Evaluation of the IAST *plus* Project

Literature Review

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The Tasmanian Institute of Law Enforcement Studies

The Tasmanian Institute of Law Enforcement Studies (TILES) is committed to excellence in law enforcement research. Collaborative research that links academics with practitioners is a hallmark of that research. The institute focuses on four strategic priorities, namely research, teaching, communication, and professionalism. These support university and faculty initiatives for the University of Tasmania to be in the top echelon of research universities in Australia. The priorities also support DPEM initiatives to meet the goals of Tasmania Together '*Confident, friendly and safe communities*'.

Our vision

To achieve an international reputation for excellence in law enforcement research.

Our mission

To conduct and promote evidence-based research to improve the quality of law enforcement and enhance community safety.

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THE IAST+ Pilot Program

The 'IAST+: Three Approaches to case Coordination' (IAST+) works from the premise that interagency cooperation and collaboration is essential for effective delivery of services to at risk young people and their families. The IAST+ is an initiative hosted by DHHS, under the auspices of the Office for Children (OfC), using the existing Inter-Agency Support Team (IAST) system as a starting point. It considers how 'agencies can be supported to work together to intervene earlier to achieve better outcomes for young people identified at risk' (OfC, 2013, 7). The precept of the IAST+ is to encourage multiple services to collaborate in responding to issues relating to the care of children and young people, while testing new means of collaboration and information sharing, and designing better performance management tools or avenues. The IAST+ project essentially focuses on three different approaches to collaboration, in three different sites throughout Tasmania: Glenorchy, Launceston and Devonport.

The 'self-directed' pilot is hosted by the Glenorchy IAST. IAST stakeholders are provided with ongoing external support (by way of professional development, invitees, workshops, etc) to look at ways to work more effectively. The Launceston pilot, also known as the 'collocated team' or the 'Directed Model', is provided with an additional resource of DHHS health practitioners, who assess families' needs and recommend specific interventions based on these assessments. The 'Existing Model' is based in Devonport, where the IAST stakeholders are supported by existing mechanisms, and act as a control site (OfC, 2013).

The IAST+ management team consists of three permanent positions at the Office for Children, who ensure the administration of the scheme, communication with hierarchy and act as a contact point for the research team. These three key personnel also act in coordination with the IAST management team from the DPEM.

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List of Acronyms and Abbreviations

ADS	Alcohol and Drug Services
CP	Child Protection Services
DHHS	Department of Health and Human Services
DoE	Department of Education
DPEM	Department of Police and Emergency Management
IAST	Interagency Support Teams
IAST+	Interagency Support Teams + (pilot project)
NGOs	Non-government organisations
OfC	Office for Children
TILES	Tasmanian Institute of Law Enforcement Studies
UTAS	University of Tasmania
YJ	Youth Justice

The research team

Dr Isabelle Bartkowiak-Théron is the coordinator of Police Studies at the University of Tasmania, and a senior researcher at the Tasmanian Institute of Law Enforcement Studies. Having worked with youth at risk in France, Isabelle became known in Australia for having managed the Youth Pilot Project of the Australian National University-Victoria Police Nexus Policing ARC linkage from 2004 until 2006. She also ran the two-year evaluation of the School-Liaison Police and the first stage of the Mental Health Intervention Teams evaluation in New South Wales, for the New South Wales Police Force, from 2007 until 2009. Isabelle specialises in the qualitative and quantitative study of policing and policing services targeting vulnerable populations (e.g., young people, refugees, Aboriginal community members) and is in regular contact with representatives of these vulnerable populations. She contextualises data according to information gathered from the field and relevant literature. She is used to handling confidential information gathered by government and non-government organisations as well as sensitive information garnered from police data gathering systems. Her work in partnership with a number of government and non-government agencies has contributed to her being contracted in 2011 on a Proceeds of Crime Funding scheme to evaluate a restorative conferencing project in the area of Albury (NSW), an initiative run and monitored by Albury Family Youth that targeted young recidivist offenders. Isabelle also evaluated the Tasmania Early Intervention Pilot Program for the Department of Police and Emergency Services, and the Mental Health Diversion List for the Hobart Magistrates Court. She is the co-editor (with Nicole Asquith) of *Policing Vulnerability* (Federation Press, 2012). She is a member of several research governance and community engagement committees throughout Australia, and sits on the Australian Crime Prevention Council as an executive member for Tasmania. She is an Advisory Board member for the Centre for Law Enforcement and Public Health, and an editorial board member of the *Journal of Criminological Research, Policy and Practice*.

Associate Professor Roberta Julian was appointed to the position of Director, Tasmanian Institute of Law Enforcement Studies, in July 2003. Prior to this, she was a Senior Lecturer in Sociology at the University of Tasmania where she had been involved in teaching, research and administration for over 20 years. Roberta has an established record of scholarship within the discipline of sociology including a strong track record in applied social research. She has an international reputation based on her research exploring migrant and refugee populations. Roberta conducted research on the resettlement of Hmong refugees from Laos for over ten years and published book chapters and journal articles on Hmong identity and Hmong women in Race, Gender and Class, Asian and Pacific Migration Journal and Women's Studies International Forum. Her community-based research interests have now been extended to include issues surrounding other 'at-risk' populations such as young offenders. Roberta has been Chief Investigator for evaluations of projects managed by Tasmania Police, including: the U-Turn Program, a young recidivist car theft offender program;

Project Currawong, a series of adventure programs aimed at challenging young people and providing pathways into community participation; the Risk Assessment Screening Tool (RAST) used in family violence incidents. In 2004 she was awarded a three-year Australian Research Council (ARC) Linkage Grant to examine issues surrounding community policing and refugee settlement in Tasmania. In 2006-7, she was one of three Chief Investigators (with Dr Clarissa Hughes and Inspector Matthew Richman) awarded almost $0.5 million to conduct the first Australian trial of an innovative alcohol misuse prevention approach known as 'Social Norms'. Roberta is currently the lead Chief Investigator in a five-year Australian Research Council Linkage Grant with Victoria Police, the Australian Federal Police (AFP) and the National Institute of Forensic Science (NIFS) that began in 2009 (awarded almost $1 million). This project is examining the effectiveness of forensic science in the criminal justice system with a focus on police investigations and court outcomes. Roberta is a member of the Board of Studies of the Australian Institute of Police Management (AIPM), an Associate Investigator with the Centre of Excellence in Policing and Security (CEPS), a member of the Editorial Board for the Australian and New Zealand Journal of Criminology, a past President of The Australian Sociological Association (TASA) and a current member of the Committee of Management of the Australian and New Zealand Society of Criminology.

Dr. Sally Kelty is an applied psychologist with a background in project development within health and criminal justice agencies. She has worked in research project design and evaluation in Human Resources in private industry, in university research centres and in government departments. Her program development and evaluation work includes the development and evaluation of prison-based rehabilitation programs for domestic violence, substance use and generalist offending programs for men and women; independent community living programs for adults with cognitive impairments; and the development of psychological test batteries in recruitment and criminal justice settings. Sally has worked on several health-related projects including the management of a three-year longitudinal study exploring the experiences and outcomes for 160 high-risk adolescent mothers and their children, and also headed up the adolescent program within an environmental health promotion research centre exploring interagency and private industry collaborations in designing and evaluating safer and healthier urban residential spaces for adolescents which would reduce delinquency and obesity. Sally joined TILES in July 2009 as a Research Fellow working on a five-year project mapping the effective use of forensic science and forensic evidence by policing and legal agencies in criminal investigations and court outcomes. In this project, Sally works with several police jurisdictions and has completed several applied projects including identifying the key attributes of Australia's top-performing crime scene examiners. More recently, she has been the lead program developer for a recruitment strategy and career advancement program for forensic scientists within police agencies. Sally was the Chief Investigator on a National Institute of Forensic Science project exploring 'The Interfaces between Science, Medicine and Law Enforcement' which examined inter-justice-

agency communication and working relationships between four professions/professional groups (law enforcement, forensic medicine and health, forensic science, and law). The final report detailed the different forms of interagency steering groups and working groups currently operating across Australia, how and why they meet and the benefits and pitfall of current arrangements. The seven recommendations included mapping out more effective interagency collaborations and information sharing; the recommendations are currently being developed for implementation. Sally is the president of the Tasmanian Branch of the Association of Psychiatry, Psychology and Law.

Loene Howes [MA, MTeach, BSocSci (Psych)(Hons)] is a PhD candidate and Research Assistant at the University of Tasmania in the School of Social Sciences and School of Medicine (Psychology). Prior to commencing at UTAS, Loene was a high school teacher for 14 years. During that time, she was a Year Advisor for a cohort of approximately 120 students for a period of five years. This role gave her some first-hand experience of participating in a multi-agency approach to support young people. Loene has participated in previous evaluation research within her capacity as a research assistant at TILES. Her research interests include career decision-making, communication in the context of police intelligence and investigative interviews, and the communication of expert evidence in the criminal justice system.

1. Literature Review: Elements of successful interagency collaboration, cooperation and information-sharing in child protection, child health and criminal justice

Overview

Interagency collaboration and information-sharing is increasingly viewed as the prominent framework necessary in order to reduce risk of adverse outcomes and ineffective interventions for children and young people at risk (Carter 2005, Carter 2006, Kelty 2013), and ineffective investigations into child neglect and abuse (NSW Ombudsman. 2009, Winkworth & White 2011). Partnership approaches are based upon the view that no single agency alone can be responsible for managing the complexity of community safety and reducing the risk of child maltreatment and crime (Carter 2005). Information sharing presents in a number of forms and whilst it i**s** important for agencies to remain within professional boundaries and areas of responsibilities, it is argued that practitioner awareness of the various sources of expertise available in agencies that collaborate together provides for fruitful cross-pollination of resources and ideas (Bartkowiak-Théron, 2011). Understanding key elements of how interagency partnerships can be effective in this domain is vital.

This review presents a discussion of the benefits and pitfalls of interagency collaboration, and how common pitfalls can be managed. The review is divided into three parts. Part 1 discusses the findings from child death reviews in Australia and internationally that demonstrate the importance of interagency collaboration and presents some case studies that highlight the problems of failing to collaborate successfully in complex situations. It also outlines some common pitfalls that can occur in interagency work. Part 2 overviews successful collaborations in criminal justice initiatives and systems approaches to collaboration in the child protection. Part 3 provides an overview of the key elements required for successful collaboration that emerge from the empirical literature reviewed.

2. Part One: Defining collaboration, ineffective collaboration cases and common pitfalls

Interagency collaboration is defined as "…a high intensity relationship between two or more parties that results in the production of something joined and new" (McDonald & Rosier 2011). McDonald and Rosier further state that although often the terms are used interchangeably, cooperation and coordination between agencies are not the same as collaboration. Collaboration involves more interdependence among agencies, taking higher risks, and a higher level of commitment to information sharing. Despite the higher involvement between agencies in collaborated responses to a given issue, collaboration does not mean integration – in which professional boundaries are blurred or practitioners' objectivity and independence are undermined (Moore & Skinner 2010). Most government and non-government agencies across Australia that work with children are increasingly expected to work collaboratively with each other. Collaboration can be successful and rewarding, although due to the intensive nature and challenge of adding more tasks to the working day, these increased demands on already busy personnel can lead to collaboration fatigue (Price-Robertson 2012).

It is commonplace for the criminal justice system, health departments and child protection agencies to be viewed as a unified entity communicating and working towards a shared single purpose and clear goal (Carter, 2005). However, ongoing reviews of the circumstances underpinning child deaths and ineffective investigations into child maltreatment paint a different picture- one in which agencies are involved in infective collaboration practices, operating as agency silos, or taking a fragmented approach to service delivery (Australian Institute of Family Studies 2012). This is not limited to Australian jurisdictions, but is often discussed as a key element underpinning child death and maltreatment cases worldwide (Wulczyn et al 2010).

2.1 Child death reviews in Australia and the UK and interagency communication

Within Australia there exist Child Death Review teams, which report on child death incidences at the state and territory level. The teams do not aim to determine the culpability of alleged offenders, the performance of child protection workers, or even the causes of child deaths. Instead, the teams collate and link data from multiple sources, such as case notes, to gain an understanding of the circumstances of each child's death. This information is used prevent future occurrences.

Since 2008, Child Death Reviews in the UK have been investigated by multi-agency and multi-disciplinary teams (Fleming n.d). The teams consist of police, social services, and medical personnel. The reviews of biennial analyses from 2000 to 2012 of serious cases in the UK have identified a number of

common themes identified with adverse outcomes for children, including child death (Sidebotham 2012). These themes included evidence of:

- Limited *meaningful* cooperation and integration, particularly between child and adult services.
- Poor communication both within and between agencies.
- Particular family characteristics associated with risk (risk of abuse and neglect highest for young children, large families, chaotic families multiple problems e.g., domestic violence, parental mental health problems and alcohol and drug abuse). Risk factors however were not always found in serious cases.
- A tendency for the needs of the child to be overlooked when a family was chaotic with multiple problems. This has been attributed in part to agency staff feeling overwhelmed.
- Cases of child death in which the family was known to child protection services, but the majority of cases of serious and fatal maltreatment of children *did not have clear indicators of risk.*
- Invisibility of children in the assessment process.
- Poor recording of information and failure to interpret information gathered.
- Professional uncertainty and a lack of professional confidence, resulting in failure to challenge other professionals' viewpoints. Siloed thinking and a failure to consider aspects of children's needs holistically (outside their own specific brief or job roles).
- The idea that because child abuse was complex (rarely related to a single factor, but the interplay of several factors in particular circumstances) there was a need for an ecological framework to enhance understanding of it.
- 'Fixed thinking' – when professionals' previous assessments of a family influenced decision-making about new findings (e.g., by perceiving neglect as a low-level long-term risk, a child's short-term safety needs may be overlooked).
- A 'rule of optimism' – when professionals avoid being judgemental of the parents, it had the potential to result in a failure to appraise risk to the child.

Many of the themes identified in the UK over the past 12 years are present in the Child Death Review Reports from each of the jurisdictions across Australia.

2.2 The problem of interagency silos in child death and miscarriages of justice

Ineffective information-sharing and interagency cooperation is a key contributor to ineffective criminal and coronial investigations and can lead to miscarriages of justice (Gould et al 2013, The Hon. Frank Vincent 2010).

The risk of making poor decisions about youth and children at risk due to a lack of information-sharing occurs because the higher the risk of adverse outcomes for children and youth the more likely their cases are managed by a larger multidisciplinary team of practitioners. The make-up of these multidisciplinary teams is complex. These teams can comprise representatives from police departments, hospitals and medical centres, child protection agencies, welfare agencies family services, school, psychologists and other NGOs. These practitioners represent a wide range of different agencies and

organisations spanning health, justice, police, welfare and private legal/medical practices. Many of these practitioners have different worldviews, different levels of training and understanding of the root causes of complex family dynamics or criminal behaviour. They also have differing views on what they believe their role is, what they believe other people's roles are, what their role should be, how their agency should be involved, if, and in what capacity they should be involved with other practitioners during discussions of child risk, family intervention planning and criminal investigations. How these teams work together is vital for effective outcomes.

The agency silo effect occurs among agencies that are a part of the criminal justice system or child protection system. The silo effect occurs when there is an absence of meaningful and regular exchange or collaboration between agencies that work on the same child and youth cases and criminal investigations involving children and youth. In essence, agency silos mean that practitioners, even within their own organisations, operate in isolation, unaware of the role, responsibilities, skills and knowledge of other personnel. This can lead to a range of expertise and knowledge being underutilised to inform decisions made by police, medical practitioners, child protection agencies, coronial and criminal lawyers about the best course of action to take in a case involving youth (Kelty et al 2013). The existence of agency silos and fragmented service delivery is not unique to child protection matters; it exists between the forensic sciences and police, between pathologists, paediatrics and forensic physicians and the police and lawyers (Kelty et al. 2013).

One recurrent theme present in the UK and all Australian state and territory Child Death Reviews is the limited interagency cooperation and integration, siloed behaviour by some agencies and limited information-sharing. This reflects the same issues found during the Interfaces project into homicide and adult sexual assault across Australia (Kelty et al 2013).

2.3 Case illustrations of the interagency silo effect

The importance of identifying effective multi-agency interactions can be seen clearly in cases with adverse outcomes.

2.3.1 The case of Ebony

A clear example of how detrimental interagency silos can be was demonstrated in the circumstances surrounding the death of a 7-year-old girl with autism, known as Ebony. Ebony was the third of four children. Ebony briefly attended pre-school but never attended school. The family was known to a range of agencies, and numerous reports of risk of harm had been made by the education department, medical staff, and community members. In April 2007, following numerous reported concerns, a child protection worker visited the home twice to interview the parents and sight and speak to the children. On these

occasions the child protection worker was told by Ebony's parents she was either next door, or asleep. At no point was an effective interagency meeting called where the various agencies known to each to have concerns for her safety met to discuss and plan an outcome. In November 2007, Ebony died; she had starved to death in her bedroom. Following Ebony's case, a commission of inquiry headed by Justice Wood into Child Protection Services in NSW was established. The major issue identified were problems in interagency communication. Specifically, in this case the Departments of Community Services, Education, Ageing, Disability and Home Care, Housing and the Police Force were noted as not working together effectively resulting in vital information not shared and warning signs went unnoticed (Ombudsman, 2009). As a result of this case, the special need for a coordinated approach for high risk families known to multiple agencies was clearly identified, and the habitual school non-attendance (as it violates the United Nations Convention on the Rights of the Child or young person to develop) was added as a risk factor for adverse outcomes.

2.3.2 The case of Farah Jama

Another clear example of the interagency silo effect within the criminal justice system is the Farah Jama in 2008 in Australia. In this case a concern were raised by one agency but was not dealt with adequately due to the silo effect. Farah Jama (FJ) was convicted of a rape he did not commit and sentenced to six years imprisonment. The jury's verdict rested solely on the basis of DNA evidence, with no other circumstantial evidence presented at the trial. In December 2009, it became apparent that there was a problem with the original DNA swabs and a prosecutor from the Victorian Public Prosecutions Office advised the Victorian Court of Appeal in Melbourne that a 'substantial miscarriage of justice' had occurred; FJ was acquitted immediately. In 2010, the Hon. Frank Vincent was asked to head the inquiry into the matter. The Vincent report into this wrongful conviction detailed the limited interactions and information flow between the medical, scientific and law enforcement practitioners involved throughout the entirety of this sexual assault case. Cases such as that of Farah Jama clearly show the importance of ensuring that criminal justice personnel interact meaningfully.

The circumstances underlying this case were as follows. A day before the sexual assault he was wrongly convicted for, FJ had voluntarily provided a DNA sample for an unrelated matter to police. This matter was dropped before any charges were laid or any investigation was carried out. However, FJ's DNA was in error uploaded to the national database. A few days later, a 48-year-old woman, M, was found semi-conscious in a nightclub toilet cubicle in Melbourne, Victoria. M had no recollection of what had occurred that evening. During discussions with various people after she was found, the issue was raised of whether she thought she may have been assaulted. M was taken to a sexual assault Crisis Care Unit within a hospital for a physical examination. Routine swabs were taken and sent to the Victoria Police Forensic Science Laboratory for DNA analysis. The Forensic Science Laboratory found a match between the swab taken from M in the Crisis Care Unit and FJ's profile on the DNA database.

The case was given to a police investigator who became concerned at the lack of other circumstantial evidence to support the DNA evidence. M could not remember anything from that night (it was found that she had drunk heavily that evening and was taking prescription medication). The CCTV footage outside the nightclub (recorded on that night) did not capture FJ (a 19 year old male). The club where the alleged incident took place was frequented by middle aged, primarily Caucasian, singles looking to meet a partner; no one, including the door and bar staff, remembered FJ being there. FJ provided an alibi that he was at his father's bedside that evening and night as his father was very ill. FJ's friends and family verified his alibi. The investigator, believing something was not right, raised a red flag by approaching her superior officer. Their superior officer contacted the Forensic Laboratory and enquired about the matter. The senior officer was told that there was no chance of contamination of that evidence in the laboratory. That was the correct answer (as discussed below the contamination was elsewhere). However it could be argued the response given was too narrow and no consideration was given to where the samples came from in the limited interactions that took place.

At no point during the investigation were any of the other agencies involved beyond the Forensic Science laboratory and the police contacted. No enquiries were made at the Crisis Care Unit or to the forensic physician who collected the evidence from M. No investigative meetings were called where all agencies involved in the process could discuss the problem that no other circumstantial evidence was present.

The most likely explanation for the contamination of the DNA samples was that it occurred in the hospital, and probably was from some of the implements left on the trolley in the examination room. In his report, Vincent found that the level of cleaning of the examination rooms was inappropriate given the presence of DNA and the taking of samples for DNA testing. The level of cleaning was at a level appropriate for a hospital to maintain infection control and to remove contaminants. This was not at the level appropriate for the collection of DNA samples (The Hon. Frank Vincent 2010).

As in the case of Ebony, noted above, a red flag was raised in the Jama investigation by a junior police detective; however it appears there were inadequate mechanisms in place to respond to the concerns. Given the circumstances outlined above, it would appear that interactions and meetings between justice, health and other related agencies are beneficial, *especially* in cases where practitioners raise red flags and believe that something may not be right in a case.

2.3 Limitations with Initiatives to combat interagency silo in child cases

In order to try and deal with agency silos, many initiatives into targeting risk factors for children have only focussed on single issues (e.g., street children, child trafficking, child labour, and HIV/AIDS prevention). These targeted initiatives were thought to deliver distinct benefits to particular child populations (Winkworth & White 2011). At the state and territory level, targeted initiatives have been implemented

through separate organisations. For example, the various agencies and departments involved in education, health, mental health, family support, criminal justice, juvenile justice, and child protection each provided some targeted initiatives. There was minimal communication between these agencies at the Commonwealth agency level (e.g., Centrelink), although there had been higher communication at the state agency level. This siloed approach often resulted in a fragmented response, characterised by inefficiency and unmet need. For example, if an agency supports children living on the street, their immediate safety needs are met by the agency. However, there is a need to address other risk factors faced by these same children in terms of their education or risks associated with returning homes in order to understand and address the issues that prevent the child from living safely (Wulczyn et al., 2010). Child protection systems around the world are highly contextualised and reflect local preferences, customs, norms, pre-existing structures, laws, and the will of participant stakeholders within the system. Systems are viewed as nested and embedded within the broader context and environment.

A 2011 review commissioned by the NSW Ombudsman, was undertaken by the researchers at the University of New South Wales into the issues faced by multi-agency child welfare initiatives. Multi-agency initiatives have been increasingly promoted over the past decade in Australia in response to the fragmentation, duplication, and gaps in service delivery. The review focussed on what did not work well, as opposed to interagency collaborative successes, and suggested that despite intuitive appeal, multi-agency approaches did not always work well or alleviate problems of silos. The review highlighted the pervasive issues of communication (inter- and intra- agency); role definition (and the fact that in the face of uncertainty about roles, children's needs are left unmet); and compliance (or take-up of new pathways for reporting, etc.). It was also noted that it is often assumed that multi-agency approaches reduce costs, but that significant time and funding resources are required to establish interagency cooperation. Furthermore, serious case reviews of the past had often found that the policies were not necessarily problematic, but that often the personnel lacked awareness and understanding of these policies (e.g., the legalities of information sharing). This highlighted the need for ongoing interagency professional development. An issue from the perspective of agencies was that often NGOs became service providers for the government organisations without a role in governance (suggesting the need for shared frameworks; (Winkworth & White, 2011). For service users, the need expressed was not always matched with the service provided. For example, families may be provided with parenting lessons, without underlying mental health needs addressed (Valentine & Hilferty 2012).

2.4 Potential errors in group decision-making: Potential pitfalls for collaboration

In addition to the risk of agency silos contributing to ineffective outcomes for children at risk, there are also several common pitfalls that occur when agencies work too closely together. These pitfalls relate to psychological processes and impact upon all group decision making. The main pitfall for any group /

interagency work that involves decision-making is that the human mind functions on a daily basis by filtering out and ignoring most of the social information it sees or hears. In reality people cannot make sense of everything they see or hear and cannot make decisions about everything; people simply could not function in complex societies without taking short cuts, but it is the short cuts that cause problems for people in groups where important decisions are made (Aronson 2010, Janis 1982). Research from cognitive science and social psychology has provided insights into the range of short-cuts that people make on a daily basis. The main errors that effect decision making in interagency meetings and casework are: groupthink, group and social conformity, tunnel vision and context bias. Each will be discussed in turn with examples to illustrate how they operate.

2.4.1 Groupthink and the Space Shuttle Challenger disaster

Groupthink manifests as a strong social pressure within certain groups to reach unanimous decisions. Although reaching a unanimous decision may be seen as advantageous, in some groups it is problematic when the desire to reach consensus comes at the expense of an increased likelihood of poor-quality and quicker, less rational decisions as fewer alternative solutions are explored, with dissenting opinions in the group minimised (Janis 1982, Mitchell & Eckstein 2009). A group is especially vulnerable to groupthink when members of the group are from similar backgrounds and are not subject to outside opinions or evaluations. Researchers looking at jury deliberations have found that jurors are susceptible to groupthink due to a lack of external reviewers present and the pressure to reach a specific outcome (guilty/not guilty). It is this pressure in jury rooms that has led to many wrongful convictions (Mitchell & Eckstein 2009).

A poignant example of groupthink occurred prior to the launch of the Space Shuttle Challenger disaster. On January 28 1986, the Space Shuttle Challenger exploded 73 seconds into flight killing all seven crew members. In the 24 hours leading up to the launch on January 28, two main concerns had been identified, cold temperatures and the build up of ice on the launch pad. These concerns were discussed in various meetings involving senior management and engineers. A case analysis of the interactions occurring in meetings between the management and engineers prior to the launch found numerous examples of groupthink. Researchers have identified two symptoms of groupthink that were clearly demonstrated before the Challenger disaster, namely, direct pressure on the dissenters to agree by suggesting their concerns were overly cautious (namely the engineers), and guarding of the concerns from (not passing the dissenters concerns to) lower level NASA personnel (Esser & Lindoerfer 1989). The phenomenon of groupthink occurred in the Challenger disaster because of the pressure to maintain schedule, pressure from management, societal expectations and media attention. When these pressures were combined the decision-makers chose to launch rather than explore other options available whilst also ignoring crucial concerns from the engineers.

2.4.2 Conformity, social influence and obedience to authority

Another problem that occurs within groups is conformity and obedience to the social influence of others. Conformity can be defined as a change in behaviour or opinion as a result of real or imagined pressure, often from another person. Group conformity refers to the thoughts and feelings people have in groups, such as feeling intimidated, wanting to be accountable, wanting to fit in. Certain people within groups have been shown to be able to exert more influence and pressure than others. For example, a younger person working with older experts, or persons of higher rank, especially those considered influential, may start to conform to the opinions of the older persons in the group (Aronson 2010).

The most widely cited experiments into conformity and obedience to authority and social pressure/influence are drawn from the work of Yale University social psychologist Stanley Milgram. Milgram's interest in the variables that underlie obedience to authority began during the war crimes trials of SS Lieutenant Colonel Adolf Eichmann. Eichmann joined the Nazi party in the early 1930s and according to him joined to advance his career rather than a commitment to Nazi philosophy. He soon rose up the ranks due to demonstrated ability to achieve results. He was originally known for his earlier work in working on a solution to "the Jewish problem" by forcible deportation from Germany to Palestine. He travelled the Middle East trying to sign treaties for this deportation with various nations, and when no agreements could be reached he returned to Germany. In the early 1940s he was enlisted by General Heydrich to join the Holocaust preparations. Eichmann was the official secretary and recorder at the Germany anti-Semitic meeting where the policy of genocide was developed. Eichmann was then given the position of Transportation Administrator of the "Final Solution". He was the architect of the mass transportation system that took the Jews to the death camps in Poland. Eichmann escaped after the war was captured by Mossad agents and taken to Israel for trial. During lengthy interrogations pre-trail, and again at trial, Eichmann, said:

I obeyed. Regardless of what I was ordered to do. I would have obeyed.... I obeyed my orders without thinking, I just did as I was told. That's where I found my - how shall I say? - my fulfilment. It made no difference what the orders were. (Jochen von Lang, 1983, p101).

In response to Eichmann's assertions (also similar to the assertions of other SS officers at the earlier Nuremberg trial), Milgram and his associates devised a series of experimental psychological studies to answer the question of whether Eichmann and others acted with full intent in the Holocaust, or whether it possible that many of the SS officers, even senior ones, became caught up in conformity and were simply being obedient to authority.

The Milgram experiments into conformity and obedience commenced with members of the general public recruited from outside of Yale University and asked if they wanted to take part in a teaching experiment. Participants were taken into a room and informed that the purpose of the experiment was to

study the effect of punishment on learning. The 'learner' in an adjoining room was introduced to the participant through a sheet of glass and the participant watched as the 'learner' (a research team member) was strapped to a chair with electrodes stuck to their arms. Curtains were then drawn across the windows. Unbeknown to the participant the 'learner' got up from the chair and left the adjoining room. The participant was told by the 'experimenter' (a research team member who was introduced as a Yale scientist) that every time the learner got a question wrong they were to press a button and administer an electric shock; this would increase in intensity. A tape recording then began of wrong answers to questions. The taped responses started as wrong answers but turned to statements begging to stop in response to the alleged increase in intensity of the shock. Despite the pleading, 65% of the participants (ordinary members of the public) continued to administer the electric shocks simply because of the assurance of the authority, a Yale scientist (Milgram 1974). This study has been replicated in various countries and under differing conditions, including people and animals depicted as 'learners'. In all the experiments, participants would shock animals and people because an authority figure said it was legitimate (Schneider et al 2012). These experiments show why people sit in groups listening to opinions they do not agree with and say nothing; often because a person in authority is present. In many real-life situations, people's opinions are often influenced by a reviewer's opinion or a doctor's recommendation (Shestakova et al 2012).

It is not unreasonable to expect to see this problem occurring in interagency groups where less experienced representatives of participating agencies (including child protection, police, Non-Government Organisations) conform to the authority of older or more experienced practitioners who present an assertive opposing view to their own. This is especially so in some agencies and organisations which are structured hierarchically with clear chains of command in which obedience to senior staff is implicitly expected.

2.4.3 Tunnel vision

A pervasive contributor to wrongful convictions and ineffective interagency work is tunnel vision. Tunnel vision refers to seeing an incident or series of events through a narrow lens. It can result in case planning, case discussion and investigations zoning in on a single cause or outcome whilst ignoring or suppressing alternative explanations or solutions that contradicts personal beliefs (Findley 2010).

Tunnel vision can occur, for example, in mistaken eyewitness identifications and it is suggested that this is the most common cause of wrongful convictions (Gould et al 2013). Tunnel vision has occurred in several prominent miscarriages of justice where the guilt of a suspect has become the sole focus of an investigation, rather than looking for alternative explanations (Findley 2010). For example, tunnel vision can lead to incomplete investigations of crime scenes, for example in the case of Madeleine McCann who went missing on holiday in Portugal. The police at first believed her parents were responsible, and it was only two months later after suspicions dropped that the apartment was sealed as crime scene. However, by

that time it had been used by other holiday makers and vital forensic evidence was lost. A recent study by Landon and Wilson into the causes of 32 miscarriages of justice found that tunnel vision was a major contributing factor in close to 50% of the cases they assessed. Examples were the deliberate distorting of a witness's statement to conform with assumed, albeit unreliable facts or ignoring evidence that potentially disproved a suspect's involvement (Langdon & Wilson 2005).

2.4.4 Combating pitfalls in interagency meetings

Research has suggested that strong group leadership qualities are important in minimising the risk of groupthink, tunnel vision and conformity in decision making groups. Although these risks cannot be eliminated, reducing them may be achievable by having a leader who is participative rather than directive or authoritarian in style, combined with high level group work skills that allow them to recognise and manage negative group dynamics (Baron & Kerr 2011, West 2012).

3. Part Two: Successful interagency work: The empirical research

The literature presented below overviews the findings from large evaluation studies that have assessed how successful collaborations operate. One area of success is in family violence initiatives between police, health and community services. A second is work by police, parole offices and community service agencies to collaborate in crime reduction strategies. Understanding the key elements of why collaborative community initiatives work is a first step in understanding how police, medicine, law, education, child protection and welfare agencies and other NGOS can work effectively together in cases and risk mitigation involving children and youth.

3.1 Successful interagency collaborations: Family violence initiatives

A comprehensive international review in 2003 assessed the elements of successful agency information-sharing from family violence initiatives across Australia, the US, Canada and the UK (Mulroney 2003). This review looked at successful collaboration between law enforcement, health departments, child protection and the courts. The Mulroney review noted that several aspects of interagency collaboration led to improved service delivery for people experiencing family violence in that the service delivery was more targeted, and more appropriate for families and victims. In the area of family violence, successful information-sharing and intervention was best achieved at the local level as this provided for communities/districts to take into account applicable regional legislation while ensuring the needs of families in their area matched what local providers were able to realistically offer. Mulroney found that effective collaborations, regardless of country, depended on a number of agency needs as follows. Agencies needed:

- to be adequately resourced to be able to supply what was promised;
- suitable structure that allowed for interagency collaboration;
- support for individuals within agencies to drive effective information-flow;
- clear commitment from senior management and formal agency agreements, such as the memoranda of understanding (MOUs);
- clear policies and a strategic plan to articulate principles, aims and objectives of the interagency work (ideally formulated from best practice models); and
- where appropriate, cross-agency training initiatives (Mulroney 2003).

Similar results were obtained recently in a New Zealand study where family violence was found to be reduced through interagency collaborative service delivery (Murphy & Fanslow 2012).

3.2 Successful partnerships between police and community justice

Similar findings were published in a US Department of Justice evaluation report which outlined the elements underpinning nine effective working partnerships projects between police departments and parole agencies (both adult and juvenile justice) across different states in the US. The aims of the partnership projects reviewed were to reduce breaches of parole and bail for offenders living in the community as well as reducing the impact on the community of gang related activity (Jannetta & Lachman 2011). The elements for developing long-term successful partnerships from the outset were as follows:

- An appropriate level of planning is crucial, including setting out specific strategies and goals;
- Agency-wide commitment is required for collaborations to be recognised and valued;
- The personnel who are members of groups must have role-clarity, be open-minded and willing to devote time to the group;
- Agencies must support staff attending groups and be willing to assist in information dissemination and sharing between agencies, such as reworking data systems;
- Any differences in modes of working between agencies must be openly explored and discussed; and
- Skilled and motivated leadership is fundamental and each agency must support a staff member as the group's champion.

These findings were mirrored in a UK report assessing the impact of crime reduction initiatives through partnership policing (Berry et al 2011).

3.3 Successful interagency collaborations: US Defence Force training programs

The US Armed Forces have a history of developing interagency collaboration. In 2007, a project reported upon the challenges that need to be overcome for two successful collaborative projects that developed training materials for personnel from the Air Force, Army, Coast Guard and Navy (Twitchell et al 2007). The aim of the two task-focused projects was to combine interagency resources to create healthcare related course material that would be useable and suitable for all course participants regardless of agency. The Department of Defence specifically encourages this form of sharing, as evidenced in their Instruction 1322.20 which required agencies to apply the Sharable Content Object Reference Model (SCORM) 2004 to program development (Department of Defence 2006). This is a model specification developed by the Advanced Distributed Learning Initiative (ADL) as collaboration between government, industry and academia to establish a learning environment that allows for the interpretability of learning materials across federal agencies. Within the two projects, the challenges to the success of the partnership were divided into three categories: management, team dynamics and communication (Twitchell et al 2007). These are as follows:

- Managerial challenges included gaining visibility for the projects, negotiating agreements (MOUs) and unravelling bureaucratic red tape;
- Challenges for team dynamics included facilitating team communication, modifying project roles and training team members on policies, procedures and technologies;
- Communication challenges included upholding standards for quality, designing for agency-specific needs and supporting accreditation.

3.4 Successful interagency collaboration in Australian homicide investigations

The Interfaces project was devised to explore current forms of communication and practices and to identify if these interactions could be effective in shielding police, forensic science, forensic medicine and lawyers from becoming too isolated from each other during the investigative and trial process in homicide and sexual assault matters. Researchers interviewed 103 practitioners across six Australian states to see whether the current forms of communication between and within agencies were at a level where red flags could be responded to adequately. Five main themes were identified from the project and clearly showed that in 2013, across Australia, in cases of adult and child sexual assault there was very limited, sometimes non-existent communication and information-sharing between police, medical practitioners, scientists and lawyers. In contrast, in homicide cases, there were clear arrangements in place between different agencies for how they would communicate and cooperate across most states of Australia (Kelty et al., 2013).

One pattern evident was that in homicide investigations face-to-face meetings were more common, almost routine. The more successful interagency patterns in homicide investigations had the following elements:

- The meetings were formalised and it was documented clearly who would attend and at what stages various agencies would be involved. One of the states had in place clear guidelines for the types of interactions that would take place between practitioners from forensic science, medicine, police and prosecution;
- Practitioners gained insight and found it highly beneficial to attend interagency practice improvement groups where *past* cases were discussed to see where interagency collaboration was optimal;
- More effective practice improvement groups had a formalised structure with signed policy documents or MOUs in place;
- Formal policy documents to clearly set out roles, ensuring a clear separation of professional boundaries was discussed and procedures laid out for how agencies involved in serious criminal matters would collaborate and share information; and
- Clear aims for case meetings; and
- Agencies encouraged and supported joint training exercises.

4. Part Three: Seven key elements and recommendations for successful interagency collaborations

The research presented in Parts One and Two, when combined, suggests that for interagency information sharing to work a multi-faceted approach is needed that is underpinned by seven key elements.

These seven elements can be considered recommendations that aim to improve the effectiveness of collaborations between agencies that work on serious criminal matters or risk assessments for children and youth at risk of adverse outcomes. Many of these recommendations require long-term support and commitment from senior management.

The seven elements of effective interagency collaboration are:

1. To map out workflow processes to plot the end-to-end stages of investigations into child abuse or neglect or other risk assessment. The resulting flowcharts should detail the range of different agencies and practitioners involved in each step. This will provide the information necessary to ensure that all parties who have a decision making role are visible and can be included in any interagency work (thus reducing the risk of agency silos)

2. To determine a joint known common purpose for the group (all members of the group are committed, know the purpose of the group and have clearly defined roles/responsibilities);

3. To facilitate the competence of motivated group leaders (a clearly defined, well-trained group leader with strong group facilitation skills. The group leader needs to be participatory, not directive in style, and are skilled in recognising negative group dynamics);

4. To provide organisational support (staff have the resources to fulfil their roles/responsibilities and time to attend meetings, prepare for meetings and where advantageous joint interagency training);

5. To recognise the value of interagency collaboration to the organisation (firm commitment from each organisation, especially senior managers to challenge the partnership/collaboration/information-sharing, committed to ongoing partnerships and to implementing any changes, as evidenced by signed MOUs);

6. To ensure clear and adequate recording and dissemination of information, especially decisions made in the groups. Dissemination of information is a clear role that one or two group members have responsibility for.

7. To combat adverse outcomes caused by negative group dynamics such as group think, conformity and tunnel-vision ensure that all meetings or information-sharing is open and transparent, al personnel who attend are skilled in critical and lateral thinking, clear attention is paid by the group leader to maintaining professional boundaries.

5. Future research step: Development and validation of an interagency meeting analysis framework and measurement tool

Development of an interagency meeting analysis tool for use in the IAST+ evaluation

In order to assess the success of the current interagency meetings of the IAST+ groups in three locations (Devonport, Launceston and Glenorchy) it was decided that a meeting analysis tool would be developed. The tool will take the form of an observation checklist for completion by meeting observer/analysts. It will be underpinned by current empirical knowledge (as presented in this literature review), effective group process (Baron & Kerr, 2011), effective teamwork patterns (West, 2012), social-psychological processes and organisational sociology (Schneider, Gruman, & Coutts, 2012) and organisational management (Mullins, 2013).

Elements of the Interagency Meeting Analysis Tool (IA-MAT) will include:

- Dynamics of meeting facilitation led by the team leader or chair;
- Age/gender/occupation/responsivity of meeting participants;
- Deep or surface structure of the meeting discussions;
- Future or past focus of the material discussed;
- Characteristics of group decision-making;
- Mapping the direction of dialogue;
- Levels of participation and group-think;
- Meeting management qualities; and
- Analysis of the five key elements of successful interagency collaborations presented above

This tool will be developed and trialled from October 2014

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