Quality Framework Multi-Disciplinary Approach ++

*An effective approach to child abuse, domestic violence and sexual violence in the Netherlands.*

How can you organise better and quicker availability of multiple sectors with the objective of stopping violence, achieving sustainable security, restoration of development opportunities and quality of life? The Multi-Disciplinary Approach (MDA)++ offers opportunities. This quality framework identifies what you, as municipality and professional from the care, medical and judicial chain must think about when you want to get started with MDA++.

The expectations of MDA++ are high; it is expected that, at the end of 2018, a network with national coverage will be established that will also provide guidance on cooperation in the implementation and on the conditions. Domestic violence, child abuse and sexual violence constitute a complex and frequently persistent problem. There are often problems with multiple family members in various spheres of life, which are interrelated and can be passed on from one generation to the next. The pattern of violence and insecurity and the dynamics between the family members should be turned around and broken. The complexity, the severity and the persistence of the problematic demand for specific knowledge, suitable methods, an integrated approach and taking joint responsibility.

**What is MDA++?**

With MDA++, we are referring to the system-oriented, phased, multidisciplinary, multi-sectoral, trauma-informed, directed and integral approach from within a single team surrounding every customer system. An approach where experts, the various sectors, local team and the family with its social network cooperate. In terms of composition, the team may vary depending on the course that the customer system undergoes. This course is supported by the cooperating organisations from the various sectors, which facilitate their professionals with the objective of offering result-oriented care for this target group. Based on the available knowledge, there is a justified expectation that this approach will lead to the desired result: stopping violence, achieving sustainable security, restoration of development opportunities and quality of life. MDA++ is a network, not a separate organisation. A team consisting of professionals who, from and with the permission of their own institutions and, on demand and based on a security or care plan, are deployed in a case. One works with the family in question, in the investigative phase, when compiling and monitoring the plan in a permanent MDA++ basic system. In the implementation phase, the composition varies in terms of size and in disciplines, based on what is required per case.

MDA stands for

*Specialist:* all professionals have knowledge of the effect of trauma, of severe forms of violence on individuals and relationships: the 1st +

*Multi-sectoral:* cooperation between the care provision chain (among others, social district team Youth Aid, Women's shelters and Mental Health Care [GGZ], the security chain (among others, Safe Home, Police, Public Prosecutor Department, the Parole Board, certified bodies and the Child Care and Protection Board) and the medical care circuit (among others, general practitioner, JGZ [Youth Health Care] and hospital): the 2nd +.

*System-oriented:* The support is offered to both children and adults, to both victims and perpetrators and other persons involved. It is directed at the dynamics of the violence between the family members and at the restoration of secure relationships. The objective is to help the customer system regain control over security and recovery.

*Multidisciplinary:* cooperation between parents, children and professionals from various professions such as the general practitioner, psychotherapist, police, prosecutor, youth psychiatrist, teacher from school, behavioural expert, paediatrician, youth health care worker and social worker.

*Phased:* first cooperate for immediate security and then for stable security. By working in phases, the natural recovery period of the customer system is supported and followed now. It offers the professionals and overview and rest during the process of care provision. The analysis of the problem also proceeds in phases, first, the security assessment for the security planning, then the risk assessment for risk-driven care and then diagnostics for restorative care.

*Trauma informed:* the treatment of customers and the care offered in the entire chain are based on knowledge of all professionals about the effect of traumatic incidents on individuals and relationships.

*Multi-sectoral:* cooperation between the care provision chain (among others, social district team, Youth Aid, Women's shelters and Mental Health Care [GGZ], the safety chain (among others, Safe Home, Police, Public Prosecutor Department, the Parole Board, certified bodies and the Child Care and Protection Board) and the medical care circuit (among others, general practitioner, JGZ [Youth Health Care] and hospital).

*Directed:* a case manager takes care that a good cooperative relationship with the family develops, that the immediate security always takes priority, that the ongoing care is subsequently risk-driven and is optimally adjusted to the customer system and that there is a current security plan in case of transfer of the case management. He or she is the recognisable and trusted face for the family and manages the phased care process. The joint plan is the most important resource in the management. Management rests with all existing officials tasked with management in their package of the area team (1 family, 1 plan, 1 manager), Safe Home, the certified body or the Parole Board.

*Integral:* the approach focuses on all prevailing forms of violence and insecurity in the relationships; both on child abuse and neglect as well as on partner violence and sexual violence. The help is mutually coordinated and presented in a jointly prepared plan.

**Why MDA++?**

With the Domestic Violence and Child Abuse Reporting Code, the action protocol and the triage-instrument, Safe Home, we, in the Netherlands, have made great strides in reporting of child abuse, domestic violence, neglect and sexual violence. This lays a good foundation, but in case of acute danger of structural (recurrent) insecurity in families and relationships, Safe Home and the exiting chain cannot provide for security. Not in the short term, neither in the long term. Because of this, customers almost constantly and often for multiple generations find themselves in the protection system and the criminal justice system, without result.

MDA++ was developed by the trend setter of the MDA++ in the Netherlands (MDCK Kennemerland, MDCK Friesland, Centra Seksueel Geweld [Sexual Violence Centres], Safe Home/FJC Central Brabant, Mutsaers Foundation, Intersectoral approach Child Abuse Gelderland, Safe Home/Intervention team Western Brabant, Safe Further Teams, The Hague) with the cooperation of the Stay Group, National staff Child Care and Protection Board, Public Prosecution Department, Member Executive Committee National Network Safe Home, Police, Parole Board of the Netherlands and with the support of Movisie and the Dutch Youth Institute. The starting point is the National Vision Paper "First collaborate for security, then collaborate for risk-driven care"[i].

The hope and expectation is that the regions can benefit from the knowledge that the joint leaders acquired over the past 10 years by trial and error.

**What is required?**

To provide security in the short and long term not only requires additional effort and expertise, but also result-oriented cooperation and a smooth and well-functioning connection in the care, medical and judicial chain. However, these terms and conditions are not accessible and available at the right time in the regions. Professionals from the various chain focus on a sub-problem where that sub-problem is not approached in relation to the violence, the neglect or the abuse and where a joint approach is lacking. From reports from the Inspectorate and from research it then also continuously becomes apparent that the violence and insecurity will not stop, let alone will a stable security develop that could facilitate the desired recovery for the victims. The alderman of the 35 central municipalities therefore decided on 27 November 2015, followed by the VNG-committee Health and Welfare the following December, that, by the end of 2018, the Netherlands will have a Multidisciplinary approach in every region for acute and structural violence: the MDA++.

**Objectives of the MDA++**

MDA++'s ambition is the sequential realisation of immediate security, of stable security in the relationships and recovery from trauma, recovering development opportunities, participation and quality of life for children and adults. To achieve this, the approach and the cooperation further focus on the victims, perpetrators and their (in)formal network in a phased way:

**1. First, immediate safety**

The first objective is establishing an emergency measure for immediate security by the professionals who are already involved with the family together with the network directed by Safe Home. The first conversations with the family members focus on what is required to secure the basic requirements for security. A proper security plan is used for that. If necessary, a tailored investigation plan is compiled: injury examination, evidence examination, factual examination of the perpetrator and victim(s), assessment perpetrator's risk profile and diagnostics of the dynamics of the violence. Where necessary, coordinate with the judicial chain. In case of intrusive traumatic memories, severe irritability and avoidance behaviour, short-term treatment is required.

**2. Then, risk-driven care**

If, with the aid of the emergency measure, the basic requirements for security have been met, it must become clear what is needed for a proper care plan directed at the causes of the violence to achieve stable security. To that end, the pattern of violence is always assessed and mapped. In discussion with the customer system and with the help of the system-oriented risk assessment, the risk factors that have the most impact on security in the relationship are prioritised. The caregivers involved with this family, together with the customers, formulate objectives focusing on these factors and further make arrangements for the implementation and the cooperation.

**3. Then, restorative care**

If stable security has been achieved to a sufficient extent, focus on the consequences of the violence. What trauma care is needed to repair the damage, what care is needed for improving the development opportunities and quality of life of all family members? The question whether everyone is now indeed feeling secure, should be asked. To this end, experiences of violence and insecurity should be processed, psychological and medical complaints should be treated, the personal development must be stimulated and the social and societal participation must be promoted. Not only individually, but also in the family relationships and network.

**4. Then, on with life**

With a plan, most customers who experienced or perpetrated severe violence, neglect or abuse, can continue independently. Yet, after a phased approach, some still seem so vulnerable that structural support for security and suitable societal participation is and remains necessary. To this end, support should be customised because after this carefully trodden path, it will be possible to substantiate where structural support is indeed needed and where not.

**How to approach this?**

The customer is approached respectfully as a citizen entitled to manage his own care path. Customers do not coincide with the problems they have, they are experts in their own field, have the potential and capability of trying to regain control. Where structural insecurity in the relationships and the lacking awareness of the importance of the family members do not allow the customer to be fully in charge, the customer will still be informed in advance about the approach and be made capable of influencing decision-making. In addition to the security requirements, the objectives of the customer form the base for the plan.

- The triage-instrument Safe home points out customer systems with acute and structural insecurity problems for the integral approach of the MDA++. In case of acute cases concerning sexual abuse, there is direct access via the Centre for Sexual Violence (CSG).

- Seeing that, in case of an acutely insecure situation, there is also mostly underlying structural

insecurity, the MDA++ is organised as such that an additional screening is conducted for the existence of structural insecurity after the acute insecure situation has been dissolved.

- A shared vision of security by institutions and the workers:
  - o Safety of the victims and the children is paramount from the beginning to the end and a joint responsibility. Everyone knows what this means.
  - o Safety, speed and effectiveness of action are paramount. The team agrees on the joint objective and the way forward to achieve it. The shared vision about the approach and the result-oriented way of work are supported or mandated by the own organization. The customers are central, not the way in which the institution works. The own organisation stimulates the vision that the interest of the child/victims and family members is paramount in determining what is required and who can do it best. There is an active search for (economic) incentives to facilitate this.

- The approach is objective- and result-oriented, customised and directed:
  - o Directed at all people involved (victim, perpetrators, children, relevant network).
  - o A combined plan of approach, based on a proper security assessment, risk assessment and diagnostics is used.
  - o As close to home as possible and, as far as possible, organised around the child, victim, perpetrator, family and the local and already involved professional network.
  - o There is clarity about the roles and responsibility and the way in which cooperation and coordination will take shape. This leads fewer professionals in the implementation.
  - o A manager maintains an overview and is the trusted person for the family members.

- Case management, in addition to security, cohesion and coordination, is paramount until the objectives up to and including recovery have been achieved. This management role has been assigned to the existing officials as described above. For such management of security, these officials have a nationwide and uniform task and job description with matching training based on the quality framework. This guarantees the continuity and further provides protection to transitions of vulnerable customers from one manager to another and to a next phase of care. In advance, it has been arranged that a manager scales up as representative at an institution in case of, for whatever reason, failure in a part of the implementation.

- The required expertise and commitment are available.
  - o A solid, close-knit, well-cooperating basic team, the whole is more than the sums of its parts.
  - o Specialist expertise from the care domain, the medical domain and the security domain (civil and criminal) is available, accessible 24/7, has continuity and a customised application.
  - o The specialists coordinate to, as far as possible, prevent the victim from having to repeat his or her story numerous times.
  - o The local network is supplemented by provisions and specialists from other sectors and therefore always form part of the effort.
  - o All professionals involved in the MDA++ work trauma-informed.
  - o There is a case manager who can be used for this family for a long period.
  - o The team assisting the family or the partners has a chairperson who leads the consultations. He/she ensures that the plans of approach are targeted, system-oriented and integral in accordance with the Vision Paper "First collaborate for security, then collaborate for risk-driven care".
  - o This neutral and expert chairperson is substantively and procedurally qualified and supports the case manager. After all, cooperation is a subject that we still must learn and professionalise.
  - o There is single victim-friendly place where the child or adult can be interviewed for investigative purposes, medically and psychologically examined and can be assisted in case of a crisis after being questioned by the police.

- Information Department
  - o Security is paramount at the Information Department in case of (suspicion of) child abuse and sexual abuse. Not the consent principle, but the transparency principle is the key if security is at stake.

- Quality of the care:

- o The trend setters for an integral approach to child abuse (in Kennemerland, Friesland and Gelderland), domestic violence (Tilburg, The Hague, Breda, Helmond) and sexual violence (the Centres for Sexual Violence - CSG) use best practices, descriptions of work processes, information material for all people involved, results of their approach.
- o Specialist quality is guaranteed by developing the existing best practices of the joint MDA++ into care standards based on the National Vision Paper "First collaborate for security, then collaborate for risk-driven care", in accordance with the What Works principles (RNR model) and the international guidelines in investigation and treatment in case of these target groups.
- o Targeted training linked to the standards of care.
- o Link the work in the MDA++ to practice-based investigation.

What expertise is immediately available (basic team)?

- Safe Home
- Paediatrician
- The Youth Mental Health Services [Jeugd GGZ] (diagnostics and, as necessary, active encouragement to undergo treatment in a group or individually)
- Forensic Mental Health Services [GGZ] establishing contact with the perpetrator and victim, violence dynamics and, as necessary, with forensic Mental Health Services [GGZ] (perpetrator treatment) regular Mental Health Services [GGZ] (assessment, support, treatment)
  - Police: specialised in listening to victims (including children) and perpetrators
  - Local team in question

What expertise is quickly available in case of need in specific cases?

- Case manager (official with management in his package)
- Forensic physician/nurse for physical examination
- Forensic psychologist/remedial educationalist to conduct interviews with the child and family members
- Consultation opportunities and the option of immediate access to Mental Health Services [GGZ] (trauma treatment, system-oriented risk-driven care), LVB [Mild Mental Disability] and Addiction care
- Consultation at the National Expertise Centre for Child Abuse [Landelijk Expertisecentrum Kindermishandeling] (LECK)
- Advocacy: Public Prosecutor Department (if the prosecution of the perpetrator is indicated or could be supportive

- Child Care and Protection Board for consultation about a(n) (emergency) measure and investigation. The Dutch Parole Board for individual risk assessment and supervision in the framework of specific conditions imposed by OM or ZM

- Immediate access to secure crisis intervention and 24 hours' accessibility service
- There is the option of being able to consult informed colleagues in any area, such as in case of the Paediatric Condition Falsification (Munchhausen by proxy), honour-related violence, and others

[i] National Vision Paper "First collaborate for security, then collaborate for risk-driven care".
L. Vogtländer & S. van Arum (2016) GGD GHOR, Utrecht

- https://vng.nl/files/vng/201605_visiedocument_gefaseerde_ketensamenwerkingvogtlander_van_arum_0.pdf

Call to action

TAKE THE STEP

With the integral approach to child abuse, domestic violence, sexual violence, we can take an important step in improving the assistance to victims and perpetrators. The compilers of this Quality Framework work together to give municipalities and professionals information and the support in shaping the MDA++ in their region.

Questions or advice?

Please contact: Janet van Bavel, janetvanbavel@kenterjeugdhulp.nl