Framework

COORDINATED COMMUNITY RESPONSE TO HIGH RISK/HIGH DANGER DOMESTIC/INTIMATE PARTNER VIOLENCE IN NEW BRUNSWICK

April 8, 2022
Justice and Public Safety

New Nouveau Brunswick

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Since CCR's pilot launch in April 2017 in its two pilot sites (Fredericton and Edmundston / Grand Falls) there has been significant effort invested in the CCR model by its various partners. Necessary adjustments to the CCR model were made based on notably the CCR pilot site teams' input working with individuals at high risk / high danger of serious injury and homicide by an intimate or former intimate partner.

In October 2020, CCR's Provincial Steering Committee decided it was time to implement CCR province-wide; all New Brunswickers in high risk Domestic / Intimate Partner Violence situations deserve to access CCR. This marked the exciting transition in CCR's development from pilot project to program.

Though 'housed' in the Department of Justice and Public Safety, CCR remains a multi-partner program. This is a key strength in effectively meeting the needs of individuals in high risk / high danger Domestic / Intimate Partner Violence situations.

This Framework services as a guide for CCR's various partners – both community and government – as they participate in making our province a safer place.

1. FRAMEWORK PURPOSE

The purpose of the Coordinated Community Response Framework is to outline the CCR model and provide structure and guidance to our various CCR partners. While the basic components of CCR will be provincially consistent, communities may require flexibility to operate CCR in a way that reflects their reality, strengths, and resources.

2. INTRODUCTION

2.1 BACKGROUND

Violence against women continues to be a serious societal issue in New Brunswick. As in other provinces and territories, women experienced a higher rate of intimate partner violence. Moreover, in every province and territory in 2019, the rate of intimate partner violence increased from the previous year. The largest provincial increases were noted in New Brunswick (+25%)[i]. New Brunswick has the highest rate of women and girls killed among the Atlantic provinces. Nationally, accused tend to be male. Further, in 2019 results showed that the relationship between the primary victim and the primary accused was known in over three-quarters of the incidents (77%, N=75)... 52 percent of the primary victims were the current or former female partner of the accused.[ii]

With the high levels of violence against women, intimate partner violence remains a significant problem with a huge social and economic impact on the province. The cost is estimated at $165 million a year in New Brunswick.[iii] The Roundtable on Crime and Public Safety[1] has selected and continues to have Domestic/Intimate Partner Violence as one of its' priority of the New Brunswick Crime Prevention and Reduction Strategy.

[1] *The Roundtable and its working groups bring together over 55 representatives from community agencies, the police, the private sector, academia, First Nations groups, municipal and federal governments, and several provincial departments to collaborate on improvements to crime prevention policy and practice through the New Brunswick Crime Prevention and Reduction Strategy.*

The need for a coordinated response to the most serious Domestic/Intimate Partner Violence (D/IPV) cases had been identified as an important next step in enhancing the effectiveness and efficiency of community and government responses to risk assessment and risk management. Action to develop a coordinated response was identified as an important activity in the New Brunswick Crime Prevention and Reduction Strategy Action Plan (hereby referred to as "the Strategy"). Coordinated, multi-agency approaches can enhance community and criminal justice responses to high risk/high danger cases through improved information sharing, collaborative safety planning and risk mitigation strategies.

This work builds on the province-wide training of all front-line police officers on D/IPV and the Ontario Domestic Assault Risk Assessment (ODARA) tool; use of the Danger Assessment (DA) by Victim Services coordinators and the domestic violence sector; the Woman Victims of Abuse Protocols; work of the New Brunswick Domestic Violence Death Review Committee; the Moncton Domestic Violence Court; the National Framework for Collective Police Action; and other D/IPV Strategy Activities.

The Roundtable on Crime and Public Safety approved the Charter for a Coordinated Community Response to D/IPV cases in New Brunswick ("the Charter") in March 2015. The Charter defines the scope, objectives, guiding principles and overall approach to develop and implement a coordinated response to intervening with victims and offenders in medium to high risk/danger D/IPV cases in New Brunswick. The Guiding Principles from this Charter are included below (point 2).

The resulting CCR model was built on a jurisdictional scan and review of best practice research as well as the collaboration of several government departments, non- governmental organizations, and academics.

The Coordinated Community Response to High Risk/High Danger Domestic/Intimate Partner Violence (CCR) model was piloted in two New Brunswick sites: RSC 11 (Fredericton) and RSC 1 (Edmundston and Grand Falls) for a period of 18 months (inclusive of evaluation). This pilot provided the opportunity to learn what works well, what does not, and what needs to be adapted to ensure CCR achieves its stated objectives.

In Fall 2020 the CCR Steering Committee decided that the CCR model was finalized and ready to be implemented province wide; all individuals living in high risk/high danger domestic/intimate partner violence situations deserve access to this multi-partner, integrated and collaborative model.

While domestic/intimate partner violence is a gendered social problem, anyone can be a victim of domestic/intimate partner violence and anyone can commit acts of domestic/intimate partner violence.

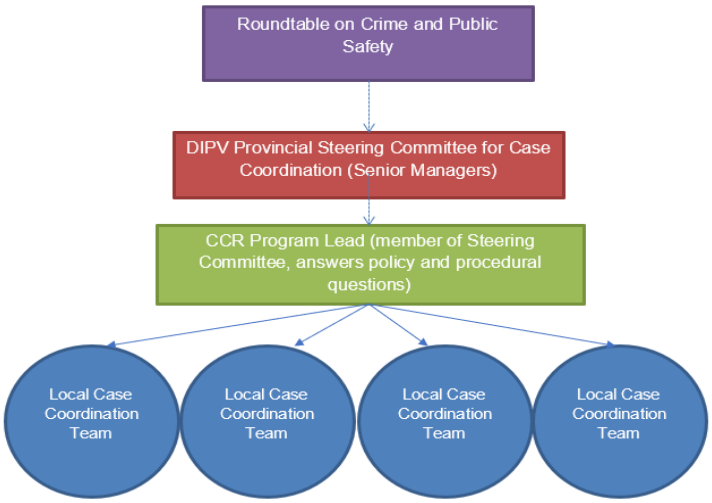
2.2 APPROACH

The current focus of the CCR model is on victimized partners and those connected to them who are also at risk. The model involves community and government partners working together to enhance the safety and well-being of New Brunswick families by coordinating interventions and services and making the best use of existing resources.

We recognize that work pertaining to high risk/high danger D/IPV cases needs to include work with the abusive partner. Our plan is to return to this work with the abusive partner once provincial implementation of CCR is complete.

2.3 GOVERNANCE STRUCTURE

D/IPV Provincial Steering Committee for Case Coordination was established and remains a permanent committee responsible for making collective decisions regarding the design and implementation of the CCR model and its protocols. The committee will aim to ensure consistency in CCR approaches and provide information and support regarding policies and procedures via the Provincial Program Lead to local case coordination teams when issues arise. Specifically, the D/IPV Provincial Steering Committee for Case Coordination2 will:



- Oversee the development, implementation and evaluation of the CCR model;
- Collaborate with government departments and partner agencies on adjustments to D/IPV policies and procedures as necessary;
- Receive reports and recommendations from any working group and subcommittee(s) established in the course of this work and provide support as required;
- Seek government approval where required; and
- Ensure policy and procedures of their respective agencies are consistent with provincial D/IPV policy, procedures and protocols and the CCR model.

2.4 GUIDING PRINCIPLES

The way we collectively think about D/IPV is critical for a collaborative multiagency response to D/IPV. The development of the CCR model is based on several core principles. The Provincial Steering Committee for Case Coordination has added points to inform our collective understanding of D/IPV. It is important our work is informed by recognizing and acting on the following:

1. D/IPV is independent of age, socio-economic status, culture, and religion.

2. Families of diverse compositions and contexts must be respected.

3. Risk is dynamic and situational; the level of risk or danger can go up or down depending on personal and social context and can change rapidly.

4. Although no risk instrument to date is capable of producing a 100% accurate prediction of future violence, actuarial tools are significantly more accurate in predicting risk than unstructured professional judgment alone.[iv]

5. Timely access to services and support reduces risk; isolation and lack of access to services and support increases risk.

[2] *The Terms of Reference for the D/IPV Provincial Steering Committee for Case Coordination are found in Appendix C.*

6. Risk assessments and safety plans should be updated regularly, particularly when circumstances change.

7. Not all D/IPV is the same.

8. Identification of pattern and type of D/IPV is important as different types of D/IPV have different implications in terms of appropriate services, risk and risk management.

9. There is a need to move beyond dichotomous thinking and dominant D/IPV discourse (i.e., victim=passive, abuser=evil).

10. D/IPV is not a series of isolated incidents affecting an individual victim; rather, D/IPV is a pattern of abusive behavior used by an identifiable individual that can encompass multiple victims (children and adults) in the past, present and future.[v]

11. Children, new partners, extended family, workplace colleagues and pets[vi] are vulnerable to harm when a D/IPV case is high risk/high danger.[vii]

12. The cumulative, patterned nature of D/IPV requires dominant aggressor assessments of responsibility for the *pattern* of D/IPV over time rather than primary aggressor assessments of responsibility for *incident(s)* of D/IPV.

13. D/IPV is a form of entrapment, therefore:

    - It is not appropriate to give victims the responsibility for keeping themselves and their children safe;
    - Simply providing victims with a standard set of safety actions they can take is likely to be an ineffective response to their help-seeking;
    - Victim safety requires systemic responses that focus on curtailing the abusive person's use of violence;
    - Structural inequities and ineffective responses to D/IPV compound the entrapment of victims and their families; and
    - Victims' responses to abuse (asking for help, changing phone numbers, altering children's routines, using violent resistance to protect herself and her children, etc.) are acts of resistance rather than acts of empowerment.[viii]

14. D/IPV is, by its nature, chronic. Prolonged abuse and trauma result in complex neurobiological and psychological effects. These effects interfere with the way victims access safety; make self-protective decisions; process information; and remember details. Not only does trauma affect help-seeking and decision-making, it also increases risk of being isolated and controlled.[ix]

15. Violence against women is internationally recognized as a violation of women's human rights and fundamental freedoms and impairs or nullifies their enjoyment of those rights and freedoms.[x]

16. Although women are more likely to be victimized by D/IPV[xi], and men tend to more commonly be the abuser, D/IPV can be directed at male victims by other males or female abusers as well. Thus, a gendered awareness of D/IPV is necessary and appropriate, but it should not be used to exclude the recognition of D/IPV in these other intimate relationship contexts.

17. Aboriginal women[xii] are at increased risk of victimization[xiii] due to racism and sexism as well as additional risk factors. Compared to the non-Aboriginal population, Aboriginal women are more likely to have low incomes, problems finding and accessing housing, alcohol abuse and suffer from residential school abuse and its intergenerational impacts – all factors which increase abuse and must be taken into account by service providers who are working together to create solutions that address both the root causes and consequences of violence.[xiv]

18. The collective understanding of violence in immigrant families, especially in New Brunswick, is limited.[xv] However, we do know that immigrant victims of D/IPV may face unique barriers including social isolation, language barriers, distrust of public officials and police, and fear loss of contact with their children or deportation if abuse is reported.[xvi]

19. When the woman is at risk of being victimized, her children are also at risk. Similarly, when a woman's life is in potential danger in a D/IPV context, the child's life is in danger, too.

20. D/IPV and child abuse and neglect are entangled forms of abuse. Child exposure to D/IPV is child abuse and neglect.[xvii] Parents who perpetrate D/IPV may also directly abuse their children. The offending partner's/parent's decision to abuse an intimate partner who is a parent is a parenting decision.[xviii]

21. There are many possible barriers to a victim leaving an abusive situation. Threats of injury, death and harm to children, family members, pets and property can be barriers, as well as religion, culture, social stigma, tradition and finances, among others.

22. To maximize the Strategy's impact to reduce D/IPV, support services need to be directed towards both the abuser and the victim(s). Abusers and victims may reconcile a number of times before making a final separation or may remain in the relationship while abuse continues. Abusers may abuse subsequent partners while victims are vulnerable to abuse in other relationships. Providing support services to victims and abusers attempts to respond to the violence to decrease the likelihood of victimization and perpetration.

23. Verified risk and danger assessment tools in the D/IPV context depend on relatively new science. The tools are evolving rapidly in part because the application and validity of D/IPV risk and danger assessment tools depend heavily on social and cultural context. Thus, one of the guiding principles of CCR is receptivity to new research and verified assessment tools as they emerge. For example, new tools are being developed now for use in First Nations and multicultural contexts.

24. Effective risk management depends on accurate risk assessment. Thus, ongoing training in D/IPV and in risk and danger assessment is integral to a CCR model in order to ensure ongoing effectiveness and long-term sustainability.

25. The safety and wellbeing of child and adult victims cannot be achieved by victims alone. Social issues and/or forms of vulnerability such as trauma, mental health and addiction issues, and poverty typically intersect and are concurrent with D/IPV. Therefore, multiagency strategies that address the complexities of people's lives are needed to keep people safe. Victim empowerment is the end goal, not the initial premise, of a collective safety response.xix

3. CCR GOALS AND OBJECTIVES

3.1 GOALS (THE WHAT) OF CCR ARE TO:

- Increase the safety of victimized partners, their children and others who may be at risk;
- Reduce the offending partner's risk to re-victimize; and
- Make the best use of available resources.

3.2 OBJECTIVES (THE HOW) OF CCR ARE TO:

- Build new and strengthen existing relationships based upon trust between service agencies, and with program participants based upon trust;
- Improve information sharing;
- Collaborate on victim safety planning; and
- Collaborate on risk/danger mitigation strategies.

Please see **Appendix B** for logic model that describes the theory behind the CCR model.

4. CONFIDENTIALITY AND CONSENT

Researchers, policymakers and practitioners have long recognized the need for collaboration among various agencies (both community and justice) to ensure system interventions prioritize safety. "Referred to as a 'coordinated community response' (or CCR), these collaborations take many forms and have differing members but have an overall goal of coordinating services within a community to enhance response to victims."[xx] At the core of a CCR approach is consistent, proactive and timely information-sharing with the victim and among community partners as a means to collaborate on safety planning and risk/danger mitigation strategies.[xxi] New Brunswick's Domestic Violence Death Review Committee made a recommendation specific to this issue:

> *"That Government agencies involved with victims and perpetrators adopt an interagency information sharing protocol to respond to the potential risk for violence and lethality in situations of intimate partner violence while ensuring confidentiality and respecting privacy legislation."* [xxii]

Confidentiality is vital to the safety of victimized partners and their children, as well as to their sense of control over their own information.[xxiii] The protection of information underlines three important goals: to keep victimized partners safe and prevent further harm by their offending partners; to provide the privacy needed to allow a victimized partner to speak freely about the abuse in order to effectively plan for safety; and to recognize and reinforce victimized partners' autonomy.[xxiv]

The CCR model is not meant to replace existing applicable legislation and protocols (i.e. *the Criminal Code of Canada, Family Services Act, Intimate Partner Violence Intervention Act, Woman Victims of Abuse Protocols, Child Victims of Abuse and Neglect Protocols,* etc.); it is meant to complement and enhance existing practices. As such, when a victimized partner is determined to be at high danger for serious harm or lethality, or when an offending partner is determined to be at high risk to re-assault and consent to share information is refused, the threat to the health, safety and security of the parties involved, including any children, shall be taken into consideration to determine whether or not information is shared with the appropriate authorities, within each respective partner's professional role, outside of the CCR model.

Subsequent sections in this Framework outline Team members' roles and responsibilities and CCR procedures

5. EVALUATION

The CCR pilot was evaluated to determine if the model was implemented as designed (process evaluation). A streamlining exercise was conducted in 2020 to identify and address resources inefficiencies while remaining client centered. A key recommendation led to CCR adopting a common electronic system that streamlines the CCR process and provides team members with (for example) timely updates (e.g. Critical Developments). Another benefit is the auditing capacity Workspaces provides, enabling safeguarding of clients' data.

Evaluation of CCR will continue so it remains an effective, client-centered response to high response to high risk/high danger D/IPV cases.

6. COORDINATED COMMUNITY RESPONSE (CCR) TEAMS

The foundation of CCR is a multi-agency team based on equal partnership. The CCR Team brings together existing service providers to collaborate on a common plan for high risk/high danger referrals. The CCR model is not intended to replace the work of each team member within their respective departments/agencies. All team members are expected to continue delivery of regular services to eligible clients according to their respective departmental/agency policies and protocols. While team composition may vary by location and case, each team should be comprised of a CCR Team Coordinator and a representative from the following primary service providers:

- Police (RCMP and/or Municipal)
- Department of Justice and Public Safety – Victim Services
- Department of Social Development
- Regional Health Authorities – Community Mental Health Centres/Mental Health and Addiction Services
- Domestic Violence sector (domestic violence outreach worker, transition house and/or second stage program)

In selecting members to be a part of the CCR team, implicated departments and community partner agencies are asked to read the CCR Membership Guidelines (please see Appendix D for CCR Membership Guidelines).

Depending upon the specifics of each case, other agencies may be invited to be part of the CCR meeting if the client and team determine their involvement is key to the development and implementation of the risk management strategy. These parties would sign a confidentiality agreement and only attend the portion of the meeting that pertains to them. These additional parties could include but not limited to:

- Other services at Social Development (e.g. Income Assistance, Housing, etc.)
- Multicultural agencies
- First Nations' service providers; Elders
- Diversity based support services (e.g., LGBT)
- Crown Prosecutor, NB Legal Aid Services Commission (family and/or criminal legal aid),
- Private lawyer (family and/or criminal defense)
- Men's intervention programs
- Youth service providers
- Schools

- Resource centres
- Military services
- Canada Border Services Agency
- Citizenship and Immigration Canada
- Correctional Service Canada- Parole
- Regional Multicultural Association Representative
- Other support identified by client

Representation from both community and system-based organizations on the CCR Team working together enable team members to accomplish the goals of CCR.

7. CULTURAL SAFETY

Cultural safety is the outcome of interactions where individuals experience their cultural identity and way of being as having been respected or, at least, not challenged or harmed. It comes from a combination of being culturally sensitive (appreciating that there are differences among cultures and recognizing the history of Aboriginal people that contributes to the contemporary conditions of many (colonization, residential schools, etc.), and being culturally competent (being skilled in how to interact with members of a culture on their own terms). [xxv]

It is expected that some victimized partners who take part in CCR will identify as Aboriginal. The CCR Team will recognize, be sensitive to and respect differences in culture and create an environment that is physically, spiritually, socially and emotionally safe. The pilot was an opportunity to learn and document best practices for achieving cultural safety.

It should also be noted that the New Brunswick Multicultural Council (NBMC) is working on a complementary project for a Coordinated Community Response to Domestic and Intimate Partner Violence Experienced by Non-status, Refugee, and Immigrant (NSRI) Women in New Brunswick. This project is working to address the systematic barriers NSRI women experience while accessing the D/IPV support services, aiming to build better understanding, cross-sector responsive collaboration, and sharing of information between the violence prevention sector, immigrants serving agencies, and multicultural associations. With this understanding, the CCR Teams will endeavor to practice cultural safety where the victimized partner is a newcomer or immigrant woman and look to share experience with, and learn from, the NBMC project**.**

8. TRAUMA INFORMED APPROACH

When working with a (potential) client keep in mind that the individual may be experiencing considerable trauma (i.e., anxiety, stress, lack of self esteem, Post Traumatic Stress Disorder, Traumatic Brain Injury). Further, these types of injuries due to violence may make the person to seem disorganized, angry, hostile, depressed or lacking in emotion.

Traumatic injuries can also affect memory, capacity to recall events, ability to convey information in linear sequence, ability to retain and follow directions. Disclosures of severe traumatic events may occur slowly over time. The individual may need time and encouragement to begin to develop trust and the confidence to convey deeply their personal traumatic information.

Therefore, the foundations of trauma informed practice: safety, trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical, and gender issues should be incorporated in all areas of CCR work.

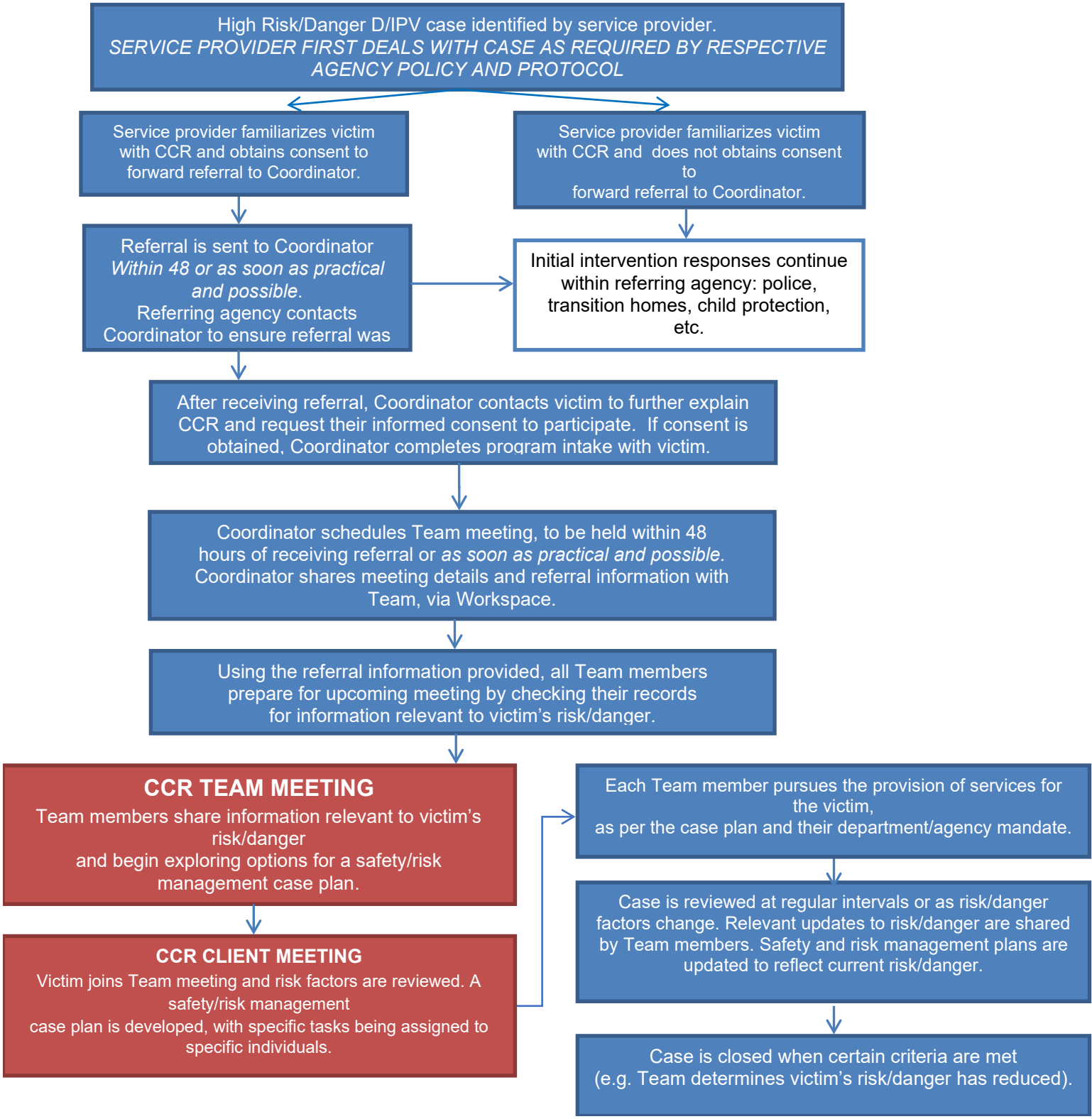
Trauma-informed practice begins with takin time to put the individual at ease. Ask questions to ensure that the individual feels physically and emotionally safe including in the meeting location. Ask questions to address the individual's comfort (e.g., the surroundings). Respond, and attempt to address, discomfort and concerns about safety. The following practices could also be helpful:

- minimize distractions;
- minimize bright lights and noise;
- make use of checklists;
- encourage use of journals;
- repeat information and ask questions to ensure the information was understood;
- assist with developing priorities and identifying small tangible steps to take toward the priorities;
- discuss strategies for remembering appointments and dates;
- focus on one task at a time;
- talk slowly and on point;
- enable breaks when needed;
- avoid abstract concepts;
- offer encouragement and reassurance;
- assist with forms;
- identify supports, including medical, psychological and social;
- encourage mutual collaboration, participation and choice.

If the potential client has been punched in the head, choked or strangled with loss of consciousness, has had their head shoved into walls or has been repeatedly shaken, refer the client for medical brain trauma assessment. [3]

[3] Pemberton, Jennifer V. and Loeb, Tamra B. Impact of Sexual and Interpersonal Violence and Trauma on Women: Trauma-Informed Practice and Feminist Theory JOURNAL OF FEMINIST FAMILY THERAPY 2020, VOL. 32, NOS. 1–2, 115–131 https://doi.org/10.1080/08952833.2020.1793564

9. CCR MODEL


High Risk/Danger D/IPV case identified by service provider.
SERVICE PROVIDER FIRST DEALS WITH CASE AS REQUIRED BY RESPECTIVE AGENCY POLICY AND PROTOCOL
Service provider familiarizes victim with CCR and obtains consent to forward referral to Coordinator.
Service provider familiarizes victim with CCR and does not obtains consent to forward referral to Coordinator.
Referral is sent to Coordinator Within 48 or as soon as practical and possible. Referring agency contacts Coordinator to ensure referral was
Initial intervention responses continue within referring agency: police, transition homes, child protection, etc.
After receiving referral, Coordinator contacts victim to further explain CCR and request their informed consent to participate. If consent is obtained, Coordinator completes program intake with victim.
Coordinator schedules Team meeting, to be held within 48 hours of receiving referral or as soon as practical and possible. Coordinator shares meeting details and referral information with Team, via Workspace.
Using the referral information provided, all Team members prepare for upcoming meeting by checking their records for information relevant to victim's risk/danger.
CCR TEAM MEETING
Team members share information relevant to victim's risk/danger and begin exploring options for a safety/risk management case plan.
CCR CLIENT MEETING
Victim joins Team meeting and risk factors are reviewed. A safety/risk management case plan is developed, with specific tasks being assigned to specific individuals.
Each Team member pursues the provision of services for the victim, as per the case plan and their department/agency mandate.
Case is reviewed at regular intervals or as risk/danger factors change. Relevant updates to risk/danger are shared by Team members. Safety and risk management plans are updated to reflect current risk/danger.
Case is closed when certain criteria are met (e.g. Team determines victim's risk/danger has reduced).

10. ROLES AND RESPONSIBILITIES

The following roles and responsibilities are specific to the CCR model. CCR is not meant to replace existing applicable legislation, policy and protocols (*i.e. CCC, IPVI Act , Family Services Act, Woman Victims of Abuse Protocols, Child Victims of Abuse and Neglect Protocol etc.*); rather it is meant to complement and enhance existing practices in order to achieve better outcomes for victims, abusive partners and their families.

10.1 FRONT LINE STAFF OF PRIMARY SERVICE PROVIDER AGENCIES MAKING UP CCR TEAM

- Continue to provide agency mandated services to eligible clients.
- Identify high risk/high danger D/IPV cases using the ODARA, Danger Assessment and professional judgement as appropriate to their role.
- Determine if a safety plan has been developed. If not, develop a safety plan with a victimized partner or refer victimized client to Victim Services or Domestic Violence sector (as appropriate).
- Obtain consent from the victimized partner to make an initial referral (name and contact information only) to the CCR Team Coordinator (*CCR Request to Contact Form*).
- Inform agency CCR Team member that the referral is being made.
- Liaise with respective agency CCR Team member for ongoing collaboration and monitoring of service delivery/engagement as required by the client's case plan.

10.2 CCR TEAM MEMBER

- Complete a risk assessment using either the ODARA or Danger Assessment tool as appropriate.
- All CCR Team members must complete the Danger Assessment training and obtain certification. New CCR members are not required to complete the training and certification before joining the team. New team members should complete training and certification as soon as a training session becomes available. Training will be offered on an ongoing basis in different formats and in both official languages.
- Obtain consent from the victimized partner to make a referral (name and contact information only) to the CCR Team Coordinator (*CCR Request to Contact Form*) if not already done so by front line staff.
- If an existing relationship with the victimized partner exists, continue as key contact person with victimized partner (otherwise the CCR Team Coordinator will take on this role).
- Sign an *Affirmation of Confidentiality* thereby agreeing to only use or disclose a client's information with their consent and to keep all CCR matters confidential.
- Attend CCR Team meetings as called by the CCR Team Coordinator (within 48 hours of receipt of new CCR referral and/or to respond to a critical development).
- After receiving notification of CCR Team meeting, all team members will search their agency for records for risk related information related to the victimized partner and/or the offending partner (if applicable).

- Share pertinent information, specifically relative to risk factors, from their respective agencies with the team, specific to the victimized partner and/or the offending partner (if applicable) and relevant to the development of a risk management plan (*the least amount of information required to effectively plan for safety and risk mitigation*).
- Using the *Coordinated Community Response Client Intake Form/Risk Factors* as a guide, review indicators and vulnerabilities with the CCR Team to confirm level of risk/danger and appropriateness of referral.
- Represent respective department/agency and contribute expertise on the availability of departmental/agency programs and services including eligibility criteria, and how clients can access programs and services at the local level.
- Work collaboratively to develop a risk management plan and assist in the coordination of services to the high risk victimized partner and their family.
- Take responsibility for department/agency role in risk management plan and follow through on action with consideration given to urgent nature for triaging and timely access to services, as relevant.
- Facilitate access to agency program/service and liaise with the relevant frontline staff (pre-existing or newly established) for ongoing collaboration and monitoring of service delivery/engagement.
- Monitor and report on the victimized partner's and the offending partner's level of risk (if applicable).
- Be attentive for any critical developments related to the victimized partner, the offending partner, and others who may be at risk.
- Advise the other members of the CCR Team and the CCR Team Coordinator of all critical developments using the *Critical Development Ongoing Information Sharing Form*.
- When critical developments arise, respond to this information in a timely and efficient manner (e.g. notifying CCR Team Coordinator, scheduling meeting).
- Engage in ongoing communication with the CCR Team and the CCR Team Coordinator as required.
- Attend meetings to review process and discuss improvements to the CCR model (chaired by the Provincial Program Staff).
- Attend required training.
- Participate in program monitoring and evaluation activities.

10.3 CCR TEAM COORDINATOR

The CCR Team Coordinator's primary role is to bring CCR Team members together upon the receipt of a high risk/high danger D/IPV referral and facilitate the CCR process. JPS Victim Services will fill this role. More specifically, the CCR Team Coordinator's role will be:

- To receive referrals of high risk/high danger cases.
- To initiate CCR process and chair CCR Team meetings.
- To build and maintain relationships with local CCR Team members.
- To be a key contact person with victimized partner when an existing relationship with a service provider does not already exist.
- To oversee work of the CCR Team.
- To liaise with Provincial Program Lead.

- To ensure CCR program data and information is recorded and filed.
- To compile and file CCR statistics and share with Provincial Program Staff.
- Attend CCR related meetings (chaired by the Provincial Program Lead).

Specific responsibilities of the CCR Team Coordinator throughout the CCR process include:

- Receive and process the referral from primary service providers:
    - If the victimized partner consented to the referral to CCR Team Coordinator, contact the victimized partner, explain CCR, and invite them to participate in the development of an immediate safety/risk management plan.
    - Obtain informed consent from the victimized partner to participate in CCR to acquire and disclose information specific to them and relevant to the development of collaborative actions.
    - Complete the Danger Assessment with the victimized partner if one has not already been completed (i.e., the victimized partner was referred to CCR based on ODARA results or based on professional judgement).
    - Communicate and seek input from the victimized partner about immediate safety planning.
    - Initiate CCR process for proactive referrals (as soon as possible).
    - Complete *CCR Client Intake Form/Risk Factors* with the victimized partner.
    - Arrange meeting (in person, online or by teleconference) of the CCR Team within 48 hours of receiving the referral or as soon as possible ensuring immediate safety needs are addressed
    - Any CCR team member may carry out the above responsibilities in partnership with the CCR Coordinator if it makes the process client-centre for the victimized partner (e.g. if a CCR team member from the Domestic Violence sector has an established relationship with the client then it might be more client-centred to have the CCR team member initiate CCR process including intake process).
- Coordinate CCR Team Meeting
    - Initiate meeting by notifying team members and uploading Sharing of Participant Referral Information with CCR Team onto Workspaces.
    - Using the Coordinated Community Response Client Intake Form/Risk Factors as a guide, review indicators and vulnerabilities with the CCR Team to confirm level of risk/danger.
    - Document the risk management plan developed with the CCR Team.
    - Any CCR team member may carry out the above responsibilities in partnership with the CCR Coordinator if it makes the process more client-centre for the victimized partner (e.g. if a CCR team member with Social Development has an established relationship with the client then it might be easier for the client to have the team member from Social Development coordinate and chair the meeting.
- Critical Developments:
    - Engage in ongoing communication with the victimized partner and CCR Team members.
    - Be attentive for critical developments related to the victimized partner, the offending partner, and others who may be at risk.
    - Advise the CCR Team of all critical developments immediately
    - Reconvene CCR Team to respond to critical developments and revise risk management plan as necessary.
    - Review risk/lethality level when a critical development occurs, one month from the beginning of the CCR process, regularly and prior to closing file and/or as determined by the CCR team.

10.4 VICTIMIZED PARTNER

The inclusion of the victimized partner's wishes and ongoing assessment of risk is essential to the CCR process. Victim empowerment is central to the CCR Team as plans are made to increase their immediate safety, and to address their ongoing needs.

Victimized partner participation in CCR would entail:

- Deciding whether to participate in CCR, and the level at which they wish to be involved.
- Providing consent to service providers to share risk relevant information to be used in the development of a risk management plan.
- Receiving support from a multi-disciplinary team to increase immediate and long-term safety and connect her/him to services that can help her/him deal with the long-term impacts of abuse.

10.5 POLICE

Specific to their role in the CCR Team, the police representative will:

- Liaise with front-line officers to identify high risk D/IPV cases using ODARA and professional judgement.[xxvi]
- Share the ODARA score for CCR purpose with CCR Team Coordinator.
- Work with the CCR Team Coordinator to ensure all the tasks of risk assessment, referral and case plan coordination in high risk/high danger cases are completed as outlined in the role of CCR Team member above.

10.6 DEPARTMENT OF JUSTICE AND PUBLIC SAFETY – VICTIM SERVICES

Victim Services will continue to offer ongoing support services to victims of crime as outlined by agency policy and protocol. Specific to CCR, when not functioning as the designated CCR Team Coordinator, Victim Services will:

- Complete the Danger Assessment with the victimized partner to assess the risk of serious harm or homicide.
- Identify victimized partners at high danger using Danger Assessment, professional judgement, training and experience.
- Determine if a safety plan has been developed. If not, develop a safety plan with the victimized partner.
- Work with the CCR Team Coordinator and other CCR team members to ensure all the tasks of risk assessment, referral and case plan coordination in high risk/high danger cases are completed.

10.7 DEPARTMENT OF SOCIAL DEVELOPMENT (ZONE REPRESENTATION FROM THE FOLLOWING PROGRAM AREAS: ADULT PROTECTION, CHILD AND YOUTH SERVICES, SOCIAL ASSISTANCE AND HOUSING)

Specific to their role in CCR, Social Development CCR Team members will:

- Liaise with front-line child and adult protection workers to identify high risk D/IPV cases using the Danger Assessment, professional judgement, training and experience.
- Work with the CCR Team Coordinator to ensure all the tasks of risk assessment, referral and case plan coordination in high risk/high danger cases are completed as outlined in the role of CCR Team member above.

10.8 REGIONAL HEALTH AUTHORITIES: MENTAL HEALTH AND ADDICTION SERVICES

Specific to their role in CCR, mental health and addiction services CCR Team members will:

- Liaise with front-line mental health and addictions counsellors to identify high risk D/IPV cases using the Danger Assessment, professional judgement, training and experience.
- Work with the CCR Team Coordinator to ensure all the tasks of risk assessment, referral and case plan coordination in high risk/high danger cases are completed as outlined in the role of CCR Team member above.

10.9 DOMESTIC VIOLENCE (DV) SECTOR: DOMESTIC VIOLENCE OUTREACH, TRANSITION HOUSE OR SECOND STAGE HOUSING

Specific to their role in CCR, CCR team members from the DV sector will:

- Liaise with front-line domestic violence sector staff to identify high risk/high danger D/IPV cases using the Danger Assessment, professional judgement, training and experience.
- Work with the CCR Team Coordinator to ensure all the tasks of risk assessment, referral and case plan coordination in high risk/high danger cases are completed as outlined in the role of CCR Team member above.

11. PROCEDURES

The following procedures have been outlined for the CCR model. It is recognized that procedures may be added or changed due to changes (e.g. technology) over time to reflect and meet the needs of CCR regions and high risk/high danger D/IPV cases.

11.1 INITIAL REFERRAL TO CCR

Any primary service provider who believes a referral to CCR is necessary, either based on a high risk ODARA score (score of 7-13), Extreme Danger Assessment score (score of 18+), and/or professional judgement are required to make the individual aware of CCR. If they receive consent from the victimized partner, they will send their first name, last name and a safe contact number where they can be reached by CCR Team Coordinator (*CCR Request to Contact Form*).

Once consent to refer has been obtained from the client, the front-line primary service provider sends the completed form directly to the CCR Team Coordinator and informs their respective CCR Team member that a referral has been made. It is also possible that the CCR Team members make the referral themselves.

11.2 OBTAINING INFORMED CONSENT FOR PARTICIPATION IN CCR

Upon receipt of the initial referral form, the CCR Team Coordinator will contact the victimized partner, who will be invited to a discussion (in person or by phone, whichever is preferred by the victimized partner), about CCR and how it can help. Informed consent must be obtained in writing to move forward (*Participant Consent to Collect, Use and Disclose Personal Information Form*). Informed consent means that the CCR Team Coordinator has explained to the victimized partner and check sin with the victimized partner to determine if they understand:

- the purpose of sharing information with the CCR Team (to coordinate services and collaborate on planning for their safety, case coordination and the safety of children or others);
- what information will be shared (i.e. personal information such as name, address, phone number, risk/danger factors, risk/danger assessment results and risk related information regarding the abusive partner provided by the victimized partner to other service providers); and
- who the information will be shared with (i.e. the CCR Team).

The CCR Team Coordinator must also explain the exceptions to confidentiality:

- Suspected abuse and neglect of children **must** be reported to the Department of Social Development as per the Family Services Act.
- Threats to harm self or others must also be reported to the police.
- It is possible that members of the CCR Team could be subpoenaed (i.e., court-ordered) to testify in court or to submit records to the court. If such a situation occurs, then those named in the subpoena must comply.
    - Should such a situation arise, the victimized partner will be notified as soon as possible. CCR Team members will seek to minimize the amount and nature of information to be shared

whenever possible. But they cannot guarantee complete confidentiality. They will also do what they can to address an increase in risk that may arise in this situation.

11.3 CCR INTAKE

Once the victimized partner consents to participation in the CCR model, the CCR Team Coordinator will complete the initial *CCR Client Intake/Risk Factors Form*. A file number is assigned as follows

- Fredericton: 1 _Date of referral (MMDDYYYY)_Initials (Last name, First Name)
  - E.g.: 1_03092017_RA
- Grand Falls: 2-_Date of referral (MMDDYYYY)_Initials (Last name, First Name)
  - E.g.: 2_03092017_KL
- Edmundston: 3_ Date of referral (MMDDYYYY)_Initials (Last name, First Name)
  - E.g.: 3_03092017_WK

11.4 SHARING OF VICTIMIZED PARTNER REFERRAL INFORMATION WITH CCR TEAM

- Once consent is obtained from the victimized partner, the victimized partner's information (name and date of birth) and name of the abusive partner (name only) is shared through Workspace with the CCR Team.
- Each team member will then search their databases solely for **information on the named victimized partner that is relevant for collaborative risk assessment and coordinating responses**.

*Any information contained in the victimized partner's file that discloses the abusive partner's personal information (i.e., diagnoses, participation in services etc.) cannot be shared with the CCR Team without informed consent of the abusive partner. The abusive partner's name is provided solely for the purpose of identifying information in the victimized partner's file that is **relevant to patterns of abuse and level of risk.**

**** It should be noted that the abusive partner's file/case information is not to be accessed under their own name or file. Consent must be obtained from the abusive partner before their file may be accessed.**

11.5 INVITING VICTIMIZED PARTNER TO MEET

- To ensure practice is trauma informed and consistent with victim-advocacy principles, the victimized partner will be invited to participate in their case planning. It is their choice to make an informed decision to accept or decline participation in this process.
- The victimized partner may join a team meeting at the most appropriate stage (i.e. after preliminary information sharing processes have been completed or at the beginning of risk management plan development). The CCR Team will share information regarding the victimized partner and their situation prior to meeting with the victimized partner. The victimized partner can join the meeting at any point after the CCR team has had the opportunity to familiarize themselves with the file

- Consideration must be given to the nature of the information sharing process in the initial stages of CCR, where it is possible that past traumatic events will be discussed in order to comprehensively assess risk with the team members. This process has potential to re-traumatize the victimized partner.
- The CCR Team Coordinator and victimized partner will make the decision together regarding the timing and level of involvement for her/his participation. It is recommended that this conversation take place with the victimized partner in a welcoming, safe and comfortable environment, where the victimized partner is informed about what information will be shared, and is able to make an informed decision about her/his participation based on this conversation. This approach should consider various factors (as observed, and as expressed by victimized partner) such as the emotional state of the victimized partner, duration of abuse, level of trauma, level of urgency, ability to comprehend discussions, victimized partner safety, referral source, location, childcare issues and transportation issues.
- It is possible that the initial contact with the victimized partner will be immediate safety planning and that a conversation on level of involvement must be held at another time. CCR Team Coordinators are encouraged to use their professional judgement to determine at what point this conversation will happen.
- The victimized partner can ask for, and be provided with, information concerning her/his CCR process at any time.
- The victimized partner is able to bring a support person to the meeting. If the support person is from another department or agency, appropriate confidentiality and consent forms must be completed.
- If the support person is a family member or friend of the victimized partner, the Coordinator can discuss with the victimized partner how they will be a support at the meeting (e.g. remind victimized client questions they want to ask). The intention is not to tell the victimized partner what and how their support person will support the victimized partner. Rather, it is to learn how this individual is or will be a support to the victimized partner to understand support that support person provides for the victimized client which can be helpful.
- If the victimized partner has a connection with another CCR team member then that team member may participate in this discussion along with, or instead of, the CCR Coordinator.

11.6 HOLDING THE CCR TEAM MEETING

- All team members must sign an *Affirmation of Confidentiality. Affirmations of Confidentiality* are reviewed and signed annually. New Team members sign this from when they join the CCR team or others (e.g. ad hoc members) attend CCR meetings.
- At the initial meeting, the CCR Team members share information relevant to victim's risk/danger and consensus is reached whether the case is Highest Risk/Highest Danger using the information communicated by the participant in the *Coordinated Community Response Client Intake Form/Risk Factors Form*.
- A Risk Management Plan is developed based on the risk factors in the client's situation with input from team members including the client. See *Risk Management Plan Form*. This document can be used to record of interventions/services being offered and accessed. The CCR Team is responsible for implementing their actions in the plan within their respective agencies.
- **Chair**: The chair of the CCR Team is the CCR Team Coordinator, with the responsibility of organizing the meetings and logistics**.**
- **Meetings Frequency**

- Meetings regarding high risk/high danger situations will be held on an as-needed basis, and within 48 hours or as soon as possible after initial referrals and critical developments.

- **Operating Policies**
  - CCR team members will plan meetings choosing the format - in person, online, by telephone or a combination thereof – that makes sense from a safety and practical perspective. CCR Team members will work to ensure a confidential and safe space during meetings and when working with the victimized partner.
  - Members should be open and co-operative.
  - The CCR Team Coordinator will be the team contact when it comes to communication between the CCR Program Team or Victim Services.
  - CCR teams may communicate with each other to address high risk/high danger ideally with the client's consent.
  - Questions regarding work with CCR clients can be sent to the CCR Team Coordinator or whichever team member makes sense for further clarification and/or addressed at the regular CCR Team meeting.
  - The CCR team will attempt to resolve any conflicts together. Unresolved conflicts may be referred to the Program Lead. The Program Lead will access the Provincial Steering Committee for Case Coordination as needed.
- **Case records and storage**
  - Notes taken by the CCR Team Coordinator should be recorded and stored on separate sheets for each case reviewed or updated.
  - The only document that individual CCR Team members retain should be their personal notes related to their agency's commitments to the risk management plans and next steps.
  - All hard copy files, documents and notes (originals and copies) related to each CCR case should be kept in a locked storage location in the JPS Victim Services Coordinator's office location.
  - Electronic (originals and copies) will be stored on the secure CCR Workspace.

11.7 CRITICAL DEVELOPMENTS

After a risk management plan has been developed, primary service providers will provide ongoing information in accordance with their mandates, at the time of a critical development (see definition in Appendix A) using *Critical Development Identification/Critical Development Ongoing Information Sharing* form.

11.8 CONFLICTS OF INTEREST

If you feel your role in a certain CCR file presents a conflict for yourself, the victimized partner or offending partner, identify it immediately with the CCR team coordinator or team and make alternative arrangements for representation from your department/agency for CCR team meetings and other communications regarding that specific CCR file.

12. NON-CONSENT

When an individual does not consent to participate in CCR, action may still need to be taken to prevent severe harm or death of that individual and/or someone connected to that individual (e.g. the individual's child, a new partner).

Keep in mind that the individual may be experiencing considerable trauma (i.e., anxiety, stress, lack of self esteem, Post Traumatic Stress Disorder, Traumatic Brain Injury). Further, these types of injuries due to violence may cause the person to seem disorganized, angry, hostile, depressed or lacking in emotion.

As discussed above, traumatic injuries can affect memory, capacity to recall events, ability to convey information in linear sequence and ability to retain and follow directions. These disclosures of severe traumatic events may occur slowly over time. The individual may need time and encouragement to begin to develop trust and the confidence to convey deeply personal traumatic information.

The foundations of trauma informed practice: safety, trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical, and gender issues[4] should be incorporated in all areas of CCR work.

Take time to put the individual at ease. Ask questions to ensure that the individual feels physically and emotionally safe at the time including in the meeting location. Ask questions to address the individual's comfort (e.g., the surroundings). Respond, and attempt, to address discomfort and concerns about safety.

As covered above, the following practices could be helpful:

- minimize distractions;
- minimize bright lights and noise;
- make use of checklists;
- encourage use of journals;
- repeat information and ask questions to ensure the information was understood;
- assist with developing priorities and identifying small tangible steps to take toward the priorities; discuss strategies for remembering appointments and dates;
- focus on one task at a time;
- talk slowly and on point;
- enable breaks when needed;
- avoid abstract concepts;
- offer encouragement and reassurance;
- assist with forms;
- identify supports, including medical, psychological and social; and
- encourage mutual collaboration, participation and choice.

[4] Pemberton, Jennifer V. and Loeb, Tamra B. Impact of Sexual and Interpersonal Violence and Trauma on Women: Trauma-Informed Practice and Feminist Theory JOURNAL OF FEMINIST FAMILY THERAPY 2020, VOL. 32, NOS. 1–2, 115–131 https://doi.org/10.1080/08952833.2020.1793564

The following steps outline what happens when a CCR team member is interacting with an individual at high risk for serious harm or lethality:

- Explain your role and what you can and cannot do for the individual.
- Explain the CCR and consent process.
- Determine whether individual is at high risk (e.g. Danger Assessment, intake)

12.1 PROCEDURES

If the potential client has been punched in the head, choked or strangled with loss of consciousness, had their head shoved into walls or has been repeatedly shaken, refer the client for medical brain trauma assessment.

Engage in a purposeful conversation with the individual regarding their level of risk and danger, the safety plans and supports available to them and the benefits of the CCR program

- If individual consents to be a part of CCR: continue with CCR process
- Offer space and time for the individual to ask questions and to attempt to address their concerns about CCR.

If an individual does not consent to be a part of CCR and it is determined that an individual is at high risk for serious harm or lethality, the Coordinator or CCR team member should express support and concern and have a clear, purposeful discussion regarding the risk they identify in the individual's situation keeping in mind the following elements:

- Explain that participation in CCR will enable her to collaborate with people in the community who can help to protect her and her children and that her participation will ensure that she can participate directly in decisions about her life.
- Respect and rapport are the foundation of any interaction with the individual. What can be done to encourage engagement? In the case where the individual is **not** known to the CCR team member, it could be asking the individual if there is a service provider (e.g., referral source, service provider they know and trust) that could be included in the conversation (this may or may not be possible). It could be taking time to establish rapport by asking the individual questions about their children, what activities they enjoy, or about hobbies or future aspirations.
- Explain what CCR is, how it works and what it does including being clear who is a part of the team and how the team members can assist. This may have already been done. But more time may be needed to fully explore with the individual what CCR is, what participation looks like, etc..
- An individual could be resistant to the CCR process for a variety of reasons. The goal is to determine what is behind the individual's hesitancy or resistance. If it is a matter that they distrust a team member's department or agency, then identifying and addressing the reasons for the individual's distrust may be helpful. If the fear of their abusive partner's threats or reaction to participation is preventing their involvement in CCR, then that is a different conversation focusing on what steps need to be taken to ensure safety.
- Conversation is focussed on the individual's well-being and any goals they have identified, and the risk identified that puts the individual's well-being and their goals at risk.

- Clear, plain language is needed to help ensure individuals' understanding of their situation and risk (e.g., "The assaults are happening more and more often, and they are getting worse. I am genuinely concerned that the next time your partner assaults you will end up in the hospital."
- Explain how the risk identified in the individual's situation relates to risk and danger, their own and potentially their children and other people who love and support them
- Keep in mind throughout the conversation the need to ensure that the individual understands fully the level of risk and danger especially if you do not know the individual; it is their life and ideally, we want to work with them in addressing the risk in their lives. There could be any number of factors that prevent, or make it difficult, for the individual to understand you including language barriers, trauma and lack of knowledge regarding risk.
- Check in with the individual throughout the conversation; what do they understand from what you have said so far? What else would they like to know? It could be the individual feels something else in their life is a priority. If the individual is focussed on another matter, it could be helpful to know what that is. Sometimes helping them with helping them with another priority that is distracting them of blocking their participation could help to support them in overcoming resistance.

If, after having a thoughtful and direct conversation, the individual still doesn't consent to be a part of the CCR process and the CCR team coordinator or team member believes the release of the information to CCR Committee is, as per the Right to Information and Protection of Privacy Act – section 46(1)(i) "**necessary to protect the mental or physical health or the safety or any individual or group of individuals**" the CCR Coordinator or team member will inform the individual at risk and explain the reasons information must be communicated. The CCR Coordinator will work collaboratively with the individual to identify and to limit any concerns the individual has about negative consequences of disclosure. The CCR team member will explain that they are going to call a meeting of CCR team members, explain what information will be conveyed to who, and that the information will be limited to information needed to enable action on the risk identified in the individual's situation. Informing the individual of this next step is preferable unless it is thought this would interfere with actions to be taken to address risk in the individual's situation.

The CCR Coordinator or team member will schedule a meeting of select CCR team members within 48 hours or as soon as possible as they normally would. In the meantime, they will also work with the individual to do safety planning or take other measures to address immediate concerns to individual's risk as they normally do.

12.2 ROLES OF CCR TEAM MEMBERS WHEN INDIVIDUAL DOES NOT CONSENT TO BE A PART OF CCR PROCESS

12.2.1 VICTIMIZED PARTNER

The inclusion of the victimized partner's wishes and ongoing assessment of risk while essential to the CCR process will now be focussed on maintaining a connection with the victimized partner and ongoing risk assessment and risk management. Victim empowerment is still central to the CCR Team as plans are made to increase their immediate safety, and to address their ongoing needs.

Victimized partner participation in CCR could still include:

- Deciding whether to participate in CCR, and the level at which they wish to be involved; they can still decide to participate in the CCR at any time.

- Receiving support from a multi-disciplinary team to increase immediate and long-term safety and connecting her/him to services that can help her/him deal with the long term impacts of abuse.

12.2.2 POLICE

Specific to their role in the CCR Team, the police representative will:

- Still be able to be involved due to the nature of their role even if the individual did not consent for police to participate in CCR process.
- Liaise with front-line officers to identify high risk D/IPV cases using ODARA and professional judgement.[xxvii]
- Share the ODARA for CCR purpose with CCR Team Coordinator.
- Work with the CCR Team Coordinator to ensure all the tasks of risk assessment, referral and case plan coordination in high risk/high danger cases are completed as outlined in the role of CCR Team member above.

12.2.3 DEPARTMENT OF JUSTICE AND PUBLIC SAFETY – VICTIM SERVICES

Victim Services will continue to offer ongoing support services to victims of crime as outlined by agency policy and protocol. Specific to CCR Victim Services will:

- Complete the Danger Assessment with the victimized partner to assess the risk of serious harm or homicide.
- Identify victimized partners at high danger using Danger Assessment, professional judgement, training and experience.
- Determine if a safety plan has been developed. If not, develop a safety plan with the victimized partner and adjusti the safety plan as required
- Work with the CCR Team Coordinator (where applicable) to ensure all the tasks of risk assessment, referral and case plan coordination in high risk/high danger cases are completed as outlined in the role of CCR Team member above.

12.2.4 DEPARTMENT OF SOCIAL DEVELOPMENT (ADULT PROTECTION, CHILD AND YOUTH SERVICES)

Specific to their role in CCR, Social Development CCR Team members will:

- While the individual did not consent to participate in CCR process the Social Development member is still able to be involved due to the nature of their role.
- Liaise with front-line child and adult protection workers to identify high risk D/IPV cases using the Danger Assessment, professional judgement, training and experience.
- Work with the CCR Team Coordinator to ensure all the tasks of risk assessment, referral and case plan coordination in high risk/high danger cases are completed as outlined in the role of CCR Team member above.

12.2.5 REGIONAL HEALTH AUTHORITIES: MENTAL HEALTH AND ADDICTION SERVICES

Specific to their role in CCR, mental health and addiction services CCR Team members will:

- If the individual did not consent to participate in the CCR process the Regional Health Authorities member(s) will not participate directly participate in the CCR process. But, they can support their fellow team members (e.g. provide information on their services) and the victim outside of the CCR process as they normally would.

12.2.6 DOMESTIC VIOLENCE SECTOR: DOMESTIC VIOLENCE OUTREACH, TRANSITION HOUSE OR SECOND STAGE HOUSING

Specific to their role in CCR, CCR team members from the Domestic Violence sector will:

- If the individual did not consent to participate in the CCR process the Domestic Violence member(s) will not participate directly in the CCR process. But, they can support their fellow team members (e.g. provide information on their services) and the victim outside of the CCR process as they normally would.

APPENDIX A: DEFINITIONS

Offending Partner

For the purposes of this document, the term “offending partner” will be used to identify the partner who uses violence or is violent toward the other partner or others such as children, family members or third parties. Other common terms used by service providers may include abuser, accused, offender or perpetrator. It is recognized that CCR clients’ partners may or may not be involved with police or other aspects of justice system.

The terms victim and 'victimized' reflect that violence is present and current in the relationship or former relationship. The terms are also inclusive of gender. Therefore, the terms 'victimized partner' and 'offending partner' are used in these materials to refer to the person targeted with violence and to the dominant aggressor.[xxviii]

Case Coordination

Case Coordination refers to the process of collaboration amongst service providers to prevent re-assault of a victimized partner or to lower her risk of lethality. The Case Coordination process will be primarily based on the concepts of open lines of communication and information sharing. In recognition of various limitations to open sharing of information, protocols will be set in place to ensure there are no gaps created or left open once the Case Coordination process has been set in motion. Information will continue to be shared amongst the team of service providers immediately after the high risk referral has been made and confirmed as high risk/danger, and will continue to be shared so long as the case exists at the high risk level.

Critical Developments

A critical development is a change in situation or factors that can increase the risk for the victimized partner or other person to be harmed or killed and the offending partner to re-assault.

1. An offending partner is alleged to have committed another offence.
2. An accused is released by police on a promise to appear.
3. A primary service provider becomes aware the contact occurs between victimized partner and the offending partner (pre-release, or throughout the justice process). This could include regular contact; sporadic, subtle intimidation; or victim agreement to vary a court order.
4. An offending partner is released on judicial interim release (bail) or a Family Court hearing has resulted in conditions that prevent the offending partner from returning to the family home, contacting the victimized partner/children or having unauthorized contact with the children.
5. A primary service provider becomes aware that the victimized partner, during the criminal justice process, enters a new relationship (or initiates other major changes, e.g., relocation).
6. An offending partner breaches a court order by, for example, having unauthorized contact with the victimized partner/children, or by the use of alcohol and/or drugs or by not following a prescribed treatment plan/intervention.
7. A primary service provider becomes aware that either the victimized partner or the offending partner takes an action that is contrary to an agreed upon safety plan or intervention.
8. An application is made for a peace bond.
9. Trial and/or sentencing dates are approaching.
10. An offending partner is released from custody at the end of the sentence.
11. Family Court proceedings are initiated or approaching (i.e. separation hearing, divorce matters, etc.).

12. Service providers are unable to reach/locate the victimized partner or the offending partner.
13. Changes in risk factors can also serve as a critical development that increases risk. Please refer to the *Coordinated Community Response Client Intake Form/Risk Factors* form.

*These critical developments are identified for the purposes of distinguishing when and how information will be shared with primary service providers. It is recognized, however, that this list is not exhaustive and there may be other critical developments identified through an ongoing process of information sharing.

Domestic/Intimate Partner Violence

A common definition of D/IPV has been developed and is used by all police forces (both RCMP and municipal/regional) in New Brunswick. The definition is consistent with the description used by the Provincial Court - Domestic Violence in Moncton, by prosecution services of the Office of the Attorney General, and New Brunswick's Crime Prevention and Reduction Strategy. Domestic and intimate partner violence occurs when a person (regardless of their gender) uses abusive, threatening, harassing or violent behaviour as a means to psychologically, physically, sexually or financially coerce, dominate and control the other member of their intimate personal relationship. This definition includes individuals who were previously or who are currently involved in an intimate/romantic relationship with each other (married, common-law, or dating), irrespective of whether this relationship was between same-gender or different-gendered couples and whether the couple cohabitated. D/IPV is also considered to have occurred when an individual or family member on the individual's behalf, directly or indirectly, resorts to abusive, threatening, harassing or violent behaviour towards the partner's or ex-partner's children, relatives, friends, employers and work colleagues, or new partner as a means to psychologically intimidate, dominate and control the current or ex-partner.

Coercive Control

A pattern of abusive behaviours such as hurting, threatening, monitoring, exploiting, gaslighting, isolating, humiliating, intimidating and dominating another person. Some of these behaviours can be very subtle. They can make a person fear being physically harmed even if there is no physical violence – and can also lead to physical violence, including homicide. Coercive control negatively affects a victim's self-esteem, mental health, and ability to function and perform daily activities (e.g. get up, eat, perform chores, go to work, care for children, make decisions, etc.). An individual who is subjected to coercive control may be dependent, scared or isolated. This is text integrated from WEB, Love Shouldn't Hurt, Mary Aspinall, Carmen Gill. (Evan Stark work)

Danger Assessment (DA)

The DA is a tool used by Domestic Violence sector and Victim Services Coordinators with victimized partners. It is a tool that helps to determine the level of danger an abused woman has of being killed by her intimate partner. The tool was originally developed by Jacquelyn Campbell (1986) with consultation and content validity support from battered women, shelter workers, law enforcement officials, and other clinical experts on battering.

Extreme Danger

A case that has been found to be at a level of Extreme Danger, a score of 18 or higher on the Danger Assessment, identifies that after much consideration of circumstances, there are a large number of predictive factors present in the victim's life that have been found to lead to lethality by their offending partner. This will be accepted to the CCR as high danger.

High Risk

A case that has been defined as high risk case means that after considering all of the circumstances, the offender has the potential and is at high risk of reoffending and/or poses a threat of escalating violent behaviour likely to cause bodily harm or death to a victim or victimsxxix. For the purposes of this CCR, a score of 7-13 on the ODARA is considered high risk.

Ongoing Information Sharing

Ongoing information sharing is information shared with CCR team members who are primary service providers subsequent to an initial referral or at the time of a critical development where risk increases, and as long as the case is identified as high risk by any primary service provider.

Ontario Domestic Assault Risk Assessment (ODARA)

ODARA is a tool used by police and probation officers with offending partners. The ODARA is a risk assessment tool that has been developed and validated to assess the risk of future domestic assault, in addition to the frequency and severity of future assaults. Police can complete this risk assessment through various avenues, including speaking with the victim and/or using police records to ensure as much information as possible is included.

Primary Service Providers

Primary Service Providers include Police, Department of Justice and Public Safety – Victim Services, Social Development – Child and Adult Protection, Domestic Violence Sector, and a member from the Health sector. These service providers will make up the various CCR teams across the province and work collaboratively with one another to ensure the victimized partner's safety.

Professional Judgment

A service provider may have serious concerns about a victimized partner's situation. There may be situations where the context of a case gives rise to serious concerns even if the victimized partner has been unable to disclose the information that might highlight their risk more clearly. This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers. The judgment would be based on the professional's experience and/or the victim's perception of their risk in addition to the outcome of a risk assessment that assesses level of risk of re-assault/lethality. In those cases, a referral may be made to the CCR Team Coordinator, in addition to a brief rationale for referring the case which should be documented on CCR Request to Contact form.

Proactive Referral

After completion of a risk assessment and receiving verbal consent from the client to share their information with the CCR Team Coordinator, the referring agency has a maximum of 48 hours to send this referral to the CCR Team Coordinator. Upon receipt of the referral, the CCR Team Coordinator must notify the CCR Team regarding the new client referral within 48 hours. In the event that it is not possible to have the initial client meeting with the entire CCR Team held within 48 hours, the CCR Team Coordinator will meet with the client to create a safety plan and aid the client with any immediate needs and concerns, advising the CCR Team of the risk and steps taken. If the situation warrants immediacy the Team Coordinator may hold an ad hoc meeting with select CCR Team members essential to the most pressing risks and or needs of the client between Team meetings.

Risk Assessment

Not all people are equally at risk. It is important to determine the risk factors that are present in a person's life that may increase his/her likelihood of future re-offending or being victimized. In the context of D/IPV, risk assessment involves making probabilistic estimates about how likely a person is to perpetrate or be subjected to D/IPV behaviour in the future.

There are varying approaches to assess the risk of future assault or homicide. There are tools designed to predict domestic violence re-assault and tools which assess the likelihood of a domestic violence related homicide. Risk assessment tools have their respective strengths and limitations.

Risk Management Plan

A risk management plan includes strategies put in place because of collaboration by the CCR Team to manage and reduce level of risk of re-assault or homicide/suicide. It can include strategies that complement the victimized partner's safety planning and intervention support to the victimized partner.

It is important to note that a person's risk for criminal behaviour, including D/IPV, is dynamic; it can change over time and due changes to factors in the situation. This means that after a risk level is assigned, it can change with intervention and circumstance. It is important that interventions be more intensive, responding to the level of risk/danger and responsive to the factors that tend to increase risk including substance use, mental health, etc. When critical developments occur, the level of risk must be re-assessed. The CCR Team is responsible for determining what the most appropriate approach is for each specific case.

Victimized Partner

Anyone can experience domestic/intimate partner violence in their relationship. D/IPV is independent of age, socio-economic status, culture and religion; therefore, it is difficult to pin-point a definition of a victim. For the purposes of this document, the term "victimized partner" will be used to identify the individual within the relationship who is being subjected to the violence. Other terms used by service providers may include victim or survivor.

The terms victim and 'victimized' reflect that violence is present and current in the relationship or former relationship. The terms are also inclusive of gender. Therefore, the terms 'victimized partner' and 'offending partner' are used in these materials to refer to the person targeted with violence and to the dominant aggressor.[xxx]

Workspaces

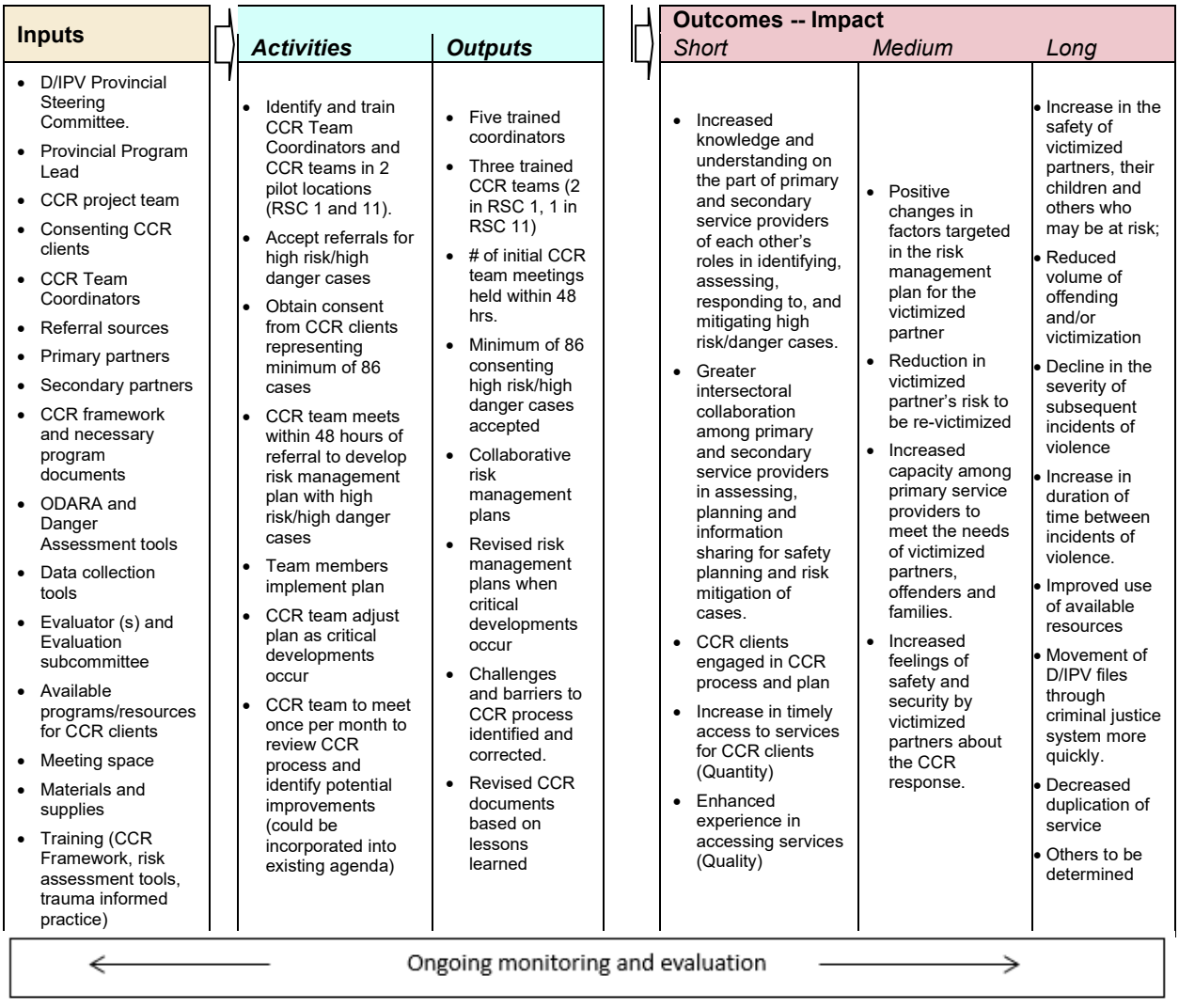
Workspaces is an online secure file storage system allowing CCR team members the ability to access and use client files and other documents securely. Workspaces includes an audit capability allowing administrators to view and control individual team members access to Workspaces.

APPENDIX B: CCR LOGIC MODEL

Program Logic Model: Coordinated Community Response to high risk/high danger in D/IPV cases

Situation: New Brunswick has high rates of intimate partner violence (IPV) and IPV related homicide. There is a need for prevention through better information sharing when a person has been identified at high risk of harm or lethality. Other jurisdictions have implemented similar models with success.

Solution: CCR is an evidence-based, trauma-informed collaborative model that will enhance integration across government and community services in working with high-risk perpetrators, high-danger victims and their families. At the core of CCR are multi-disciplinary teams that will foster cross-sectoral collaboration to improve service delivery and outcomes. **The goals of CCR are to**: increase the safety of victimized partners, their children and others who may be at risk; and make the best use of available resources. ***It should be noted that the CCR model is not meant to replace existing applicable legislation and protocols (i.e. CCC, IPVI Act (pending), Family Services Act, Woman Victims of Abuse Protocols, Child Victim of Abuse protocols etc.); rather it is meant to complement and enhance existing practices in order to achieve the above stated goals.*



APPENDIX C: TERMS OF REFERENCE FOR D/IPV PROVINCIAL STEERING COMMITTEE FOR CASE COORDINATION

BACKGROUND

Domestic/intimate partner violence is a significant social, health and economic issue throughout Canada and the world. In New Brunswick, domestic/intimate partner violence, violence against women in particular, is a real and prevalent problem. In fact, New Brunswick has the highest rate of women killed by their intimate partner than any other Atlantic province.[xxxi] New Brunswick also has the highest rate of police-reported victims of violent crime by an intimate partner in Atlantic Canada.[xxxii] Outside the territories, criminal harassment against women is most prevalent in New Brunswick.[xxxiii] Despite the high levels of violence against women, intimate partner violence remains a hidden problem with a huge social, health and economic cost to the Province. The economic cost is estimated at $165 million a year in New Brunswick.[xxxiv]

A common definition of D/IPV, inclusive of diverse sexual orientation, gender identity and gender expression has been developed and is used by all police forces in New Brunswick. The definition is consistent with the description used by the Specialized Domestic Violence Court in Moncton and by prosecution services of the Office of the Attorney General. The definition is also complementary to the definition entrenched in the Woman Victims of Abuse Protocols. *Domestic and Intimate Partner Violence is defined as behavior that occurs when a person, who is currently or was previously in an intimate personal relationship, monitors or stalks or uses abusive, threatening, harassing or violent behaviour as a means to psychologically, physically, sexually or financially coerce, dominate and control the other member of the relationship.* This definition includes individuals who were previously or who are currently involved in an intimate/romantic relationship with each other (married, common-law, or dating), regardless of whether this relationship was between same-sex or different-sex couples and whether the couple cohabited. D/IPV is also considered to have occurred when an individual or family member on the individual's behalf, directly or indirectly, resorts to abusive threatening, harassing or violent behaviour towards the partner's or ex-partner's children, relatives, friends, employers and work colleagues, or new partner as a means to psychologically intimidate, dominate and control the complainant.

D/IPV is a serious and ongoing social problem. Supporting victims of violence and their families is complex and requires collaboration across sectors. Multi-sectoral approaches that engage organizations from various segments of society (e.g., non-profit, governmental, for-profit, academia) with complementary sets of expertise (e.g., violence against women, health, justice, policing) are needed to address complex social issues like domestic and intimate partner violence.[xxxv] Thus action to develop a coordinated response to high risk D/IPV cases and cases that suggest a potential for lethal outcome is an important activity in the 2014-2016 and 2016-2019 New Brunswick Crime Prevention and Reduction Strategy Action Plan. Coordinated, multi-agency approaches will enhance community and justice responses to these cases through improved information sharing, collaborative safety planning and risk mitigation strategies.[xxxvi] This work builds on the province-wide training of all front-line police officers on D/IPV and the Ontario Domestic Assault Risk Assessment (ODARA) tool; use of the Danger Assessment by Victim Services Coordinators and the domestic violence sector; the

revised Woman Victims of Abuse Protocols; work of the New Brunswick Domestic Violence Death Review Committee; the Moncton Domestic Violence Court; and other D/IPV Strategy Activities.

As indicated in the Charter for a Coordinated Community Response to D/IPV in New Brunswick, the overall goals of case coordination, at the provincial and community level, are to increase the safety of victims and children; reduce the abuser's risk to re-victimize; and make the best use of available resources.

FUNCTIONS

Consistent with the goals, objectives and guiding principles of the Charter for a Coordinated Community Response to Domestic/Intimate Violence (D/IPV) cases in New Brunswick, a D/IPV Provincial Steering Committee for Case Coordination will be established and will become a permanent committee that will be responsible for making collective decisions regarding the design and protocols of the Coordinated Community Response (CCR) model and will support decision-making regarding the model development and implementation. They are the "go to" committee when a policy or procedure concern arises.

Specifically, the D/IPV Provincial Steering Committee for Case Coordination will:

- Oversee the development, implementation and evaluation of the CCR model;
- Collaborate with government departments and partner agencies on adjustments to D/IPV policies and procedures as necessary;
- Receive reports and recommendations from any working group and subcommittee(s) established in the course of this work and provide support as required;
- Seek Government approval where required; and
- Ensure policy and procedures of their respective agencies are consistent with provincial D/IPV policy, procedures and protocols and the CCR model.

MEMBERSHIP

The D/IPV Provincial Steering Committee for Case Coordination is to include one member from each of the following:

- Justice and Public Safety
- Office of Attorney General
- New Brunswick Association of Chiefs of Police
- RCMP 'J' Division
- Women's Equality Branch
- Social Development
- Health
- Education and Early Childhood Development
- Domestic Violence Sector representative (such as domestic violence outreach, transition house or second stage housing)
- First Nation front-line representative
- Perpetrator or Offender Program representative
- Academic (Ph.D., research and publications in the domestic or family violence field)

Each agency will commit and select one representative to be part of the D/IPV Provincial Steering Committee for Case Coordination and that the representative has decision-making authority. There will be a permanent position on the Steering Committee for an academic with expertise in the domestic or family violence field. The academic's position will rotate every 2 years, with a 2 year period in between repeat service.

COMMITTEE LOGISTICS

Duration: The Committee will meet quarterly at a mutually agreed upon time and place. Additional meetings may be scheduled where necessary.

Participation: Every effort should be made to ensure members attend the Committee meetings.

Record of Decisions: Attendance, decisions, and action items will be recorded in Meeting Minutes.

Co-Chairs: The Committee Co-Chairs will be representatives of the Department of Justice and Public Safety and Women's Equality Branch. The Co-Chairs are responsible for running the meeting according to the Committee agenda, and hold no more authority than other Committee members.

Reporting Relationships: Committee members will report to the leadership of their respective agencies as required.

RELATIONSHIPS TO OTHER GROUPS

The Committee may from time to time include representation of subject matter experts to consider specialist issues and to bring forward recommendations, such as a representative of the academic community having a research focus on domestic violence.

The Committee may establish subcommittees to complete specific tasks.

The D/IPV Provincial Steering Committee for Case Coordination reports to the New Brunswick Roundtable on Crime and Public Safety and its Crime Prevention and Reduction Strategy.

AMENDMENTS TO TERMS OF REFERENCE

Members of the Steering Committee acknowledge that the terms of reference may need to be amended from time to time.

APPENDIX D: CCR MEMBERSHIP GUIDELINES

Co-ordinated Community Response to High Risk/High Danger Domestic/Intimate Partner Violence (CCR)

CCR Membership Information Tool for managers and people contemplating CCR membership

Roles and Responsibilities for new CCR members

These guidelines are intended to help managers, supervisors and staff determine the best "fit" when assigning an employee to a Co-ordinated Community Response to High Risk/High Danger Domestic/Intimate Partner Violence (CCR) team.

The foundation of CCR is the way we collectively think about domestic/intimate partner violence (D/IPV) which is critical for a collaborative multiagency response to D/IPV.

CCR team members work together with the client/survivor to address high danger/high risk D/IPV in which they are living.

An employee with the following attributes, skills and knowledge is better suited to be a CCR team member:

- work collaboratively with a team to confirm the level of danger or risk and to come up with a plan to address this risk.
- come together in face-to-face meetings, or use technology such as conference calling, zoom, skype - as long as privacy and confidentiality can be assured for the client.
- exchange expertise and knowledge to conduct a risk assessment and safety plan for the participant and their family
- awareness of the services and resources their respective organizations can offer a client and can make internal inquiries to address gaps when they emerge.
- provide timely and effective responses and support for CCR participants and CCR team members due to the urgency of these situations.
- utilize trauma-informed principles and practice i.e. recognizing the effect of violence on an individual and their trauma responses; building relational collaborations; establishing a respectful, safe and accepting environment for survivors; emphasizing client strengths and resilience; minimizing triggers associated with re-traumatization; providing culturally competent services; acknowledging the need to be vigilant for signs of Compassion Fatigue and Vicarious Trauma themselves, team members and front-line service providers.
- are respectful of all team members and the clients they serve. While all clients in the CCR Program are at risk and require intervention; interventions are developed and delivered for individual clients and can vary due to several factors including gender, socio-economic status, culture, language, immigration status, sexual orientation, age, physical and mental disabilities, mental health status, geographic location, family situation and lifestyle, among other factors.

DOMESTIC AND INTIMATE PARTNER VIOLENCE

- D/IPV includes verbal, physical, sexual, emotional, financial and spiritual abuse which are tactics of power and control.
- D/IPV is, by its nature, chronic. Prolonged abuse and trauma result in complex neurobiological and psychological effects. These effects interfere with the way victims access safety; make self-protective decisions; process information; and remember details. Not only does trauma affect help-seeking and decision-making, it also increases risk of being isolated and controlled.[xxxvii]
- Although women are more likely to be victimized by D/IPV[xxxviii], and men tend to more commonly be the abuser, D/IPV can be directed at male victims by other males or female abusers as well. Thus, a gendered awareness of D/IPV is necessary and appropriate, but it should not be used to exclude the recognition of D/IPV in these other intimate relationship contexts.
- D/IPV is not a series of isolated incidents affecting an individual victim; rather, D/IPV is a pattern of abusive behavior used by an identifiable individual that can encompass multiple victims (children and adults) in the past, present and future.[xxxix]
- Children, new partners, extended family, workplace colleagues and pets[xl] are vulnerable to harm when a D/IPV case is high risk/high danger.[xli]
- D/IPV and child abuse and neglect are entangled forms of abuse. Child exposure to D/IPV is child abuse and neglect.[xlii] Parents who perpetrate D/IPV may also directly abuse their children. The offending partner's/parent's decision to abuse an intimate partner who is a parent is a parenting decision.[xliii] When the woman is at risk of being victimized, her children are also at risk. Similarly, when a woman's life is in potential danger in a D/IPV context, the child's life is in danger, too.

ASSESSING RISK OF RE-ASSAULT AND LETHALITY IN D/IPV CASES

- New Brunswick's domestic violence sector, Victim Services and others are currently using Danger Assessment to assess the level of danger for a victim to be seriously harmed or killed due to D/IPV while police are currently using ODARA (Ontario Domestic Assault Risk Assessment) to assess the level of risk for an abusive partner to re-assault their intimate partner. Currently, these tools are the basis of CCR.
- Risk is dynamic and situational and escalates or decreases depending on personal and social context and can change rapidly.
- Risk assessments and safety plans should be updated regularly, particularly when circumstances change.
- Critical developments are incidents or situations that are more likely to increase the level of risk, so it is important that team members understand the nature of critical developments and share with each other when there is a critical development.
- CCR teams discuss risk factors for re-assault and lethality and factors that impact the safety of the client which are commonly referred to vulnerability and protective factors.
- CCR teams work together to develop a risk management plan, recognizing the risk factors present and working with the client to ensure the plan in implemented

CCR TEAM MEMBER TIME COMMITMENT

CCR team membership is complementary to the work that many employees are currently doing. Many of the clients are already on the caseload of the agency however CCR adds another layer to that work with additional time commitment. A CCR team member may have responsibility to complete an additional assessment and may need to do some preliminary safety planning depending on the client's situation. Completing documentation to make a referral to the CCR team coordinator is a new step as is setting time aside for the CCR team/client meeting. Follow-up tasks to support the safety and manage risk for the client that are generated by the CCR team may require additional time. Managers need to consider how this differs from the employee's responsibilities to their client that are already part of their work.

At the outset a New CCR team member will commit to four sessions for a total of approximately eight hours of onboarding and training to prepare for seeing clients. They will need to complete a six-hour Danger Assessment training offered by Women's Equality Branch if they haven't already done so. Ongoing safety assessment, safety planning and risk management with the client varies depending on the risk factors and the level of risk. The time commitment for the team member will vary depending on their relationship and their role with the client. Estimates from pilot sites indicate between eight and 10 hours are required on one CCR file over the course of their involvement with the team. There is currently no data on the average length of time a case file is active. Due to the nature of CCR working with high risk/high danger clients, a file cannot be closed until there has been a reduction in risk to the client and this may take time to present itself CCR team meetings can be held in person, which may require travel to/from sites, or by conference call or virtually. CCR teams can adapt this process as they evolve.

[1] Haskell, L. (2015, September 23). Violence, victimization and trauma: The complexity of trauma responses. Presentation training to Provincial Partners in Action Conference, Fredericton, New Brunswick.

[1] The vast majority of victims of police-reported intimate partner violence are women, accounting for 80% of victims in 2011, a finding consistent over time. Women are much more likely than men to be victims of spousal homicide. In 2011, more than 6 times as many women were killed by a current or former spouse as men (81 women, 13 men). In DV situations, women are twice as likely as men to be injured, three times more likely to fear for their lives, twice as likely to suffer serious injury, and six times as likely to seek medical attention – Sinha, M. (2013). Family violence in Canada: A statistical profile, 2011. *Juristat.* (Statistics Canada Catalogue no. 85-002-X).

[1] Wellington: Family Violence Death Review Committee. (2016, February). Family Violence Death Review Committee, 2014. Fifth Report: January 2014 to December 2015. Wellington, New Zealand: Health Quality & Safety Commission.

1 See: Safe For Pets Too in Transition with you http://nbvma-amvnb.ca/pet-owners/pet-owners-safe-for-pets/

[1] Community Coordination for Women's Safety (CCWS). (2014, September). Information Bulletin May 2014: What are Domestic Violence Interagency Case Assessment Teams and what do they do?

[1] New Brunswick *Family Services Act*, s.31(1) The security or development of a child may be in danger when (f) the child is living in a situation where there is domestic violence.

[1] Wellington: Family Violence Death Review Committee. (2016, February). Family Violence Death Review Committee, 2014. Fifth Report: January 2014 to December 2015. Wellington, New Zealand: Health Quality & Safety Commission.

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i Conroy, Shana. (2019). Family Violence in Canada: A statistical profile, 2019. Juristat (Statistics Canada Caatalogue no. 85-002-x).

ii Myrna Dawson, Danielle Sutton, Michelle Carrigan, Valérie Grand'Maison, Danielle Bader, Angelika Zecha and Ciara Boyd. #Callitfemicide: Understanding gender-related killings of women and girls in Canada 2019. Canadian Femicide Observatory for Justice and Accountability.

iii Total economic impact of IPV in 2009: $7.4 billion ($220 per Canadian). In NB alone (with population 751,171), cost was $165 million. Total economic impact of IPV in 2009: $7.4 billion ($220 per Canadian). In NB alone (with population 751,171), cost was $165 million. Total economic impact of IPV in 2009: $7.4 billion ($220 per Canadian). In NB alone (with population 751,171), cost was $165 million. Zhang, T., Hoddenbagh, J., McDonald, S., & Scrim, K. (2012). An estimation of the economic impact of spousal violence in Canada, 2009. Department of Justice Canada.

iv Most of the well-established risk instruments used for assessing future violence produce predictive validities in the moderate range. Canales, D., Macaulay, A., McDougall, A., Wei, R., & Campbell, M. A. (2013). A brief synopsis of risk assessment screening tools for frontline professionals responding to intimate partner violence. Centre for Criminal Justice Studies, University of New Brunswick-Saint John.

v Wellington: Family Violence Death Review Committee. (2016, February). Family Violence Death Review Committee, 2014. Fifth Report: January 2014 to December 2015. Wellington, New Zealand: Health Quality & Safety Commission.

vi See: Safe For Pets Too in Transition with you http://nbvma-amvnb.ca/pet-owners/pet-owners-safe-for-pets/

vii Community Coordination for Women's Safety (CCWS). (2014, September). Information Bulletin May 2014: What are Domestic Violence Interagency Case Assessment Teams and what do they do?

viii Ibid.

ix Haskell, L. (2015, September 23). Violence, victimization and trauma: The complexity of trauma responses. Presentation training to Provincial Partners in Action Conference, Fredericton, New Brunswick.

x Canada has human rights obligations under international laws and universal human rights instruments, including the Universal Declaration of Human Rights, Convention on the Elimination of All Forms of Discrimination Against Women, Convention on the Rights of the Child, Convention on the Rights of Persons with Disabilities, and the Vienna Declaration and Programme of Action of the World Conference on Human Rights among others.

xi The vast majority of victims of police-reported intimate partner violence are women, accounting for 80% of victims in 2011, a finding consistent over time. Women are much more likely than men to be victims of spousal homicide. In 2011, more than 6 times as many women were killed by a current or former spouse as men (81 women, 13 men). In DV situations, women are twice as likely as men to be injured, three times more likely to fear for their lives, twice as likely to suffer serious injury, and six times as likely to seek medical attention – Sinha, M. (2013). Family violence in Canada: A statistical profile, 2011. Juristat. (Statistics Canada Catalogue no. 85-002-X).

xii Aboriginal women are not a homogenous group; all have different experiences, realities and histories despite the commonality of being Aboriginal which includes First Nations, Inuit and Métis [The Government of New Brunswick. (2014). Woman Victims of Abuse Protocols.].

xiii Nearly a quarter of all Aboriginal women in Canada have experienced IPV - three times the number of non-Aboriginal women. Not only are Aboriginal women more likely than non-Aboriginal women to be victims of IPV; they are subjected to more frequent and severe violence, more likely to suffer serious injuries, to fear for their lives, and to be murdered by their spouses. The rate of Aboriginal women killed by intimate partners is four times the rate of non-Aboriginal women [Brzozowski, J.A., Taylor-Butts, A., & Johnson, S. (2006). Victimization and offending among the Aboriginal population in Canada. Ottawa: Canadian Centre for Justice Statistics; Perreault, S. (2011). Violent victimization of Aboriginal people in the Canadian provinces, 2009. Statistics Canada catalogue no. 85-002-X; Johnson, H. (2006). Measuring Violence Against Women: Statistical Trends, 2006. Statistics Canada catalogue no. 85-570-XIE.].

xiv Solutions addressing violence against Aboriginal women in New Brunswick, living both on and off First Nations communities, must first take in account the historical context of Aboriginal women in Canada: the intergenerational impacts of colonization, Indian Act legislation (reservation system, loss of First Nation status rights by First Nations women who marry non-First Nations men), poverty, racism and discrimination, loss of traditional way of life including language and ceremonies, residential school system, and the "Sixties Scoop" of Aboriginal children by provincial child welfare agencies (The Government of New Brunswick. (2014). Woman Victims of Abuse Protocols.).

xv Barrett, B., St. Pierre, M., & Vaillancourt, N. (2011). Police response to intimate partner violence in Canada: Do victim characteristics matter? Women & Criminal Justice, 21(1), 38-62.

xvi A project is currently underway in New Brunswick to assess and understand the systemic and structural barriers as well as the state of public services relating to immigrant women experiencing D/IPV in the province. A key project objective is to inform the CCR model to high risk/high danger D/IPV cases in New Brunswick.

xvii New Brunswick Family Services Act, s.31(1) The security or development of a child may be in danger when (f) the child is living in a situation where there is domestic violence.

xviii Wellington: Family Violence Death Review Committee. (2016, February). Family Violence Death Review Committee, 2014. Fifth Report: January 2014 to December 2015. Wellington, New Zealand: Health Quality & Safety Commission.

xix Ibid.

xx Ibid.

xxi Light, L., Ruebsaat, G., Turner, D., Novakowski, M., & Walsh, W. (2008). Keeping women safe: Eight critical components of an effective justice response to domestic violence. British Columbia; British Columbia Ministry of Public Safety and Solicitor General. (2010). Domestic violence response: A community framework for maximizing women's safety.

xxii Office of the Chief Coroner. (ND). Recommendations from the Domestic Violence Death Review Committee (2012-2013).

xxiii Grey Bruce Violence Prevention Coordinating Committee. (2011). Community response protocol: A coordinated and collaborative response to sexual assault and domestic violence in Grey and Bruce counties.

xxiv Tibbetts Murphy, S. (2011). Advocacy challenges in a CCR: Protecting confidentiality while promoting a coordinated response. Minneaplis, MN: The Battered Women's Justice Project.

xxv Brascoupé,S. & Waters. C. (2009). Cultural Safety: Exploring the Applicability of the Concept of Cultural Safety to Aboriginal Health and Community Wellness. Department of Sociology and Anthropology, Carleton University.; Ball, J. (n.d). Cultural Safety in Practice with Children, Families and Communities. School of Child and Youth Care, University of Victoria.

xxvi Even if the abusive partner does not score high on ODARA or the ODARA is not scored because the case does not meet the scoring criteria, a referral can still be made to the D/IPV CCR Team Coordinator.

xxvii Even if the abusive partner does not score high on ODARA or the ODARA is not scored because the case does not meet the scoring criteria, a referral can still be made to the D/IPV CCR Team Coordinator.

xxviii Neilson, L. C. (2014) Enhancing safety: When domestic violence cases are in multiple legal systems (criminal, family, child protection) A family law, domestic violence perspective (Ottawa: Department of Justice); Renforcement de la sécurité: Affaires de violence conjugale faisant intervenir plusieurs systèmesjuridiques (en matière de droit pénal, de droit de la famille et de protection de la jeunesse) Perspective du droit de la famille sur la violence conjugale (Ottawa: Ministère de la Justice) 145 pages.

xxix Grey Bruce Violence Prevention Coordinating Committee. (2011). Community response protocol: A coordinated and collaborative response to sexual assault and domestic violence in Grey and Bruce counties.

xxx Neilson, L. C. (2014) Enhancing safety: When domestic violence cases are in multiple legal systems (criminal, family, child protection) A family law, domestic violence perspective (Ottawa: Department of Justice); Renforcement de la sécurité: Affaires de violence conjugale faisant intervenir plusieurs systèmesjuridiques (en matière de droit pénal, de droit de la famille et de protection de la jeunesse) Perspective du droit de la famille sur la violence conjugale (Ottawa: Ministère de la Justice) 145 pages.

xxxi Sinha, M. (2012). Family violence in Canada: A statistical profile, 2010. Juristat. (Statistics Canada Catalogue no. 85-002-X).

xxxii Sinha, M. (2013). Family violence in Canada: A statistical profile, 2011. Juristat (Statistics Canada Catalogue no. 85-002-X).

xxxiii Sinha, M. (2013). Measuring violence against women: Statistical trends. Juristat (Statistics Canada Catalogue no. 85-002-X).

xxxiv Zhang, T., Hoddenbagh, J., McDonald, S., & Scrim, K. (2012). An estimation of the economic impact of spousal violence in Canada, 2009. Department of Justice Canada. Total economic impact of IPV in 2009: $7.4 billion ($220 per Canadian). In NB alone (with population 751,171), cost was $165 million.

xxxv Public Health Agency of Canada. (2015). Supporting the Health of Victims of Domestic Violence and Child Abuse through Community Programs.

xxxvi Department of Justice. (2014). Making Links in Family Violence Cases: Collaboration among the Family, Child Protection, and Criminal Justice Systems; Neilson, L. C. (2014). Enhancing Safety: When Domestic Violence Cases are in Multiple Legal Systems. Ottawa: Department of Justice; United Nations, Report of the Expert Group Meeting. (2010). Good Practices in National Action Plans on Violence Against Women (UN Women). Available online at: http://www.un.org/womenwatch/daw/vaw/egm/nap2010/MF_FINAL_FINAL_23_May.pdf; UN Women.

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xxxviii The vast majority of victims of police-reported intimate partner violence are women, accounting for 80% of victims in 2011, a finding consistent over time. Women are much more likely than men to be victims of spousal homicide. In 2011, more than 6 times as many women were killed by a current or former spouse as men (81 women, 13 men). In DV situations, women are twice as likely as men to be injured, three times more likely to fear for their lives, twice as likely to suffer serious injury, and six times as likely to seek medical attention – Sinha, M. (2013). Family violence in Canada: A statistical profile, 2011. Juristat. (Statistics Canada Catalogue no. 85-002-X).

xxxix Wellington: Family Violence Death Review Committee. (2016, February). Family Violence Death Review Committee, 2014. Fifth Report: January 2014 to December 2015. Wellington, New Zealand: Health Quality & Safety Commission.

xl See: Safe For Pets Too in Transition with you http://nbvma-amvnb.ca/pet-owners/pet-owners-safe-for-pets/

xli Community Coordination for Women's Safety (CCWS). (2014, September). Information Bulletin May 2014: What are Domestic Violence Interagency Case Assessment Teams and what do they do?

xlii New Brunswick Family Services Act, s.31(1) The security or development of a child may be in danger when (f) the child is living in a situation where there is domestic violence.

xliii Wellington: Family Violence Death Review Committee. (2016, February). Family Violence Death Review Committee, 2014. Fifth Report: January 2014 to December 2015. Wellington, New Zealand: Health Quality & Safety Commission.