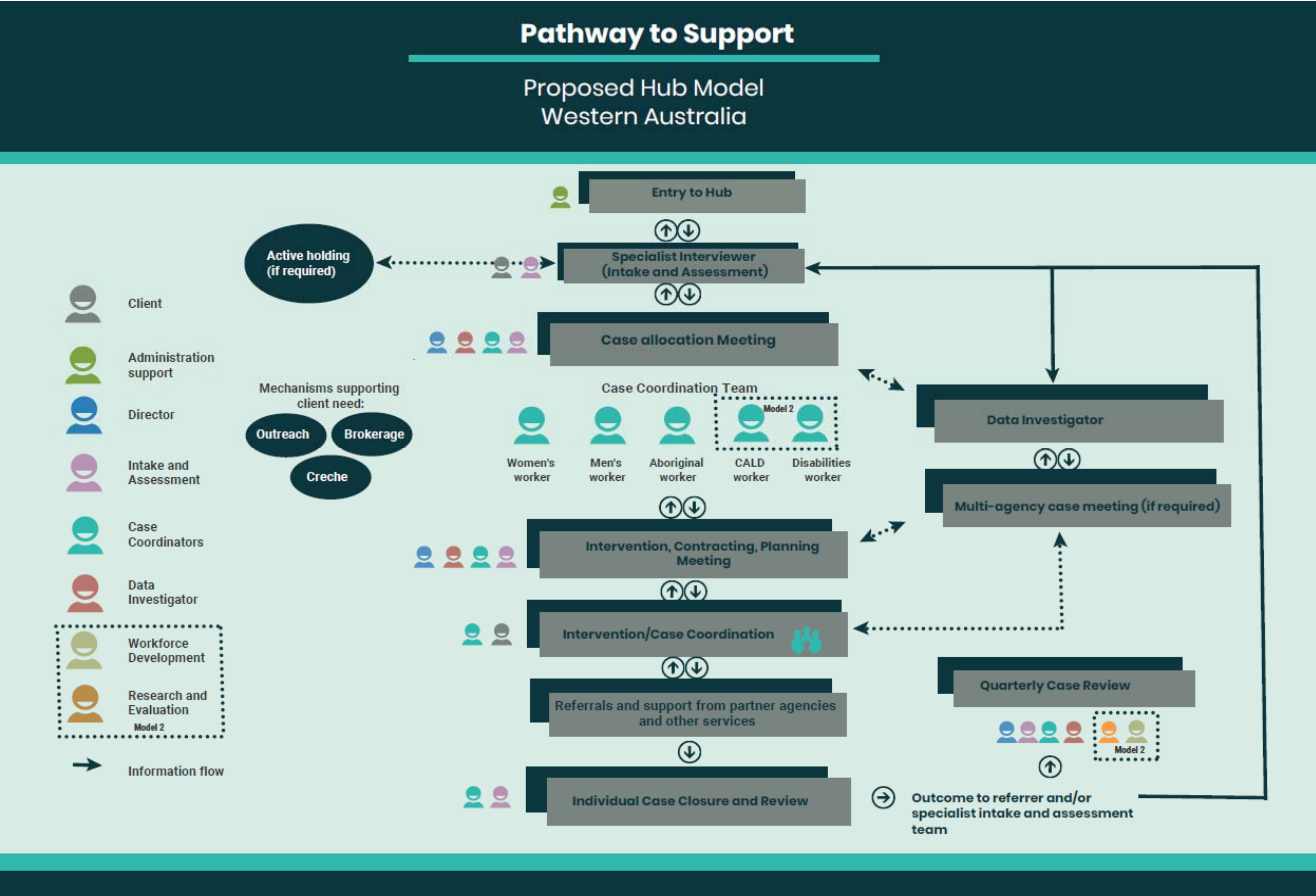
Hub models have been developed and modified according to the body of evidence and feedback about the fit within the WA context, which also varies according to locality. We have also documented potential opportunities and important implementation factors for consideration within the final composition of the hub models.

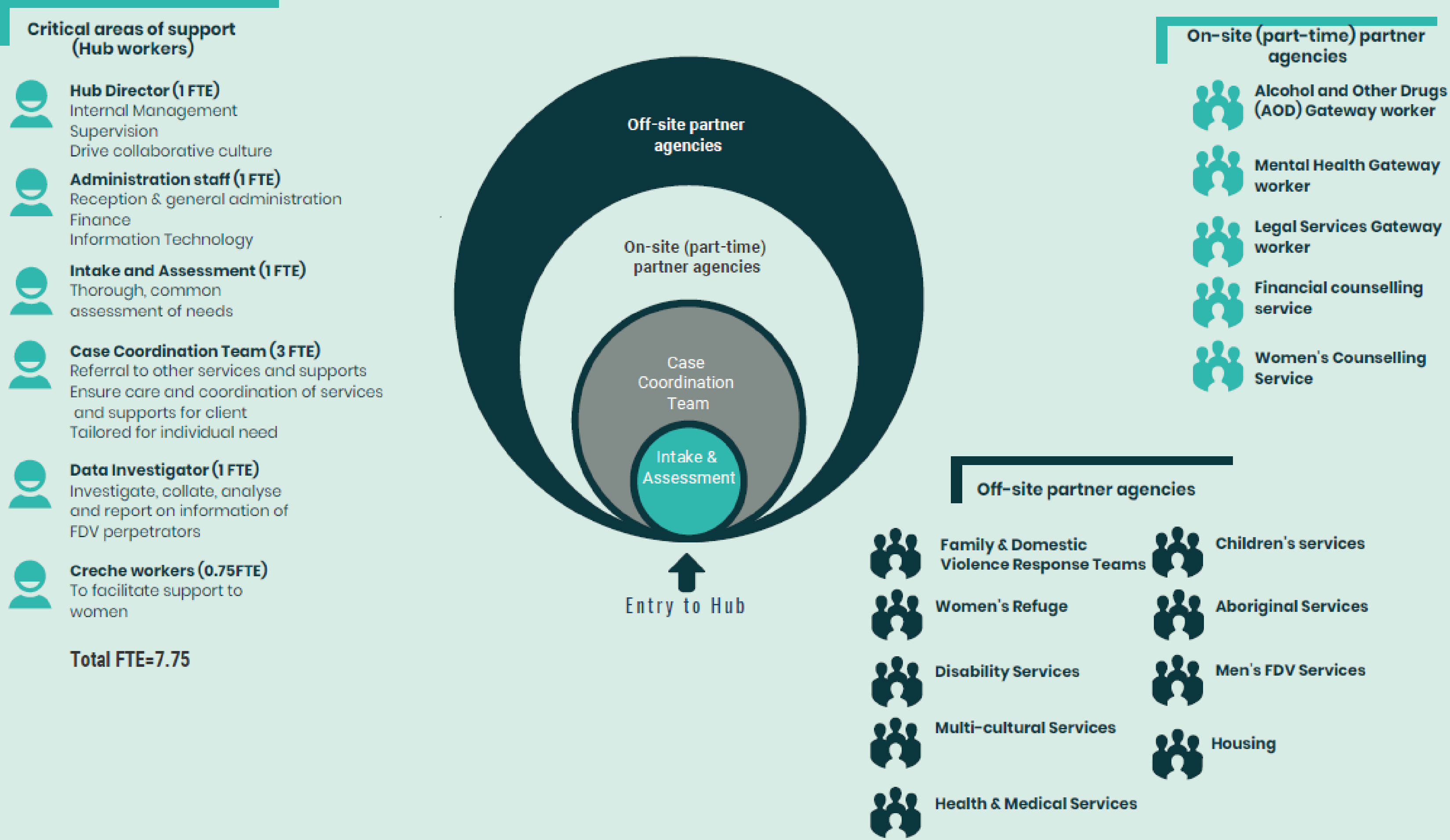
Proposed Hub Models of Service Design

Considerations underpinning the proposed models

A key implementation lesson across the evidence reviewed suggests that a 'sudden' and 'substantive' change to service delivery design can result in a sense of failure of such reforms because in the case of collaborative models, not enough attention was paid to the details of how a new approach would operate. Often described as being a case of the 'devil is in the detail'. As requested in the brief for the design of hub service delivery we have provided two models. We have designed the models as a staged implementation with Model 1 an initial development and Model 2 the next phase of development. This enables implementation issues to be addressed and solutions found to 'teething problems' whilst collaborative practices and procedures are refined for both operators of the hub and the partner agencies and the pathways for service users.

Model 1 & Model 2




Base Model (Model 1)
Proposed Hub Model
Western Australia
Critical areas of support (Hub workers)
Hub Director (1 FTE)
Internal Management
Supervision
Drive collaborative culture
Administration staff (1 FTE)
Reception & general administration
Finance
Information Technology
Intake and Assessment (1 FTE)
Thorough, common assessment of needs
Case Coordination Team (3 FTE)
Referral to other services and supports
Ensure care and coordination of services and supports for client
Tailored for individual need
Data Investigator (1 FTE)
Investigate, collate, analyse and report on information of FDV perpetrators
Creche workers (0.75FTE)
To facilitate support to women
Total FTE=7.75
Off-site partner agencies
On-site (part-time) partner agencies
Case Coordination Team
Intake & Assessment
Entry to Hub
On-site (part-time) partner agencies
Alcohol and Other Drugs (AOD) Gateway worker
Mental Health Gateway worker
Legal Services Gateway worker
Financial counselling service
Women's Counselling Service
Off-site partner agencies
Family & Domestic Violence Response Teams
Children's services
Women's Refuge
Aboriginal Services
Disability Services
Men's FDV Services
Multi-cultural Services
Housing
Health & Medical Services

Enhanced Base Model (Model 2)

Proposed Hub Model
Western Australia

Critical areas of support (Hub workers)

Hub Director (1 FTE)
Internal Management
Supervision
Drive collaborative culture

Administration staff (2 FTE)
Reception & general administration
Finance
Information Technology

Intake and Assessment (2 FTE)
Thorough, common assessment of needs

Case Coordination Team (5 FTE)
Referral to other services and supports
Ensure care and coordination of services and supports for client
Tailored for individual need

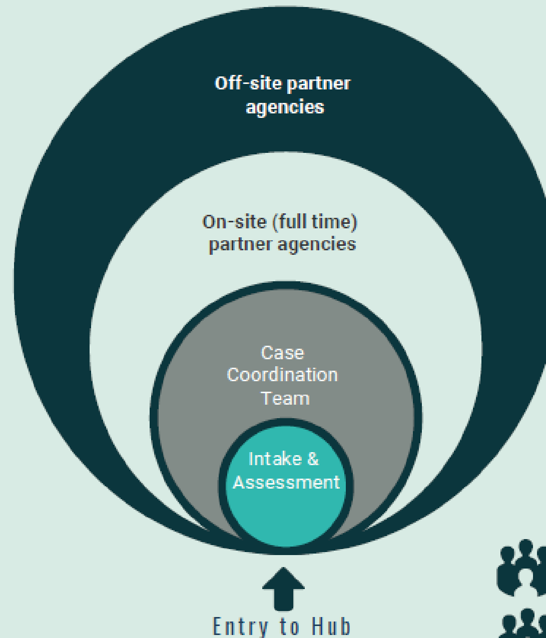
Data Investigator (1 FTE)
Investigate, collate, analyse and report on information of FDV perpetrators

Workforce development (1 FTE)
Internal/external training
Supervision
Student placements
Knowledge dissemination

Research and evaluation (1 FTE)
Support the hub as a place of learning, development and training

Creche workers (1.5 FTE)
To facilitate support to women

Total FTE=14.5



On-site (full time) partner agencies

Alcohol and Other Drugs (AOD) Gateway worker

Mental Health Gateway worker

Legal Services Gateway worker

Financial counselling service

Women's Counselling Service

Off-site partner agencies

Family & Domestic Violence Response Teams

Children's services

Women's Refuge

Aboriginal Services

Disability Services

Men's FDV Services

Multi-cultural Services

Housing

Health & Medical Services

The hub service design should offer a single pathway for access to support for all involved in situations of FDV: women, children, young people, and men. In addition, we would suggest that there is a short term response available to family and friends of those living with FDV. We make this suggestion because the research consistently indicates that these informal supporters are often the first to know about what is happening or at least suspect FDV. Family and friends often wish to support victims but are not sure how to do so without making matters worse. We recognise the importance of services' policies which require the person to contact the service directly and thus we are not suggesting that there is intervention without anyone's consent, rather that family and friends have an opportunity via short term support to seek advice and support so that they are best able to respond when necessary. This can reduce their distress and also offer tangible ways in which they can be supportive. This has not typically been a key consideration in service design, however, increasing evidence points to the need to offer safe and supportive advice to informal supports. It also has a flow on effect to raising awareness of the dynamics of FDV in the community. The piloting of a short term response to support and offer advice family and friends is incorporated within the design.

It is proposed that the service hub is operated by WA Government with partnership arrangements and agreements with government and not for profit agencies. Whilst there has been a trend to contract out the delivery of human services by governments internationally, it is recommended that the base of the hub is operated by government as it is a single pathway approach and it is important that the community do not view the hub as an operation of a specific agency. This will avoid the perception that only specific agencies services are available within the hub.

Key Features of the Hub Designs

The key features have taken account of existing evidence, local stakeholder response to the WA context, and experiences in other locations with hub services for FDV. FDV hub designs exist on a continuum ranging from:

- co-location of commonly recognised specialist FDV and key mainstream services where the focus is on the architecture of sharing the building and there is an assumption by sharing space it will be easier for those seeking help and make it easier for agencies to develop collaborative working relationships; through to

- co-location involving a clear logic and intention to develop a collaborative approach between agencies which requires a shared agreement of purpose, vision of the roles for respective agencies which in practice are interlocking and recognise the interdependence of agencies' roles in FDV responses and are focused on how that creates a pathway for those seeking support and safety.

The latter is being proposed as the aspiration for the hub design in WA, particularly as the other end of the continuum does not result in a robust or consistent service model.

The proposed design includes the involvement of agencies that in Australia have not typically played a central role in FDV coordinated system approaches. In this instance, we are proposing the inclusion of mental health services and alcohol and other drug services as on-site agency partners in the hub. The rationale is that often perpetrators and some victims are also experiencing mental ill-health and problem substance use whilst in FDV. This is not to suggest a causal FDV pathway, but rather that for individuals and families living at the intersection of all or a combination of these three, a service response which can work across these has historically been non-existent or at best patchy. This would require the two government departments to work co-operatively in co-designing a response with respective agencies. The intention would be a suitable service response that addresses the complexity, is FDV-informed and creates safety for all parties.

In some hub designs, the services for perpetrators are co-located with services for women and children on the same site. This raises the obvious safety concerns, and whilst it is recognised this may be appropriate in some situations of FDV, as this would be a single pathway it does not seem suited to trial this at this time. There would be a men's worker located in the hub, however, men who are perpetrators would be seen off-site in a local agency with which there is a partnership agreement.

The hub is likely to include Aboriginal and non-Aboriginal families seeking support, therefore it is important that Aboriginal community controlled organisations have a presence at the hub as well as strong links and access to direct individuals and families to Aboriginal community controlled organisations. The aim being to ensure that pathways are culturally safe and responsive. It is considered key that the hub service is accessible to individuals who

are in same sex relationships and heterosexual relationships. As older women do not often attend refuges and older men do not tend to be referred to perpetrator programs, it is recommended that the hub service model promote their responses as suited to a range of people across the age spectrum. It is also proposed that specialist CaLD services are available at the hub with relevant interpreter access where required.

Description of the Hub model in action

The Hub model is designed to provide a complete and thorough service response to FDV. This response begins with the first initial contact a client makes with the Hub, initiated through another agency or self-referral. The service pathway proceeds as follows.

1. At the point of initial first contact, the client is provided with a comprehensive assessment by the Specialist Interviewer (Intake and Assessment) and they are registered with the Hub. This assessment is used to inform the intervention response that follows, and also any safety concerns that require immediate action. If necessary, the Specialist Interviewer can triage an immediate safety response for very high risk situations. The assessment is documented and stored centrally, with access to such information for both on-site and off-site partner agencies being determined through the Hub Information Sharing policies which are managed by the Director.
2. Following the initial assessment, a case allocation meeting is held between the Specialist Interviewer, the Case Coordination team, the Hub Director and the Data Investigator as needed. The purpose of this meeting is to discuss active assessments and to allocate clients to Case Coordinators. The Director provides procedural oversight to this process and ensures that the process is collaborative and comprehensive. The case coordination team comprise a mix of expertise[1]. It is anticipated that all workers will be allocated cases, but this mix of expertise will be used to support the workings of the team and provides for the kinds of expertise required to address the often multiple and complex needs of women and children experiencing FDV. Depending on need, clients may be allocated to Case Coordinators in accordance with their expertise. A men's worker will provide active contact,

[1] See model diagrams – Women's Worker, Men's Worker, Aboriginal Worker in both models, with the inclusion of CALD worker and Disabilities worker in the enhanced model.

referrals, and outreach (where appropriate) to male adolescents and men identified as perpetrators of violence. The men's worker will also assist with increasing the visibility and knowledge of perpetrators and the perpetrators risk for all agencies as a way of enhancing and supporting women and children's safety. The Data Investigator contributes to this process with additional information from external sources on perpetrators (where possible) that will assist in managing risk and safety factors, and this information will provide for an additional layer of accountability. This additional information will complement the information gathered at the point of assessment, and will help with safety planning. All active referrals are discussed at this meeting, and an outcome of this meeting is that clients are allocated to Case Coordinators.

3. Once the client has been allocated to a Case Coordinator—who now has access to relevant information—the Case Coordinator works with the Data Investigator, Director and other relevant Hub partners (e.g. AOD, Mental Health, Legal, Refuge) to discuss a provisional intervention response plan for the client. This may include deciding on the scope of intervention, working out what other services need to be involved, and taking into account any risk and safety factors that need consideration. At this point, a multi-agency meeting with other partner agencies may be convened to discuss and plan other agency service responses and the scope of their involvement. The Case Coordinator works directly and collaboratively with the client to develop, contract and implement the intervention plan. This may include referral to other off-site partner services and supports (e.g. Women's Refuge, Health and Medical Services, Aboriginal Services). The Case Coordinator ensures care and coordination of services and supports for the client, and works to tailor the intervention to meet individual need. The Case Coordinator has complete oversight of the total intervention, and will coordinate the involvement of other on-site Hub partners or off-site external services (where relevant). The Case Coordinator stays actively involved with the client throughout the process, until all relevant services and responses are in place and completed as planned, and until the objectives of the intervention are achieved.
4. Once the intervention plan is completed, a case closure and review meeting is convened between the Case Coordinator and Specialist Interviewer. This meeting is

held to report on progress and to ensure that all relevant factors identified in the initial assessment and case planning meeting have been adequately addressed. If it is deemed there are unresolved matters, the situation has changed, or new information has come to light that warrants a further response, an outcome from this step may include re-assessment and the development of a further intervention plan and response.

5. A quarterly review meeting is held for all cases. The Director, Case Coordinators, Data Investigator (and in the enhanced model, Workforce Development Worker and Research and Evaluation Worker) review all cases, processes and outcomes. The purpose of this quarterly review meeting is quality assurance, evaluation and development of the Hub and best practice.

Parallel support to the Hub

In parallel to this intervention process, the Hub is supported with an on-site staffed crèche to enable women with children to access meetings and appointments with Hub workers. The crèche is there to support on-site appointments, but could be expanded as a much wider service to enable women to access off-site appointments if required.

Further support is provided by a Workforce Development worker (in the enhanced model), who will coordinate and provide internal and external training, supervision, knowledge dissemination, and to coordinate and manage student placements. The purpose of this role is to ensure that the Hub workforce receives a high level of on-going training and professional development, and that the Hub is based on the most up-to-date theoretical and empirical knowledge.

The Hub is also supported by a Research and Evaluation worker (in the enhanced model), who will coordinate and develop on-going reviews and evaluations of the Hub model and its outcomes, so that the Hub can achieve continuous review and improvement by gathering, analysing and reporting on evidence of its effectiveness in responding to FDV. The information from the research and evaluation will also support continual refinement and development of the model (including the development of operational procedures and protocols), and it will also inform the training and professional development agenda of Hub workers.

The Hub is supported by a Director, who has oversight of internal operations and standards, but this is also a key role for driving and supporting a culture of collaboration, both internal and external to the Hub. The Director needs to establish those links and relationships, which may include building relationships and agreements with the management level of other services. It is the role of the Director to build and maintain the collaborative relationships with on-site and off-site Hub partners, and promote and build the reputation of the Hub in the community. The Hub is also supported by Administration worker(s), who provides reception, administration, financial management, record keeping and IT support to the Hub and to the Director.

Implementation considerations

The consultation process resulted in key areas of consensus and divergence with regard to the development and implementation of the FDV hubs within a Western Australian context. Analysis resulted in areas that are key to consider for successful implementation:

Governance

Governance of the FDV hubs was identified as a major challenge to implementation. Based on the consultations, literature review and desktop scan any implementation plan should consider the issue of authorisation for hub activities and the interface with existing services and agencies. It is recommended that the hubs be developed under the auspice of the State Government, as their own, independent entities.

Opportunities for extended collaboration

The hubs were viewed as being an opportunity for legitimate collaboration between agencies which would assist in delivering a more comprehensive service with increased levels of perpetrator visibility. Formal agreements and a strong operating environment were seen as critical to ensure the hub is more than just sharing a space and resources, but genuinely acts as a centre for collaboration, and expertise with opportunity to improve understandings and responses to FDV at worker, service, and sector level.

Co-location of services

There was agreement that co-location would facilitate and enhance the flow of information and support, facilitate collaboration between services and clients and also improve accessibility and safety for women. Although overall seen as positive, concerns were expressed around the possibility for some agencies continuing to operate as discreet silos,

even if they were co-located together. This underscores the centrality of genuine collaboration and not merely one of co-location.

Location of Hubs

Taking into consideration feedback from the consultations the data indicates the preference is for the hubs to operate in a local context and in response to local issues which is relevant for both metropolitan and regional areas. This would involve careful selection of the site location, service boundaries to a local context, and extensive relationship building and community engagement, under the leadership of the hub Director. The research findings also suggest that the hubs should be located in an area of high risk and high need, in reasonable proximity to other relevant services, and close to public transport. Whilst there were mixed views around the visibility of the hub in the community in the metropolitan area, this is less of a concern in regional areas with often there being little choice available around anonymity.

Expertise of hub workers

The expertise and skills of the hub workers were seen as critical. In particular, this includes workers involved at the initial interview and assessment, which informs the intervention response. Interviewers and assessors need to have significant authority and expertise, and be able to work with multiple sources of data, trained in the responsible use of information sharing and collaborate well with other workers and agencies. Interviewers and assessors need to be able to triage and provide critical responses to high risk situations—they should be knowledgeable in FDV, trauma, and culturally appropriate knowledge and skills. The ability to build trust and rapport was identified as a key skill required of workers.

As noted in the research data, a highly skilled and trained workforce is recommended for the hub. This is a matter for recruitment and staff selection, but also for a program of ongoing professional development, training supervision and knowledge building. These have been factored into the hub staffing design. Consideration for enhancing and developing the current workforce through providing professional development opportunities and potentially linking in with universities to arrange student placement opportunities may be other strategies utilised to assist in the development of the workforce.

Information management and sharing

Information management and sharing was identified as crucial to supporting women and children's safety and promoting perpetrator accountability. The development of policy and processes for addressing consent, confidentiality and legal implications of sharing information with statutory services was seen as crucial to successful implementation. Benefits of "joining up" information include: more timely information sharing; active collaborative decision-making; enhancing relationships and understanding of roles and responsibilities; sharing of risk related information and assessments, which reduces the burden on service users having to repeat their stories. The hub could also act as an information repository, as a way of storing information collected through assessments or small research projects carried out via collaboration between agencies. This was viewed as potentially being a very significant benefit as currently there are no mechanisms that facilitate this.

Development of a central comprehensive assessment process and case management processes

A comprehensive assessment is also key to the case coordination process, which involve developing and coordinating an intervention plan and response. A central, comprehensive assessment was viewed positively as contributing towards collective case planning for needs, streamlining work processes, reducing the burden and traumatisation of retelling stories.

Inclusion of a crèche facility

A very strong and unanimous theme throughout the focus groups was the importance of having an on-site crèche for hub clients, which was seen as a very practical way to support women and children's needs. This has been identified as essential to facilitating care-givers engagement in services (Shelby Consulting Pty Ltd, 2017).

Incorporate evaluation framework

Evidence suggests that incorporating evaluation and review points can provide opportunity to identify areas working well as well as those needing improvement. The Refuge Service System Model Emergency Response utilised evaluation points from inception as a means for reviewing and refining processes which led to implementation issues being addressed (Chung, Chugani, & Marchant, 2016). Incorporating evaluation processes are also

consistently recognised as important for monitoring the quality of responses over time (Breckenridge, Rees, Valentine, & Murray, 2016; Herbert & Bromfield, 2017).

Recommendations for model adoption

Metropolitan Hub

From the analysis of existing services, there appears to be limited opportunities from which a FDV hub could be combined with in a way that adequately supports the ethos of the proposed new service. It is therefore recommended that a new entity be created that can establish its own identity.

Regional Hub

Our research has identified the possibility for a FDV hub to be incorporated with an existing refuge service in a regional area. Women's refuges in these areas are integral avenues of support to women and children experiencing FDV, already having developed the trust and respect needed to provide effective support to their community. They are well known; provide safe and culturally appropriate support; and are well connected to other services and supports in the local area. Consideration would need to be given to the location of the hub as it is recommended it be kept separate from residential accommodation to ensure that women and children experiencing FDV are continued to be provided with a safe space for healing.

Project Overview

Background

The McGowan Labor Government is dedicated to stopping family and domestic violence (FDV) and has made a number of policy commitments to address the issue. One policy commitment includes establishing two 'One Stop Hubs' to provide services to victims of family and domestic violence. The policy commitment states:

> *A McGowan Labor Government will initially establish two specialised "One Stop Hubs" to provide specialist family and domestic violence services at one location, making it easier for victims to access medical, police, legal, and accommodation, financial and other services.*
>
> *The location of the two hubs will be determined in consultation with stakeholders but will include one metropolitan and one regional location.*
>
> *These "One Stop Hubs" will provide appropriate infrastructure and technology, integrated intake teams and specialised practitioners and after hours crisis response. It is crucial to provide integrated specialists' services at the one location to reduce the need for victims to repeat their story numerous times, which in many cases will re-traumatise victims.*
>
> *Further, a McGowan Labor Government will ensure that these "One Stop Hubs" include culturally appropriate service delivery for Aboriginal and CaLD victims.*
>
> *A lack of financial independence is often a contributing factor to victims of FDV unable to leave abusive partners. Indeed, financial or economic abuse is considered a form of FDV.*
>
> *A McGowan Labor Government will increase access to financial counselling services as part of the One-Stop-Hub facility model. After three years, a review will be undertaken on the effectiveness of the two "One Stop Hubs" before making decisions on possible expansions of these facilities* (WA Labor, 2017, p. 5).

Research Agreement

Department for Communities contracted Curtin University to conduct research on hub service models with the aim of identifying suitable models for the Western Australian context. An agreement was reached between the Department for Communities and Curtin University on the 3rd of April 2018 for Curtin to conduct the research. The original contract expiry date of 30 June 2018 was extended as Department for Communities requested the

research team to undertake additional consultations on 19 June 2018. Further consultations were also undertaken on 2 August 2018 at the request of the Department for Communities.

Research Team

The research team consisted of Professor Donna Chung (Chief Investigator), Curtin University School of Occupational Therapy, Social Work and Speech Pathology; Dr David Hodgson and Dr Lynelle Watts, Senior Lecturers in Social Work at Edith Cowan University South West who were subcontracted to the project by Curtin University; Ms Darcee Schulze, Ms Sarah Anderson and Ms Amy Warren Research Assistants at Curtin University School of Occupational Therapy, Social Work and Speech Pathology.

Project Activities

The project involved six key activities:

1. Literature review.
2. Desktop scan and analysis of the existing hub service models.
3. Design of hub models for the consultations.
4. Conducting targeted consultations with professionals in the community services sector and other key stakeholders.
5. Design of the proposed hub models.
6. Analysis of existing hub service models in WA.

Project Outcomes

The final report presents the results of the project's key activities, including an overview of models currently operating in WA on which the proposed hub could be built. The final report provides a detailed proposal of hub models that could be implemented in Western Australia as outlined in the Government's election commitment.

Methodology

The methodology of the six key project activities is presented below.

1. Literature Review

The literature review included academic and grey literature which was conducted in April and May 2018. Manual searching of key article reference lists was also undertaken. Grey

literature on some of the more well-known collaborative partnerships in the FDV sector, nationally and internationally, was examined as a means to understand and inform the development of the hub model designs. In addition, collaborative ways of working outside the FDV sector were also explored. The knowledge gained from the literature review informed the development of the hub model designs and gave insight into interagency and collaborative working.

2. Desktop Scan and Analysis

The desktop scan involved identifying key hub service models and integrated responses that are being used nationally and internationally in the FDV sector and other contexts. The desktop scan also identified the types of agencies/services involved with the hub service models and the key features. The analysis included an examination of the strengths, weaknesses of the service model and how it could contribute to the design of the WA hub. The desktop scan identified and reported on:

- 47 hub service models used nationally and internationally in the FDV sector and in other contexts;
    - 18 hub service models that have been used in WA;
    - 13 from other Australian jurisdictions; and
    - 16 international designs from USA, UK and Ireland, Canada and New Zealand.

The findings of the desktop scan and analysis are presented in the attached compendium.

3. Hub Models presented at the Consultations

Following the reviews of evidence outlined, hub designs were drafted for a point of discussion at the consultations. The models were designed with the following intention:

> *How can existing interagency and collaborative workings be enhanced and improved to effectively address the experiences and complexities of women who experience FDV, their families, and perpetrators of FDV?*

The hub models were presented at the consultations with the aim of gaining feedback from professionals and stakeholders in community services sector on the models' possible effectiveness and challenges.

4. Targeted Consultations

a. Focus groups

Focus groups were used as a central way to gather stakeholder input into the hubs design. For the purposes of this research, focus groups were used to explore the merits, considerations and design elements of family and domestic violence hubs in Western Australia. In total, six focus groups were held in the Perth metropolitan area, and two focus groups were held in Broome.

b. Participants

A total of 62 people participated in the focus groups - 45 people participated in the Perth focus groups, and 17 in the Broome focus groups. Purposive sampling was used to select participants who could offer advice and critique, the participant list was developed with assistance from the Department for Communities. Participants were identified based on their expertise and knowledge of the family and domestic violence sector in Western Australia, and included people who provide or manage human services in other areas. The participants reflected a broad cross-section of the FDV sector: justice; legal; police; multicultural services; disability services; health; child protection; youth services; women's refuges; women's specialist FDV services; men's FDV perpetrator programs; housing services; mental health; and, Aboriginal health. A mix of front-line service practitioners, service leaders and managers, and policy officers were included in the sample, and drawn from government and non-government organisations.

c. Data collection

Participants in the focus groups reviewed two draft hub models. Participants were asked what they perceived as the benefits of the proposed hub models and what implementation issues require consideration. Participants were asked to consider services in terms of accessibility, effectiveness, accountability and safety, and how a hub model might increase interagency collaboration. Participants were also asked to comment on any perceived challenges with a hub model, including risks and limitations of the models. Finally, participants were asked to comment on their preferred model (Hub Model One or Two) and the reasons for their preferences.

At the end of each focus group, a paper-based questionnaire was distributed to participants for them to complete. This was to allow participants an opportunity to record any additional information that was not covered in the focus group, and to allow them to include anonymous responses. Questionnaires asked participants to provide qualitative written comment on what workforce issues would need to be addressed to establish and operate a FDV hub, where they thought the hubs should be located, and their preference for either model one or two. A total of 39 questionnaires were returned.

d. Data analysis

Themes and subthemes were organised according to perceived benefits of the hubs, main challenges or concerns, and significant considerations. These themes became the foundation for the data discussion presented below. These focus groups were audio recorded, and notes were taken from the recordings by a member of the research team. The specific issues around the importance of place and locality were noted with the focus groups undertaken in the remote areas and from regional perspectives.

e. Ethics

This research has ethics approval through Curtin University (Curtin Ref: HRE2018-0250).

5. Proposed Hub Model Designs

The targeted consultations gave insight into the possible effectiveness and challenges of the hub models that were presented at the consultations. Based on the feedback from the targeted consultations, the research team amended the hub model designs, added additional details, such as the key processes of the proposed models. The hub models were also scaled as far as possible according to resources to meet the project requirements.

6. Analysis of Existing Models in WA

In light of the findings from the consultation, the hub service models currently operating in WA were further examined to determine whether they could be built upon for the purposes of the proposed hub. The following criteria was used to assess the existing services: organisational lead; agency lead; agency focus; target population of agency(s); type(s) of service delivery; areas of alignment; and, impact on original service. Services that were examined included: Family and Domestic Violence Response Teams (FDVRT); Family Safety

Teams, Kimberley Region; Refuge Service System Model Emergency Response; Safe At Home; Domestic Violence Advisory Service (DVAS); Barndimalgu Family Violence Court in Geraldton; Women's Resource and Engagement Network (WREN); Marninwarntikura Fitzroy Women's Resource Centre (MFWRC), Fitzroy Crossing; Safe as Houses; Family Support Networks; George Jones Child Advocacy Centre; Multiagency Investigation and Support Team (MIST); Child and Parent Centres; National Partnership Agreement on Homelessness (NPAH); and headspace.

Review of Evidence about Hub Model Service Design

There has been a substantive number of reports and research advocating the importance of collaboration in the delivery of public services. These approaches are preferred because they are seen are seen to offer the best prospect for providing a cohesive and comprehensive way of supporting people experiencing complex social problems such as FDV or homelessness. Whilst these aim to offer a single pathway, the research evidence about the outcomes of these forms of system design is limited. This is partly due to the multi-faceted aspects of addressing FDV and partly because, whilst agencies may work closely together, the policy domains involved in FDV remain largely siloed, so the evaluation research follows in these silos and not across government. Consequently, with some exceptions, the majority of evaluation research on FDV is focused on how specific parts of the FDV response system operates which is largely at program level, for example, an evaluation of a perpetrator program, reviews of how effective refuge services are in identifying and managing risk and supporting women to become safely housed. The 'effects' or 'value adding' of having a coordinated response itself has received less research and evaluation attention. With this in mind the following evidence review highlights the conditions in place to initiate, implement and improve integrated service designs.

The evidence review was conducted with a comprehensive search of published national and international literature, grey literature about the more well-known collaborative partnerships in the FDV sector nationally and internationally was examined. Literature on public service collaboration more generally is included in the review to distil factors that support interagency and interdisciplinary collaboration.

Collaboration in public services

Purpose Driven Collaboration

There is no single definition or means of running a coordinated or integrated hub model service design. However, as with most service design it is critical it is fit for purpose. In the case of the WA FDV hubs the overall goals are increasing women's, children's and family safety and increasing perpetrator accountability by providing joined up responses through a single pathway in which the violence can be addressed. It is anticipated that the proposed hub design will build on the history of collaborative practice. In reviewing collaborative approaches in public services Nylén (2007) identified three main collaborative strategies with differing degrees of intensity, formalisation and resource requirements.

1. Collaborative strategy one, coordination between agencies, is the least intensive, with moderate (e.g. MOUs between agencies with regard to referral pathways) and this generally takes place within existing structures.
2. Collaborative strategy two is higher in intensity but is lower in formality as it develops between professionals and is dependent on "reputation, commitment and trust" (Nylen, 2007, p. 161).
3. Lastly, collaborative strategy three involves the creation of a new organisational unit and is high in both intensity (involves advanced integration) and in formalisation. Strategy three is the most resource intensive strategy and adopted when "managing complex interdependencies and clients with multiple needs" (Nylén, 2007, p. 162) thus making it a recommended strategy to enable the community hub to add value to existing systems aimed at addressing both safety and accountability.

In this way the hub design is the next step in a maturing of collaborative practice in WA, and that the hub as an additional organisational unit is well suited to consolidating existing FDV responses.

Maturing Collaborative Practice

Bronstein (2003) outlines a model for interdisciplinary collaboration, particularly relevant in situations where people with different disciplinary backgrounds and orientations must work together for a common purpose or goal. Five necessary conditions for collaboration have been identified.

- *Interdependence between agencies to address an issue has been a driver for hub developments.* This includes a clear understanding of an agency/practitioner's role, how it differs and complements others' roles, it contributes to the overall purpose or vision, and demands information discussion, reflection and deliberation with other colleagues. In practice, this requires clear lines of responsibility and delegations, and open working spaces to facilitate regular informal discussion which is pivotal to collaborative practice.
- *Newly created professional activities* which emerge as a consequence of the interdependence and in order to have collaborative practice. The establishment of new roles or activities that can only be realised through collaboration; they do not simply replicate existing practice. In practice, this means the Hub must institute new roles, functions and practices that can only be realised via collaboration and will be shaped by the agencies represented and location.
- *Collective ownership of goals. G*oals, values, processes and overarching objectives should be shared so that all parties have a stake in the success of the collaboration. In practice, this means that the Hub must be designed in a way that facilitates shared input into its vision and operations, each stakeholder is jointly responsible for its form, its success or failure.
- *Flexibility.* The intention or purpose of roles and functions should be clear, but not rigidly defined. There needs to be enough flexibility in the system to allow some blurring or sharing of roles and tasks. In practice, this means that the Hub needs to be able to flexibly adapt to prevailing circumstances and practitioners and services need to have some flexible scope in their roles. Without such commitment by agencies' representatives, practitioners work will not be collaborative, the services will just be jointly housed, and there will be no real difference to outcomes.
- *Reflection on process.* Spaces for conversation, discussion, professional learning and feedback loops. In practice, the Hub should be practically and architecturally designed to allow for organic and structured face-to-face deliberation and dialogue to manifest itself as a regular and normative aspect of its operation.

Whilst the literature clearly indicates that FDV is well suited to a hub style of collaborative practice researchers also point to the realities of implementing such collaborative practice.

Organisations are most likely to collaborate when it is obvious better outcomes can be achieved working together than is possible than an agency acting alone. McDonald, Powell Davies, Jayasuriya, and Fort Harris (2011) found that all collaboration requires time and effort, with cost being higher across diverse organisations. Collaboration is easier between like-sized organisations with similar missions, underlying values and methods of working. Supports to collaboration include common referral pathways, education and training opportunities and consultation practice (McDonald et al., 2011).

Likewise research by Edwards (2015) suggests that for interagency and inter-professional collaboration to be successfully united towards common purpose, the Hub must have a very clearly and consistently articulated purpose, which is subject to ongoing discussion, reflection, learning and deliberation in light of the various practices that are the responsibilities of those working in the Hub. The intentional focus on what motivates practice and how it is negotiated and mediated by wider organisational purpose and leadership is an important step towards collaboration. Action and all forms of practice are motivated by deep social, cultural, historical and personal factors, and these are subject to differing and changing levels of alignment to wider organisational or policy purposes and strategic goals. This presents a significant argument for co-location that would enable processes that could foster the development of practice alignment and learning within the community hub.

In implementing interagency collaboration it can also be fraught with difficulties; for example, the reality or perception that scarce resources are being split or diverted to the hub and not directly to agencies, and limited understanding or demonstration of the benefits of collaboration can compromise successful collaboration (Hill & Laurence, 2003). Providers are conditioned by different incentives and motivations to collaborate, and assuming providers will collaborate purely on moral grounds is spurious.

Hill and Laurence (2003) categorise aspects of successful collaboration into two areas: 1) incentives and governance; and 2) hub processers and practices.

In the first category, the focus should be on incentives such as adequate resourcing, a central governing or administrative authority, performance criterion, and formal agreements to coordinate and resolve disputes. The second category includes focussing on

developing joint statements of purpose, shared assets and workspaces, joint training exercises and value-based agreements and partnerships. Mechanisms that increase the relational and social connectedness of different stakeholders will support the development of effective collaboration.

A longitudinal case study of collaboration in the UK by Vangen, Hayes and Cornforth (2015) found attention should be paid to three key elements: structure, actors and processes. Structure is the "totality of the partners… involved in the collaboration and the formal interconnections between them" (Vangen et al., 2015, p. 1246). Actors are influencers and people with the ability to get things done to propel the agenda of the collaborative. Processes are those elements that enable communications, responsibility, shared purpose and can take the form of workshops, plans, and committees. Vangen et al., (2015, p. 1258) conclude that "paying attention to the structures, processes and actors is key to directing, coordinating and allocating resources for the collaboration as a whole and to account for its activities."

In short, the evidence about interagency and collaborative practice and organisation in public services highlights its suitability to areas of complex problems or concerns that involves multiple agency stakeholders and where there are interdependencies between agencies. A single or small number of pathways to a hub model are both an outcome of the collaboration and ultimately result in a better outcome for those served by the hub. In practice a hub model requires this common purpose to be agreed, for agency and practitioner roles to be aligned with the common purpose and common mechanisms for working together which are robust and reliable. This requires leadership and stakeholder support for the hub along with an understanding that collaboration will continue to build and take shape in its local context. The research indicates that this will be largely resource intensive and require reflection and capacity to be flexible as the best processes emerge between stakeholders. These collaborative principles and practices are echoed in the research on integrated responses to FDV.

Integrated responses to FDV in Australia and internationally

> *At its best, collaboration is the embodiment of the whole becoming more than its constituent parts. Each professional performs their role with reference to and respect for other roles, ensuring that the synergy and collective wisdom of different types of expertise are brought to bear upon a complex issue. At worst it can become a minefield of bureaucratic procedures or turf wars' that hinder effective action and impede separate professional goals and imperatives* (Australian Attorney-General's Department, 2010, p. 2).

Integrated responses to FDV have become a familiar approach to addressing an issue which has disproportionate and significant impacts on women and children's safety, health and wellbeing. The term integrated response is often used interchangeably with other phrases such as "collaborative", multi-agency", "partnership", "interagency", and "coordinated response" (Breckenridge, Rees, Valentine, & Murray, 2015, p. 10; Wilcox, 2010). It is generally understood as being "a partnership response that involves formalised agreements regarding processes, roles, responsibilities and cross-unit accountability" (Meyer, 2014, p. 2). Such responses have largely evolved around three key systems: criminal justice, child protection and domestic violence services (Ross, Healey, Diemer, & Humphreys, 2016; Wilcox, 2010), with a variety of other agency involvement often needed to attend to the multitude of needs which co-exists with violence (Macvean, Humphreys, & Healey, 2018).

Legal and non-legal services which support Australia's response to FDV include the criminal justice system, legal aid units, court advocacy services, family violence courts, women's legal services, community legal centres, specialist child protection, support and outreach, refuges, family support, health, counselling and therapeutic services (Ross et al., 2016; Wilcox, 2010). Service siloing is a recognised consequence of the differing agency remits with secondary victimisation of women in particular resulting from systems generated practices which tend to hold women responsible for the effects of the abuse, and which can unintentionally create inaccessible and complex support pathways (Meyer, 2014; National Council to reduce Violence against Women and their Children, 2009; Wilcox, 2010). An example is when women are forced to leave the home with accompanying children to be eligible to access safe and supportive services. The development of specialised, integrated responses to FDV is an attempt to combat the effects of these service silos and the fragmentation, gaps and overlapping of services which can ensue (Macvean et al., 2018;

Potito, Day, Carson, & Leary, 2009). This approach is currently considered best practice in facilitating more streamlined processes and better communication between agencies, key to enhancing victim safety and holding perpetrators accountable for their violence (Breckenridge et al., 2016; Fine et al., 2000; Meyer, 2014; National Council to reduce Violence against Women and their Children, 2009; Potito et al., 2009). Specific benefits of integration to service providers and clients are identified as including:

Service provider benefits:

- Cost-effectiveness achieved through minimising duplication of services
- Formalised information sharing between services
- Potential up-skilling of workers across different issues
- Enhanced transparency and accountability between services and workers

Client benefits:

- Simplified coordinated response to multiple clients' needs particularly when they are one-stop shops
- Multiple entry points for intervention
- Minimisation of secondary victimisation

Source: As cited in Breckenridge et al. (2015, p. 9).

Integrated responses which have been established and trialled in Australia and internationally are numerous, each with varying levels of partnerships, service models and intervention points (Breckenridge et al., 2015; Meyer, 2014). In Australia, some states and territories have implemented state-wide integrated systems (e.g. ACT, South Australia, Tasmania, Victoria, Western Australia) whilst others are more localised in their approach (e.g. Queensland, New South Wales, Northern Territory) (Australian Law Reform Commission (ALRC), 2010; Meyer, 2014). The depth of collaboration and integration between services, however, differs described as ranging from "…collaborative networking to full scale integrated systems…" (Meyer, 2014, p. 1018). This is not unique to FDV as was indicated in the research discussed above. Conceptualisation of these variances as a 'continuum', depicted in Table 1, provides an explanation of how different practice contexts, even within the same service system, may operationalise integration (Breckenridge et al., 2015, p. 10; Wilcox, 2010).

Table 1: Continuum of integrated service delivery

Service autonomy	Collaborative practice	Streamlined referrals	Cooperation	Coordination	Integration
With networking	Formalised networking arrangements and organisational policy	Incident-based processes, such as police fax backs	Regular communication around clients and some common goals	Agreed plans and protocols or a separately appointed coordinator	Single system with sub-units and cross-unit accountability

Source: Breckenridge (2015, p.10).

Appendix 3 outlines some of the integrated responses currently in Australia. The diversity between the integrated responses implemented has made evaluating their impact difficult to determine (discussed later in this report). However, in a recent meta-evaluation of integrated services in Australia Breckenridge et al. (2016, p. 4) identified some of the typical characteristics and goals that were common across the 33 programs they reviewed, including:

- Case coordination, information sharing and/or multi-disciplinary service delivery were central to the interagency models
- Police were the key participants in the majority of the responses
- One third of the responses involved housing and accommodation support
- One third of the responses involved multi-agency risk assessment and safety planning for FDV victims
- Few of the responses focused on responding to sexual assault
- Perpetrator responses were very limited.

Significantly, these findings highlight potential gaps and inconsistencies around perpetrator response, victim safety, and linking in with existing key services; areas that the development of integrated responses were designed to address. These are key areas for advancement in the future, and the recent Victorian ‘orange door’ model aims to redress such limitations.

Facilitators to integrated responses

Collaborative partnerships are founded on several key assumptions: no one person or agency can provide for the variety of client needs on their own; participants should include a diverse range of individuals and groups as a way of representing the concern, population and/or geographic area; and, shared interests and goals facilitate consensus among partners (Roussos & Fawcett, 2000, p. 370). Broad key features of interagency working have been the

focus of much research, with elements such as communication (informal and formal), trust (within and between agencies), shared goals, shared language, equity between agencies, and leadership frequently cited as being central to creating and sustaining collaborative partnerships (Breckenridge et al., 2015; Potito et al., 2009; Ross et al., 2016; Worrall-Davies & Cottrell, 2009). There is also widespread recognition that formalised agreements between partnership agencies around the sharing of service principles and approaches often forms the basis from which integrated relationships are established (Breckenridge et al., 2015). Wilcox (2008, p. 4) in her review of some of Australia's integrated responses, identified some of the component features of interagency working which demonstrate good practice. These are presented in Table 2.

Table 2: Features of good practice in interagency responses to family violence

Focus on victim safety and offender accountability
Inclusion of all family violence-related services at all levels (service delivery, policy, problem solving)
Shared missions, aims, values, approaches to family violence protocols
Collaborative approach to policy development and memoranda of understanding
Willingness to change organisational practice to meet the aims of the response and develop operating procedures to achieve this
Practices and protocols which ensure cultural safety, inclusivity and access and equity issues
Information sharing system
Adequately trained and professional staff
Senior level commitment and coordination
Adequate resourcing
Workable structure of governance, with coordination, steering, troubleshooting and monitoring functions
Transparency, particularly in regard to outcomes, including criminal justice system outcomes and evaluation processes
Commitment to continual self-auditing, with data collection and monitoring processes to enable this
Regular and frequent coordinated case management meetings
Mechanisms to enhance legal equality, such as access to legal services and representation
Identification of service gaps (e.g. children's counselling) and development of new services to address them
Incorporation of specialist courts with concurrent family law jurisdiction

Source: Wilcox, 2008, p. 5

Whilst these features are important elements, of particular interest to Governments, researchers and policy makers are the mechanisms needed for establishing integrated responses which meet these good practice ideologies. A recent scoping review of models of interagency working between child protection and either domestic violence services or family law services in Australia, United States and United Kingdom identified 22 facilitators for collaboration which are grouped according to five interagency collaboration enablers, presented in Table 3 (Macvean et al., 2018). These enablers and facilitating processes are a

useful framework from which integrated models of working can be implemented and potentially reviewed against.

Table 3: Processes to facilitate the interface between child protection and other services

Enablers	Facilitating processes	
Shared vision	(1)	Shared vision
	(2)	Shared goals
	(3)	Shared theoretical framework
Formalisation of the model	(4)	Formal agreements for collaboration
	(5)	Operations protocols/manuals
	(6)	Co-location of services/agencies
Authorising environment	(7)	Appointment of agency representation on committees
	(8)	Regularly scheduled meetings
	(9)	Appointment of a coordinator or liaison between agencies
	(10)	Clearly defined roles
	(11)	Shared intake and referral procedures
	(12)	Common or agreed risk assessments
	(13)	Provision of funding for child protection involvement
	(14)	Agreement to include child protection in assessment
	(15)	Agreement to include child protection in service planning
	(16)	Agreement to include child protection in case closure
Leadership	(17)	Training on collaboration and interagency work
	(18)	Cross-agency leadership
	(19)	Formation of committees and boards
Information sharing	(20)	Development of information sharing agreements
	(21)	Data management systems
	(22)	Security systems for shared data

Source: Macvean 2018 p. 154

A crucial feature of integrated responses is the level of connection between these individual factors; that is, responses are more comprehensive and integrated when their system elements are carried out in a coordinated manner. For example, developing shared information systems are more effectively implemented when there is strong managerial leadership in conjunction with multi-sectoral partnership involvement. On its own, this may not constitute a comprehensive response; however, together with support from management, multi-agency involvement, as well as policy development and implementation this can facilitate an effective integrated response (Colombini, Dockerty, & Mayhew, 2017). In short, it is the sum of all parts working together that makes an integrated responses successful. The literature points to the importance of agencies involved in collaborative, integrated type service arrangements working towards and ascribing to shared principles of practice which are actively nurtured not only at management level but by individual workers. The challenge is to ensure that such collaborative practice becomes orthodox and not an exceptional way of working.

Challenges around integrated working

> *The problem isn't that their collaboration is not working, but that because of the new policy we are asking them to work differently, which means breaking up established successful and effective working relationships and building new ones* (Huxham & Vangen, 2008, p. 37)

There is widespread acknowledgement that interagency working and collaborative arrangements are vulnerable to many challenges. A significant issue impacting on the development and sustainability of integrated responses to FDV is related to how common policy models are interpreted into front line service delivery partnerships (Atwool, 2003; Ross et al., 2016). Whilst this can be impacted by other wide ranging factors (discussed below), the contribution, support and understandings of stakeholders are critical. Nowell (2009) speaks of the impact of stakeholders holding different or unacknowledged philosophical differences which can lead to discordance and indeed the breakdown of collaborative arrangements if not worked through accordingly. Such susceptibilities can be heightened when there are changes in organisational representatives or shifts in strategic focus that can increase the importance of certain stakeholders previously more peripheral.

Other barriers or challenges identified as inhibiting the success of interagency working, include:

- Power imbalances, competitive relationships, and lack of common ground between perspectives, disciplines and agencies (Atwool, 2003; Breckenridge et al., 2016; Worrall-Davies & Cottrell, 2009);
- Individual (client) perceptions of cross-agency control (Breckenridge et al., 2016, p. 3);
- Communication problems between and across services can be frustrating for clients and workers (these vary by jurisdiction/geographical area and include issues such as information sharing concerns, which can lead to ineffective case management) (Atwool, 2003; Breckenridge et al., 2016; Wilcox, 2008);
- Unsustainable resourcing limitations (e.g. including tangible resources such as money, and intangible resources such as time and energy) (Atwool, 2003; Breckenridge et al., 2016; Colombini et al., 2017);
- Loss of specialisation and tailored responses (Breckenridge et al., 2016, p. 3);

- History of conflict between individuals and agencies (Atwool, 2003; Worrall-Davies & Cottrell, 2009);
- Monitoring and accountability issues including disagreement or misunderstanding about roles and responsibilities (Atwool, 2003; Colombini et al., 2017; Wilcox, 2008; Worrall-Davies & Cottrell, 2009);
- Competition for resources (Atwool, 2003, p. 31);
- Failing to recognise a need to make changes at the organisational level rather than continuing to expect individuals to change, e.g. education (Atwool, 2003, p. 31);
- Difficulty maintaining networks (Atwool, 2003, p. 32);
- Bureaucratic needs constrain or interfere with delivery of services (Atwool, 2003; Worrall-Davies & Cottrell, 2009);
- Agencies having different intervention focuses e.g. adult focused as opposed to child focused agencies (Atwool, 2003);
- Exclusion of key agencies (leading to competition for clients or gaps in the response's capacity) (Wilcox, 2008, p. 5);
- Inadequate governance (Wilcox, 2008); and
- Substantial gaps in service provision, particularly in areas which lack government-funded family violence services (Wilcox, 2008).

Effectiveness of integrated responses

Whilst there is a significant amount of literature describing the facilitators to and challenges of integrated responses to FDV, there appears to be limited empirical evidence around their effectiveness (O'Looney, 1993; Roussos & Fawcett, 2000). There are a number of reasons for this. As alluded to earlier, the diversity that exists between responses makes it fundamentally difficult for programs to be compared, with each having variances in the contexts and mechanisms through which they operate including their geographic scale, specific goals, duration, service types, and levels of agency-to-agency partnering (Ross et al., 2016; Roussos & Fawcett, 2000). Methodological issues across evaluations, in particular inconsistent study designs, are also identified as problematic when trying to draw conclusions about the success, or not, of such models or programs (Breckenridge et al., 2016). Additionally, Breckenridge (2015) identified the absence of guidance evaluation frameworks as contributing to these issues. Despite this dearth in evidence, integrated

responses are, however, being appraised ‘naturalistically’ and positive effects are being experienced. Shifts in ways of working, increased inter-agency collaboration and improvements in professional respect and knowledge were positive indications. In many cases, integrated responses were attributed with successfully bringing agencies closer to shared understandings of violence and risk, key to supporting the safety and wellbeing of women and children. Criticisms associated with integrated working have been summarised by Breckenridge et al (2016, p.28).

> “Criticisms of integration, however, have included limiting women’s choices, reducing a diversity of approaches, limiting practical options (such as services offering different times and access opportunities), and potentially threatening privacy when data are shared within integrated services (Bennett, Riger, Schewe, Howard, & Wasco, 2004; Browne, Kingston, Grdisa, & Markle-Reid, 2007)”.

Evaluations that included the perspectives of clients had promising results, with clients indicating they valued the support they received (Breckenridge et al., 2016). Breckenridge et al. (2016) also highlighted that many evaluations of integrated responses do not include analyses of the experiences or outcomes for diverse population groups (e.g. culturally and linguistically diverse clients, clients with disabilities or clients living in rural or remote areas), adding to the complexity in determining whether such models cater for varying needs adequately. This is a major gap in knowledge which would be important to address in any WA model, to ensure inclusiveness and responsiveness to the diverse contexts of those affected by FDV.

Roussos and Fawcett (2000) further suggest that determining the effectiveness of an integrated response can be impacted by the length of time often needed to see the visible effects; sometimes this not able to be detected until long after the initiatives have ended. This is largely linked to funding cycles and demands for outcomes that are not matched to the time taken for outcomes to occur and be documented.

‘One Stop’ service delivery models

‘One Stop’ service delivery models (referred to as OSSs) have recently become an influential design across varying public service sectors. Known by varying terms including ‘One Stop Shops’, ‘One Stop Service Centres’, and ‘Single Window Services’ (Askim, Fimreite, Moseley, & Pedersen, 2011) they potentially offer a way of streamlining services thereby improving

efficiencies through providing a single entry point where service users can attain all the services they require (Howard, 2017; Reid & Wettenhall, 2015). Popularity has grown from the concern that delivery of services is increasingly fragmented, which can result in often vulnerable people having to deal with “multiple dispersed and disconnected service providers” (Howard, 2017, p. 1). In Australia, the model was introduced to the welfare sector in the 1970s as a way of easing “poor people’s access to welfare service providers” (Askim et al., 2011, p. 1452) and has similarly been used in many other countries as gateways to public services (Askim et al., 2011). The central tenet of OSSs is to provide a more holistic and customer focused service which is simpler to navigate (Reid & Wettenhall, 2015). However, whilst adopting such models appear to be driven by an increased interest in addressing the needs of users through ‘bottom-up’ processes, ‘top-down’ political endorsement is generally required to implement (Howard, 2017).

Key benefits identified as resulting from the successful implementation of an OSS include: *Integration*, where multiple services are offered in one place which are coherent or seamless in their delivery; *Efficiency*, there is reduced duplication resulting in lower delivery costs; and *Satisfaction*, in service users and staff experience of service delivery (Howard, 2017, p. 2). As far back as the 1970s, the Royal Commission report (Coombs, 1976, p. 161) stated:

> The object of the 'one stop shop' is to provide as nearly as possible a complete service (including if possible the power to make decisions) in one place, at one visit, and with members of the public having to deal with not more than one or two different officers.

OSSs have thus come about from an identified need to achieve a higher level of integration in service provision. They often involve the creation of “new, dedicated service organisations, or as horizontal partnerships between separate organisations” (Howard, 2017, p. 5), although varying types of OSSs are documented. Kubicek, 2001 (as cited in Howard, 2017, p.5) refer to three models of OSSs, summarised as being:

- Superficial one stop shop (physical or virtual): where users enter and are then directed on to service providers, who remain separate. Is not a true one-stop as at least a second stop is required.

- Convenience store: where different agencies locate themselves together so users don't need to move around. Typically, more complex services cannot be delivered as they require they require more knowledge or time to complete.
- True one-stop shop: where users can obtain all services from the one organisation. A single contact person to manage all a client's concerns often characterises this approach.

Working towards success

According to Howard's (2017) recent systematic review of OSS implementation, ascertaining the effectiveness of OSS service delivery models is difficult to determine due to the limitations associated with available research. These include: "a lack of systematic evidence concerning the role of administrative culture in service integration, inadequate quantitative data on the budgetary costs and benefits of OSSs, and a lack of attention to the impacts of OSS reforms on citizen satisfaction" (p. 2). Consequently, we cannot say with certainty that inception of the proposed FDV Hubs in Western Australia will result in any cost efficiencies or improvement in service user satisfaction. This is not to say that positive outcomes will not ensue, but rather that consideration should be given from the outset to the myriad of potential costs and risks documented as common in implementing this type of service delivery model as a way of mitigating their impact.

Murray et al. (2014) in their examination of the outcomes and planning processes of Family Justice Centres' (FJC) in the US emphasise the critical importance of the early planning stages in influencing their sustainability. Practical strategies they see as important in this phase include:

- Assessing the community's readiness: In their view, this type of model is not appropriate when there has not been a history of collaboration among agencies related to domestic violence nor if the local criminal justice agency does not prioritise domestic violence.
- Learning from others' experiences: visiting with other communities with existing FJCs to learn how they function.
- Facilitating buy-in from community organisations: identifying a champion or key supporter to propel the planning process forward can be helpful. Special consideration should also be given to establishing or building upon the already

strong relationships among the involved agencies as FJCs are then more likely to succeed. In their opinion, forced collaborations that are not given the time to naturally develop are hardly ever effective. As such, Murray et al. (2014) agree with Howard (2017) that managing issues of turf and competition, particularly when there are limited financial resources can be challenging.

- Securing funding: funding strategies or commitments are critical to implementation and sustainability.
- Establishing information sharing policies from the outset.
- Meeting the needs of the local community: accessibility to various cultural groups and those living in regional areas.

Potential areas identified as impacting on the success of OSSs include:

- Resistance to integration caused by a preoccupation with turf. Success lies in the ability of parties to give up some power as a way of facilitating collaboration across vertical and horizontal levels. Conflicts can be exacerbated when non-government partners and contractors are involved in such arrangements.
- Cultures embedded in siloed ways of thinking are also a major impediment to integration. Service planning to promote integrated mindsets and realising service excellence amongst employees is fundamental to achieving joined up service delivery.
- Inadequate resourcing can have a substantial impact on the implementation and development of OSS. Assumptions that these type of service delivery models will result in cost reductions and efficiencies can mean that start-up and ongoing expenses associated with acquiring new space, information technology, branding and marketing, reorganisation of staffing structures, recruiting and training of staff are often underestimated.
- Additionally, assigning unrealistic timeframes to see changes or improvements or not allowing an appropriate level of time and attention towards adjusting administrative practices essential to managing the changes in service delivery arrangements can impact on its sustainability.
- The breadth of staff capabilities needed to deliver services that are efficient, meet client needs as well as policy requirements can also be obstacles to implementation,

particularly if there is inadequate training, insufficient time for worker development, and the work performed is not divided between the horizontal and vertical layers of an organisation to permit specialisation. Such specialisation dilemmas have led, in some cases, to OSS moving away from clientele specialisation back towards process specialisation (Howard, 2017).

In Howard's (2017) view, effective implementation of OSSs is most successful and sustainable when "the OSS goal is carefully balanced with a traditional 'siloed' approach to service production and delivery" (p. 2). This is in contrast to Deseriee (2013) who in her critique of Family Justice Centers (sic) (FJCs) believes there is a need to move beyond efforts of 'collaboration', where agencies work independently alongside each other, to that of 'consolidation'. In her view, consolidation is a true form of integrated working where agencies and workers are given a larger scope of responsibility to address the multiple needs of families. She asserts that greater numbers of smaller organisations responsible for entire families may be more effective than current approaches which tend to try and bring together all the services a family needs.

Consideration should also be given to the expectations around seamless service delivery that can be associated with the label of 'One Stop Shop' which may not be able to be realised, particularly in the short term (Minas, 2014). This indicates the importance of branding and marketing of the hubs to ensure they adequately reflect what they intend to provide from inception. More important is the need for the service to deliver on their promises with successful implementation and sustainability often reliant upon these first impressions.

Despite the critiques, promising results around the successes of these service types do exist, as demonstrated in the desktop scan of national and international initiatives around integrated service delivery models (refer to Appendix 3). Noteworthy arrangements in Western Australia include: the Family and Domestic Violence Response Teams (FDVRT), Domestic Violence Advisory Service (DVAS) Central, the East Kimberley hub, and the Family Support Network where these collaborative partnerships have demonstrated improvements in service delivery, as well as in worker and client satisfaction.

Summary of Desktop Scan and Analysis

The desktop scan and analysis contributed significantly to the design of the proposed hub and also informed the implementation considerations. The hub models and integrated responses demonstrated the diverse collaborative practices that exist and the range of agencies involved in the service. The models that were formally evaluated were constructive to the design of the hub as they provided evidence of the models' strengths and challenges. A number of models had similar limitations, such as resources (financial, material, etc.), the absence of a central database system, and insufficient information sharing protocols. The strengths of the models varied, but included strong relationships with other agencies, communication and information sharing, and coordinated responses benefiting the client. Please refer to the attached compendium for the full results of the desktop scan and analysis.

Summary of Models presented at Consultations

Based on the evidence reviewed and current models in operation in Australia and overseas the proposed hub models are intended to address the complex multifaceted issue of FDV involving multiple agencies to further build on existing collaborative efforts. At the consultations, two hub models were presented: Model One and Model Two (please refer to Appendix 1) for comment and feedback. Whilst there are differences between the two models presented, importantly there were common aims and purpose that should be the goal of services under any hub design. These common aspects are as follows.

The target groups of the hub service design

The primary target group are those victimised by FDV, who are primarily women, with or without children, who may or may not have previously accessed the service system. The secondary target group are the supporters (family and friends) of those victimised who experience the ripple like effects of FDV in their lives and are critical to her safety and support. Thirdly, those perpetrating FDV are a target group of the hub because in order to promote the safety of victims, perpetrators require pathways through which they can become safer and non-abusive to those around them.

The aims of the hubs

- To promote the safety of those victimised through collaborative actions immediate and in the longer term to prevent future violence and abuse. Those victimised include those subjected to FDV, primarily women and children, and their supporters (family and friends).
- The hub services delivered aim to respond according to the person's circumstances, recognising the diversity of their experience in planning for safety and offering support and how this impacts on the specific risks the perpetrator may pose.
- The hub services will meet victims'/survivors' needs in a timely way, facilitate pathways to immediate and longer term support and maintain their information on the pathways and responses delivered, so that responses are aligned with suitable information available.
- The hub aim to increase the visibility and knowledge of the FDV perpetrator and the perpetrator's risk for all agencies; enhancing opportunities for the perpetrator to take up stopping violence interventions; strengthening and adding value to existing arrangements of integration and partnership working while operating 'alongside' current systems; building and sustaining relationships with partner agencies and working closely with agencies not typically part of the FDV service system, such as mental health services, which can be difficult for women to access or may not directly address risk of violence
- The hub models aim to apply research informed approaches to develop the evidence base alongside its implementation in order to develop and inform best practice. This can occur through documenting and collecting data on the FDV responses. It is expected that areas of progress will be evidenced and areas which need work will be identified as a result of the research. Additionally, transparency and accountability will be promoted.

At the time of writing it seems appropriate that the hub models will operate in a local area and work alongside the current FDVRT. The hub can be accessed via self-referral (telephone and face-to-face by appointment) and referrals from agencies, such as Crisis Care, Coordinated Response Service (CRS), and other services (e.g., hospitals, GPs, child health nurse). Model Two includes a centralised state-wide contact point for information/access so

the community can be informed of available services and actively connected to relevant supports.

Features of the hubs

There a number of key features consistent in both models presented at the consultations these include:

- co-location of key workers or agencies;
- clearly defined roles and responsibilities;
- formalised agreements between partner agencies;
- robust information sharing policies, procedures and databases;
- regular face-to-face meetings;
- workforce development through outreaching to improve FDV integrated responses;
- training that is jointly run and attended by multiple agencies so that collaboration is modelled in all aspects of FDV work so it becomes the orthodoxy of practice;
- retaining specialisations to address complexity and diversity; and
- evidence-informed practice resources.

Operations of the Hubs

In both models it is proposed that there are employees of the hub specifically, not just hub partner employees as such. The rationale being that all of the evidence consistently points to the necessity of the collaborative approach being managed, driven and developed which requires oversight and stability. It is proposed that the hub is managed by Department for Communities and not the contracted responsibility of a non-government organisation. The argument for this governance is that the inter-agency operations are most likely to be improved and enhanced if the hub director/manager has a line manager within government which can offer an authorising environment for intra and inter-governmental feedback, reforms and developments. The responsibility of the hub remaining with government may have some critics who could suggest that this may prevent people accessing the hub, however, we would argue it is more important than the hub is not perceived by the community to belong to a single agency and being operate by government will safeguard against any impact from competitive tendering and subsequent hub agency participation.

Hub Organisational Structure

It was proposed that the hub model included the following staffing:

- Manager/Coordinator of the Hub
- Specialist Interviewers carrying out intake, assessments and referrals, preparing common records. Intention that across the specialist workers the following experience is available to work with CaLD communities, children and young people, LGBTQIA, people with disabilities.
- Men's worker – based at the hub to take phone referrals and calls, face to face meetings with those using violence be conducted at a local partner agency not at the hub site
- Aboriginal worker – this would give individuals the option to speak with an Aboriginal worker, worker has strong connections to specialist Aboriginal responses to FDV
- Research/Project Officer responsible for evidence development, supporting and coordinating training and development in the region

The hub design would have two forms of governance: a local advisory committee involving representatives of local agency partners and a management committee led by DoC to ensure the development and improvement of collaborative practice in the region, including monitoring and evaluation oversight.

The underpinning approaches that are pivotal to all responses by the Hub staff and partners working in the hub include:

- Promoting Safety and Minimising Harm;
- Cultural respect and safety;
- FDV and Trauma informed; and the
- Application of intersectional principles.

The hub workers for Model One and Model Two are noted in Table 4 (below) along with a brief explanation of their roles and responsibilities. Five key partners have been identified and will be co-located on-site at the hub, either part-time or all of the time, depending on

the model. Model One will have partners co-located part-time and Model Two will have partners based at the hub full-time.

Following the consultations, some revisions were made to the staffing structure of the hub. This is discussed later in this report.

Table 4: Description of roles and responsibilities within Hubs (presented at Consultations).

Position	Brief explanation of role and responsibilities
Specialist Interviewers	• Initial point of contact with services. • Undertake thorough, common assessment and share relevant information with other specialist agencies to facilitate care of service user. • Actively respond to individuals and families on an as needs basis, recognising similarities and differences of experiences. • Build and sustain relationships with partner agencies and work alongside FDVRT. • Provide continuity of care through case coordination or management, as required • Facilitate pathways. • Outreach, if needed. • Co-located with men's workers to strengthen the relationship between women's and men's services.
Men's Worker	• Provides active contact, referrals and outreach (where appropriate) to male adolescents or men identified as perpetrators of violence. • Manages issues, such as substance misuse, in an attempt to stabilise the perpetrators life; addresses factors that, while do not drive risk, contribute to it; and prepares men to take up stopping family violence interventions through increased motivation and capacity to do so. • Assists with increasing the visibility and knowledge of the perpetrator and perpetrators risk for all agencies. • Develops and maintains strong links with police, courts, men's services, drug and alcohol, mental health services. • Co-located with specialist interviewers to strengthen the relationship between women's and men's services.
Aboriginal Worker	• Provides culturally informed support. • Supports workers to help with better engagement (where appropriate) of Aboriginal People and their families.
Research/Project Officer	• Supports the hub as a place of learning, development and training • Aboriginal worker • Review and evaluate service delivery • Disseminate knowledge • Lead and develop evidence informed best practice across the FDV sector. • Up skill and train practitioners and workers in the FDV field. • Oversees and facilitates student placement opportunities
Hub Partners On-site	• Financial Services • Legal services • Mental health services • Alcohol and other drug services • Health and medical services • Women's counselling
Hub Partners Off-site	• Women's refuges • Aboriginal services • Services for children • Multicultural services • Men's FDV • Disability services • Housing

Research Findings from Consultations

Several overarching themes associated with implementation of the "One Stop Hubs" were identified from the consultations. Overall, there was support for a hub model in principle. Participants recognised the potential for interagency collaboration and that a hub model could potentially deliver a more comprehensive service with increased levels of perpetrator accountability. But participants also had some questions about the design and operations of a hub model.

Collaboration

Participants recognised the development of the "One Stop Hubs" as an opportunity for legitimate collaboration, although this was mixed with some reservation about how this would look in practice. There was also some concern over what impact the hub would have on current service delivery. Careful thought and preparation around the operationalisation of the hubs was indicated. There were a number of key areas identified and discussed that have been classified under the broader term of collaboration which were viewed as essential to establishing successful, positive partnerships between and within workers and agencies.

a. Managing and coordinating the operations of the Hub

There was some suggestion that the hub should operate as its own independent entity, to ensure that it clearly develops as a hub in its own right, and does not become an ancillary service to an existing agency. If there a multiple agencies involved in a collaborative venture, it raises question over who or what would be the lead agency and where the authorisation would come from. From the view of participants, governance was identified as major challenge when there are multiple agencies involved in the hub. For example, an existing lead agency may have an interest in branding the hub in line with its own model, which could be a barrier to help seeking and a barrier to genuine collaborative working.

It also presents a complication of potential dual accountability of workers to both their employing agency and the hub manager. This issue would be resolved by establishing the hub as its own entity, with authorisation from the state.

Participants thought it essential to establish formal agreements and a strong operating environment to ensure that the hub is more than just sharing a space and resources, but

genuinely acts as a centre for collaboration, and expertise. There was suggestion that the hub recruit and employ its own specialist workers, and that part of their role would be to build collaboration and integration with other hub partners.

Some participants asked questions about the capacity of the hub to respond to adolescent violence towards family members and managing risks around young people and parental consent. There was further comment about the capacity of other services (e.g., AOD, mental health) to accept referrals from the hub if they have existing waitlists. This is essentially a question about the responsiveness and availability of partner agencies.

Questions around the responsiveness of the hub were also posed. For example, what would be the hub's level of responsiveness outside of regular office hours? Participants appealed for extensive planning and coordination to develop timely responsiveness and to build linkages at a practical and managerial level. In short, strong governance of the hub is necessary, and it is clear that without a strong governance framework for collaboration it would not develop as a fully formed model in its own right. At the same time, the governance framework should have built in flexibility to allow for a person centred approach when developing a case management response to FDV, and to facilitate the right mix of services across different agencies.

b. Co-location of services

The literature is clear that co-location of services assists in developing and sustaining collaborative partnership arrangements (Breckenridge, Rees, Valentine, & Murray, 2015). Likewise, participants agreed co-location would facilitate and enhance the flow of information, and would support good collaboration between services and clients. For example, sharing information between women's and men's workers would support and improve safety and accountability.

A key positive identified was services being able to easily collectively case plan for a victim's needs, based on a central comprehensive assessment. The benefits of this approach were thought to be the potential for streamlining work processes and reducing the burden and re-traumatisation of women having to retell their stories to multiple different service providers. Participants thought that the services being located on-site (with experienced and knowledgeable staff) would facilitate improved practice and collaboration, and improve

knowledge of and intervention with perpetrators. Participants identified it was really important for all services to "be brought to the table" to address a family's needs holistically. Everyone needs to be on the same page and each needs to be accountable for addressing certain aspects (e.g., housing, financial, legal, refuge). Other benefits included the potential for a more long-term case management for men and women who may need ongoing support, for example, transitioning from prison or from a refuge to other accommodation arrangements.

Hub Model Two proposes partner agencies to be permanently co-located on-site, whereas Model One proposes that partner agencies co-locate part-time or intermittently. Participants thought that Model Two would increase collaboration, and agreed that the types of services identified as being part of the Hub would help improve accessibility for clients. For example, being able to access services in one place will reduce barriers to clients who ordinarily have to attend multiple appointments in different locations. Co-location was thought to improve accessibility. For example, bringing agencies under one roof has potential benefit to Aboriginal people who often experience barriers to accessing services due to lack of transport; however, the model of service needs to be accessible to Aboriginal people, and this should be reflected in the staffing and training of hub workers.

Accessing multiple different services in different locations can be difficult, and the data indicates that current siloing of services can result in breakdown of services and service accessibility to Aboriginal People. Furthermore, when services are delivering services off-site as well as on-site, this offers potential for clients to access coordinated support without having to come to the hub if they choose not to.

In short, there was a positive response towards the co-location of services, but also concerns with how this will operate in practice. For example, participants expressed caution about agencies continuing to operate as discrete silos, even if they are co-located together. This underscores the centrality of a genuine model of collaboration, and not merely one of co-location. There were some concerns about how this would be achieved, particularly if partner agencies remain off-site, as in Model One. A loose co-location arrangement (either on-site or off-site) raises questions about how genuine collaboration will be achieved, and how roles and responsibilities and timeliness of responses will be managed by the hub and partner agencies. Furthermore, it raised questions for participants about the availability of

workers to provide assistance if they are off-site; for example, if police are not available when needed. As mentioned above, the success of a hubs model turns on the degree of genuine authorisation, a culture of collaboration and strong governance and operational oversight.

c. Information sharing, management, and storage

Managing and sharing information was recognised as a very important component of the Hub operations and for supporting women and children's safety, although, there was concern expressed around determining the kind of information that can be shared, and with whom. The benefits of "joining up" information included: more timely information sharing; active collaborative decision-making; enhancing relationships and understanding of roles and responsibilities; sharing of risk related information and assessments, which reduces the burden on service users having to repeat their stories.

A key consideration of appropriate information sharing was a skilled workforce who are trained in responsible use of information sharing, particularly insofar as not to endanger safety through inadvertently sharing inappropriate information. It was suggested by participants that the hub could act as an information repository, as a way of storing information collected through assessments or small research projects carried out by agencies. This was viewed as being a very significant benefit as currently there are no mechanisms that facilitate this.

Part of the hubs model proposes the use of a shared database, and although many participants thought this was beneficial, some important considerations were deemed necessary. Information and intelligence about perpetrators can be beneficial as a point of collective oversight (this is a key aspect of the hubs in Victoria), if the hub acts as a conduit for the responsibility to collect and collate information about perpetrators, then this can be used in a timely way to inform practice and address safety. Currently, perpetrator responses are often anecdotal or based in ad hoc information, rather than being based in a central responsibility for the collection and sharing of relevant information. Data indicates that feedback loops between agencies are essential, and systems and training is needed to support this aim. However, there were some concerns expressed over the cost a shared database will impose on partner agencies, particularly in regards to set-up, maintenance and making changes to the database. This needs to be balanced against the need for a

common database for sharing information to offset the potential for duplication of service provision, or for services users having to retell their story to multiple services, as is often the situation now.

Further considerations include consent, confidentiality and legal implications of sharing information with statutory services; for example, it was thought that allowing child protection services access to hub information could be problematic if that information is potentially used against the client. Consent arrangements need to be established, and one way to address this is by establishing protocols for different levels of access to information. A shared database was seen by participants to have many benefits for sharing common information about risk, but may have differing levels of permission and access needed to clinical data. Sharing information and informed consent needs to be managed, and this requires some intellectual leadership and a culture and ethos of learning and collaboration; for example, through services learning from each other, creating expertise and a multidisciplinary approach to the collection, sharing and access to information.

d. Case management and coordination

Case management was seen by participants as important to supporting women and children's safety. For example, it was thought that working together as a team in a collaborative model would present opportunities to increase visibility of perpetrator. One participant referred to case management itself as being the heart of an intervention, rather than workers and agencies simply working in partnership. In a case management approach, opportunities exist for case managers from various agencies to come together, share expertise, and respond to complexity and different needs. The data indicated the need for the hub to broker relationships between agencies, and to authorise and coordinate case allocation and review meetings, which may involve services' practitioners coming together virtually or physically to discuss interventions and information. There were questions as to how this would work, and who or what would facilitate this practice. There was support for a centralised or single point of intake, assessment and case allocation and coordination.

e. Interface with other services and systems

Although the Hubs models were presented as operating alongside the current FDVRTs, greater clarification was needed about the relationship between the hub and FDVRT, as well as how the hubs would integrate or interact with other services and systems. There was a

general view from participants that there were a number of key players missing from the model. These included police, child protection, and justice services which some thought should be directly included in the hub and not ancillary partners. However, others saw the absence of such statutory authorities as positive, arguing that this will improve accessibility for clients. Overall, responses were divided around the appropriateness of statutory agencies being either directly located in or alongside the hub. Regardless, participants argued that clarity around the relationship between the hub and statutory services is needed. One possibility is that whilst they are not co-located agencies they would attend the case conferences and participate in information sharing and planning with the hub as partners.

There was a suggestion the hub could operate in conjunction with the Family Support Network to support clients, and the hub should work towards building links with the Network. Other participants expressed concern and FDV hub would potentially duplicate FSN or force agencies to 'choose' an alliance to either the FDV Hub or FSN. For example, there was some concern over the capacity of other services (e.g., AOD, mental health, refuges) to accept referrals and meet the work demands generated by the hub—especially in regional areas with limited services. Although it was thought that it is important for the hub to collaborate with police and other parts of the FDV system (such as refuges and Aboriginal Medical Services), expectations of access to these systems need to be considered. Furthermore, clarity around what Aboriginal service/agency would be involved as key to hubs is needed. To some degree this is limited by the final locations selected for the hubs.

In response to these concerns it is likely that some families would be likely to access both the FSN and the hub and this may be necessary and appropriate for different needs they are addressing. For example, seeking out early childhood support and also FDV counselling for the woman/mother. In order for these two entities to operate effectively side by side requires a clear differentiation of purpose and combined with information sharing with partner agencies so that families' pathways are not made more difficult regardless of entering FSN or the Hub.

The positive benefits of the hub may extend to working collaboratively with existing systems, which is essential for perpetrator visibility. It was thought that a hub could assist with generating and disseminating information to produce a more complete picture of family, and that the hub could become a holder of key information, which may assist with addressing concerns raised previously by the WA Ombudsman's (2016) report about information sharing and holding information about family members.

A place of expertise and excellence

Participants indicated the hub could be established as a place of FDV expertise and authority. This was premised on the hub staff having the expertise and skills in FDV to develop such an organisation. Participants argued that workers involved at the initial interview and assessment, which informs the intervention response, were the entry point to the pathway and played a critical role in whether or not later responses would be effective. Interviewers and assessors need to have significant authority and expertise, and they need to be able to work with multiple sources of information (data) and they need to be able to collaborate well with other workers and agencies. Interviewers and assessors need to be able to triage and provide critical responses to high risk situations. The ability to build trust and rapport was identified as a key skill required of workers.

Participants argued that hub workers need to be extremely knowledgeable and specialised to ensure the needs of diverse groups can be met in FDV. Second, and relatedly, there was some concerns expressed about the level of skills needed to deal with a broad range of issues and client groups. For example, being skilled and competent to adequately respond to victims (male and female), perpetrators, LGBTIQA, CaLD, and people with disabilities. This is also an area of concern identified in the literature, with suggestions around the need for agencies to retain their specialisations (Howard, 2017).

There was overall agreement that the hub and partner agencies be FDV and trauma informed in their practice. This may require an ongoing program of significant FDV and trauma response training and professional development, with some noting that this is a current gap across many different sectors. The organisation of the hub and its culture also needed to reflect a trauma-informed and safe space for those using the hub so it went beyond workers' practice.

Some saw the hub as an opportunity to improve understanding and responses to FDV at practitioner, service and sector level, and were supportive of a researcher/project officer in the hub to promote best practice. There was support for an embedded approach to evaluation, continuous improvement, reflection and monitoring—all of which were argued as an important component with any hub model. In short, there was support for a sustained program of professional development between on-site partners, to support related collaborative aims of working together and to also develop growing awareness of what's happening in the community and of broader community issues.

In the longer term when hub collaborations had matured, some participants saw the potential to offer early intervention (prevention) based activities rather than solely focusing on responding to FDV

Resourcing and adding value to the current system

There was broad agreement amongst participants that there must be adequate, ongoing funding to support the development and operations of the hub. Concern was expressed that without adequate resourcing the hub may actually place a strain on existing systems and agencies providing services. Competitive tendering and competition for scarce resources was identified as a source of tension between agencies with competition for funding breeding unhelpful relationships. Additionally, re-tendering and new agencies being brought on board to provide services can be challenging. It was also stated that it takes time for new services to gain the trust of Aboriginal people and communities, and this is not helped by short funding cycles and evaluation phases that do not recognise the length of time needed to see results. However, participants also expressed hope that the intent of the hubs would be fulfilled as envisioned. The biggest concern was that hubs might become merely referral only services or call centres.

There was some scepticism expressed around how the proposed new hubs would add value (and continue to do so) to the current system, and some participants questioned why funds were not going to be directed to existing services to be able to do more and/or reduce waiting lists (for example, refuges). A related concern was that the proposed hubs are devaluing the work that agencies are currently undertaking.

Some participants thought that building on the many "natural" hubs already in existence would be a better option than adding a new hub/system. It was suggested that this could be achieved by implementing standards or benchmarks around multiple agencies working together and developing practice standards. Other participants felt the approach taken was very "top-down" in that "outside players" are not part of the co-design. They considered the risk that a hub will not add value to the current system as it will not meet the needs of the community. This reservation expressed by participants could be due to perceiving the hub as a threat to the current system. This is an area that requires careful consideration, as the literature suggests that concerns with turf can produce resistance to integration (Howard, 2017).

However, others identified the potential benefit of the hubs insofar as they may be able to take some pressure off of the existing system, for example, refuges. Refuges could refer to the hubs, who could link women with support, alleviating pressure on beds in refuges. Although others argued that refuges are already doing the work of the hubs and should have their funding increased. In short, participants contended that hubs must have capacity to deliver services, encourage further engagement, and work to build trust in hubs and how they integrate and work with the sector. There should be sufficient resources for the hubs to do this so the hub is able to demonstrate its benefits and attract support from stakeholders. These frank perspectives from stakeholders were very much appreciated offering important insights into implementation issues that will require attention. However, one aspect which seems to be overlooked is the impact of greater collaboration that comes from co-location and co-working (on and off site) such as all workers holding much more information about a family to inform their practice than was previously possible.

Needs and safety of victims

For many participants, the needs and safety of victims was a priority. While many understood the need to provide a non-threatening space where women could seek support, there was some reservation around how this could be achieved in the hub. Some reference was made to designing the hub with a shop-front presence (based on knowledge of DVAS), there was strong support for the hub being a place of expertise and collaborative working, which was seen to be able to enhance safety. However, as mentioned, this was on the caveat that the hub is properly resourced and services the needs of the particular locality.

To achieve this end it was deemed important to consult with the community on the hub development, location, and in response to specific needs.

a. Physical design, location and accessibility

The literature suggests there are pros and cons with visibility of FDV services. It was expressed that the hub should be designed with physical safety in mind, and the hub should look and feel safe to attend. Participants expressed some reservation of an FDV hub being visible in the community, arguing that some women (e.g., from CaLD backgrounds) potentially do not want to seek support from a highly visible FDV service due to the associated connotations. This was even more pronounced for women in rural and remote areas. There was an assumption that perpetrators would not be attending the hub for support.

Concern was expressed that a shop-front style hub may lead to people attending unannounced, posing workflow and risk and safety problems, in particular, risk to the victim. This is a dilemma as it is something that currently occurs in agencies more generally and so may just need to be a risk that is managed as it is in other sites. As also reported in the questionnaire data, participants favoured a hub location that is place based, localised, and close to public transport. Accessibility was seen as important, as was locating the hub in locations deemed high risk or high needs. The other criterion identified was that it be based on current metropolitan service corridors for the Perth hub so it would work easily with existing service networks.

A very strong and unanimous theme was the importance of having an on-site crèche for hub clients, which was seen as a very practical way to support women and children's needs. It would also provide women with relief whilst they accessed the needed services on-site.

There was also support for an outreach component of the hub to engage local communities, and this was seen as particularly important to engage Aboriginal and CaLD communities. There was some view that the hub should be uncoupled from statutory departments and develop in the context of service user needs, particularly emphasising and branding itself within a place-based and locally embedded context. This was a particularly strong point in the regional context, and this was an important means of local workers not feeling that the hub was 'another top down' imposition from Perth.

b. Sensitive to diversity

A strong theme in the focus groups was the importance for workers to be culturally competent. There was some concern that the hub may not cater for diverse needs of women and that physical visibility can act as a barrier to accessing the hub. Participants argued for flexibility in service response, particularly in relation to CaLD and Aboriginal clients. Accessibility of the hub was strongly related to the local context of the hub's location. Participants, particularly in regional contexts, advocated that the design of the hub is culturally appropriate to encourage people to access support. Others argued that the hub needs to be able to appropriately respond to people with disabilities, and there were comments that suggested the hub should not remove people's choices to access other services if they wish. In many respects, the theme of knowledge and skills in working with diversity is reflected in earlier points made about high level skills and knowledge of hub workers, and a program and ongoing commitment to training, professional learning, and research and evaluation.

c. Increasing the visibility and interventions for perpetrators

It seemed difficult for participants to understand how men's and women's workers could work together in the hub and how this arrangement could increase perpetrator accountability. There was some confusion around what perpetrator accountability and interventions may look like. There was an assumption that the work of the hub may involve working with perpetrators on-site, or have perpetrators accessing related services (e.g., AOD, mental health) in the hub that would create safety concerns. This signalled that communicating to agencies that the hub was not a site for perpetrator services was important in any rollout.

Some argued there should be separate hubs for victims (women) and perpetrators (men) to facilitate perpetrator accountability and safety for victims. Some participants did not recognise perpetrator invisibility as being a key concern of the current system, or did not recognise that this was missing from their service. There seemed to be little recognition from some participants of the role and responsibility that all services have in perpetrator accountability. This situation suggests that the hub should be involved in responses to men as perpetrators, in particular the risk posed *and* also by advocating with services such mental health and AoD where his risk as a perpetrator may be overlooked or minimised.

Other examples where the hub work could develop included perpetrator programs for Aboriginal men, which can differ from mainstream programs.

The involvement of statutory authorities in the hub was a vexed issue, as mentioned earlier some argued that it would discourage women from accessing the services, whilst in relation to perpetrators, justice was seen as missing from model. Justice as a key player was viewed by some as critical for perpetrator visibility.

A further point raised was that the hub should have a holistic family focus, offering services to address the needs of men and women. Whilst there was recognition that sometimes men and women cannot be on-site together (due to safety reasons), there was a belief that in many cases this could facilitate a more holistic, family based approach in recognition that in many/most cases women do not plan to leave their partner permanently. This way forward here may be that whilst the hub may coordinate and share information the services are offered at a partner agency site and not at the hub. A small number of participants argued the hub should have allocated areas for men perpetrating violence to seek help. Finally, information sharing (discussed earlier) was recognised as essential; however, this topic is understandably contentious and sensitive given the risks associated with use and misuse of information, which again reiterates need for highly skilled practitioners who understand dynamics of risk. It also points to the need for high level planning in design so that information about victims cannot be inadvertently shared with perpetrators or information traced back to what women have disclosed.

Regional considerations

In addition to the regional concerns that have already been raised through this report from the consultations, there was a view that the consultations to date had been very 'metro-centric'. It was argued that the hub need to be adapted to the context in which it will be located (this was also the case for metropolitan hubs). There are some issues associated with women attending hubs in small towns where there are few services to meet need, and some concerns that hubs in regional areas may present a risk to existing partnerships between agencies.

Hub location feedback

Although there was some minor reticence about the workability of a FDV hub in regional or remote areas, when considering a metropolitan location respondents indicated a preference for a small-scale location that is accessible and embedded in a local community context. This preference applied for Model One and Two. In short, an ideal location is one that is: near to public transport routes; close to or in geographical proximity with other related services; in an area of high need or risk (as indicated, for example, by crime statistics, FDV reports, open child protection cases); and, housed in a dwelling that is safe, purpose built or designed (that is, accessible but not too conspicuous).

The focus groups and questionnaire generated a substantial amount of data both general and specific. Considerations that have been identified were particularly important in shaping the models and making changes to their design. A number of the issues raised will require further consideration once a design and locations are decided.

Proposed Models

Hub Service Model Design

The two proposed hub models maintain the same focus, aim and key features as the hub models presented at the consultations. In developing the proposed hub models, the research team progressed the principles of the hub. Auspice, identity and fidelity are fundamental to the hub. Two contingencies of the proposed hub include collaborative practice and the principles identified through the literature and research findings. The proposed hub will be sustainable and build expertise amongst service sectors. Reflective and deliberative practice will be promoted. The hub will be a service pathway, providing collaborations that can manage complexity. It will ensure data security permissions and database management are in place. The depiction of the models can be found in Appendix Four.

Target Groups of the Proposed Hubs

The primary target group are those victimised by FDV, who are primarily women, with or without children, who may or may not have previously accessed the service system. The secondary target group are the supporters (family and friends) of those victimised who experience the ripple like effects of FDV in their lives and are critical to her safety and support. Thirdly, those perpetrating FDV are a target group of the hub because in order to promote the safety of victims, perpetrators require pathways through which they can become safer and non-abusive to those around them.

Description of the Hub Model in Action

The proposed hub model is designed to provide a complete and thorough service response to FDV. This response begins with the first initial contact a client makes with the hub, initiated through other agency or self-referral. The service pathway proceeds as follows:

1. At the point of initial first contact, the client is provided with a comprehensive assessment by the Specialist Interviewer (Intake and Assessment) and they are registered with the hub. This assessment is used to inform the intervention response that follows, and also any safety concerns that require immediate action. If necessary, the Specialist Interviewer can triage an immediate safety response for very high risk situations. The assessment is documented and stored centrally, with

access to such information for both on-site and off-site partner agencies being determined through the hub Information Sharing policies which are managed by the Director. Active holding of clients will take place if the hub is experiencing capacity issues. This will involve regular telephone contact and monitoring of risk and safety.

2. Following the initial assessment, a case allocation meeting is held between the Specialist Interviewer, the Case Coordination team, the hub Director and the Data Investigator as needed. The purpose of this meeting is to discuss active assessments and to allocate clients to Case Coordinators. The Director provides procedural oversight to this process and ensures that the process is collaborative and comprehensive. The case coordination team comprise a mix of expertise[2]. It is anticipated that all workers will be allocated cases, but this mix of expertise will be used to support the workings of the team and provides for the kinds of expertise required to address the often multiple and complex needs of women and children experiencing FDV. Depending on need, clients may be allocated to Case Coordinators in accordance with their expertise. A men's worker will provide active contact, referrals, and outreach (where appropriate) to male adolescents and men identified as perpetrators of violence. The men's worker will also assist with increasing the visibility and knowledge of perpetrators and the perpetrators risk for all agencies as a way of enhancing and supporting women and children's safety. The Data Investigator contributes to this process with additional information from external sources on perpetrators (where possible) that will assist in managing risk and safety factors, and this information will provide for an additional layer of accountability. This additional information will complement the information gathered at the point of assessment, and will help with safety planning. All active referrals are discussed at this meeting, and an outcome of this meeting is that clients are allocated to Case Coordinators.
3. Once the client has been allocated to a Case Coordinator—who now has access to relevant information—the Case Coordinator works with the Data Investigator, Director and other relevant hub partners (e.g. AOD, Mental Health, Legal, Refuge) to discuss a provisional intervention response plan for the client. This may include

[2] See model diagrams – Women's Worker, Men's Worker, Aboriginal Worker in both models, with the inclusion of CALD worker and Disabilities worker in the enhanced model.

deciding on the scope of intervention, working out what other services need to be involved, and taking into account any risk and safety factors that need consideration. At this point, a multi-agency meeting with other partner agencies may be convened to discuss and plan other agency service responses and the scope of their involvement. The Case Coordinator works directly and collaboratively with the client to develop, contract and implement the intervention plan. This may include referral to other off-site partner services and supports (e.g. Women's Refuge, Health and Medical Services, Aboriginal Services). The Case Coordinator ensures care and coordination of services and supports for the client, and works to tailor the intervention to meet individual need. The Case Coordinator has complete oversight of the total intervention, and will coordinate the involvement of other on-site hub partners or off-site external services (where relevant). The Case Coordinator stays actively involved with the client throughout the process, until all relevant services and responses are in place and completed as planned, and until the objectives of the intervention are achieved.

4. Once the intervention plan is completed, a case closure and review meeting is convened between the Case Coordinator and Specialist Interviewer. This meeting is held to report on progress and to ensure that all relevant factors identified in the initial assessment and case planning meeting have been adequately addressed. If it is deemed there are unresolved matters, the situation has changed, or new information has come to light that warrants a further response, an outcome from this step may include re-assessment and the development of a further intervention plan and response.
5. A quarterly review meeting is held for all cases. The Director, Case Coordinators, Data Investigator (and in the enhanced model, Workforce Development Worker and Research and Evaluation Worker) review all cases, processes and outcomes. The purpose of this quarterly review meeting is quality assurance, evaluation and development of the hub and best practice.

Parallel Support to the Hub

In parallel to this intervention process, the hub is supported with an on-site staffed crèche to enable women with children to access meetings and appointments with hub workers. The

crèche is there to support on-site appointments, but could be expanded as a much wider service to enable women to access off-site appointments, etc.

Further support is provided by a Workforce Development worker (in the enhanced model), who will coordinate and provide internal and external training, supervision, knowledge dissemination, and to coordinate and manage student placements. The purpose of this role is to ensure that the hub workforce receive a high level of ongoing training and professional development, and that the hub is based on the most up-to-date theoretical and empirical knowledge.

The hub is also supported by a Research and Evaluation worker (in the enhanced model), who will coordinate and develop ongoing reviews and evaluations of the hub model and its outcomes, so that the hub can achieve continuous review and improvement by gathering, analysing and reporting on evidence of its effectiveness in responding to FDV. The information from the research and evaluation will also support continual refinement and development of the model (including the development of operational procedures and protocols), and it will also inform the training and professional development agenda of hub workers.

The hub is supported by a Director, who has oversight of internal operations and standards, but is also key in driving and supporting a culture of collaboration, both internal and external to the hub. The Director needs to establish those links and relationships, which may include building relationships and agreements with the management level of other services. It is the role of the Director to build and maintain the collaborative relationships with on-site and off-site hub partners, and promote and build the reputation of the hub in the community.

The hub is also supported by Administration worker(s), who provides reception, administration, financial management, record keeping and IT support to the hub and to the Director.

Hub worker roles and responsibilities

An overview of the roles and responsibilities of the workers proposed to staff the hubs are outlined here. Depending on the model selected, there will be variability in the number and type of staff located at the hub.

Director

- Responsible for internal management and quality assurance of the hub.
- Convenes quarterly case review of all cases.
- Builds collaboration with partner agencies.

Administration Support

- Assists the Director with hub operations.
- Assists WDO with organising training workshops.
- Maintains ICT systems.

Crèche worker

- Provides supervision and care for the client's children/young family members while the client is meeting with hub workers or hub partners.

Specialist Interviewers (SI)

- These workers are the Initial point of contact for clients accessing services or agencies referring clients.
- Undertake thorough common assessment with client.
- Assess individuals and families on an as needs basis which recognises similarities and differences of experiences (taking into account people's experiences of disability, cultural background, same sex relationships, older people, Aboriginal people)
- In cases where significant risk to client and their family is identified, contact relevant services, such as legal and police, and refer client to reduce risk and increase safety
- Attend Intervention, Contracting and Planning Meeting to collaboratively map out best course of action to meet the needs of the client and achieve the client's desired outcomes with a holistic understanding of the client and knowledge of the perpetrator's history and current activities.
- Build and sustain relationships with referring agencies.
- Provide relevant feedback to referring agencies about the client referred.
- Collaboratively conducts Individual Case Closure and Review with CC.
- Attend Quarterly Case Review of all cases.

Case Coordinators (CC)

- In the fully funded model, there will be 5 Case Coordinators. Each will have experience in one of the following areas: CALD, Disability, Child Protection, Aboriginal services, Men's services.
- Attend Case Allocation Meeting to receive client information from the SI, discuss and allocate client cases.
- Meet with client to establish their needs and desired outcomes.
- Attend Intervention, Contracting and Planning Meeting to collaboratively map out best course of action to meet the needs of the client and achieve the client's desired outcomes with a holistic understanding of the client and knowledge of the perpetrator's history and current activities.
- Case management which includes brokerage, contracting/agreements tasks, advocacy.
- Build and sustain relationships with agencies involved in the client's journey.
- Monitoring and tracking with client and also agencies providing services to client.
- Collaboratively conducts Individual Case Closure and Review with SI.
- Attend Quarterly Case Review of all cases.

Data Investigators

- The aim of the DI is to increase visibility of perpetrator and knowledge of their risk.
- Collection information on perpetrator when requested by SI following client's intake and assessment.
- Attend Case Allocation Meeting to receive client information from the SI, discuss and determine which cases require more information to be collected on the perpetrator (cases where risk to victim and family have been identified).
- Search through existing databases, such as police records, to acquire knowledge of perpetrator's recorded history.
- Communicate with other external agencies to gather up-to-date information on the perpetrator.
- Attend Intervention, Contracting and Planning Meeting to collaboratively map out best course of action to meet the needs of the client and achieve the client's desired outcomes with a holistic understanding of the client and knowledge of the perpetrator's history and current activities.
- Gathers information on perpetrator when requested by CC during intervention/case coordination.
- Shares perpetrator information with SI, CC, and Director throughout key processes. Also, shares information with RO to assist with research process.
- Build and sustain relationships with agencies that have information on FDV perpetrators.
- Attend Quarterly Case Review of all cases.

Research Officer

- Evaluates data collected from the SI, CC and DI.
- Provides quality assurance through review and evaluation of service delivery.

Workforce Development Officer

- The WDO supports the hub as a place of learning, development and training.
- Disseminate knowledge acquired through the Hub's research activities
- Organise and deliver internal and external training.
- Provide supervision to hub workers.
- Coordinate student placements

Key Activities

A number of key activities are identified as forming the operations of the hub, outlined here.

Activity	Staff involved in Key Activity
Intake and Assessment	• Specialist Interviewer • Client
Case Allocation	• Specialist Interviewer • Case Coordinators • Data Investigator • Director
Intervention, Contracting and Planning	• Specialist Interviewer • Case Coordinators • Data Investigator • Director
Intervention/Case Coordination	• Case Coordinator • Client • Agencies (relevant)
Multi-agency meeting (if required)	• Case Coordinator • Client • Agencies (relevant)
Individual Case Closure/Review	• Case Coordinator • Specialist Interviewer
Quarterly Case Review of All Cases	• Director • Specialist Interviewer • Case Coordinators • Data Investigator • Research Officer (Enhanced model only) • Workforce Development Officer (Enhanced model only)

Options for establishing the hubs

Options for establishing the hubs within a scale-able budget are presented below. Both models will adopt the operational foundations outlined previously. Key differences between the Fully Funded (Enhanced) and Small Amount of Resourcing (Base) models are staffing levels and hub partners located on-site. Related benefits and risks for each model is included. An analysis of existing services is ensuing, providing a third option for establishing hub models.

Hub Model - Fully Funded (Enhanced model)

Staffing

Each of the hub workers will be FDV informed, culturally sensitive, and apply trauma informed and intersectional principles to their practice.

No. of workers	Position
1	Director
2	Administration Staff/PA – includes ICT
1.5	Crèche worker
2	Specialist Interviewer
5	Case Coordinators
1	Data Investigator
1	Workforce Development Officer
1	Research Officer
14.5	**FTE Staff**

Hub Partners

On-site Partners:

- Alcohol and other drug services
- Mental health services
- Health and medical services
- Financial services
- Legal Services
- Women's counselling

Off-site Partners:

- Women's refuges
- Services for children
- Men's FDV
- FDVRT
- Police
- Aboriginal services
- Multicultural services
- Disability services
- Housing

Benefits and Risks

Related benefits and risks for this model include:

Benefits:

- Is a higher intensity collaborative arrangement recognised as a more effective option for "managing complex interdependencies and clients with multiple needs" (Nylén, 2007, p. 162) which would add value to existing systems as well as address safety and accountability.
- Improved opportunity for the development of effective collaborative partnerships between agencies and workers which can be sustained over the longer term.
- Streamlined processes and better communication between agencies (Breckenridge et al., 2016) resulting in improved support and safety for clients, with partner agencies located on-site.
- Workers co-located on-site together means that spaces for conversation, discussion, professional learning and feedback loops will be inherently built in to the model (Bronstein, 2003).
- Co-location will foster development of practice alignment and learning (Edwards, 2015).
- Workforce Development officer and Research and Evaluation worker will provide opportunity to ensure high level of on-going training and professional development so that the hub is based on the most up-to-date empirical knowledge. Professional development, continuous improvement and evaluation will be built in to the model with such specialised staff.
- Co-location will help to minimise siloing of services, a key concern of Consultation participants.
- Establishment of new roles or activities that can only be realised through collaboration; they do not simply replicate existing practice (Bronstein, 2003).
- Greater opportunity for shared input into the hubs vision and operations, each stakeholder jointly responsible for its form, its success or failure (Bronstein, 2003).
- Reduced risk of power imbalances, competitive relationships, and lack of common ground between perspectives, disciplines and agencies (Atwool, 2003; Breckenridge et al., 2016; Worrall-Davies & Cottrell, 2009).

- Sharing of responsibility and resources (e.g. money, time, energy, risk).
- Retain specialisations but improved understanding of other agency roles and responsibilities.
- Improved accessibility for clients due to being able to access services in one place.

Risks:

- May be more difficult to implement initially, requiring greater time and effort into developing and sustaining collaborative relationships, especially across diverse organisations (McDonald et al., 2011).
- More staff means higher costs in terms of salaries and office accommodation.
- Agencies having differing foci for their interventions which could be difficult to navigate (Atwool, 2003).
- Power imbalances, competitive relationships related to tendering, and lack of common ground between perspectives, disciplines and agencies is also a possible area requiring attention (Atwool, 2003; Breckenridge et al., 2016; Worrall-Davies & Cottrell, 2009).

Hub Model - Small Amount of Resourcing (Base Model)

Staffing

Each of the hub workers will be FDV informed, culturally sensitive, and apply trauma informed and intersectional principles to their practice.

No. of workers	Position
1	Director
1	Administration Staff/PA – includes ICT
0.75	Crèche worker
1	Specialist Interviewer
3	Case Coordinators
1	Data Investigator
0	Workforce Development Officer
0	Research Officer
7.75	**FTE Staff**

Hub Partners

All partner agencies are located off-site, and the intent is to provide space within the hub for hub workers, clients and partner agencies to meet.

Off-site Partners:

- Alcohol and other drug services
- Mental health services
- Health and medical services
- Financial services
- Legal Services
- Women's counselling
- Women's refuges
- Services for children
- Men's FDV
- FDVRT
- Police
- Aboriginal services
- Multicultural services
- Disability services
- Housing

Benefits and Risks

Related benefits and risks for this model include:

Benefits:

- The smaller scale potentially means it is easier to integrate with an existing service, but also least intensive in terms of level of response (Nylén, 2007).
- Easier to implement initially (but harder to develop and sustain in the future).
- Lower staffing levels means cheaper to operate in terms of salaries and office accommodation.

Risks:

- Is a lower intensity kind of collaborative arrangement which has potential to not meet the 'One Stop Shop' brief, resulting in criticism to Government and not effectively meeting the needs of women and children.
- Perception of duplication of processes and resources requires skilled negotiation and knowledge of local conditions.
- With some partner agencies locate off-site, it is anticipated it will be difficult to create and sustain collaborative relationships between agencies. Concern was expressed by Consultation participants about how this model would become a genuine model of collaboration if partner agencies remain off-site.
- Concern was also expressed by Consultation participants about the availability of workers to provide assistance if they are off-site.
- Increased risk of service siloing and thus no real change to current system.

- Relatively small number of case coordinators limits number of clients able to coordinate and support.
- Staff diversity is limited.
- Greater difficulty in promoting mechanisms that support the development of effective collaboration (Hill & Laurence, 2003).
- Individual (client) perceptions of cross-agency control (Breckenridge et al., 2016).
- Not being co-located could lead to communication problems between and across services, which can be frustrating for clients and workers (e.g. information sharing concerns, which can lead to ineffective case management) (Atwool, 2003; Breckenridge et al., 2016; Wilcox, 2010).
- Overcoming embedded siloed ways of thinking could be more difficult when agencies and workers are not located together (Howard, 2017).

Hub Model - Cost Neutral

Based on the definition and aim of the hub and the research findings, it has been determined that it is not possible to design and establish a cost neutral FDV hub service model for WA. To achieve a cost neutral model, the proposed hub would need to be reduced to one or two people networking, and this is not a hub. The lack of numbers would result in a lack of resilience within the hub.

The research findings indicate that drawing on existing services to implement a cost neutral hub would create problems in the service sector. A recurring comment from the consultations has been to put more funding into existing services instead of implementing a new service. In addition, drawing on existing services will result in services' being short staffed, which reduces their capacity to provide effective support to victims and their families, and potentially increases the risk to victims and their families. A cost neutral model cannot claim to reduce risk or add value. Validating the participants concerns, literature warns that diverting resources from services can compromise collaboration (Hill & Laurence, 2003). It is advisable to leave the current system as it is rather than establish a cost neutral hub.

Analysis of Existing Services in WA

An analysis of potential opportunities with existing key integrated services in Western Australia (identified in the desktop review) was conducted, the results of which are presented. The analysis demonstrates there may be some opportunities which a Hub model could be integrated with. This must be weighed up with the benefits and challenges associated with adopting a "cut and paste" type approach.

Benefits and Risks

The perceived benefits and challenges of integrating a hub model with existing services include:

Benefits:

- Building on the knowledge, strengths of current services and existing relationships;
- Resultant up-skilling of workers across different issues;
- Potential cost benefits associated with utilising existing resources such as workers and accommodation (although in many cases, additional staff and office space will be required);
- Services and the community already being familiar with the agency or service provider with which the Hub will be integrated with;
- Alleviating disruption to the service system should evaluation or changes in funding indicate the model should not or cannot continue. This is an issue that must be realistically weighed up in the context of changing Governments, priorities, and relatively short funding cycles, a concern expressed by many of the consultation participants.

Risks:

- "Cut and pasting" over the top of an existing service can be more difficult than starting from new;
- Services and the community not having a positive experience of the original service, impacting on future help seeking practices;
- Governance issues: managing the relationship between Government and Non-Government agencies;

- Achieving buy in from agencies and staff, particularly in situations where they have had little involvement in developing and implementing the new approach;
- Disruption to existing service: not just in a practical sense around staffing and accommodation, but also with reconfiguring roles, responsibilities, training and up skilling of staff;
- Tensions between workers of original service and new workers bought on board;
- Mitigating diverging areas of focus. There is also potential for the aim and focus of the Hub to undermine the aim and focus of the original service which can impact on service delivery.

Additional costs associated with establishing new processes, procedures, systems and administration as well as the time needed to forging collaborative partnerships. Literature indicates this can often be underestimated (Howard, 2017; KPMG, 2013)

The services most aligned with the criteria were selected as possible opportunities to build the proposed hub upon. The research team recommends that, at a minimum, the model with a small amount of funding be adopted meaning that all of the possible services identified would require additional staff to operationalise the hubs. It is anticipated that more office space will also be required to accommodate the increase in staffing levels. Of the services analysed, seven were identified as possible options that the proposed Hub could be built upon. These services are briefly outlined below with further information provided at Appendix 2. Should any of the options listed be adopted, careful consideration on the impact to the existing and new service is needed, along with thought given to the target population that the hubs aim to support.

Metropolitan Area

FDVRTs

Expanding the FDVRT is identified as a possibility with the proposed hub potentially being another “spoke” of the FDVRT or a partner hub, adding to the already existing, well established, state-wide service. A significant barrier for women accessing support is the known, strong relationship between Police and Child Protection which would be difficult to obscure. Strong partnerships are already established between Government and Non-Government providers and could be supplemented with additional partnerships. The Family Safety Teams in the Kimberley region and the Safe at Home program have already been

integrated into the current FDVRT and whilst they are identified as being well aligned with the proposed hubs, it is not seen as being beneficial to disrupt the relatively new arrangement.

Domestic Violence Advisory Service (DVAS)

Expanding the current DVAS model is also identified as a potential opportunity. Unfortunately, there is possibility that the changes which resulted in a much more scaled down DVAS model than its initial inception some years ago may have damaged its reputation in the community. This could impact referrals from support agencies and potential clients accessing the service. There is possibility for the service to be rebranded and marketed, with existing staff absorbed and additional workers employed, however, Government currently has little influence over the operations. The association DVAS presently has with a well-known women's health service in Northbridge is seen as positive, although feedback from the consultations indicate its current location may need to be reviewed.

Women's Resource and Engagement Network (WREN)

If the proposed hub were to be incorporated with this service, additional staff would be required. Additionally, the location and available office space would need reviewing. The already established links with legal and health services is viewed as being particularly beneficial, and would form a strong basis from which the hub could build on. The service is community based and thus probably well known within the area it serves. The link with health potentially offers a way of reaching women who may not necessarily have come into contact with the FDV service system, yet may require significant support. As this is a Health Justice partnership with an Australia wide basis, further exploration around whether the existing partnership can be altered is required before this option is pursued.

Safe as Houses

Similar to WREN, the already established links this service has with legal and health services is seen as being particularly beneficial in reaching women who may not have come into contact with the FDV service system, yet may require significant support. The service is still in its infancy, established as a pilot program in 2017 funded through grants provided by Lotterywest and the Criminal Property Confiscation program. The service received an award in the Attorney-General's Community Service Law Awards this year, with funding scheduled

to end in September 2018. Additional staffing would be required as this is a relatively small service, and the location and available office space would need to be reviewed. The service could be one that the hub uses as a foundation to build on, although the relationship between the Government and Non-Government provider would need to be considered.

Family Support Networks (FSNs)

The different focus of this service (child protection) and positioning of a child protection worker on site are potentially major barriers to women and children seeking support and could impact significantly on the aim and operations of the proposed hub. The target population of FSNs, families, is also a potential barrier for women without children if the current branding remains. Worker skills are well aligned with the proposed FDV hub, along with the strong partnerships, policies, protocols and practices already established with relevant partner agencies which have potential to provide a good foundation from which the proposed hub could operate from or alongside. There is indication (from informal discussions in Victoria) that having more than a singular focus at inception of a new FDV hub could be problematic, an issue for consideration. Governance issues between the Government and Non-Government provider and tensions between workers with diverging areas of focus are issues requiring deliberation.

Regional Area

Marninwarntikura Fitzroy Women's Resource Centre (MFWRC), Fitzroy Crossing

The MFWRC has a proven track record of strong, community collaborations. It operates multiple services, programs and supports including a women's refuge and legal services and is very well known and trusted in the local community. They are well connected with other community organisations including the cultural health service, and have a proven track record of leading transformative change (alcohol prohibition in response to addressing the impact of *Foetal Alcohol Spectrum Disorder* (FASD) in children). The Centre is identified as being a potential site which the proposed hub could be integrated with, providing an enhanced way of working in the Pilbara region.

Possible adaptation in a regional setting

Women's Refuge Services

Although not identified as a formal integrated partnership, the research team has recognised the possibility for women's refuges in regional areas to be provided with additional funding and resourcing to undertake the operations and management of the proposed hub. Women's refuges in these areas are integral avenues of support to women and children experiencing FDV, already having developed the trust and respect needed to provide effective support to their community. They are well known; provide safe and culturally appropriate support; and are well connected to other services and supports in the local area. Consideration would need to be given to the location of the hub as it is recommended it be kept separate from residential accommodation to ensure that women and children experiencing FDV are continued to be provided with a safe space for healing.

Implementation Considerations

The following section summarises the key areas of consensus and divergence resulting from the consultations. Recommendations with regard to the development and implementation of the FDV hubs are ensuing.

Areas of Consensus

Opportunity for legitimate collaboration

The hubs were viewed as being an opportunity for legitimate collaboration between agencies which would assist in delivering a more comprehensive service with increased levels of perpetrator visibility. Formal agreements and a strong operating environment were seen as critical to ensure the hub is more than just sharing a space and resources, but genuinely acts as a centre for collaboration, and expertise with opportunity to improve understandings and responses to FDV at worker, service, and sector level.

Co-location of services

There was agreement that co-location would facilitate and enhance the flow of information and support, facilitate collaboration between services and clients and also improve accessibility and safety for women. Although overall seen as positive, concerns were expressed around the possibility for some agencies continuing to operate as discreet silos, even if they were co-located together. This underscores the centrality of genuine collaboration and not merely one of co-location. Questions were also raised around how genuine collaboration will be achieved if partner agencies are intermittently located on site.

Experienced and knowledgeable staff

The expertise and skills of the hub workers were seen as critical. In particular, this includes workers involved at the initial interview and assessment, which informs the intervention response. Interviewers and assessors need to have significant authority and expertise, and be able to work with multiple sources of data, trained in the responsible use of information sharing and collaborate well with other workers and agencies. Interviewers and assessors need to be able to triage and provide critical responses to high risk situations—they should be knowledgeable in FDV, trauma, and culturally appropriate knowledge and skills. The ability to build trust and rapport was identified as a key skill required of workers.

There were some concerns expressed about the level of skills needed to deal with a broad range of issues and client groups. For example, being skilled and competent to adequately respond to victims (male and female), perpetrators, LGBTIQ, CaLD, and people with disabilities. This is also an area of concern identified in the literature, with suggestions around the need for agencies to retain their process specialisations (Howard, 2017). Further to this, feedback from Victoria expressed the need to separate intake and assessment from case coordination. Although it was viewed as theoretically ideal for the one worker to provide client support, it was suggested that this can be too much for one person to take full responsibility for. Balancing workload along with the differing requirements of each was suggested as potentially impacting on service delivery and the ability of workers to adequately manage risk and safety.

Information management and sharing

Information management and sharing was identified as crucial to supporting women and children's safety and promoting perpetrator accountability. Benefits of "joining up" information were discussed including: more timely information sharing; active collaborative decision-making; enhancing relationships and understanding of roles and responsibilities; sharing of risk related information and assessments, which reduces the burden on service users having to repeat their stories. There was suggestion that the hub could also act as an information repository, as a way of storing information collected through assessments or small research projects carried out by agencies. This was viewed as potentially being a very significant benefit as currently there are no mechanisms that facilitate this. There were some concerns expressed over the cost a shared database will impose on partner agencies, particularly in regards to set-up, maintenance and making changes to the database. Further considerations included consent, confidentiality and legal implications of sharing information with statutory services.

Central, comprehensive assessment

A central, comprehensive assessment was viewed positively as contributing towards collective case planning for needs, streamlining work processes, reducing burden and traumatisation of retelling stories. A comprehensive assessment is also key to the case coordination process, which involve developing and coordinating an intervention plan and response.

Case management and coordination

Case management and coordination was viewed as important to supporting women and children's safety. For example, it was thought that working together as a team in a collaborative model would present opportunities to increase the visibility of perpetrators. One participant referred to case management itself as being the heart of an intervention, rather than workers and agencies simply working in partnership. In a case management approach, opportunities exist for case managers from various agencies to come together, share expertise, respond to complexity and different needs. The data indicated the need for the hub to broker relationships between agencies, and to authorise and coordinate case allocation and review meetings, which may involve services coming together virtually or physically to discuss interventions and information. There were questions as to how this would work, and who or what would facilitate this practice. There was support for a centralised or single point of intake, assessment and case allocation and coordination.

Funding

There was consensus that adequate, ongoing funding is essential to support the development and operations of the hubs. Concerns were expressed that without adequate resourcing the hub may actually place a strain on existing systems and agencies providing services. In establishing the Safety and Support Hubs, the Victorian Government has provided additional funding to non-government agencies to employ additional staff to assist in alleviating this pressure. Competition of resources and competitive tendering was identified as a cause of tension between agencies with competition for funding breeding unhelpful relationships. There was some scepticism expressed around how the proposed new hubs would add value (and continue to do so) to the current system, and some participants questioned why funds were not going to be directed to existing services to build on and improve further (for example, refuges). In short, there were concerns that the hubs would become little more than call centres or referral only services (which were likened to DVAS and the Family Support Networks).

Crèche

A very strong and unanimous theme throughout the focus groups was the importance of having an on-site crèche for hub clients, which was seen as a very practical way to support

women and children's needs. This has been identified as essential to facilitating care-givers engagement in services (Shelby Consulting Pty Ltd, 2017).

Areas of Divergence

Interface with other services and systems

There was a general view from participants that there were a number of key players missing from the model. These included police, child protection, and justice services that some thought should be directly included in the hub and not just as an ancillary to it. However, others saw the absence of mandated agencies as positive, arguing that this will improve accessibility for service users. Overall, responses were divided around the appropriateness of statutory agencies being either directly located in or alongside the hub. Regardless, participants argued that clarity around the relationship between the hub and statutory services is needed.

Adding value to the current system

Not all participants were supportive of the hub proposal, with some participants seeing it as devaluing the work that is currently being done by services. Many of the participants thought that building on the many 'natural' hubs already in existence would be a better option than adding a new hub/system. For example, some suggested that this could be achieved through implementing standards or benchmarks around multiple agencies working together along with practice standards. Other participants expressed they felt the approach taken towards development of the hubs was very 'top-down' in that 'outside players' are not part of the co-design. They considered the risk is that a hub will not add value to the current system as it will not meet the needs of the community. However, others identified the potential benefit of the hubs insofar as they may be able to take some pressure off existing system, for example, refuges. Refuges could refer to a hub who could link women in with support, alleviating pressure on beds in refuges. Others, however, argued that refuges are already doing the work of the proposed hubs and should have their funding increased. In short, participants contended that the hubs must have capacity to deliver services, encourage further engagement, and work to build trust in the hub and how they integrate and work with the sector.

Increasing the visibility and interventions for perpetrators

It seemed difficult for participants to understand how men's and women's workers could work together in the hub and how this arrangement could increase perpetrator accountability. There was some confusion around what perpetrator accountability and interventions may look like. There was an assumption that the work of the hub may involve working with perpetrators on-site, or have perpetrators accessing related services (e.g. AOD, Mental Health) in the hub that would create safety concerns. There was some views that there should be separate hubs for victims (women) and men (perpetrators) to facilitate perpetrator accountability and safety for victims. Some participants did not recognise perpetrator invisibility as being a key concern of the current system, or did not recognise that this was missing from their service. There seemed to be little recognition from some participants of role and responsibility that all services have in perpetrator accountability. A further point raised was that the hubs should have a holistic family focus that services the needs of men and women. Whilst there was recognition that sometimes men and women cannot be on-site together (due to safety reasons), there was a belief that in many cases this could facilitate a more holistic, family based approach in recognition that in many cases women do not plan to leave their partner permanently.

Other Important Considerations

Governance

Governance was identified as major challenge if multiple agencies involved with hub. Questions over who or what would be the lead agency and where the authorisation would come from were raised. For example, an existing lead agency may have an interest in branding the hub in line with its own model or service, which could be a barrier to help seeking and an obstacle to genuine, collaborative working. If looking to utilise existing services as a foundation for operationalising the hubs, this is also an important consideration. There was suggestion that the hub recruit and employ its own specialist workers as a way of integrating its governance. This can assist with streamlining reporting structures and organisational management, an area identified as challenging in Victoria with workers in the new Safety and Support Hubs reported as being employed by various non-government agencies which has in effect resulted in tiered organisational arrangements with workers accountable to multiple organisations.

Responsiveness and capacity of partner agencies

Concerns were expressed around the ability of partner agencies to accept referrals and manage the overall demand placed on them by the hub, particularly in an environment when services are already at capacity. Specific issues raised were around the management of waitlists, hours of operation, and the ability of the hubs to manage risks with regard to young people. Extensive planning and coordination to develop timely responses and build linkages at a practical and managerial level were identified and related to the importance of having a strong governance framework.

Impact on current service delivery

As noted in the data, there was some concern that the hub (if not properly resourced and authorised) could actually increase the workload of other services and could lead to further siloing of services. These issues are responded to in the hub design, to have its own authorisation and brand, to have a highly skilled workforce, to have adequate resourcing and funding, and to have interagency collaboration as a central focus of its purpose.

Case management

Flexibility to have person centred response, to facilitate the right mix of services across different agencies is required over the longer term.

Visibility and accessibility of the Hub

It was expressed that the hub should be designed with physical safety in mind, and the hub should look and feel safe to attend. Branding and marketing of the hub is an important consideration and significant learning's can be taken from headspace who have been very successful in attracting young people from marginalised and at risk groups which has included a significantly higher proportion of Indigenous youths and those living in regional areas (Hilferty et al., 2015). Accessibility and continued engagement with headspace was attributed with the creation of a safe, friendly, non-clinical environment; the use of innovative engagement strategies; relatable and non-judgemental staff; the service being free or low cost; the wide ranging services provided on- site as well as practical services (e.g. transportation) they offered. These are all areas worthy of consideration for the development of the hubs.

Participants in the hub consultations expressed some reservation around an FDV hub being visible in the community, arguing that some women (e.g. from CaLD backgrounds) potentially not wanting to seek support from a highly visible FDV service due to the connotations associated. There was also a related concern that a shop-front style may encourage people to attend unannounced, posing workflow and risk and safety problems. For example, there are concerns for women's safety in a shop-front environment (in Victoria, this appears to be a similar concern with security guards employed to stand at the entrance of the Hubs). In regional areas, visibility in the community does not seem to be as much of a concern with limited services and small towns meaning that options around anonymity are restricted. Accessibility of the hub was strongly related to the local context that the hub would be located. Participants, particularly in respect to regional contexts, expressed there is a need to ensure the design of the hub is culturally appropriate to encourage people to access support. Others argued that the hub needs to be able to appropriately respond to people with disabilities, and there was some comment that suggested the hub should not remove people's choices to access other services if they wish.

Model design needs to be adapted to local context

As reported in the questionnaire data, participants favoured a hub location that is place based, localised, close to public transport and it be adapted to the context in which it will be located. This is particularly important in regional areas with high Indigenous populations, fewer services, and challenges in meeting the needs of its communities due to geographical size and location. Specifically, there were some issues raised around women attending a hub in a small town where there are few services to meet their needs, and some concerns that hubs in regional areas may present a risk to existing partnerships between agencies. Participants argued for flexibility in service responses, particularly in relation to CaLD and Aboriginal service users. There was some view that the design of the models and consultations were very 'metro-centric.'

Model Variations

The two models developed maintain similar foundations; however, differ predominantly in the number and type of critical support staff identified as essential to the operations of the hub as well as co-location arrangements of partner agencies. Changes made to the original concept designs resulting from the research data are outlined below.

Appointment of a Hub Director

Appointment of a hub director has been included to manage the operations of the hub. Key responsibilities will be to promote and support the development of collaborative partnerships within and between staff and partner agencies. There is evidence to say that having a staff member dedicated to fostering partnerships and maintaining relationships is integral to success of the model (Breckenridge et al., 2016). The hub Director would also be responsible for providing intellectual leadership and promoting a culture and ethos of learning and collaboration, for example, through services learning from each other, creating expertise and a multidisciplinary approach to the collection, sharing and access to information.

Administration support

Administration support was not included in the original design. However, this role has since been identified as essential to supporting the operations of the hub and ensuring specialised staff are not caught up unnecessarily with carrying out administrative duties such as reception, finance or IT related duties. Administration support was an area identified by Breckenridge et al. (2016) in their evaluation as crucial to sustaining the DVAS service.

Data Investigation Team

To support the hub as a conduit for the responsibility to collect and collate information about perpetrators to inform practice, address safety and support perpetrator accountability efforts. This is a key aspect of the hub models in Victoria, one that was described as significantly enhancing FDV responses.

Separating Intake and Assessment from Case Coordination

Although the initial models indicated that one worker would carry out these functions, it has become clear that these functions should be separated. However, in the design of the hub it is envisaged that these roles work closely together. The reason for the separation is to retain specialisation of skills and knowledge and reduce the burden on worker to undertake dual roles. In the design, the Specialist Interviewer is responsible for carrying out a thorough and comprehensive interview and assessment, and triaging responses to very high risk situations. Case coordinators have responsibility for coordinating and managing the intervention plan. Both these positions have clear roles, yet they collaborate together to share information. Interviewers provide advice and guidance to case coordinators who have

varying backgrounds and expertise around best practice or considerations needed when working with clients with diverse needs.

Case Coordination Team

The case coordination team is proposed to comprise a mix of expertise including a Women's worker, Men's worker, and Aboriginal worker in both models, with the inclusion of a CaLD worker and Disabilities worker in the enhanced model (Model Two). It is anticipated that all workers will be allocated cases, but this mix of expertise will be used to support the workings of the team and provides for the kinds of expertise required to address the often multiple and complex needs of women and children experiencing FDV. Depending on need, clients may be allocated to Case Coordinators in accordance with their expertise although this is not essential, with it being envisaged that the team will be able to collaborate and provide advice and guidance to each other around the best way to support clients. The Case Coordination Team are essential in ensuring a comprehensive service response that can assist with practical support and facilitate access to other services. Employing staff from diverse backgrounds and with varied skills and knowledge has been identified as assisting with building collaborative partnerships (Shelby Consulting Pty Ltd, 2017).

Brokerage

The provision of brokerage is a recognised mechanism through which individual, tailored, practical support can be provided to clients with varying needs (Breckenridge et al., 2016; Cant, Meddin, & Penter, 2013). It is envisaged that funds may be used flexibly, to provide support for safety enhancements, food or other household needs, employment related issues or help with accessing support or services for children. Notably, the evaluation of the Family Support Networks identified having access to capacity building funds as essential to assisting with freeing up capacity in existing partner agency services that have waitlists and providing new services to address gaps in service delivery (KPMG, 2014).

Outreach

Outreach is also an identified mechanism through which client's needs can be supported and would enable hub workers to meet with clients off-site in the community or other locations if preferred or needed. It would also enable workers to support clients in attending court or other appointments outside of the hub. Outreach services are key to the Safe at

Home program (Breckenridge et al., 2016) and identified as a valuable strategy for enhancing service delivery (Hilferty et al., 2015).

Quarterly case review process

Quarterly case review process is an identified accountability mechanism through which quality assurance, evaluation and development of the hub and best practice can be facilitated. It is proposed to hold this quarterly to review all cases, processes and outcomes and will involve the Director, Case Coordinators, Data Investigator (and in the enhanced model, Workforce Development Worker and Research and Evaluation Worker).

Moving Forward: Recommendations

The following recommendations are provided as a way of assisting with moving forward the development of the FDV hubs.

State Government to provide Governance

This is recommended to alleviate issues around the management and driving the operations of the hub, it is recommended the hubs be developed under the auspice of the State Government, as their own, independent entities.

Identify a "champion leader" who can drive the implementation process

There is evidence that identifying a key ally or a champion leader can assist with achieving successful organisational change (Forsdike et al., 2018). This may also help with achieving "buy-in" and support from identified partner agencies as well as assist with maintaining transparency in the development and implementation of the hubs.

Determine support from potential partner agencies

This is to assist with planning and implementation of the hubs.

Adopt a change management process

This is to prepare and support implementation and sustainability of the hub service design. Adequate planning and building the foundation of the operations of the hubs within a realistic timeframe is essential prior to them becoming fully operational. Areas requiring careful consideration include: the development of policies, procedures, and practice guidelines around operations and collaborative partnerships; workforce development; attaining buy-in from agencies; maintaining transparency around the process of the hub development; and incorporating evaluation and review mechanisms at predetermined critical points of implementation. Although it is anticipated that evaluation points will identify areas requiring improvement, it is critical that appropriate time and energy be put into developing the operating framework before commencement as taking an evolving approach following implementation may prove difficult to manage and has potential to impact on service delivery.

Establish a strong Governance framework for collaboration

Consistently recognised as key to the successful implementation and sustainability of any partnership arrangement at a management and practical level.

Incorporate mechanisms to support collaborative practice

Important to support the success of genuine collaboration which is more than agencies co-locating and important to addressing "cultures of 'vertical' or 'silo' thinking" (Howard, 2017, p. 7). Proposed mechanisms to support and promote collaborative partnerships include: appointment of a hub Director and champion leader to drive implementation; development of policies, procedures, collective goals, values, objectives and processes; cross agency training and professional development; supervision and reflective practice; and staff willing to nurture and engage with collaborative ways of working (Bronstein, 2003).

Commitment of long term, sustainable funding

This is critical to support the longevity and success of the hub as well as to providing adequate, effective support to people impacted by FDV. Sufficient funding for start-up and ongoing expenses should be allowed for and provided which may include the refurbishment or acquisition of new space, information technology, branding and marketing, reorganisation of staffing structures, and the recruiting and training of staff (Howard, 2017). Indirect costs for agencies may be incurred such as the additional time spent on administration, setting up processes and systems and attending meetings should also be considered (KPMG, 2013). Funding (or lack of) is a consistently identified issue which has impacted on a variety of services, for example, DVAS and the Kimberley Family Safety Hubs. Understandably, service providers expressed some trepidation around the success of the hubs to make a difference if there is no commitment to adequate, long term funding.

Workforce development

As noted in the research data, a highly skilled and trained workforce is recommended for the hub. This is a matter for recruitment and staff selection, but also for a program of ongoing professional development, training supervision and knowledge building. These have been factored into the hub staffing design. Consideration for enhancing and developing the current workforce through providing professional development opportunities and potentially linking in with universities to arrange student placement opportunities may be other strategies utilised to assist in the development of the workforce.

Select site locations

Taking into consideration feedback from the consultations. The data indicates the preference is for the hubs to operate in a local context and in response to local issues which

is relevant for both metropolitan and regional areas. This would involve careful selection of the site location, service boundaries to a local context, and extensive relationship building and community engagement, under the leadership of the hub Director. The research findings also suggest that the hubs should be located in an area of high risk and high need, in reasonable proximity to other relevant services, and close to public transport. Whilst there were mixed views around the visibility of the hub in the community in the metropolitan area, this is less of a concern in regional areas with often there being little choice available around anonymity.

Incorporate evaluation framework

Evidence suggests that incorporating evaluation and review points can provide opportunity to identify areas working well as well as those needing improvement. The Refuge Service System Model Emergency Response utilised evaluation points from inception as a means for reviewing and refining processes which led to implementation issues being addressed (Chung et al., 2016). Incorporating evaluation processes are also consistently recognised as important for monitoring the quality of responses over time (Breckenridge et al., 2016; Herbert & Bromfield, 2017).

Model Adoption

Metropolitan Hub

From the analysis of existing services, there appears to be limited opportunities from which a FDV hub could be combined with in a way that adequately supports the ethos of the proposed new service. It is therefore recommended that a new entity be created that can establish its own identity.

Regional Hub

Our research has identified the possibility for a FDV hub to be incorporated with an existing refuge service in a regional area. Women's refuges in these areas are integral avenues of support to women and children experiencing FDV, already having developed the trust and respect needed to provide effective support to their community. They are well known; provide safe and culturally appropriate support; and are well connected to other services and supports in the local area. Consideration would need to be given to the location of the hub as it is recommended it be kept separate from residential

accommodation to ensure that women and children experiencing FDV are continued to be provided with a safe space for healing.

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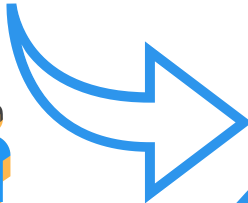
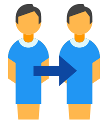
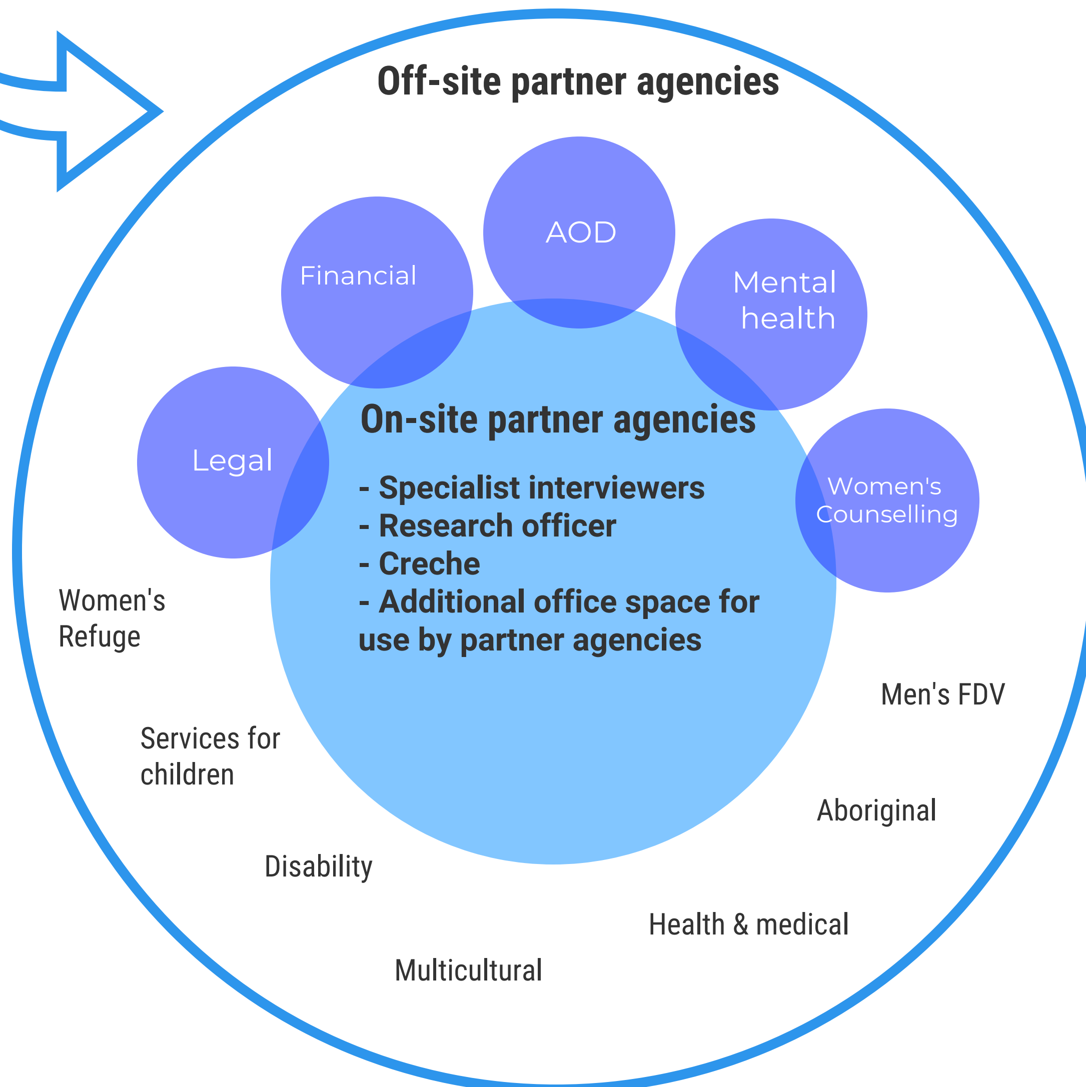
Hub model 1

Accessing the hub

Localised response
- Self referral; telephone, face to face by appointment
- Crisis care referral
- CRS referral
- Other agency referral







Role of the hub:

- Thorough, common assessment; individualised to meet needs of client
- Case coordination/management
- Facilitate pathways
- Outreach
- Holding'the client for the whole journey
- Build and sustain relationships with partner agencies

Staffing

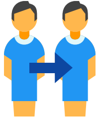
Specialist interviewers (incl. Men's and Aboriginal worker)
- Hold relevant qualifications
- Trauma informed
- Culturally sensitive
- Apply intersectional principles

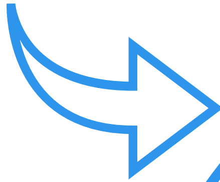
Research officer
- To support best practice
- Evaluation

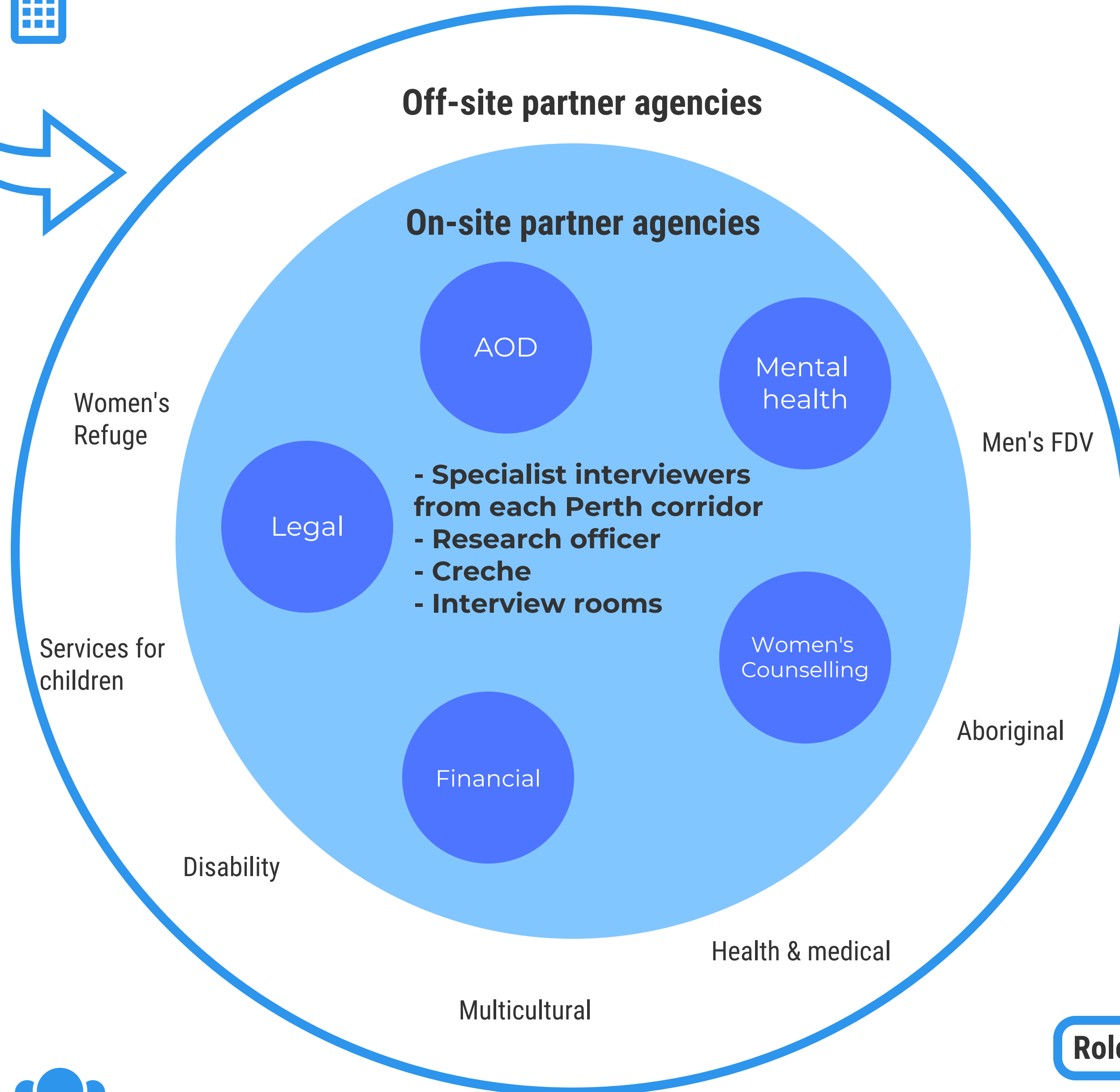
Hub model 2

Accessing the hub

State-wide response
- State wide telephone number
- Self referral; telephone, face to face by appointment
- Crisis care referral
- CRS referral
- Other agency referral







Staffing

Specialist interviewers (incl. Men's & Aboriginal worker)
- Hold relevant qualifications
- Trauma informed
- Culturally sensitive
- Apply intersectional principles

Research officer
- To support best practice
- Evaluation

Role of the hub

- Linkages with services in other corridors
- Thorough, common assessment: individualised to meet needs of client
- Case coordination/management
- Facilitate pathways
- Outreach
- 'Holding'the client for the whole journey
- Build and sustain relationships with partner agencies

Appendix 2

Name of model	Organisational lead	Agency lead	Agency focus	Target population of agency	Type of service delivery	Areas of Alignment	Impact on original service
Family and Domestic Violence Response Teams (FDVRTs)	Government	Government: Department of Communities (Child Protection and Family Support)	FDV specialist	All populations	• Crisis management	✓Well matched workforce skills ✓Strong, relevant existing collaborations ✓Information sharing established ✓Shared database established ✓Multi-agency working	• State-wide key response to FDV; Police and Child Protection presence could be potential barrier to accessing service. • Expanding service could address gaps in service responses and managing volume of DVIRs in some areas, adding relatively seamlessly to already existing, well known service. • Additional FTE's required (unable to reallocate existing FDVRT staff). • Not recommended to be co-located at police station. • Political undercurrents associated with expanding FDVRTs as these were introduced by previous Government. • **Potential opportunity.**
Family Safety Teams (FST), Kimberley region	Government	Government: Department of Communities (Child Protection and Family Support)	FDV specialist	ATSI men, women and children (whole of family)	• Crisis management • Case Management	✓Well matched workforce skills ✓Strong, relevant existing collaborations ✓Information sharing established ✓Shared database established ✓Multi-agency working	• Part of state-wide key response to FDV; links with Police and Child Protection could be potential barrier to accessing service. • Localised response as part of Kimberley Plan to address FDV in the region: services regional and remote sites only. • Intended as specialised response to ATSI. • Additional FTE's required (unable to reallocate existing staff). • Difficult to recruit workers.

							• Political undercurrents associated with expanding FDVRTs as these were introduced by previous Government. • **Not deemed suitable as part of FDVRT.**
Refuge Service System Model Emergency Response (RSSMER)	Government	Non-Government: Women's Refuge Services	FDV specialist	Women and children (FDV victims)	• Crisis management	× Well matched workforce skills × Strong, relevant existing collaborations × Information sharing established × Shared database established ✓ Multi-agency working	• Specialised response to providing and managing crisis accommodation for women and children at risk of immediate harm. • **Not deemed as suitable.**
Safe at Home (SaH)	Government	Non-Government: Women's Refuge Services	FDV specialist	All populations. Case Management to women and children only (FDV victims).	• Crisis management • Case Management	✓ Well matched workforce skills ✓ Strong, relevant existing collaborations ✓ Information sharing established ✓ Shared database established ✓ Multi-agency working	• Part of state-wide key response to FDV; links with Police and Child Protection could be potential barrier to accessing service. • Not recommended to be co-located at police station or women's refuge. • Potentially competes against the intent of SaH program to provide support to women and children who are or plan to separate from the perpetrator. • Reallocating SaH program staff (of which there are only one or two available) would impact on FDVRT, which would be disruptive to relatively new arrangement. Additional FTE's would be required to undertake triage and case management functions for Level 2 DVIRs thereby negating any benefit.

							• **Not deemed suitable as part of FDVRT.**
Barndimalgu Family Violence Court in Geraldton	Government	Government: Attorney General's and Corrective Services	FDV specialist	ATSI (FDV perpetrators)	• Justice based program	× Well matched workforce skills × Strong, relevant existing collaborations × Information sharing established × Shared database established ✓ Multi-agency working	• Specialised court response to FDV perpetrators of violence who identify as Aboriginal. • **Not deemed suitable.**
Domestic Violence Advisory Service (DVAS)	Non-Government	Non-Government: Women's Health and Family Services.	FDV specialist	Women, Children & Young People CALD ATSI (FDV victims)	• Advocacy only	✓Well matched workforce skills ✓Strong, relevant existing collaborations ×Information sharing established ×Shared database established ✓ Multi-agency working	• Possible governance issues; not managed by Government. • Additional FTE's required (unable to reallocate existing staff). • Whilst has strong, relevant existing collaborations with some organisations, this is relatively limited now. • Location of service (Northbridge and Joondalup) may not serve area of most need. • Historical knowledge of DVAS, impact on service user accessibility. • Close links/co-location with women's health service positive. • **Possible opportunity.**
Women's Resource and Engagement Network (WREN)	Non-Government	Non-Government: Northern Suburbs Community Legal Centre Inc.	FDV specialist	Women Children & Young People, Older People, CALD, ATSI (FDV victims)	• Case Management	✓Well matched workforce skills ✓Strong, relevant existing collaborations ×Information sharing established ×Shared database established ✓Multi-agency working	• Possible governance issues; not managed by Government. • Additional FTE's required (as relatively small team, consisting of two lawyers, a domestic violence advocate and client services officer). • Already established link with legal and health service positive.

							• Information sharing mechanisms limited. • Location of service (Mirrabooka and Joondalup) may not serve area of most need. New location and premises may be required. • **Possible opportunity.**
Marninwarntikura Fitzroy Women's Resource Centre (MFWRC), Fitzroy Crossing	Non-Government	Non-Government: Marninwarntikura Fitzroy Women's Resource Centre	FDV specialist & women's service	Women and Children, ATSI (FDV victims)	• Crisis management • Case Management	✗ Well matched workforce skills ✓ Strong, relevant existing collaborations ✗ Information sharing established ✗ Shared database established ✓ Multi-agency working	• Possible governance issues; not managed by Government. • Unsure re staffing levels; may be possible to retain and up skill existing staff. • Very strong community links which have driven transformative change in the region. • **Possible opportunity (for Pilbara area).**
Safe as Houses	Non-Government	Non-Government: Tenancy WA	FDV specialist	Women and Children, CALD ATSI (FDV victims)	• Crisis management • Case Management	✓ Well matched workforce skills ✓ Strong, relevant existing collaborations ✗ Information sharing established ✗ Shared database established ✓ Multi-agency working	• Possible governance issues; not managed by Government. • Additional FTE's required as relatively small team with limited case management capacity. • Strong community links with key services required to support women experiencing FDV. • **Possible opportunity.**
Family Support Networks (FSNs)	Government	Government: Department of Communities (Child Protection and Family Support)	Non FDV (although significant number of cases have history of FDV or FDV present)	Families, CALD, ATSI	• Case Management	✓ Well matched workforce skills ✓ Strong, relevant existing collaborations ✓ Information sharing established	• Not a crisis intervention service, case management model (family support). • Would be multiple focus: child protection and FDV. Informal reports from Melbourne indicate having more than a singular focus to begin with can be problematic.

						✓ Shared database established ✓ Multi-agency working	• Child protection worker located on site, potential barrier to women and children seeking support • Additional FTEs would be required to manage demand; already operating beyond capacity. • FSN workers have relevant qualifications and experience and strong partnerships, policies, protocols and practice already established. • **Possible opportunity.**
George Jones Child Advocacy Centre	Non-Government	Non-Government: Parkerville Children and Youth Care Inc.	Non FDV	Children & Young People	• Case Management	✗ Well matched workforce skills ✗ Strong, relevant existing collaborations ✗ Information sharing established ✗ Shared database established ✓ Multi-agency working	• Very specialised response to child sexual abuse. • Areas of focus do not align: child sexual abuse and FDV. • Police and Child Protection located on site, barrier to accessing support. • **Not deemed suitable.**
Multi-agency Investigation and Support Team (MIST)	Government	Government: WA Police (Child Abuse Squad)	Non FDV	Children & Young People	• Case Management	✗ Well matched workforce skills ✗ Strong, relevant existing collaborations ✗ Information sharing established ✗ Shared database established ✓ Multi-agency working	• Very specialised response to child sexual abuse. • Areas of focus do not align: child sexual abuse and FDV. • Police and Child Protection located on site, barrier to accessing support. • **Not deemed suitable.**
Child and Parent Centres	Government	Government: Education Department	Non FDV	Families	• Education • Groups	✗ Well matched workforce skills	• Focused on early childhood development, parenting and family support; areas of focus do not align.

						✗ Strong, relevant existing collaborations ✗ Information sharing established ✗ Shared database established ✓ Multi-agency working	• **Not deemed suitable.**
National Partnership Agreement on Homelessness (NPAH)	Government	Department of Communities (Child Protection and Family Support)	FDV mainstream	All populations	• Crisis management • Case Management	✗ Well matched workforce skills ✓ Strong, relevant existing collaborations ✗ Information sharing established ✗ Shared database established ✓ Multi-agency working	• Very targeted response to issue of homelessness involving multiple agencies. • Whilst areas of focus overlap (homelessness and FDV), the arrangement is considered too large in its scope to manage an FDV Hub. • **Not deemed suitable.**
headspace	Government		Non FDV	Children & Young People	• Crisis management • Case Management • One on one • Groups	✗ Well matched workforce skills ✗ Strong, relevant existing collaborations ✗ Information sharing established ✗ Shared database established ✓ Multi-agency working	• Targeted at youth experiencing mental health issues and not seen as suitable for combining a FDV hub with, although partnering with the service may offer streamlined support to young people who have experienced or who have perpetrated abuse. • **Not deemed suitable.**

Appendix 3

Key Integrated Responses Nationally and Internationally

Compiled August 2018 by Curtin University for Department of Communities as part of the project: Research for the Development of Two 'One Stop Hubs.'

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Key FDV Integrated Responses, Western Australia

Model	Agencies Involved	Key Features	Benefits	Challenges	Contribution to WA Hub service model
Family & Domestic Violence Response Teams (FDVRT) State-wide service operating out of police and child protection districts, total of 17 teams. Commenced 2009 in metropolitan area and 2010 in regional and is currently key response to FDV in WA. Eight in metropolitan districts (two per police district) and nine in regional districts (Community Development and Justice	• Lead agency: Department of Communities. • WA Police. • Anglicare WA. • Lucy Saw Centre. • Mission Australia. • Patricia Giles Centre. • Ruah Community Centres. • Starick Services. • Koolkuna. • Share and Care Community Services. • Waratah. • Women's Health and Family Services. • Safe at Home teams. • Men's Domestic Violence Helpline. (Breckenridge, Rees, Valentine, & Murray, 2016).	• Supported by legislation and policies. • Collaborative multi-agency approach • In most locations, workers from Police, Child Protection and non-government domestic violence service are co-located at police stations. • Joint risk assessments of Domestic Violence Incident Reports (DVIRs) using a common framework. • Shared database. • Supported and streamlined client pathways through service system. • Multi-agency safety planning. • Expanded 2017 to include Safe at Home teams and Men's Domestic Violence Helpline as part of FDVRT. (Department of Communities, 2017).	• Identification of opportunities for early intervention and proactive outreach, streamlining of service response and multi-agency case management. • Timely responses following police call out for FDV. • Led to more robust risk assessment processes that include multiple sources of information and perspectives about risk. • Increased number of families receiving support following police call out. • Families receiving more appropriate responses tailored to their needs and circumstances. • Strong working relationships between partner agencies. • Improved opportunities for joint or coordinated responses between agencies. • Physical co-location has fostered sense of partnership and shared responsibility between key agencies e.g. joint assessment can occur over the course of the day, multi-agency responses coordinated as needed,	• Managing the volume of DVIRs within each district. • Mismatch of boundaries between child protection and police – difficult to manage when there were inconsistent or different FDVRT processes occurring in overlapping areas (e.g. different assessment and triage processes) which in some areas have led to confusion about agency roles and responsibilities • Challenge in service delivery around meeting unique risks and needs of Aboriginal and CaLD women (e.g. For Aboriginal women: appropriateness and availability of relevant services, gaps in services in regional and rural areas, language and communication barriers, and co-occurrence of structural disadvantage including housing availability. For CaLD women: forced marriages, honour based violence, financial dependency, language barriers, isolation, and limited or little knowledge about services or their rights).	• This model prompts consideration about the interface of proposed hub with FDVRT and the ability of the hub to respond within current system constraints, particularly in regional areas. It is thought that the proposed hub could incorporate an evaluation framework in the model to monitor quality of responses over time. Additionally, the proposed hub could fill gaps in service by providing response to non-police referrals and meeting the diverse needs of Aboriginal and CaLD women.

Standing Committee, 2010).			team members in constant contact with each other. • Interface of databases has contributed to streamlined joint assessment and triage processes and promoted consistency between regions around how decisions are recorded, referral and case collaboration. • All regions reported strengthened relationships with agencies and service providers outside of the FDVRT including increased cooperation, information sharing and feedback about clients. Also assisted in managing high risk cases. • Increase in quantity and quality of services responses have improved over time. (Breckenridge et al., 2016).	• Issues impacting on effectiveness of service responses include: o Gaps in service responses, especially in regional and remote locations o Increase in adolescent to parent violence o Lack of housing/homelessness for women and children escaping domestic violence o Transience of clients o Visa issues for women and children o Substance misuse by perpetrator and/or victim (Breckenridge et al., 2016).	
Family Safety Teams (Kim-berley region) 5 x regional/remo te sites: Broome, Derby, Kununurra, Halls Creek, Fitzroy Crossing.	• Lead agency: Department of Communities. • WA Police. • Department of Corrective Services. • Kimberley Family Violence Service (Anglicare WA). • Department of the Attorney General. (Department for Child Protection	• Men's family violence workers based in Broome, Derby, Kununurra, and Halls Creek. • Women's family violence workers based in Broome and Fitzroy Crossing. • An extension to the FDVRT teams. • Whole-of-family service response. • Co-location (where possible).	• No formal evaluation available.	• No formal evaluation available.	• This model is an example of starting small and building on concept which is a consideration for the WA Hub model. • As an extension of FDVRT model, it prompts the question, "could the WA Hub be built on the FDVRT?"

Commenced 2016, still currently operating.	and Family Support, 2015).	• Joint assessment and triage of WA Police Domestic Violence Incident Reports (DVIR). • Proactive outreach to families identified in DVIRs. • Central referral point for families identified in DVIRs. • Multi-agency case management for high risk cases. • Community engagement and education targeted at prevention and early intervention. (Department for Child Protection and Family Support, 2015).			
Refuge Service System Model Emergency Response Run via 3 x corridors in the metropolitan area. Commenced 2015, still currently operating.	• Lead agency: Women's Council for Domestic and Family Violence. • Women's refuges, including corridor leads Pat Giles Centre, Lucy Saw Centre and Starick Services.	• Rationalisation of metropolitan refuges across three corridors, where lead agency in each agency is contracted to provide emergency accommodation. • Lead agency responsible for triaging access to refuges if required beyond 48 hours. • If beds not available, lead agency responsible for arranging motel accommodation and outreach support. • Centralised intake through Crisis Care, where a common risk assessment	• Improved inter-agency collaboration and stronger sense of accountability between lead agencies, Crisis Care and refuges. • Improved communication, coordination and trust between agencies. • Increased knowledge about roles and responsibilities of agency partners. • Improved access to secure emergency accommodation for single women and Aboriginal women with children. • Able to accommodate large families, which previously was difficult.	• Implementation concerns. Differences between agencies around emergency response protocol and implementation in practice was evident. • Process issues included: Referral pathways; Crisis Care completion of CRARMF and refuge obligations to accept assessment; triaging of beds across corridors; and which agencies were responsible for organising and paying for motel and providing outreach. • Capacity concerns in-cluded: Adequate funding	• A key contribution of the Refuge Service System is its common assessment framework. Other contributions include: the implementation issues which were worked through on the ground – there were evaluation points along the way which gave opportunity to review and refine processes; lead agencies were responsible for providing coordination aspect which facilitated collaboration and trust between agencies; and changing the way business was carried out

		framework (CRARMF) used to determine eligibility. • Provision of emergency accommodation for at least 48 hours. • Immediate, 24-hour access to services. • Assistance with transport where necessary. • Lead agencies are the key referral points for CPFS's Crisis Care Unit to provide better access to services for women and children in imminent danger. • Support referral processes across the FDV service system by assisting women to locate the most appropriate service (Chung, Chugani, & Marchant, 2016).	• CRARMF - strengthened the depth and consistency of risk assessment across workers/agencies. • Provides a stronger common understanding of risk across the service system, which means women are less likely to fall through the gaps. • Improved access to beds for women within and between corridors. • Streamlining of refuge processes enabling quicker access compared to business as usual. • Decrease in number of times women had to repeat their story and the number of times women had to repeat their story. • Relatively small financial outlay required. (Chung et al., 2016).	to cover the cost of having an allocated bed and loss of income not having it taken by a longer term client; staffing numbers to provide 24-hour cover; limited flexibility in accommodation configuration; security upgrades at some sites; discharge arrangements following the 48-hour period if there were no refuge or similar places. • There were implementation issues, however, these were worked through on the ground – there were evaluation points along the way which gave opportunity to review and refine processes. • Lead agencies were responsible for providing coordination aspect which facilitated collaboration and trust between agencies. • Use of common assessment strengthened depth and consistency of risk assessment. • Changing the way business was carried out resulted in positive outcome at minimal cost. (Chung et al., 2016).	resulted in positive outcome at minimal cost. The WA Hub proposes to include the refuge system as an off-site partner of the Hub.

Safe at Home 5 x metropolitan sites 2 x regional sites Commenced 2010, funded by Federal Government. Still currently operating.	• Lead agency: Child protection. • Pat Giles Centre. • Stirling Women's Centre. • Lucy Saw Centre. • Ruah. • Starick Services. • South West Refuge. • Share and Care Community Services (Wheatbelt). (Women's Council for Domestic & Family Violence Services (WA), 2011).	• Collaborate with police, other FDV support services and other agencies depending on client needs. • Provide practical support to stabilise housing and increase security through brokerage funds. • Wraparound case management response that can respond to the individual needs of women including risk assessment, safety planning, security upgrades, court support, referrals to other services, strong links with police and other FDV services, including perpetrator programs, refuge accommodation.	• Provided comprehensive and seamless service to women and children, including safety audits, home security modifications, and ongoing case management for up to 12 months. • Key benefits reported include domestic violence education to women, linkages to other support services, support for children to attend school regularly, referrals or information around financial management, maintenance of accommodation. • Addresses both root causes and on-going consequences	• Difficulties for clients contacting workers or having workers return calls • Delays between contact and worker's response to women's requests for service. (Cant et al., 2013)	• The key features of Safe at Home contribute to the design of the WA Hub service model, in particular its intake, assessment and case management service, wrap around case management that provides individualised support, and its ability to provide longer term support if needed. In addition, the brokerage funds to help with practical support and the interface with existing systems are also considerations in the design of WA Hub.

		• Facilitate access to crisis accommodation if needed. • Work in collaboration with Perpetrator Response Service to improve safety of women and children. • Long-term support (up to 12 months). • MoU with police and working relationships with other relevant agencies. (Breckenridge et al., 2016; Cant, Meddin, & Penter, 2013).	of violence towards women and their children. • Addresses material and practical intervention and also emotional support, advice, and advocacy. • Appropriate for CALD and Aboriginal women because the case management and individualised approach enables specific needs to be addressed. • Overwhelmingly positive feedback received from clients in regard to the impact Safe at Home has had on their lives and the lives of their children. (Breckenridge et al., 2016).		
Specialist Family Violence Courts 5 x Metropolitan Family Violence Courts (MFVC): Joondalup, Rockingham, Fremantle, Midland, Armadale, Perth) 1 x Barndimalgu Family	• Lead agencies: joint partnership between Department of the Attorney General and Department of Corrective Services. • Magistrates Court. • Police. • Family Violence Service (Department of Justice). • Kinway. • Relationships Australia. • Department of Communities (Child Protection	• Specialise in family violence matters. • Specialist victim support services available – provide a range of advocacy, support and referral services, including assistance with VROs. • Linked to a specialist police FDV investigation unit which investigated all reported family violence matters in the region. • Includes a specialist magistrate, police prosecutor and duty lawyer. • Monitoring of offenders on perpetrator programs by	• Pilot evaluation showed an increased number of charges laid from call-outs (from 7.1% to 39%). • Victim feedback: indicated that most victims were positive about the support and assistance they received. The range of services and supports provided to them including counselling, practical assistance, accessing other supports and emotional support was helpful. • MFVC victims said that they felt safe because of their case coordinator. • Receiving information about the court process was	Recidivism: • MFVC was found to be producing less effective results in terms of likelihood of re-offending than in mainstream courts. • BFVC intervention did not significantly impact on reoffending. Participation in BFVC does not produce a more effective result in terms of reoffending than the mainstream court. • Evaluation of the Barndimalgu Court, although slightly more positive, are not significantly different to those in the mainstream court. Victim feedback:	• The evaluation of the Specialist Family Violence Courts highlights the importance of having specialist support for FDV victims and also information on the perpetrator. These features contribute to the design of the WA Hub.

Violence Court in Geraldton (BFVC). Pilot site in metropolitan area commenced 1999, no longer operating. Barndimalgu Court in Geraldton commenced in 2007, still operating.	and Family Support).	magistrate and case management team. • Supported by Family Violence Service. • MFVC: to be eligible offender must please guilty to family violence and agree to undertake assessment for participation. • BFVC: to be eligible for the BFVC, offenders need to identify as Aboriginal or Torres Strait Islander, have committed a family violence offence that can be seen in the Magistrates Court, plead guilty and agree to participate. (Department of Attorney General, 2014).	identified by victims as one of the most valuable service provided. Also knowing when the offender was going to be sentenced also important as allowed time to seek further protection if needed. • BFVC: most victims reported being satisfied with the court program overall. • Behaviour Change Program had mixed views, with some victims reporting it had helped in the perpetrator understanding the impact of his violence on children and using alternative strategies. Comments indicated there was still some way to go for them to accept responsibility for their actions. (Department of Attorney General, 2014).	• Some victims expressed dissatisfaction with support they received, particularly around lack of information on violence restraining orders, case management and court protocols. • BFVC victims reported wider variety of outcomes. Some victims appearing to continue to be at risk, requiring additional Violence Restraining Orders or increased protective bail conditions, where others report a dramatically reduced risk, and others in between • BFVC: Many Aboriginal women were reluctant to participate; feelings of shame, unfamiliarity with service, lack of personal resources or self-esteem, distance to victims who live in areas outside of Geraldton. Venue at court house not appropriate for children or victims separated from perpetrators. Behaviour Change Program: • Mixed views, with some victims reporting it had helped in the perpetrator understanding the impact of his violence on children and using alternative strategies. Comments indicated there	

				was still some way to go for them to accept responsibility for their actions. Costs analyses: • MFVC has higher unit cost than mainstream courts. The average cost per hearing and per finalisation was significantly greater for the BFVC compared to the mainstream court. Indigenous imprisonment outcomes: • MFVC: Indigenous offenders were more likely to receive a prison sentence than non-Indigenous offenders. • BFVC: overall the majority of Indigenous family violence offenders in Geraldton Court did not receive an outcome of imprisonment. (Department of Attorney General, 2014).	
Domestic Violence Advocacy Service (DVAS) Central 1 x metropolitan site Commences approximately	*DVAS is still currently operating, however, it is operating on a smaller scale out of the Women's Health and Family Services, providing access to advocacy, legal, and child protection services (is a referral service only).*	• Aimed to be a "one-stop" service with a focus on client needs and service. • Co-located integrated model. • Partner agencies all ascribed to shared responsibilities, including: ○ "Working in spirit of co-operation and partnership;	• Enhances perceptions of safety for clients and their families. • Prevents re-victimisation. • Co-location. • Facilitates consistent response across agencies. • Allows clients to access police in a non-threatening environment. • Allows staff to focus entirely on FDV and not be	Gaps in services: • Inability to provide advice around family law. • Crisis counselling unavailable, but required • Unable to adequately identify and monitor issues that children may experience as a result of domestic violence • Staff needed to provide administrative and	• Both the benefits and limitations of DVAS contribute to the design of the WA Hub.

2003, evaluated in 2005 (data collection between July 2004 and March 2005 after first year of operation). No longer operating as initially intended presumably due to changes in funding (unsure when arrangements changed).	At time of implementation, On-site partners: • Lead agency: Orana House. • WA Police. • Department for Community Development (Perth office). • Domestic Violence Legal Unit. • Yorgum Aboriginal Corporation. • Women's Health Care House – Multicultural Women's Advocacy Service. • Department of Justice Victim Support Service. • Domestic Violence Children's Counselling Service. • Nardine Wimmin's Refuge Outreach Program. Off-site partners: • Family and Domestic Violence Unit. • Perth West Domestic Violence Action Group. • Central Metropolitan Region Prevention	o Participating in team meetings (Partnership meetings); o Contributing to the efficient and effective running of the agency and being flexible and practical about their role; o Abiding by the policies and procedures, statements of intent, protocols, memorandum of understandings and any other documentation set down by the Steering Committee and Leadership Group; o Meeting obligations and responsibilities of the worker's employing agency; o Providing appropriate supervision and support for their staff; and o Working toward the vision, goals and objectives of the DVAS Central" (Breckenridge et al., p.281). (Breckenridge et al., 2016).	distracted by competing demands. • Minimises duplication of efforts, allows for hybridisation of skills and knowledge within agency staff. • Cost-efficient – minimises overhead costs which are shared amongst stakeholder agencies. • Increased accountability among agencies (staff are more open to scrutiny from others from different agencies). • Role dedicated to coordination of the service: position is essential fostering partnerships and maintaining relationships which contributes to the success of the model. • Model works well for clients, staff, the community and the State. (Breckenridge et al., 2016).	receptionist support to sustain service • Lack of staff available onsite to assist CALD women was seen as a gap, despite there being telephone advice and workers would walk women to the multicultural service • Difficulties securing and maintaining agency commitment; seen as critical to securing ongoing future of the service. • Identified need to find way for agencies committed to the model and the service to have a physical presence on site. • "Coordination of the various stakeholders and seeing the service through to fruition" (Breckenridge et al., p. 283) is very time consuming (although essential to sustainability of the model). Ongoing funding for Co-ordinator needed. • DVAS has not achieved all of its statements of intent/agency commitments. (Breckenridge et al., 2016). Recommendations made by Breckenridge et al. (2016) with regard to DVAS include: • Service should continue in its present form.	

	of Domestic Violence Committee. • Women's Refuge Group of WA (now known as Women's Council for Domestic and Family Violence Services (WA). (Breckenridge et al., 2016).			• If model is to be duplicated, then financial commitment and commitment from agencies to provide staff on-site and on an on-gong basis essential. • Attend to gaps in commitment so model can be realised in its intended form. • Ongoing funding for co-ordinator critical. Also need administration and reception support. • Services should continue to be based in the community. • Effective and efficient operation of collaborative service delivery of one-stop shops require agency staff to be located on-site. Police and Legal Aid seen as key. • Close supervision by relevant agencies for inexperienced staff or staff in training needed. • Representatives from Family law, Crisis counselling needed. • Establish working party to review and clarify needs for children. • Future initiatives draw on principles of DVAS Central model, particularly physical setting and on-site presence of key personnel. • Need to review financial and funding arrangements for	

				domestic violence services as this issue crosses Government departments and boundaries. • There is a need for performance indicators. • Appropriate attention needs to be paid to the centrality of relationships at all levels of all agencies in interagency work, and strengthening relationship between key services. Other comments: • Impact of changing funding arrangements on service provision; service is no longer operating as first intended. • Singular focus important, able to give direct attention to FDV. • Governance essential to sustaining: Leadership Group, Steering Committee, Partnership Group. (Breckenridge et al., 2016).	

Women's Resource and Engagement Network (WREN) Services North Eastern region: City of Joondalup, City of Wanneroo, City of Stirling & City of Swan. Concept was introduced by the Health Justice Partnerships Network. Commenced 2015 funded under Federal Government Women's Safety Package, still currently operating (Mental Health Commission of New South Wales, 2016).	• Lead agency: Northern Suburbs Community Legal Centre. • Partnership between Northern Suburbs Community Legal Centre and Joondalup Health Campus. (https://nsclegal.org.au/).	• Medical/legal partnerships first emerged in the early 1990's in Boston the US. • Staffed by two lawyers, a domestic violence advocate and a client service officer. • A specialist Domestic Violence Unit and Health Justice Partnership. • Provides wrap around legal and non-legal services to women experiencing domestic violence. • Case management approach helps women to access other support services such as crisis accommodation, counselling, family law services, employment services and financial advice. • Through the partnerships, legal professionals train doctors and health workers to better identify and respond to domestic violence by making referrals to support services, including legal services. • Lawyers provide advice and assistance on-site to patients at hospitals and health centres, helping women to access help in a safe location.	• No formal evaluation of this site in particular available. • There is some evidence base available around health justice partnerships nationally and internationally on the Health Justice Australia website (www.healthjustice.org.au/resources/researchers/#evidence).	• No formal evaluation of this site in particular available. • There are some resources around health justice partnerships nationally and internationally on the Health Justice Australia website (www.healthjustice.org.au/resources/researchers/#evidence).	• Champions of interventions within teams recommended to help achieve organisational culture change (Forsdike et al., 2018). This recommendation is considered in the design of the WA Hub model. It has been considered whether the hub can be built upon the already existing health/justice partnerships.

		• Also operates a specialist legal service 'The Older Peoples Rights Services': legal and social work response service for those at risk of elder abuse. (https://nsclegal.org.au/; www.ag.gov.au).			
Armadale Domestic Violence Intervention Project (ADVIP) 1 x metropolitan site. Commenced 1993, no longer operating.	• Multicultural Women's Advocacy Service. • Aboriginal Family Support Service. • Mission Australia. • Relationships Australia. • Department of Education and Training. • Moorditch Koolaak Housing Project. • Gosnells Community Legal Centre. • Starick Services. • Communicare Breathing Space. • Police. • Child Protection. • Armadale Health Service.	• Adapted from the Duluth model (coordinated criminal justice model of intervention). • Inter-agency coordination through the development of policies and protocols, and information sharing. • Inter-agency Safety Committee (made up of representatives from regional government and non-government agencies). • Core group made up of 'coal-face' practitioners ensure accountability through collaborative monitoring of agencies' responses to cases. • Coordinator who attends all meetings, provides reports to various ADVIP groups, liaise with the FDV Unit and other regional coordinators, coordinates	• Takes the responsibility for having to end the abuse away from the client • Improved protection, safety and support for clients • Frees police up to deal with perpetrators, thus enhancing families' safety (Gardiner, 1996).	• Inadequate coordination of gathering, documenting and sharing of information – prevents achievement of goals of protecting victims and holding perpetrators accountable • 'Victim blaming' practices pervasive in organisations. Interventions tend to hold victims of abuse responsible for offenders' behaviour in ways that undermine the goals of safety and accountability and frequently lead to increased, rather than diminished, risk for adult and child victims of domestic violence • Systems of accountability in place preventing the achievement of goals related to offender accountability and victim safety	• Two key contributions of the ADVIP to the WA Hub are: 1) the accountability through collaborative monitoring of agencies responses to cases; and 2) the importance of identification and resolution of systemic issues which compromise victim safety and offender accountability.

	• Department of Housing and Works. • Kinway/Anglicare. (Pence & Aoina, 2007).	community member agencies and provides community education. (Pence & Aoina, 2007).		• Problematic institutional discourses and assumptions appearing in practice • Missed opportunities to identify and resolve systemic issues that compromise victim safety and offender accountability by only focusing on inter-agency collaboration on individual cases (Pence & Aoina, 2007).	

East Kimberley Family Violence Hub and Outreach Service
 	
4 x remote communities: Kununurra, Warmun, Wyndham, Kalumburu.
 	
Federally funded for three years. Commenced July 2010 and ceased operation in September 2012.
	• Lead agency: Department of Child Protection.
	• Starick Services.
	• Cross Borders Program.
		• Aimed to support Aboriginal families and children.
		• Hub staff consisted of a manager, men's and women's outreach workers, and two community educators.
		• Provided brokerage and capacity building, infrastructure development and community education.
		• Case Management and Coordination Service (CMCS) was developed which assisted in multi-agency case management for high risk cases.
		• Outreach model.
		• Funded and supported local services – adding resources and specialist interventions to complement existing service delivery.
			• Hub workers had high level of satisfaction with work and roles (Department of Child Protection, 2012).
			• Substantial impact on the quality of responses to FDV in the communities the Hubs served, including:
			  ○ Refurbishment of community buildings to provide safe spaces for victims and children as well as spaces for men.
			  ○ Increasing service providers' knowledge (mainstream and specialist services) about family violence and their capacity to respond.
			  ○ Increasing of resources in communities to provide safety focused responses to victims
				• Little known about medium and long term outcomes of model.
				• Unable to determine if reduction in family violence occurred.
				• Implementation challenges included:
				  ○ Remoteness of the locations from each other and the metropolitan area.
				  ○ Outreach model was not effective in all sites – some community members indicated they would prefer services and workers with a constant presence in the community.
				  ○ Short-term funding and intervention undermines potential
					• The following strengths and challenges contribute to the design of the WA Hub: inter-agency training which support shared understandings of FDV and help to achieve common goals and shared responsibilities, an awareness of the time needed to determine outcomes, and the impact of short term funding on interventions.

			and timely perpetrator interventions. o Clients were overwhelmingly positive about the services they were provided with. Community members reported feeling safer and service providers noticed changed behaviours in communities, with some individuals choosing not to use violence and community members intervening to protect women and children. • Multi-pronged approach, including prevention, early intervention and tertiary responses (e.g promoting awareness/understanding of family violence to communities and young people, communities taking collective responsibility for violence, building infrastructure, supporting collaborative responses between agencies). • Improved communication, greater information sharing, and enhanced understandings and management of risk evident. • Inter-agency training (supported shared or	success and benefits of program/interventions. o High staff turnover. (Breckenridge et al., 2016).	

			common understandings of FDV and a sense of common goals and shared responsibilities) • Capacity building of existing services. • Direct provision of services to men and perpetrators was critical component. (Breckenridge et al., 2016; Department of Child Protection, 2012).		
Coordinated Family Dispute Resolution (CDFR) (WA, QLD, NSW, TAS) Commenced 2010, no longer operating.	• Lead agency: Legal Aid WA. • FDRPs: Midland FRC (Centrecare WA); Joondalup FRC & Mandurah FRC (Anglicare WA); Perth FRC (Relationships Australia WA); Gosnells Community Legal Centre. • Legal Services: Legal Aid WA; Fremantle Community Legal Centre; Gosnells Community Legal Centre; Southern Communities Advocacy Legal Education Services (SCALES); Sussex Street Community Law Service;	• Pilot Program was implemented in five sites in four jurisdictions as a multi-disciplinary initiative in family law. • "Involves the conscious application of mediation where there has been a history of past and/or current family violence. It also involves collaborative multidisciplinary practice in a multi-agency setting, with the nature of the collaboration being clinical rather than at the level of referral and support" (Kaspiew et al., 2012, p. 144). • The lead agency in each site was different (in WA, Legal Aid) but each partnership included: ○ A service providing FDR (including professionals who are	• "Multi-disciplinary practice has a number of benefits, and provides a more comprehensive and holistic service" (Kaspiew et al., 2012, p. 142). • "Role of lawyers and MSPs important in adjusting expectations – evidence to suggest that "where these professionals see clients together there is a greater possibility of shifts in attitude occurring" (Kaspiew et al., 2012, p. 145). • "Modest conclusion that CFDR "heightens (but does not guarantee) the possibility that the appropriate process for considering arrangements consistent with 'best interests' will be applied in any given matter" (Kaspiew et al., 2012, p. 142).	• "Due to limited number of cases, question arises as to whether the process should be primarily FDR, or "a service focussed more on referral and support with FDR (and possible agreement) as an ancillary component of the process" (Kaspiew et al., 2012, p. 140). • "In practice, the focus of CFDR is significantly wider than dispute resolution: the proportion of single-party cases and the level of service they receive highlights the wider role of CFDR as a support and referral mechanism" (Kaspiew et al., 2012, p. 141). • Different approaches to risk assessment were undertaken at different pilot sites, and different	• Recommendations around best practice for integration are considered in the design of the WA Hub.

	Women's Law Centre of WA; Aboriginal Legal Service WA. • Family Violence Services: Legal Aid WA; Centrecare WA; Relationships Australia WA; Women's Health and Family Services; Anglicare WA. • Men's Services: Centrecare WA; Communicare Breathing Space; Relationships Australia WA; Anglicare WA. • Child consultants: Relationships Australia WA; Anglicare WA; Legal Aid WA.	accredited FDR practitioners and, if appropriate, qualified "child practitioners"); o A specialist domestic violence service; o A men's service; and o Legal services able to provide legal assistance and advice to each party. (Breckenridge et al., 2016; Kaspiew, Maio, Deblaquiere, & Horsfall, 2012).		approaches could create partnership tensions. • "It is clear that processes around risk assessment and management and making clinical judgments about the conduct of FDR are areas in which particular challenges arise in multi-disciplinary, multi-agency practice" (Kaspiew et al., 2012, p. 144). • Some clients felt emotionally unsafe despite efforts to address power imbalances between parents, while others felt empowered and supported when participating in FDR. • Information sharing was complex part of collaborative practice. • Number of caseloads across all pilot sites considerably fewer than anticipated: data suggests this was due to a slow build of referrals and challenges in engaging both parents. (Kaspiew et al., 2012; Breckenridge et al., 2016).	

Marninwarntikura Fitzroy Women's Resource Centre (MFWRC), Fitzroy Crossing Women's Shelter commenced in 1995, still operating.	• Lead agency: Marninwarntikura Fitzroy Women's Resource Centre. • Women's Shelter. • Family Violence Prevention Legal Services (FVPLS). • Fetal Alcohol Spectrum Disorder Unit. • Family Centre • Indigenous Parent Support services. (www.options.wahousinghub.org.au).	• Family Violence Prevention Legal Services (FVPLS) service is co-located with a women's refuge, offering a holistic, wrap-around support which includes counselling and legal advice. Both are situated within the MFRC which acts as a hub for a diversity of women's issues. • Community based programs MFWRC provides include; early childhood program, playgroups, parenting, art therapy, shelter/crisis accommodation and family violence prevention legal services. Also collaborates with Men's Shed and other services around the provision of support to men. • MFWRC has strong links with other local community organisations, for example the Nindilingarri Cultural Health Services. Marulu Unit at Marninwarntikura Women's Resource Centre in Fitzroy Crossing was set up to respond to the findings of the Lililwan Study and support families living with FASD. The Lililwan FASD Prevalence Study commenced in 2010	No formal evaluation of the partnership between the Women's Refuge and Family Violence Prevention Legal Service available. • The Marninwarntikura Women's Resource Centre were instrumental in implementing alcohol restrictions in the region; the main reasons for this community led action was the impact that alcohol was having on unborn children. This initiative has been recognised nationally and internationally as leading a transformative change. (Blagg, Bluett-Boyd, & Williams, 2015).	No formal evaluation of the partnership between the Women's Refuge and Family Violence Prevention Legal Service available.	• MFWRC demonstrates the importance of strong leadership led by the community and partnerships with local communities, culturally appropriate services, and Indigenous model of health. These important features contribute to the design of the Hub.

		as a partnership between Nindilingarri Cultural Health Services, Marninwarntikura Women's Resource Centre, The George Institute for Global Health and Sydney University. (Robinson, Genat, & Smith, 2013). (Robinson, Genat, & Smith, 2013; www. mwrc.com.au).			
Safe as Houses Commenced 2017 as pilot program, funded through grants through Lotterywest and the Criminal Property Confiscation Grants program.	• Lead agency: Tenancy WA. • Partnership between three WA community legal centres: o Tenancy WA (lead agency) – provides advice on tenancy disputes. o Women's Law Centre – focuses on family law issues. o Street Law Centre WA – provides free legal information, advice and casework to those at risk of homelessness. • Advice and representation provide around	• Focus: FDV, health, legal, homelessness. • Funded by WA Department of Commerce and the Commonwealth Attorney General's Department as a part of the Community Legal Service program in the National Partnership Agreement on Legal Assistance Services. • Aims to prevent homelessness for women and children affected family and domestic violence. • Case managements approach: aims to provide integrated and holistic legal and practical support services to support complex needs. (www.tenancywa.org.au).	No formal evaluation carried out. • Won award in Attorney General's Community Service Law Awards this year for providing specialist legal advice, representation and education to a group who are at greater risk of homelessness than other in the community. (www.tenancywa.org.au).	No formal evaluation carried out. • Funding not secured – funding ends in September 2018. (www.tenancywa.org.au).	• The case management approach contributes to the design of the WA Hub. It is also important to consider that this model provides legal services as the Hub proposes to include legal services as a partner agency. Additionally, it has been considered whether there is opportunity to build on the already established service prior to its funding ending in September 2018.

	issues including identity documents, fine and infringements, early release, superannuation and Magistrates court criminal matters (www.safeashouses.tenancywa.org.au). • Supported by partnerships with UnitingCare West, the Women's Council for Family and Domestic Violence Services, King Edward Memorial Hospital and relevant government departments (www.tenancywa.org.au).				

Key Integrated Responses in other contexts, Western Australia

Model	Agencies involved	Key features	Benefits	Challenges	Contribution to WA Hub service model

Family Support Networks (FSN)
 	
3 x metropolitan sites
1 x regional site
 	
Pilot site commenced 2012 in Armadale. Additional metropolitan sites commenced 2014 and 2016, regional site commenced 2016. Still operating.
	• Lead agency: Department of Communities.
	• Parkerville Children and Youth Care (lead agency for FSNs in the Armadale and Midwest area).
	• MercyCare (lead agency for Mirrabooka area).
	
	Lead agencies operate in partnership with agencies who are providers of secondary family support services.
	
	Partner agencies involved in Armadale pilot:
	• Armadale Youth Resources.
	• Centrecare.
	• Communicare.
	• Coolabaroo.
	• Department for Child Protection and Family Support, Armadale District.
	• Drug ARM WA.
	• Minnawarra House.
		Focus: Child Protection.
		Components of FSN model:
		• Partnership between lead agency, CPFS & secondary family support services.
		• Provides a common entry point to services.
		• Senior child protection worker is collocated at common entry point to provide expertise when there are safety and wellbeing concerns for a child.
		• "No wrong door" philosophy and common assessment framework utilised.
		• Collaboration – allocation meetings between key agency representatives
		• Self-directed service design – assessment process incorporates family input around their needs, goals and services they wish to access.
		• Active holding strategy will be implemented if services are not available, rather than families being waitlisted.
		• Information sharing policies and protocols have been implemented. Joint allocation, case planning, case review, and cross agency IT system underpin
			• Referral patterns indicate that accessibility and profile of FSN within the community has increased, has also led to family self-referral and clients returning.
			• Self-directed partnership approach FSN takes with families.
			• Delivery of family support services to families with complex needs in a coordinated way: families do not have to repeat their stories, assessments were not duplicated, and record searches were not repeated.
			• Common assessment framework and joint allocation and review meetings contributed to more efficient and coordinated responses.
			• FSN was able to keep track of families circumstances as well as their contact with partner and non-partner agencies to prevent families from "falling through the cracks" (KPMG, 2014, p. 9).
			• Flexible and integrated approach with partner and non-partner agencies enables families to be supported in a way that meets their needs and alleviates statutory child protection intervention.
				• While there are promising indicators showing FSNs and partner agencies are impacting positively, changes will only be evident over the medium and long term rather than the short term: minimum of three years needed.
				• Additional costs for lead and partner agencies experienced, separate to funding provided by CPFS, including indirect costs resulting from additional time spent on administration, setting up processes and systems and attending meetings.
				• Common entry point has emphasised need for flexibility as the resource levels have increased in response to increasing demand.
				• Lack of comprehensive implementation planning for the Armadale FSN as a result of short timelines impacted on the overall effectiveness of the model.
				• Specific impacts included:
				  o Engagement of partners into the FSN;
				  o Partner agencies not understanding the
					• FSN contributes to the WA Hub through its achievements and strengths, for example, implementation planning was critical to its success, and its use of capacity building funds allows FSN to free up capacity in existing partner agency services that have waiting lists and to provide new services to address gaps in service delivery. FSN also demonstrates the importance of the lead agency as it directs practice, processes and collaborative partnerships. The proposed hub has similar components to this model.

	• Mission Australia. • Relationships Australia. • Ruah Community Services. • Starick Services. • Wanslea Family Services. (KPMG, 2013; 2014).	effective information sharing. • Governance framework provides strategic and operational level steering committees and information sharing opportunities. (KPMG, 2014).	• Investing time in ground up approach to relationship development, information sharing, and working towards coordination prior to establishing FSN can lead to efficiencies later in time. • There is value in choosing a lead agency which already has existing relationships and partnerships with family support agencies and local providers. • The model components of the FSN are identified as a good foundation for addressing the "scattered, cross agency work" which characterises Western Australia's approach to vulnerable family's needs (KPMG, 2014, p. 10). • Learning from already established FSN is beneficial in establishing new FSNs. • Better identification of gaps and needs in secondary family support provision. • Using capacity building funds to respond to gaps and needs is successful. Accessing capacity building funds is more targeted and efficient than other mechanisms available – is quicker to access than normal CPFS procurement processes. • Promising evidence that demonstrates FSNs and partner agencies are positively influencing and delivering improvements to families.	FSN concept as were not involved in development; o Operations of the FSN beginning whilst implementation still underway; o Finalisation of protocols and agreements, such as information management, capacity management, and working relationships with CPFS. • Outcome information should be developed and captured from the beginning of operations and processes in place for case closure reviews to ensure that required outcome data is captured for the majority of clients/cases. • Lack of clarity around the role of the Leader Child Protection and of partnership between CPFS and FSN. (KPMG, 2013, 2014).	

			• Reduction in inappropriate referrals to FSNs and CPFS. • Progress made in maintaining effective and efficient response to demand. • Works with clients from diverse backgrounds: attributed with connections with partner agencies. • The economic analysis demonstrates that benefits resulting from participation in the FSN are likely to significantly outweigh the costs associated with the program. (KPMG, 2013, 2014).		
George Jones Child Advocacy Centre 1 x metropolitan site (Additional metropolitan site currently in development, to be located in Midland) Commenced 2011, still operating.	• Lead agency: Parkerville Children and Youth Care. • Local agencies. • Government partners. Staff includes: • Child and Family Advocates (CFA). • Psychologists. • A paediatrician. • Administrative support staff. • Police and child protection interviewers. (Parkerville Children and Youth Care Inc., 2013).	*Focus: Child Sexual Abuse.* • Developed in the US in the 1980s. • Located at multiple sites across the US, Europe and now one site in Australia (Armadale). • Aims to address the issues often associated with responses to child sexual abuse including, "the traumatic nature of many investigations, low conviction and prosecution rates, and the lack of psychological and other support services alongside the investigation" (Herbert & Bromfield, 2016, p. 341). • Key services delivered include: medical examinations, psychological	A formal evaluation of the George Jones Child Advocacy Centre was undertaken by the University of South Australia in 2018; report not yet available. • Klenig (2012, as cited in Herbert & Bromfield, 2016) reported that service users valued the services they were provided with by the George Jones Child Advocacy Centre. • Evaluations of Child Advocacy Centres more broadly have identified the following benefits: o "CACs showed significantly more evidence of coordinated investigations; o More children involved with a CAC received a forensic medical examination;	A formal evaluation of the George Jones Child Advocacy Centre was undertaken by the University of South Australia 2018; report not yet available. • Little evidence is available around the efficacy of CACs in terms of child and family outcomes. (Herbert & Bromfield, 2016).	• This service prompts the WA Hub to incorporate evaluation methods into the model from the outset.

		support, and advocacy services at a stand-alone child friendly facility, which also serves as the central point for a multidisciplinary and multiagency team who collaborate on the investigation. • Model components: multi-disciplinary teams (MDT), evidence-informed forensic interviewing practices and victim advocacy. • Accreditation is based on ten standards: MDTs, forensic interviews, victim support and advocacy, child focused setting, mental health services, medical examinations, case review, case tracking, cultural competency and diversity, and organisational capacity. • Intends to provide an easily accessible service in the community which promotes the importance of child safety and wellbeing. Runs community activities and programs as well as supports professionals. • Police and child protection interviewers undertake forensic interviews of children at the GJCAC work alongside a Child and Family Advocate. • A CFA is also co-located with Police and Department of	o 60% of CAC cases included a referral for mental health services versus only 22% of comparison community cases; o Parents and caregivers in the CAC sample were more satisfied with the investigation than in the comparison sample; o CACs are effective at increasing multi-agency involvement in child abuse cases; o With strong involvement from law enforcement and district attorneys CACs showed an impact on criminal justice outcomes" (Finkelhor D, Cross T, Jones L, Walsh W, & Simone M, 2006, pp. 1-2).		

		Child Protection interviewers at their central city building. (Herbert & Bromfield, 2017; Parkerville Children and Youth Care Inc., 2013; [http://parkerville.org.au/george-jones-child-advocacy-centre)](http://parkerville.org.au/george-jones-child-advocacy-centre).			
Multiagency Investigation and Support Team (MIST) 1 x metropolitan site in Armadale (additional metropolitan site currently in develop-ment). Commenced 2015 as pilot project, still operating.	• WA Police (Child Abuse Squad). • Department for Child Protection & Family Support, Child First Armadale and Cannington Districts. • WA Department of Health (Princess Margaret Hospital). • Department of Attorney General (Child Witness Service). • Parkerville Children and Youth Care Inc. (Herbert & Bromfield, 2017)	*Focus: Child Abuse (primarily sexual abuse and severe physical abuse).* • Intent is to "set up framework to support collaboration and communication between workers that respond to abuse cases and to embed the resources to support abused children and families in the response" (Herbert & Bromfield, 2017, p. 19). • Planned to provide a holistic response to child abuse by cross agency, cross disciplinary team who are responsible for carrying out criminal and child protection investigations whilst also facilitating health services for the child and therapeutic treatment and support for the child and family. • Co-location of a Child Abuse Squad team, police and child protection specialist child interviewers, child protection worker (that works across two districts), Child and	• "The model is theoretically sound, and aligns with international evidence for best practice; it compares favourably to responses operating within the Australian context" (Herbert & Bromfield, 2017, p. 11). • Appears to have significantly improved the responsiveness of police and child protection to cases. • Volume of cases being processes by MIST team is equivalent if not more than practice as usual. • Practitioners believe the response to be more victim centred: is localised response and actively incorporates therapeutic engagement through advocates. • Caregivers expressed high level of satisfaction with MIST response. • Staff also appeared positive about pilot and work within it. • Improved collaboration between professionals: in particular, CPFS worker on-site has contributed with this.	• No significant differences to "practice as usual" in regards to outcomes found in evaluation. • Unable to determine how effective the implementation of the MIST pilot has been in improving the referral to support services to abused children and their (non-abusive) caregivers although the degree of service delivery and uptake was high. • Appears to have had a negligible effect on attrition from the investigation of abuse. However, this did not account for the fact that MIST seemed to be responding to cases that may not have received an investigation in practice as usual. • Does not appear to be translating into greater arrests/cautions. • Investigation of additional cases may be contributing unnecessarily to workload of	• MIST also prompts the WA Hub to incorporate evaluation methods into model from the outset. It also encourages consideration into how the Hub will manage potential broader capacity challenges in service system?

		Family Advocates, and therapeutic support services. • Children in MIST pilot also receive support from the George Jones Child Advocacy Centre. • WAPOL and CPFS MIST team are responsible for early processing and assessment of cases. They often receive cases that may have been screened out prior to allocation to a detective in practice as usual model due to the lack of disclosure of other evidence to investigate. (Herbert & Bromfield, 2017).	• Consistent support for families and children as well as support being provided to children and families that may not otherwise have received support were identified. • Referral to support services alongside investigation process, improved convenience for families, minimising child and family distress and opportunity to divert families from CPFS involvement were other identified positives. • Indicated there was a benefit to centralised oversight of allocation as it facilitated workload redistribution when a squad was at capacity which will be important for maintaining timely investigations. (Herbert & Bromfield, 2017)	interviewers and Child Abuse Squad detectives. • Gaps in cross agency collaboration remained; within CPFS districts, Chid Protection Unit and Child Witness Service. • Need for cross agency data system that allows case tracking/monitoring by all agencies and monitoring of clearly identified and measured outcomes. • Need for clearer cross agency protocols and procedures and effective governance of these. • Issues identified in process of consultation and development of MIST response and ongoing case management • Concerns related to potentially overlapping role of advocates with regards to work of CPFS districts and child witness service. • Broader capacity challenges in service system; greater emphasis on networking across services and managing limited resources may be warranted. • Difficulties with collaboration including: Complexity of working across agencies, Interview process, Isolation, Problems with Information Sharing,	

				Continuity among police, Concern about referrals being too Parkerville centric, Relationship between Parkerville and clients. • Capacity and resource issues: IT issues and limited ability to do home visits. • Issues with pilot: interagency politics with the establishment of the pilot and uncertainty associated including lack of clarity around the purpose of the pilot. Agencies were resentful that this was an imposed structure. • Setting up in-house medical response: recruiting skilled staff and then enough cases to retain expertise. • Differences between CPFS districts. • Lack of awareness of MIST across broader agencies. (Herbert & Bromfield, 2017).	
Child and Parent Centres Built on school sites in communities with high numbers of vulnerable children.	• Lead agency: Department Health. Operate in partnership with government and non-government organisations: • Department for Child Protection and Family Support.	*Focus: Early childhood development* • Provides support to families with young children (pre-birth to eight years). • Facilities and services are provided on public primary school sites. • Seeks to support development, health and learning outcomes of young children at risk.	• Rollout of Centres was phased and was overall successful with progressing service delivery without waiting for the Centres to be completed. • Majority of the Centres were well located. • A strong accountability framework is provided through the LAC and Data Collection Framework.	• Location of Centres to other existing services caused confusion in the community (e.g. one Centre was close to an existing Family and Children's Centre which caused as each had different focus, one was early childhood, another adolescence). • Unavailability of land to accommodate Centre	• A number of key features, benefits and limitations of the Child and Parent Centres contribute to the WA Hub, including: its location and proximity with other services; a crèche; quality of staff; employing staff from diverse cultural backgrounds and knowledge of disabilities to improve accessibility,

There are 21 centres across metropolitan and regional areas of WA. Commenced 2013, still operating.	• Department of Local Government and Communities. • Department of Education. • Funded by the State Government through the Department of Education as one of the lead agencies. • Non-government community services. (Shelby Consulting Pty Ltd, 2017)	• Aims to give families easy access to advice, programs and services, as well as give schools the opportunity to work with families from birth to starting school and beyond. • Department of Health, Department for Child Protection and Family Support, and Department of Local Government and Communities have committed to work with the Department of Education on the Initiative. • Non-government agencies in the community services are contracted to operate, manage, and report on the centres. • Services and supports include: o Maternal and child health services. o Speech therapy support. o Paediatric services and paediatric referrals. o Family psychological services. o Counselling services. o Antenatal classes. o Early learning programs. o Early literacy/ numeracy programs. o Cultural programs.	• Relationship between host school and Centre is key to implementation. • The Centres are largely meeting their outcomes, performance indicators and deliverables. • Customer feedback ratings were very high. Specifically, staff and the centre itself were seen as welcoming, family friendly, supportive and inclusive which are key elements in providing an accessible service. • Programs and services are adapted to meet the needs of families and professionals are working together to deliver services to families. • Employment of staff from diverse cultural backgrounds, and knowledgeable of disabilities to help with accessibility. • Centres are bringing services to local communities where they are more easily accessed by those needing them. • There is some variation in the level of success of individual Centres, but on the whole, the initiative is on track to meet State Government objectives and outcomes. • Feedback from families indicated that having a range of services, activities and workshops available in the one place was appreciated.	impacted on where Centre was placed. • Some Centres have had to create wait lists for families to access services. Most common services in over demand include child health nurse, allied health services, and playgroups. Some Centres have developed systems that provide families with access to some services while having to wait for others. • Reaching the most disadvantaged, vulnerable and at risk families identified as main challenge: many Centres found it difficult to engage with Aboriginal families and in some areas new migrants (including refugees). Takes time to build trust. Some sites run Aboriginal children program which may assist with engaging Aboriginal families. • Attracting secure, long term funding to meet community need. • There were some constraints imposed by different departments having to adhere to different protocols which can impact on coordination and integration of services. • Difficult to ascertain the effectiveness and extent that	dependant on community hub services; cross discipline professional development; commitment to partnering and collaboration between professionals; the time needed to assess effectiveness or impact on outcomes; the impact of attracting secure, long term funding.

		◦ Child support activities. ◦ Playgroups, including Best Start Aboriginal playgroups run by the Department of Local Government and Communities. ◦ School holiday programs. ◦ Other child support programs, for example, Rhyme Time, Aboriginal Story Time. ◦ Parenting and family support. ◦ Parent literacy support. ◦ Parent workshops and groups, (e.g. Positive Parenting Program (Triple P), protective behaviour workshops, new parent and baby groups, young parent workshops and managing behaviour workshops). ◦ Transition schooling activities. ◦ Multicultural programs and services. ◦ Referrals to other services. (Shelby Consulting Pty Ltd., 2017; https://childandparentcentres.wa.edu.au/).	• The free crèche has supported care-givers to attend the workshops and information sessions. • Workshops, information sessions and playgroups have contributed to people feeling a sense of belonging in the community. • Service providers indicated the Centres were ideal for delivering programs due to its location, quality of the facilities, free crèche, and welcoming, friendly atmosphere. Availability of Child and Parent Centre staff to co-facilitate and follow up with families was also seen as beneficial. • Location at school makes access easier; proximity, feels safer and not as intimidating as hospital, clinic or government office. • Timing/scheduling of services to fit in with school aged children, sleeping patterns of children as well as other services programs to maximise families' participation. • Working closer with CPFS to engage higher risk families. • Networking and cross discipline professional development is assisting agency staff to understand issues outside their own profession that they might otherwise be unaware of. • Strong collaboration between professionals has resulted in	collaboration through shared professional development is occurring. • Too early to determine whether there are improvements in school attendance, development and learning outcomes. • Availability of staff can impact on service provision, e.g. child health nurses only available for one day per week. • In areas where model is working less well, this is attributed with staff not being given same flexibility, are not able to work cooperatively, or are not suited to working in a community setting. • Gaps in community services identified. • Unintended consequences on existing services, either providing competition to make them become unviable or causing other services to be cut. (Shelby Consulting Pty Ltd, 2017).	

			programs and services that meet needs of families more effectively. • Sharing information important to continuity of care and leads to little or no duplication/more joined up services. (Shelby Consulting Pty Ltd, 2017).		
National Partnership Agreement on Homelessness (NPAH)	• Lead agency: Department of Communities (Child Protection and Family Support). • Joint Commonwealth/ State initiative. • Multiple non-government service providers involved, including: 55 Central Inc.; Accord West, Albany Halfway House Association Inc.; Anglicare WA Inc.; Anglicare WA Inc. in partnership with Palmerston Association Inc.; Australian Red Cross Avon Youth Community and Family Services Inc.; Bega Garnbirringu	*Focus: Homelessness.* • Engagement and integration with mainstream services is an integral element of all the programs. • Mainstream agencies including Child Protection, Centrelink, Housing, Mental Health, Drug and Alcohol and Corrective Services have been closely involved in the development of the initiatives. • Extensive consultation has been undertaken with the non-government agencies which deliver the services. These agencies have also been closely involved in the development and implementation of the programs. • Principles that underpin NPAH: o "Early intervention and prevention to stop people becoming homeless and to lessen	Evaluation of 14 NPAH programs carried out between January 2011 and December 2012. Key findings include: • The availability of affordable accommodation together with appropriate support to address the issues contributing to homelessness can achieve positive results and long term accommodation for even the most vulnerable clients. • Assisting clients to access or maintain accommodation, providing intensive short term support to stabilise their living situation, and linking clients to mainstream services for ongoing support was shown to be successful. • The development and implementation of the NPAH programs has afforded opportunities to progress the reform of the homelessness sector in Western Australia. • The NPAH has been an important catalyst for improving	• Accommodation shortages impact on the effectiveness of the NPAH. • Services face additional challenges in regional areas, particularly in the more remote regions of the State. • Fewer specialist services and those that are there are usually present in regional centre. • Emergency and transitional accommodation is lacking. • Lack of affordable accommodation for staff and clients in the North West. • No suitable private rental accommodation for those on low incomes and public housing is limited. • Some NPAH services have had trouble recruiting and retaining staff which caused one service to cease operations. • Those that are housing ready but unable to be accommodated can cause distress to clients and staff.	• NPAH involved agencies in the implementation of the program which is recommended for the WA Hub. NPAH gives example of the importance of committed workers and also brokerage funding which is necessary to provide flexible support. This formalised model has been the catalyst for improved integrated working.

	Health Services Inc.; Carnarvon Family Support Service Inc.; Centacare Kimberley Association Inc.; Centrecare Inc.; City of Stirling; Chrysalis Support Services Inc.; Esperance Crisis Accommodation Service; Foundation Housing Limited; Fremantle Multicultural Centre; Geraldton Resource Centre Inc.; Goldfields Women's Refuge Assoc. Inc.; Hills Community Support Group Inc.; Kimberley Community Legal Services Inc.; Lamp Inc.; Lucy Saw Centre Association Inc.; Marnin Bowa Dumbara Aboriginal Corporation; Mercy Community Services Inc.; Mission Australia,	the impact of homelessness. o Breaking the cycle of homelessness by boosting specialist models of supported accommodation to keep people housed in long term stable housing; and o Improving and expanding the service system to ensure people experiencing homelessness receive timely responses from mainstream services" (Department for Child Protection, n.d, p. 1). • The Housing Authority is a key delivery partner responsible for allocating or acquiring dwellings for seven of the programs, including: A Place to Call Home, Street to Home, Housing Support Worker- Mental Health, Housing Support Worker – Drug and Alcohol, Housing Support Worker – Corrections – Adult and Juvenile, Homelessness Accommodation Support Workers, and People with Exceptionally Complex Needs. • The Housing Authority will also manage government	integration with mainstream services. • NPAH services have provided clients with intensive case management, including linking clients and their children with mainstream services such as education, training, employment, mental health and drug and alcohol services. • The implementation of the NPAH has resulted in more effective working relationships between specialist homelessness services and mainstream agencies (e.g. Department of Housing and WA Police). • Strengthened and streamlined processes for specialist homelessness services to work in a more collaborative manner to support mutual clients. • The programs have saved some lives where living conditions would have led to premature death or despair driven the client to suicide. • Assisted clients to restore their dignity, self-respect and confidence. Clients have been able to get on with their lives, children have been supported to continue their normal activities and parents and children separated by homelessness, mental illness or drug and alcohol abuse have been re-united. • Worker support (quality and commitment) identified as being	• Lack of affordable alternative accommodation or women escaping family violence can mean they have to relocate away from support networks or stay with the violent perpetrator. • Separation from a violent perpetrator can also mean loss of house if housing is subsidised or owned by Government employees or mining companies. (Cant et al., 2013)	

	Multicultural Services Centre of Western Australia Inc.; Nindilingarri Cultural Health Services Inc.; Parkerville Children and Youth Care Inc.; Patricia Giles Centre Inc.; Pat Thomas Memorial Community House Inc.; Pilbara Community Legal Service; Ruah Community Services; Share and Care Community Services Inc.; St Bartholomew's House Inc.; St Patrick's Community Support Centre; St Patrick's Community Support Centre - The Sister's Place; South West Refuge Inc.; Swan Emergency Accommodation Inc. The Salvation Army; UnitingCare West; WestAus Crisis	funding of the major capital works. (Department of Communities (Housing), 2018).	the most helpful aspect of the program. • Lottery west grants were instrumental in providing practical, intensive support. • Brokerage funding, which could be used flexibly to address varying client needs was an important factor. • Placing NPAH services within a host agency seen as beneficial: able to access array of programs and services, clients avoided long waitlists, client information readily available so client did not have to repeat their story, wrap-around service provided, workers felt less isolated, received ongoing supervision and access to professional development. • Provision of housing provided a platform for the delivery of a wide array of social and human services which contributed to improving quality of life and outcomes for clients and their families. Also enabled provision of support to clients while in the interim waiting period before accessing other services (Cant et al., 2013)		

	and Welfare Services Inc.; Women's Health Care Association Inc.; Women's Council for Family and Domestic Violence Service Inc.; Youth Futures WA Inc. (Department for Child Protection, n.d).				
headspace (national program) Established in 2006, there were approximately 80 headspace centres across Australia in 2015 with the Federal Government announcing additional funding to expand the centre total to 100 by the end of 2016 (Hilferty et	• heapspace draws on the expertise of a lead agency and a number of local partner organisations, each with expertise in different areas (such as primary health care, mental health care and vocational training) (Hilferty et al., 2015, p. 9).	*Focus: Mental health, Young People* • headspace aims to improve the mental health and social and emotional wellbeing of young people in Australia through the provision of evidence-based, integrated, youth-centred and holistic services" (Hilferty et al., 2015, p. 1). • headspace centres are "a network of enhanced primary care services where young people (12-25 years) with mild to moderate mental health problems are able to access a broad range of in-house services or be connected to complementary services within the community" (Hilferty et al., 2015, p. 9). • headspace centres provide integrated care across four	• Program is being accessed by diverse range of young people with high level of psychological distress. • Has been successful in attracting young people from marginalised and at risk groups; significantly higher proportions of Indigenous youths and those living in regional areas. • Clients, staff and parents indicated headspace to be accessible and engaging; youth friendly environment, innovative engagement strategies, friendly, relatable and non-judgemental staff, free or low cost service, wide ranging services provided and practical services (e.g. transportation) commonly mentioned as factors that encouraged young people to stay engaged with service.	• CALD young people under represented in service. • Many parents had not heard of headspace prior to young person attending. • Family-based treatment identified as being the main service gap (p. 5). • Increased provision of outreach services was the second most clearly identified strategy for enhancing headspace service (p.5). • Workforce issues present a challenge for many centres and impact on the provision of seamless service provision. Almost half of centre managers surveyed (n=14/29) reported they were operating with a staffing vacancy. • Service gaps for a range of positions were common,	• Accessibility key to model • Has become well known and well renowned in the community: positive marketing and experiences. • Supported by on-line platform.

al., 2015, p. 9).		key areas: mental health, physical health, drug and alcohol use, and social and vocational participation. The holistic care of young people is facilitated by the centre model that draws on the expertise of a lead agency and a number of local partner organisations, each with expertise in different areas (such as primary health care, mental health care and vocational training) (Hilferty et al., 2015, p. 9).	• Indication that headspace plays protective role for young people experiencing severe mental health distress. • Service model ensures that young people with a range of problems can access different practitioner types in the one location. • There is variability in the connections centres have with local services, with some working effectively with local providers and tensions being evident in others • eheadspace was used by about 30% of clients that had accessed headspace services. eheadspace viewed by staff as an effective additional component of headspace that can provide young people with information about headspace including what to expect at centres. Can also assist in "holding young people steady" (Hilferty et al., 2015, p. 5)while they wait to access services (however, this was not evaluated). • Has been relatively effective in building brand awareness and promoting mental health and help seeking among young people (Hilferty et al., 2015, p. 5).	but additional GP and psychiatrist hours were identified as the most common (p. 75). • Other service gaps identified included sexual health counselling, provision of drug and alcohol services, outreach mental health services, and free legal advice for young people (p. 75). • headspace is yet to develop a long-term, sustainable funding approach (p. 76) (Hilferty et al., 2015).	

Key FDV Integrated Responses, Australia

Model	Agencies involved	Key features	Benefits	Challenges	Contribution to WA Hub service model
Australian Capital Territory					
Family Violence Intervention Program (FVIP) State wide response. Commenced 1998, still operating - has grown in phases. *Note: ACT Government are currently working with the community services sector to design a Family Safety Hub in response to inquiries which have emphasised the critical importance of services working together to provide an effective response to family violence (www.communityservices.act.gov.au).*	• Australian Federal Police (ACT policing). • Office of the Director of Public Prosecutions. • ACT Magistrates Court. • ACT Corrective Services. • Department of Justice and Community Safety. • Office of the Victims of Crime Coordinator. • Domestic Violence Crisis Service. • Canberra Rape Crisis Service. • Legal Aid. • Office for Children, Youth and Family Support. (Australian Law Reform Commission (ALRC), 2010)	*Focus: criminal justice system in the context of family violence.* • Based on Duluth model. • Steered by a coordinating committee chaired by the Victims of Crime Coordinator (acting as the Domestic Violence Project Coordinator). • The committee acts as the forum for discussion about strategic planning and coordination as well as policy and procedural frameworks. • Core components include: o Pro-arrest, pro-charge policies with a presumption against bail. o Early provision of victim support (by DVCS). o Pro-prosecution policies. o Coordination and case management. o Program from offenders as a sentencing option. • Objectives of FVIP: o Work cooperatively together.	• Commitment of government, agencies and staff were identified as a positive feature of FVIP. • Stakeholders support purpose of FVIP and understand each of their roles within. • Effective in establishing relationships between agencies and working collaboratively. • Responses to FDV by the criminal justice system have improved resulting in better agency responses. Key improvements were in the areas of: o Evidence collection. o Case meetings. o Collaboration. o Victim support. • Information sharing. • Focus on victims. (Cussen & Lyneham, 2012).	The review suggested further development or improvements in the following areas: • A more structured governance arrangement to ensure continued effectiveness and growth. • Developing information sharing protocols between agencies and legislation to allow this. • Training to be the same across agencies. • Agencies to be sufficiently resourced. • Equip agencies to collect and analyse data which will assist with providing appropriate responses. • Create a case manager model to ensure coordination of information occurs. • It is seen as becoming stagnate. (Cussen & Lyneham, 2012).	• FVIP highlights the need to develop legislation and protocols around information, which has been a consideration in the design of the WA Hub model. It also emphasises the importance of support from stakeholders, clear definition of roles and a structured governance, all contributing to the design of the WA hub.

		o Maximise safety and protection for victims of family violence. o Provide opportunities for offender accountability and rehabilitation. o Work towards continual improvement of FVIP. (ALRC, 2010; Cussen & Lyneham, 2012).			
Tasmania					
Safe At Home State-wide response. Commencement unknown.	• Departments of Justice. • Police and Public Safety. • Health and Human Services. • Premier and Cabinet, Police.	• Whole of government, criminal justice response. • 24/7 Family Violence Response and Referral Line – refers either to police, counselling or support service. • Specialist Victim Safety Response Teams (VSRT). • Specialist police prosecutors. • Weekly Integrated Case Coordination (ICC) meetings. • Pro-arrest, pro-prosecution. • Part of Safe Families Tasmania, taking on a case management role. (ALRC, 2010; Breckenridge et al., 2016).	• Effective, short term response. • Coordinated support services and information sharing has decreased the need for victims to re-tell their stories. • ICC model increases ability of the system to address immediate risk and safety issues. • Responsible for an attitudinal shift in the community – FDV now recognised as a crime. • Pro-arrest, pro-prosecution policy seen as ensuring perpetrator accountability. (ALRC, 2010; Breckenridge et al., 2016).	• Cuts made to the number of VSRTs and staffing levels – integral to the Safe at Home response system.	• Safe at Home's outcome - decreasing the need for victims to retell their stories – is also the desired outcome for the proposed hub. This model gives example of how to achieve the outcome – through regular ICC meetings, coordinated services and information sharing.
Safe Families Tasmania	• Department of Police and	• Aims to hold perpetrators to account and coordinate	• No formal evaluation has been made available.	• No formal evaluation has been made available.	• This model gives example of co-locating workers from various agencies which the WA

	Emergency Management. • Department of Justice. • Department of Health and Human Services. • Department of Education. • (Department of Premier and Cabinet, 2015)	support services for victims. • Co-location of officers from multiple agencies in a single unit providing timely responses to FDV. • Provides Safe Choices in partnership with local NGOs – includes practical planning and support for people in or exiting violent situations, and assistance to high risk groups (e.g. women with disabilities and ATSI or CALD women). (Department of Premier and Cabinet, 2015).			Hub proposes to do with its on-site partners.
South Australia					
Multi-Agency Protection Services (MAPS) State wide response. Commenced prior to February 2015.	• Police. • Department of Education and Childhood Development. • Department for Communities and Social Inclusion. • SA Health, Families SA. • Department of Corrections. • Housing SA. • Victim Support Services. (Government of South Australia, 2015).	• Co-location. • Information sharing, including integration of information from multiple sources. • Focus on complex, high-risk cases. • Multi-agency action planning. • Provide support to Local Health Networks through case discussion and training. • Common Risk Assessment tool. (Government of South Australia, 2015).	No formal evaluation has been made available. • Enhanced information sharing and collaboration between agencies – breaking down silos. • Co-location of partner agencies. • Complements the Family Safety Framework. (Government of South Australia, 2015).	No formal evaluation has been made available. • Non-government agencies not currently included (has been recommended that this changes). (Government of South Australia, 2015).	• MAPS gives example of key agencies collaborating and breaking down the silos through information sharing and co-location.

Family Safety Framework (FSF) State wide response Commenced 2007. Implemented state wide 2013.	• Police. • Department for Child Protection. • Housing SA. • Department for Correctional Services. • Health services (including community, women's health, Aboriginal health, midwifery, nursing and hospital staff). • Adult Mental Health Services. • Drug and Alcohol Services SA. • Department for Education and Child Development. • Women's Domestic Violence Services. • Victim Support Service. (Office for Women, 2015).	• Underpinned by an agreement across departments and agencies for a consistent understanding and approach to FDV. • Aims to provide services to families most at risk of violence in a more structured and systematic way. • Information sharing among agencies about high risk families. • Regular Family Safety. Meetings held in police local service areas. • Accept referrals from service providers. • Provides risk assessment, safety planning and referral services. (Office for Women, 2015).	• Complemented by MAPS. • Information Sharing Protocol led to clarification and common understanding of information sharing processes. • Consistent risk assessment tool. • Enhanced accountability of agencies to respond to FDV. • Provided a more coordinated response with improved understanding of different agency responsibilities. • Raised awareness among agencies of FDV. (Breckenridge et al., 2016).	• While the program monitored perpetrators, it did not improve responses to them and did not meet its aim of increasing perpetrator accountability. (Breckenridge et al., 2016).	• FSF demonstrates the benefit for information sharing protocols – results in common understanding of the process. The WA Hub model proposes to have clear information sharing procedures that are understood by all agencies involved.

Victoria					
Northern Crisis and Advocacy Response Service (CARS)	• Police. • Women's Domestic Violence Crisis Service. • Northern Integrated Family Violence Service System.	• Provides 24-hours face-to-face crisis response. • CARS Unit – a safe, comfortable space in a residential setting within which women can explore their options, supported by a CARS worker, whilst children have 'time out' from the precipitating situation. • Developed by a network of service providers in the region to enhance the integration of the family violence service system and to provide better counselling, information, support and advocacy services. • Model delivered through a shared service agreement, with three week rosters, a protocol with the Women's Domestic Violence Crisis Line as the central referral point, and agreements with police (and to a lesser extent major local hospitals) for referrals. (Breckenridge et al., 2016).	The evaluation report conducted by Frere, Ross, Healey, Humphreys, and Diemer (2008) identified a number of strengths, including: • Better communication and integration of services. • Improved response to and contact with police. • Sharing resources with partner agencies. • Provides immediate response. • Greater adaptability in responses to women. • Providing victims with a safe place to make decisions. • Better follow through. • Enhanced services for clients from CaLD backgrounds.	The following areas were identified as needing further development: • Funding to sustain the operation of CARS. • Increase in resources – infrastructural/material, and human. • Better access to brokerage funds. • Enhance method of data collection. (Frere et al., 2008).	• Many of the strengths of CARS are in line with the aims of the Hub, such as their ability to adapt their response to the needs of the women, providing a safe place for victims, and contribute to the design of the WA Hub. The limitations are also being considered in the design of the Hub.

Queensland					
Domestic Violence Integrated Service Responses 1 x metro site. 1 x regional site. 1 x remote site (Indigenous community). Staged roll-out commenced 2017.	• Department of Child Safety. • Youth and Women. • (The State of Queensland, 2017).	• Ensuring consistent and quality support is provided to those at impacted by FDV and at high risk of serious harm. • Whole-of-family service response. • Coordination across government, non-government services and other community organisations. • Co-designed to suit local context/services. • High risk teams consisting of police, health, corrections, housing, FDV and other services. • Aims to keep victims safe, hold perpetrators accountable through provision of integrated and culturally appropriate safety responses. • (The State of Queensland, 2017).	Being evaluated by Queensland Centre for Domestic and Family Violence Research (first stage completed 30 June 2017 – no evaluation data or report available yet) (The State of Queensland, 2017).	Being evaluated by Queensland Centre for Domestic and Family Violence Research (first stage completed 30 June 2017 – no evaluation data or report available yet) (The State of Queensland, 2017).	• This service response contributes to the WA Hub model by giving example of involving both government and non-government agencies in a hub model.
Gold Coast Domestic Violence Integrated Response (GCDVIR)	The coordinating committee consists of: • Domestic Violence Prevention Centre Gold Coast Inc. • Department of Communities.	• Community-based, multi-agency response to FDV. • Partnership under which agencies work together to provide co-ordinated, appropriate and consistent responses to women and children affected by FDV and men who perpetrate FDV.	Strengths of GCDVIR include: • The distinctive role of the Women's Advocate which works with victims, their partners or ex-partners and the Probation offers to collect relevant information that contributes to the safety plan. • Implementing the family violence duty lawyer service.	The following points have been recommended: • Information sharing protocols need to be formalised. • Implementation of a common risk framework and risk assessment tool. • Services competing priorities need to be improved (e.g., child protection and FDV).	• The role of the Women's Advocate contributes to the design of the WA Hub as it aims to include a worker who gathers information on the perpetrator that will contribute to the safety plan and service response. The recommendations have also been considered in the design of the WA Hub.

	• Department of Child Safety.
	• Police.
	• Correction Services.
	• Macleod Women's Refuge.
	• Majella House Women's Refuge.
	• Legal Aid.
	• Department of Housing and Public Works.
	• Southport and Robina Hospitals.
	• Centecare - Men and Family Relationship Centre.
	• Beenleigh Domestic Violence Court Advocacy Program.
	(Domestic Violence Prevention Centre Gold Coast Inc. (DVPC), 2018).
		• Operates under a justice reform model.
		• Programs include:
		  o Police Fax Back Project.
		  o Domestic Violence Court Assistance Program – secure and specially designed at Southport Magistrates court which provides victim support, information and advocacy.
		  o Mandated Men's Program – 24-week court-ordered FDV program for perpetrators.
		• Safety First Project – basic information and comprehensive risk assessment about women leaving refuges is faxed to DVPC for quicker access to services (DVPC, 2018).
			• Collaboration with other services.
			• The strong relationship with Legal Aid Queensland. (Breckenridge et al., 2016).
				• Development of a FDV Response Team. (Breckenridge et al., 2016).	

Dovetail 1 x regional site. Commencement unknown	• ATSI Services. • Centacare. • Centrelink. • Corrective Services. • Defence Community Organisation. • Department of Child Safety. • Department of Communities. • Department of Housing. • Family Law Court. • Family Relationships Centre. • Legal Aid. • Legal Services. • North QLD DV Resource Service. • OzCare. • Police. • Relationships Australia. • Salvation Army. • Sera's Women's Shelter. • The Women's Centre.	• Focus on safety, integrated service delivery, consistent intervention, support and advocacy, law reform, and de-briefing. • Monthly meetings for services involved in the response. • Collaborating to provide consistent, pro-active intervention in FDV. • Monitoring to ensure accountability, compliance and effectiveness. (http://www.nqdvrs.org.au/dovetail.html)	No formal evaluation available (confirmed by Breckenridge et al. (2016) with program management).	No formal evaluation available (confirmed by Breckenridge et al. (2016) with program management).	• Dovetail includes monitoring the FDV programs, services and systems to ensure effectiveness and accountability, which contributes to the design of the WA Hub.

	• Townsville & Thuringowa City Councils. • Townsville Magistrates Court. (http://www.nqdvrs.org.au/dovetail.html)				
Northern Territory					
Alice Springs Integrated Response 1 x regional site. Commenced 2012, still operating.	• Department of Justice. • Department of Children & Families. • Police. • Alice Springs Court. • Department of Health. • Australian Crime Commission-er. • Alice Springs Women's Shelter. • NPY Women's Council. • Tangentyere Council. • Central Australian Aboriginal Congress. • Relationships Australia.	• Family Safety Framework – provides an action based, co-ordinated response to high risk cases. • Regular family safety meetings. • Victim Support and Advocacy Service. • Men's Behaviour Change Program. • Prevention program focused on school-age children and young people. • Community engagement. • Focus on addressing FDV in Indigenous families, due to the larger proportion of Indigenous people in the area. (Putt, Holder, & Shaw, 2017).	• Improvement in responses to FDV, according to practitioners, in terms of the quality of service provision and the way in which services collaborate and communicate. • Improvement in information sharing, which has built trust between agencies and helped engender a willingness to work together. • Improved 'safety net' for those most at risk of experiencing further FDV. • Increased support for women affected by criminal justice cases. • Created focused and purposeful attention to FDV. (Putt, Holder, & Shaw, 2017).	• Difficulties with maintaining momentum • Need for succession planning, for when those few key stakeholders with knowledge and practice experience working in FDV in the community move on. (Putt, Holder, & Shaw, 2017).	• This Integrated Response has been able to build trust between agencies and increase agencies willingness to work together through improved information sharing which contributes to the WA Hub model as it seeks to break down the silos and improve collaborative working.

	• Anglicare. • National Association for Prevention of Child Abuse and Neglect. • Central Australia Women's Legal Service. • Central Australia Aboriginal Legal Service. • Centre Australia Aboriginal Family Legal Unit. • Alice Springs Hospital. (Putt, Holder, & Shaw, 2017).				
New South Wales					
Green Valley Liverpool Domestic Violence Service (GVLDVS) 1 x metropolitan site. Commenced in 2002 as the Green Valley	• NSW Health. • Staying Home Leaving Violence. • South West Sydney Domestic Violence Court Advocacy Service.	• Brief, direct service provision including counselling, support, advocacy, therapeutic and educational programs, information provision, referral and practical support (brokerage). • Community and professional education. • Systemic advocacy.	• Formal service agreements and referral protocols facilitate collaborative practice. (Breckenridge et al., 2016; Laing & Toivonen, 2012).	• Resource issues. • Insecure ongoing funding. (Breckenridge et al., 2016; Laing & Toivonen, 2012).	• GVLDVS contributes to the WA Hub by giving example that formal agreements can facilitate collaborative practice. It also reaffirms a common challenge with many models/services – resource and funding issues.

Domestic Violence Service, extended to include Liverpool area in 2005/2006.	• Green Valley and Liverpool Local Area Commands. (Breckenridge et al., 2016; Laing & Toivonen, 2012).	• Formal service agreements and referral protocols with government and non-government agencies. (Breckenridge et al., 2016; Laing & Toivonen, 2012).			
Domestic Violence and Mental Health (DV&MH) position 1 x metropolitan site. Commenced as pilot project in 2008, unclear whether this position still exists.	• Joan Harrison Support Services for Women. • Collaborate with agencies across both mental health and FDV sectors, including government and non-government organisations. (Breckenridge et al., 2016; Laing & Toivonen, 2012).	• Coordination role between FDV and mental health sectors. • Concerned with the collaboration and facilitation of service-responses cross-sectorally, including training for service providers. • Direct service provision. (Breckenridge et al., 2016; Laing & Toivonen, 2012).	• Services women who would have otherwise "fallen through the gaps" between the mental health and FDV sectors. • Connected with hard to reach clients. • Created connections with the mental health sector which has improved identification and referrals. • Expertise of DV/MH worker highly regarded in both sectors. (Breckenridge et al., 2016; Laing & Toivonen, 2012).	• Position, not a service. • One person – limited capacity.	• The DV & MH position contributes to the WA Hub model as it gives one example of how to increase collaboration between the mental health and FDV sector.
Northern Territory, South Australia, Western Australia					
Cross Borders Justice Scheme 1 x regional/ remote area (across NT, SA &	• Ngaanyatjarra Pitjantjatjara Yankunytjatjar a Women's Council	• Focus is on police/justice system response to FDV. • Part of the NPYWC's DV Service includes: ○ Access to medical and legal services.	• Gives magistrates, police and corrections officers from all three jurisdictions the power to deal with chargers and offenders from all parts of the cross-border region.	• Remoteness of area – travel, difficulties recruiting and retaining staff, limited access to police services.	• Contributions to the WA Hub model include the importance of adequate services and resources, which has been recognised in the design on the WA Hub.

WA, covering 476,000 square kms). Commenced 2009, still operating.	(NPYWC – located in NT). • NT Police. • WA Police. • SA Police. • Justice (courts, magistrates etc.). • Aboriginal Legal Services. • Child protection. • Health and wellbeing services. (ALRC, 2010; NPY Women's Council, 2010; Putt, Shaw, Sarre, & Rowden, 2013).	○ Development of interagency protocols. ○ Holistic approach. ○ Practical assistance. ○ Individual and systemic advocacy. ○ Ongoing case management. ○ 'One stop shop' approach. • Cross-border police posts in NT and WA staffed by police from both states. • Increased number of SA police in area. • Crime prevention, early intervention for and management of offenders. • Cross-border Family Violence Program. (ALRC, 2010; NPY Women's Council, 2010; Putt et al., 2013).	• Prevents perpetrators in the region from evading apprehension by crossing the border. • Cross-border custodial facilities – allows use of Alice Springs Correctional Facility by SA and WA prisoners. • Improved collaboration among court registrars, police prosecutors, and local police. • More streamlined response by justice agencies. (ALRC, 2010; NPY Women's Council, 2010; Putt et al., 2013).	• Inadequate resourcing impacting negatively on justice response. • Inadequate support services for victims, including mental health, AOD and specialised FDV services. • Perception among practitioners that too much work is involved in the scheme. • Minimal involvement of community members and non-government sector. (ALRC, 2010; NPY Women's Council, 2010; Putt et al., 2013).	

Key FDV Integrated Responses, Internationally

Model	Agencies involved	Key features	Benefits	Challenges	Contribution to WA Hub service model
United States					
Domestic Abuse Intervention Project (DAIP) - Duluth, Minnesota Commenced 1980.	• Police. • Courts. • Shelters. • Other women's services in the local area.	• Criminal justice focus. • Provides a coordinated response to domestic violence, working in partnership and ongoing collaboration with criminal justice system including police and courts, counselling centres, shelters, and other women's services in the local area. • The project also tracks the progress of every criminal justice case to ensure good practice and carries out audits of individ-ual agencies to assess their progress. • DAIP functions as a monitoring and coordinating organisation for agencies and practitioners that work directly on cases, rather than directly providing advocacy for women who are victims of domestic violence.	• First formalised model of a community coordinated response to domestic violence. • Increased the arrest and prosecution of perpetrators and increased the safety of 'some' women. • Most states in the US that have a community coordinated response to domestic violence use the DAIP model. (Pennington-Zoellner, 2009).	• Fails to identify and include the formal and informal resources and strengths available to survivors (e.g. extended family, neighbours, friends, social groups, churches, employers). • Failure to acknowledge other systems fails to acknowledge domestic violence as social problem as opposed to individual problem. • Current focus on individual women does not address or eliminate institutional structures in society that support intimate violence against women, particularly barriers to women's economic security. • Survivors of domestic violence are not homogenous; they experience domestic violence in different ways and have varying needs and desires for the outcome of their relationships. Interventions are often directly or indirectly focused on helping women leave – when community systems impose their own expectations (e.g. leaving, mandated arrest) this can be re-victimising and disempowering. Essential to change focus of responses from leaving to empowerment, access to resources and economic security. (Pennington-Zoellner, 2009).	• Foundation of current service response (FDVRTs). • Essential to provide support that genuinely considers women's safety, needs and wants – focus of support to be on access to support, economic security and empowerment rather than leaving relationship. • Eligibility requirements for accessing support must not be service defined (e.g. not linked to attaining FVRO). • Assessment to include formal and informal resources available to the woman victim-survivor. • Monitoring, review, and evaluation informs good practice.

		• Influential in informing integrated service provision globally and continues to be replicated at sites across the US – often cited as exemplar. (Breckenridge, Rees, Valentine, & Murray, 2015; Hague & Bridge, 2008).			
Coordinated Community Responses	• Police. • Legal system. • Social service providers (e.g., victim advocates). • Government. • Health care systems. • Educational and vocational programs. (Shorey, Tirone, & Stuart, 2014).	• Integrated services (in the US) are commonly referred to as 'coordinated community responses' (CCRs). • CCRs are underpinned by legislation, supported mainly by the US Violence Against Women Act. • CCRs aim to provide more comprehensive support pathways and reduce victims' trauma, as well as positively facilitate criminal justice processes such as information sharing and evidence collection between agencies • Protocols between CCRs vary between	• Slaght and Hamilton (2005) found that combining law enforcement with rehabilitation and treatment is important to responding effectively to individuals and families experiencing domestic violence. • A joint philosophy of intervention is crucial to effective coordination. • The two judicial districts investigated were successful in providing a coordinated response to domestic violence. (Slaght & Hamilton, 2005).	• Staff turnover can impact on effectiveness of criminal justice system responses. Training of new staff (e.g. judges, state attorney's, probation staff) is critical to ensuring the understandings of the special needs of perpetrators and victims are maintained and that emphasis on prosecution does not preclude treatment. • Missing players in coordination process need to be more centrally involved (e.g. clergy, medical personnel, child welfare). • In recognition of the co-occurrence of domestic violence, mental illness, and substance abuse, multimodal treatment services are needed, and must be supported by law enforcement. • Routinely assessing the impact of interventions and effectiveness of the coordinated response in reducing recidivism is also required.	• Aim to provide more comprehensive support pathways for victims and perpetrators. • Flexibility in operating protocols underpinned by similar objectives can facilitate responses that can be tailored for local community. • Need to plan for staff turnover; important to have induction and training processes. • Consider relationship between criminal justice and treatment response agencies. • Important to consider multimodal treatment services to address the intersection of domestic violence with mental illness and substance misuse.

		each site, with each developing its own activities. However, all take an "ecological approach" which prioritises victim support, and draws together a wide range of community agencies to meet CCR objectives (Shorey et al., 2014, p. 364). • Although there are no standardised protocols, CCRs share similar objectives, with the central aims of: o Providing victim protection; o Seeking offender accountability; o Coordinating and evaluating existing services; o Developing new services; and o Changing the social climate of tolerance for domestic violence. (Salazar, Emshoff, Baker, & Crowley, 2007; Breckenridge et al., 2015).		• No significant impact on the rates of domestic violence among women in any of the 10 sites evaluated and few significant differences in rates of contact with domestic violence services. (Klevens, Baker, Shelley, & Ingram, 2008; Slaght & Hamilton, 2005).	• Consider all possible players and ensure they are centrally involved in development and implementation of service response.

Domestic Violence Coordinating Council's (DVCCs)	DVCCs include representatives from the following agencies and sectors: • Criminal justice. • Health. • Education • Social service. • Businesses. • Religious organisations. (Allen, 2006).	• Purpose relates to three core functions: ○ "assessment of the legal justice and social systems involved; ○ policy development; and ○ planning" (Breckenridge et al., 2015, p. 17). • Coordinating Council or taskforce is responsible for promoting and informing coordinated community responses. • Central concerns of each Council can differ but generally range from policy and practice to multi-sectoral communication and increasing public awareness. (Breckenridge et al., 2015).	• The promotion of dialogue between key agencies and sectors facilitates potential for a more comprehensive understanding of the range of services required to attend to the multiple needs of victims of domestic violence, identification of service gaps and more collaborative partnerships which result in improved, coordinated service provision. • Attended to training activities for variety of stakeholders. • Enhanced knowledge and awareness amongst service providers in different sectors in the community service system. • Increased access to information and resources. • Improved ability to respond to client. • Strengthened influence of partner organisations. (Allen, 2016; Breckenridge et al., 2015).	• While DVCCs play a key role in addressing much needed reforms in community responses to domestic violence they were not always considered effective. • They showed tendency to engage stakeholders from the criminal justice system and were more likely to address criminal justice issues. Reforms needed outside of criminal justice arena (e.g. relationships among child protection case workers and survivors access to community resources). • Effective leadership, shared power in decision-making, a shared mission, and active participation of a breadth of stakeholders were factors named as being related to the success/ effectiveness of Councils, the influence of each dependant on the context within the organisation operated. • It was difficult to establish a single impact measure given differences in foci for Councils. • No Council had any survivor representatives included, raising questions around whose interests the Councils are serving and the extent to which they remain focused on promoting survivor safety. (Allen, 2006; Breckenridge et al., 2015; Nowell & Foster-Fishman, 2011).	• Consider how the collaborative arrangement will be supported. • Evaluation of services - will need to be context driven. How will it be measured? • Consider including survivors voices in determining effectiveness of arrangement. • Consider how the needs of the community will be addressed adequately, particularly women outside of the criminal justice system.

Multi Agency Model Center (MAMC) & Family Justice Centers (FJC).	Operates under Family Justice Center Alliance (governing body).
	
	Partner agencies at a Family Justice Center and Multi-Agency Model may include, but are not limited to:
	• Community-based rape crisis, domestic violence, and human trafficking advocates.
	• Law enforcement.
	• Medical.
	• District attorneys and city attorneys
	• Victim-witness program.
	• Domestic violence shelter services.
	• Social services.
	• Child welfare.
		• The first FMJ was established between 1989 and 1998 in San Diego (Gwinn, Strack, Adams, Lovelace, & Norman, 2007).
		• There are 60 independently operated Centers across the US.
		• MAMC and FJC are multi-agency, multi-disciplinary co-located service centres that provide services to victims of interpersonal violence including, FDV, sexual assault, child abuse, elder or dependent adult abuse, and human trafficking.
		• Private and public and partner agencies allocate staff to provide services from one location.
		• Focus is on reducing the need for victims to retell their story, the number of services victim have to attend for support.
		Multi-Agency Model Center:
		• At least three different co-located service providers from
			• Several positives outcomes resulting from partnerships have been identified, including:
			  ○ Reduced number of homicides.
			  ○ Improved collaboration and coordination.
			  ○ "less frequent recanting of domestic violence reports by victims and other various benefits for victims and their children including more safety and empowerment and less fear and anxiety" (Murray et al., 2014, p. 118).
			• Demonstrated an improvement in the number of cases being reported to police, as well as more referrals, prosecution and sentencing being made against perpetrators. (Bostaph, 2010).
				• There is little research available that examine outcomes of these Centers and processes that are used to develop them.
				• Evaluation is complex and can take a long time before outcomes can really be evaluated.
				• Multi-faceted evaluations that consider individual outcomes of various services and goals needed. (Murray et al., 2014).
				• Challenges with data collection for the evaluation include: different types and combinations of services that can be provided, data sharing concerns and safety of data. (Bostaph, 2010; Murray et al., 2014; Townsend, Hunt, & Rhodes, 2005).
				• Each organisation works independently and as such the Center cannot be considered a true model of consolidated response to domestic violence.
				(Deseriee, 2013).
					• Similar goals and aims of proposed WA hubs; provide services from one location to reduce women having to attend multiple sites, retelling of story, increasing access to services and support for women and children and perpetrator accountability focus.
					• Variety of partner agencies involved – is multi-disciplinary rather than just multi-working.
					• Model varies depending on local context.
					• Have been operating for some years.
					• Little known about success of model.
					• Evaluation issues are outlined.

	• County health department. • City or county public assistance. • Mental health. • Civil legal service providers. (www.familyjusticecenter.org).	different disciplines working together under one roof to provide services for adults and children. • Service partners may be onsite either full-time or part-time. • Service providers may, or may not, have a centralised intake and information sharing process. Family Justice Center: • A minimum of the following full-time, co-located partners: domestic violence or sexual assault program staff, law enforcement investigators or detectives, a specialised prosecutor or prosecution unit and civil legal services. • Many Family Justice Centers have additional onsite partners on either a full or part-time basis. • An established a centralized intake and information sharing process that is HIPPAA and VAWA compliant			

		with their full-time, co-located partner agencies. (www.familyjustice-center.org).			
Greenbook Initiative	• Battered women's organisations. • Child protection agencies. • Courts. • Other partners including: Law enforcement, Probation and Parole; Prosecutors: Health care providers; Children's Advocates; Mental Health providers; Domestic violence survivors; and other community-based groups. (www.rcdvcpc.org/).	• Developed training curriculums, community assessment tools and multimedia materials. • Co-located advocate model resulted from the Greenbook Initiative. (The Greenbook National Evaluation Team, 2011). • It is a guideline recommending best practice around collaborative working across child protection services, domestic violence services, and juvenile and family courts. • Established principles and recommendations to improve the policies and practices of child protection services, domestic violence services, and juvenile courts. (https://rcdvcpc.org/resources/resource/effective-intervention-	The Greenbook National Evaluation Team (2011) examined the effects of implementing the Greenbook recommendations and found: • Significant effort was devoted to collaboration which developed over time (Janczewski, Dutch, & Wang, 2008). Activities included analyses of needs and gaps, incorporating perspective of domestic violence survivors and consumers, carrying out safety audits, and conducting systems mapping to identify service gaps or duplication, and needs for policies or information sharing. Cross system training, multi-disciplinary case review activities, collaborative leadership and working groups were also undertaken. • Conflicts were experienced, however the initiative resulted in successful collaborative efforts that lasted over time (e.g. further needed	Challenges identified by The Greenbook National Evaluation Team (2011) include: • Community and survivor input declined over time. • Identified that more work should have been done beyond the collaborative partners to engage the community • Ongoing challenges experienced around philosophical differences among partners as well as differing organisational structures, power, trust and authority (Janczewski et al., 2008). • Recurring issues with confidentiality, particularly between domestic violence and child protection agency workers. • Change was challenging to achieve and sustain. The extent to which change was implemented across sites varied due to differences in leadership, resources, community context and history of collaboration.	• Developed significant resources around collaborative working. • Suggests that collaborations require workers to be sufficiently trained and adequately equipped to deal with intersection of domestic violence and child abuse (Deseriee, 2013). • Articulates benefits and challenges of collaborative working, which we can learn from.

		in-domestic-violence-child-maltreatment-cases-guidelines-for-policy-and-pract.html).	partners were identified and added to the partnerships.) • Partners developed better understanding of each other's' agencies as well as the context and environment which shape how other systems and workers operate. • Relationship between child protection and domestic violence service providers was enhanced and seen as significant success. • There were practice level changes in work with families and children. • In some sites, co-located domestic violence victim advocates were provided to other systems. • In one area, perpetrator accountability became a greater focus which resulted in additional training.		
Canada					

Thrive Northumberland Community Hub, Cornerstone Family Violence Prevention Centre.	Onsite services are available for the client and supported by the following agencies:
	• Cornerstone Family Violence Prevention Centre.
	• Highland Shores Children's Aid.
	• Port Hope Northumberland Community Health Centre.
	• Northumberland Community Counselling.
	• Northumberland County Employment Assistance Resource Network.
	• The Help Centre.
	Offsite partners include:
	• Police.
	• Community Care Northumberland
		• Focus is on providing access to multiple services at one location for women 16+ who have experienced abuse or violence.
		• The key areas of service include crisis counselling, safety planning, legal counselling, housing and income support.
		• Onsite services consist of the following:
		  ○ Family court information.
		  ○ Crisis and supportive counselling.
		  ○ Links to shelter.
		  ○ Safety assessment and risk management strategies.
		  ○ Primary health care.
		  ○ Partner assault response program.
		  ○ Child service witness program.
		  ○ Ontario Works income and employment support.
		  ○ Social housing.
			No formal evaluation has been made available, but strengths of the hub include:
			• Community collaboration.
			• Increasing the level of service made available to women who have experienced abuse or violence and provides clients with immediate access to onsite support services and facilitates referrals to offsite partners.
			• Providing a community role on the issue of violence against women through advocacy; promotion of improved responsiveness of services; providing resources on violence; coordinating and strengthening linkages. (https://thrivenorthumberland.wordpress.com/; http://cornerstonenorthumberland.ca/dvhub/)
				No formal evaluation has been made available.	• This hub engages the services of onsite partners and offsite partners which contributes to the WA hub model design that proposes to do the same.

	(Transportation). • Addiction services. • Victim services/ assistance programs. • Settlement services. • Mental Health Services. • Hospital. • HIV/AIDS Network. • Food Security. • Healthcare Services. • Spiritual Support. • LGBTQ Support. • First Nations Support. • Community services such as Northumberland Elder Abuse Resource Network; Kawartha Sexual Assault Centre; Northumberland for	○ Ontario Electricity Support Program. ○ Children's Aid support/advice. ○ Personal action plan and community services. (https://thrivenorthumberland.wordpress.com/; http://cornerstonenorthumberland.ca/dvhub/)			

	Youth; Northumberland Child Development Centre. (http://cornerstone-northumberland.ca/dvhub/).				
United Kingdom & Ireland					
Multi Agency Safeguarding Hubs (MASH)	• Children Social Care (Social Worker). • Police. • Health. • Education. • Probation. • Housing. • Youth Offending Services. (UK Home Office, 2014).	• Focus is on safeguarding and promoting the welfare of children in the local area. • Single point of entry for notifications regarding child protection. • Co-located team of workers from key agencies. • Common aim of service delivery is "to research, interpret and determine what is proportionate and relevant to share" (Crockett, Gilchrist, Davies, Henshell, Hoggart, Chandler, Simms, & Webb, 2013, p.11). • Agreed processes for risk analysis and	The strengths of MASH as noted in the reports are: • Increased access to information from other agencies – which has resulted in better informed decisions as it provides a more comprehensive understanding of the child and their situation. • Co-location – has served to improve child protection practices; given workers opportunity to share their professional insight on cases; strengthened respect and understanding amongst the different agencies, which has led to better working relationships. • Turnaround time for referrals decreased.	The final reports outline the following weaknesses or concerns: • Lack of understanding about what can be shared. • Cultural barriers. • Risks levels set too high limiting preventative work. • Uncertainty as to who was responsible for the hub. • Insufficient resources as demands were underestimated. • Lack of integrated IT systems. • Inadequate performance management and evaluation. • Absence of co-terminus boundaries. • Lack of knowledge from professionals outside the hub on the hub's role and how it operates. (Crockett et al., 2013; UK Home Office, 2014).	• A number of key features of MASH contribute to the principles and features of the WA Hub models, namely co-location of workers from key agencies, common aim and agreed processes. The weaknesses also contribute to the design of the WA Hub. The MASH evaluation emphasises the need for the WA Hub to be culturally sensitive, have information sharing protocols, clear governance, sufficient resources, adequate IT systems, performance evaluation.

		assessment, identifying victims and information sharing. (Crockett et al., 2013; UK Home Office, 2014).	• Common assessment instrument, however, this does not solve cultural barriers. (Crockett et al., 2013; UK Home Office, 2014).		
Multiagency Public Protection Arrangements (MAPPA)	Primary services involved: • Police. • Probation. • Prison. • Other agencies or services involved: • Youth Offending Team. • Mental health. • Employment. • Health. • Disability. • Children's services. • Employment. (Ministry of Justice, 2017).	• Aim is to assess and manage the risk posed by sexual and violent offenders. • "MAPPA is not a statutory body in itself but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner. Agencies at all times retain their full statutory responsibilities and obligations" (Ministry of Justice, 2017, p. 1). • Clear guidelines have been established to define the responsibilities of agencies involved and outline operational procedures such as: o ViSOR database. o Information sharing.	The report identified the following strengths: • Inclusion of Mental Health Criminal Justice Team within MAPPA. • Good communication. • Protocols for sharing information between agencies. • Training is made available. • Detailed referrals, which improved panel preparation. • Cross checking of referrals to child protection. • Increase in victim protection and improved integration of risk management plans with care plans for children. • Risk managements plan are congruent with the documented risk factors. (Kemshall, Mackenzie, Wood, Bailey & Yates, 2014).	The report highlighted the following weaknesses: • Coordinators maintaining awareness of strategies around public protection. • Connections between Crime and Disorder Partnership and Criminal Justice Boards. • Newer agencies have limited training and experience in risk assessment which results in a misuse of risk levels and inadequate referrals. • Two different assessment tools are being used producing different risk levels for the same offender. • Probation officers not completing all sections of the risk assessment. (Kemshall, Mackenzie, Wood, Bailey & Yates, 2014).	• MAPPA provides contributions to the design of WA hub with its' clear protocols around information sharing between agencies which the WA Hub intends to develop before implementation. The referral practices and risk management plans of MAPPA also contribute to the design of the WA Hub.

		- Disclosure and risk assessment. - Risk management plans. - Multi-agency public protection meetings. • Agencies have an agreed process to work with MAPPA offenders. • An assessment is conducted with offenders to determine the risk they pose to the public. • Following the assessment, risk management plans are developed to manage the risks. • Plans to minimise the risk may include: - Offender living at a probation run accom-modation. - Enforcing behavioural conditions on the offender. - Supervision with a probation officer.			

		○ Attending programs and interventions. • Work is subject to regulation and review. (Ministry of Justice, 2017).			
Cheshire Domestic Abuse Project (CDAP)	• A wide range of agencies providing services for women. • Police. • Schools • Home Office, funding body. (Hague & Bridge, 2008).	There are four major areas of work within the project: • The Data-Collection/ Monitoring Project: involves comprehensive data monitoring and information sharing with agencies for the purpose of improving services. • The Police Project: improves collection of evidence and training on FDV. • The Outreach/ Advocacy Project: provides outreach services, such as support groups, and to builds link with other services for women. • The Education Project: develop and implement FDV programs in schools. (Hague & Bridge, 2008).	• The evaluation noted that CDAP has achieved: • A co-ordinated multi-faceted response to FDV across services. • Increased strategy-building. • Collated, comprehensive and systematic data on FDV through the development of its database. (Hague & Bridge, 2008).	• The evaluation highlighted the following concerns: • IT assistance and significant resources are required to implement co-ordinated data-monitoring. • Issues of confidentiality around information sharing across agencies. Protocols needs to be established and staff should receive training and support for information sharing. • Collecting too much information impacts on staff time and resources and can potentially isolate workers. (Hague & Bridge, 2008).	• The data collection/monitoring aspect of the CDAP contributes to the WA Hub model as the WA Hub aims to collect data with the aim of improving services and knowledge of FDV. • The concerns around the data collection/monitoring also also contribute to the design of WA Hub model. It is noted that significant resources, IT assistance information sharing protocols and training will be needed for the WA hub.

WomenCentre Safeguarding and Domestic Violence UK	The agencies involved were dependent on the site. Most sites included the following agencies: • Probation services. • Police services. • Children's social care. • Health. • Department of Education, funding body. (Peckover et al., 2013).	• The overarching aim of the Pilot was "to work with 10 sites across the north of England in order to examine and improve multi-agency approaches to safeguarding children" (Peckover, Golding & Cooling, 2013, p. 11). • For each site, formal agreements were established and responsibility was held by a multi-agency Steering Group. Key features of the Pilot included: o Case Mapping - to consider alternative approaches to working with families. o Training - sites involved were offered specialist training. o Service User Engagement – client centred approach. (Peckover et al., 2013).	According to the evaluation (Peckover et al., 2013), the strengths of the Pilot were: • Increasing awareness of FDV and safeguarding children. • Prompting reflective discussion on the issues. • Generating discussions on multi-agency work, such as the need for whole system response and how multi-agency approaches can be improved.	The evaluation of the pilot recognised a number of issues with multi-agency working in the area of FDV and child protection. Some of the issues noted that could benefit from improvement include: • Different understandings and levels of knowledge of FDV as it affects risk assessments and responses to FDV, which have an impact on the outcome. • Different understandings of roles and responsibilities of the different agencies involved. • Agencies not always aligned, impacting the links with each other, strategically and operationally. • Responses often disjointed and the issue of FDV not prioritised as a result of no single agency owning the accountability and responsibility of the work. • While the pilot highlighted issues of multi-agency working, it also demonstrated the importance of utilising a multi-agency framework to address FDV. The evaluation also identified other areas that need improvement: • Capacity for organisations, such as WomensCentre, to engage in large scale development work. • A lack of services, such as refuges, support services and services for male perpetrator. (Peckover et al., 2013).	• Peckover, Golding & Cooling (2013, p. 37) suggest that to improve multi-agency work "careful consideration at practice, policy and strategic levels across all the agencies involved" is necessary. In addition, it is recommended that professionals receive training, supervision and support. These recommendations contribute to the WA hub model.

Kingston Domestic and Sexual Violence Prevention Partnership (DSVP)	Agencies that support the DSVP: • Health professionals. • Voluntary sector. • Kingston Police. • Kingston Council – Housing. • Drug and alcohol services. • Schools and children's centres. • Children's services. • Rehabilitation services. • Probation services. (Kingston Domestic and Sexual Violence Prevention Partnership, 2014).	• Aims to respond in a way that best supports victims. The overarching vision is to end domestic and sexual violence in Kingston. • DSVP provides services, support and information to women who have experienced FDV through the following: o The Domestic Violence Hub which provides support, coordinates services and assist clients to access other services. o The Domestic Violence One Stop Shop – a walk-in service that offers free legal advice and support. o The Butterfly Project – a support group for survivors of FDV. o Semi-structured courses for women to work through issues related to FDV.	No formal evaluation has been made available, but strengths of DSVP could include: • Holistic approach. • Coordinated community response. • Training for professionals in Kingston, for example The Kingston Council Housing team were trained to work with domestic violence victims. (Kingston Domestic and Sexual Violence Prevention Partnership, 2014).	No formal evaluation has been made available.	• DSVP contributes to the WA Hub model design as it gives an example of hub that offers a range of services to support for women who have experienced FDV, including coordination of services.

		• In addition, the DSVP also provides services and support for children who children who have witness FDV. (Kingston Domestic and Sexual Violence Prevention Partnership, 2014).			
Family Justice Centre (FJC) - Croydon	• There are 33 agencies co-located within FJC including: • Police. • Legal services. • Social workers. • Counsellors. • Crisis helpline workers. • Independent Domestic Violence Advisers. • Housings services. • Probation services. (Hoyle & Palmer, 2014).	• Aims to meet the diverse needs of adults and children who have experienced domestic violence. • Based on original FJC established in California. • Co-location of varied agencies. • Funding arrangements consist of agencies within FJC funding their workers through the use of existing staff as well as funding from the local council. • Clients are referred to FJC by a number of services. The two services that refer clients most often are the police and housing services. • Facilitates access to domestic and sexual	In a study of the Croydon FJC (Hoyle & Palmer, 2014), the following strengths were identified: • Co-location of dedicated services and staff - clients do not have to travel to multiple service sites, reducing the need to retell their story. • Empower and enable clients through providing individualised support and information that assists clients to make their own informed choices. • Staff have a good understanding of clients, including an understanding of the stages of change, which recognises that clients are not on the same trajectory, they require different levels of support and will make different stages.	• Some services within FJC, such as legal and housing, were less holistic in their approach and focused on their area of specialty. • Some staff could further develop their knowledge on domestic violence. (Hoyle & Palmer, 2014).	• Hoyle and Palmer (2014) highlight the challenges victims experience in recognising the abuse and seeking help and note that FJC sensitively addresses these challenges through the co-location of skilled staff who have an understanding of domestic violence and the diverse needs of the client. FJC gives example of a model successfully reducing barriers to accessing help, which the proposed Hub aims to do. • The funding arrangements of the FJC Croydon are similar to what has been mentioned by Department of Communities for the WA Hub model. Further exploration into this arrangement is

		violence services to meet the needs of the client and their chil-dren. (Hoyle & Palmer, 2014).	• Offer practical support, including legal advice. • Advocacy. (Hoyle & Palmer, 2014).		recommended as it can create challenges for agencies.
Parent and Child Hub	• Preschools. • Schools. • Public health nurses. (Kelleher, 2014).	• A community based 'whole child' model of early intervention and long-term prevention. • Common aim. • Integrated working. • Build relationships with the services who have direct contact with targeted client group. • Support for the child and family is drawn on the resources of the child and family as well as the community and local services. • The hub is funded with existing resources. (Kelleher, 2014).	• Sustainable, utilising existing resources, including staff. • Developing links between the speech and language services and preschools. • Promoting the hub through outreach in the community. • Client can access support services relevant to their needs. (Kelleher, 2014).	No weaknesses were discussed in the review.	• It was initially thought that this model would contribute to the design of the WA hub 'cost neutral' model as it is an example of utilising existing resources. However, its context is not congruent with the WA Hub, therefore, it is not easily applicable.
New Zealand					

Family Violence Interagency Response System (FVIARS)	• Police. • Child, Youth and Family. • Women's Refuges. • Local non-government agencies. • Other Gov-ernment agencies. (Carswell, Atkin, Wilde, Lennan, & Kalapu, 2010).	• Implemented to more effectively manage cases of FDV reported to the Police. • The aim is to facilitate coordinated, collaborative interagency responses to FDV. • Key features include: o Regular meetings with partner agencies to specific cases of FDV. o Information sharing and collaboration on risk assessments and planning interventions, and monitoring of cases. o Guidelines for all partner agencies on each area of involvement. (Carswell et al. 2010).	The evaluation (Carswell et al., 2010) identified a number of strengths, including: • Developing stronger relationships between agencies through formal agreements and regular face-to-face meetings. • Collaborative and coordinated approach which benefited victim safety and perpetrator accountability. • Provision of regular, structured meetings for agencies to share information, assess risks and make decisions on cases. • Assign one lead agency to conduct follow-up. • Less agency overlap and duplication of services as a result of interagency coordinated response. • Flexibility in the model to adapt to local context.	The findings of the evaluation (Carswell et al., 2010) suggests improvement around the following: • High risk cases require data collection that is more thorough and consistent, particularly around outcomes – to better evidence the impact of FVIARS. • One common risk assessment that is understood by all agencies. • Communities had gaps in service due to no or limited capacity and capability of services, presenting a risk and a barrier to achieving desired outcomes. • Limited services around perpetrator accountability and behaviour change. • Non-attendance of agency representatives at meetings. This was found to impact collaboration, create tensions and raise questions around commitment.	• FVIARS contribute to the design of the WA hub model through the areas that need improvement. The points listed have been considered in the design in the WA hub and they receive further consideration prior to implementation.
Family Safe Net-work (Pilot – Waikato)	Government and non-government agencies including: • Police. • Child Youth and Family. • Corrections.	• Aims to reduce FDV through early and more effective interventions. • Co-located of key staff at the Hamilton	The evaluation report (Payne & Robertson, 2015) identified the following strengths: • Governance and leadership teams. • Built on strong, local history of collaboration.	The report (Payne & Robertson, 2015) suggests the following to be further developed: • The work between the police officers and refuge advocates needs to be more seamlessly. • Better training and supervision.	• The FSN contributes to the design of the WA hub model by giving example of the importance of strong governance and leadership. It also highlights the need for adequate resourcing

	• Te Wha-karuruhau Maori Women's Refuge. • Hamilton Abuse Inter-vention Pro-ject. (Payne & Robertson, 2015).	Abuse Intervention Project office. • Key processes: ○ Refuge advocate responds following a police call-out to offer support and an initial assessment of needs (referred to as a dual crisis response). ○ Within 24 hours of an FDV incident, a safety assessment and planning meeting is held to present information on the those involved in the incident, plan follow-up and refer case to relevant agencies. ○ Review follow-up actions and ensure family members are engaged with services.	• Engagement of the whole family, perpetrators, victims and children. • Co-location – knowledge and skills can more easily be shared, problems can be better identified and addressed. • Review of cases to ensure client is engaged. and accountability. • Agency accountability through the review process, which is noted as an improvement on the FVIARS.	• Increased knowledge of FSN by other organisations. • Improved technology and a centralised database system. • Adequate resourcing for sustainability.	and a centralised database system.

		(Payne & Robertson, 2015).			
Integrated Safety Response (ISR) (Pilots – Christchurch & Waikato)	There are two teams in the ISRs: Safety Assessment Meeting (SAM) and Intensive Case Management (ICM). The SAM team consists of: • Police. • Child Youth and Family. • Corrections. • Health. • Iwi/Maori. The ICM team includes the SAM team as well as the following: • ACC. • Housing New Zealand. • Education. • Ministry of Justice. • Work and Income. (New Zealand Police, 2016).	• Following reviews which identified the need for improved responses, the ISR Pilots were developed to ensure families experiencing FDV receive the support they need. • Aim is to provide safe and effective responses for victims and perpetrators of FDV immediately following a Police report of FDV or following a referral from Corrections services. • The core principle is to have collaborative meetings with relevant agencies and service providers working together to identify risks, plan coordinated responses for victims, perpetrators and their children. • Key features include: o Structured governance.	The evaluation report (Mossman et al., 2017) concluded that the ISR was efficient and effective in a number of areas, including: • Improved risk assessment, safety planning and information sharing. • More coordinated and efficient responses, including responses to perpetrators. • Increase in client engagement. • Decrease in frequency and/or severity of subsequent FDV incidents reported by the family. • More efficient case management with the customised database system. • Better understanding of capacity and resources that impact response.	The report (Mossman et al., 2017) identified that the following areas can be improved: • Co-ordination of tasks. • Ownership of plans. • Increase in training and professional development opportunities. • Improved partnership between non-government and government sectors. • Clarification on the aim and scope. • Better incorporation of the information from meetings into safety plans.	• The ISR provides contribution to the design of the WA hub model through its strengths, such as its collaborative and coordinated responses involving several key agencies/workers, customised database to record case details, and structured governance, as well as through its areas of improvement, including co-ordination of tasks, ownership of plans and partnerships between no-government and government.

		- Dedicated positions. - Program monitoring and evaluation. - Joint training and on-going professional development. - Response to every referral. - Regular meetings with the SAM to assess risk and plan a response. - Evidence-based risk assessment. - Database system to record case details. - Victim Specialists and Perpetrator Outreach Service. - Intensive Case Management for high risk cases. (Mossman, Paulin, & Wehipeihana, 2017).			

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