IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

STATEMENT OF KYM LEE-ANNE PEAKE

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I, KYM LEE-ANNE PEAKE, Acting Secretary, Department of Health and Human Services, SAY AS FOLLOWS:

1. I am the Acting Secretary of the Victorian Department of Health and Human Services (**Department**) and have held this role since 21 September 2015.

2. My substantive position is Deputy Secretary, Governance Policy and Coordination within the Victorian Department of Premier and Cabinet. I have held this role since March 2015.

3. I was Deputy Secretary of Higher Education and Skills within the Victorian Department of Education and Early Childhood Development and the Department of Business and Innovation from 2010 to November 2014, assisting with the establishment of the Department of Economic Development, Jobs, Transport and Resources between December 2014 and March 2015.

4. Prior to my appointment to the Victorian Department of Education and Early Childhood Development, I held senior executive roles in the Commonwealth Department of Prime Minister and Cabinet and the Victorian Department of Human Services.

5. I hold a Bachelor of Arts (Hons), a Bachelor of Laws and an Executive Masters of Public Administration from the University of Melbourne.

6. I have received a notice from the Royal Commission into Family Violence (**the Royal Commission**) pursuant to section 17(1)(d) of the *Inquiries Act 2014* (Vic) requiring me to attend and give evidence at the Royal Commission and to provide a witness statement.

SCOPE OF STATEMENT

7. I have been requested by the Royal Commission to provide evidence on behalf of the Department in relation to Modules 4 and 5 of the Commission's October 2015 public hearings (what should the system look like and how should it be funded?).

8. I note that the Royal Commission has heard evidence from a number of witnesses from the Department throughout the course of its July/August 2015 public hearings. In particular:

   8.1 Ms Beth Allen gave evidence in relation to Module 3 (Children: Intervention and Response);

   8.2 Ms Judith Abbott gave evidence in relation to Module 5 (Alcohol and Drugs);

   8.3 Mr Arthur Rogers gave evidence in relation to Module 7 (Housing and Homelessness);

   8.4 Dr Mark Oakley Browne gave evidence in relation to Module 8 (Mental Health);

   8.5 Mr Scott Widmer gave evidence in relation to Module 9 (Risk Assessment and Risk Management) and Module 20 (Information Sharing);

   8.6 Ms Leeanne Miller gave evidence in relation to Module 15 (Intersection with Family Law and Child Protection Laws);

8.7 Mr Rocco Fonzi gave evidence in relation to Module 17 (Diversity of Experience, Community Attitudes and Structural Impediments);

8.8 Ms Frances Diver gave evidence in relation to Module 18 (The Role of the Health System); and

8.9 Dr Varughese Pradeep Philip gave evidence in relation to Module 19 (Integrating services from the victim's perspective).

9. The Royal Commission will also hear evidence during the October 2015 public hearings from:

9.1 Ms Tracy Beaton, Chief Practitioner and Director of the Office of Professional Practice, who will give evidence in relation to the role of the Child Protection Operating Model in developing workforce capability for the Department's Child Protection workforce; and

9.2 Ms Leanne Beagley, Director, Mental Health and Drugs, who will give evidence in relation to the Victorian Dual Diagnosis Initiative (**VDDI**).

10. I do not provide, in this statement, detailed evidence about matters to which these other Departmental witnesses have referred, or will refer, in their evidence to the Royal Commission. Accordingly, this statement should be read together with the above statements and other information filed by the Department with the Royal Commission.

11. A critical issue in family violence is system design. The 'family violence system' is sometimes defined narrowly to describe police, justice and specialist family violence services provided following a family violence event. However, many people experiencing, or at risk of experiencing, family violence also require support from a broader range of health and community services. It may be more accurate to describe a family violence 'eco-system', recognising that inter-related and mutually

reinforcing changes need to be made to the design of the justice, health, community services, education and social protection systems.

12. It is my objective in this statement to provide an overall perspective on behalf of the Department of the key service delivery challenges posed by family violence, and the necessary governance and funding principles and mechanisms that must underpin changes to how health and community services work with one another and with other elements of a family violence 'eco-system'.

13. To that end, this statement is set out in three parts. In Part 1, I provide some important context and a rationale for the proposed directions for reform set out in Parts 2 and 3.

14. In Part 2, I address **three priority areas for service delivery reform** that require focussed attention, and which have been the subject of consideration in much of the evidence and submissions given to the Royal Commission to date. These are

    14.1 Changing community attitudes to gender equality and family violence;

    14.2 Intervening earlier and more effectively before violence escalates; and

    14.3 Ensuring safety and holding perpetrators to account.

15. Importantly for the Department, the latter two areas for reform will require some level of improved integration of services from the perspective of service users.

16. Finally, in Part 3, I discuss **six key enabling actions** identified by and throughout the Royal Commission public hearings. These actions will require strong government leadership, but also the involvement of all relevant actors working together to make progress towards a family violence-free Victoria. They are:

16.1 Adopting an outcomes approach;

16.2 Enabling better risk management and information sharing;

16.3 Designing fit for purpose funding and accountability models;

16.4 Strengthening data analytics, evidence, evaluation and performance reporting;

16.5 Building workforce capacity; and

16.6 Strengthening leadership and governance.

17. Together these areas for reform and enabling key actions will represent a significant and long-term change program. Achieving change will require substantial cultural and practice change for Department and non-government workforces. Leadership across all levels of government, and throughout the community will be necessary to change the cultural values and perceptions about women's roles in our society that allow family violence to occur.

18. Government, informed by the findings and recommendations of the Royal Commission, and ongoing engagement with service providers and those affected by family violence, will need to make strategic choices about "how" best to achieve new ways of working, and the sequencing of changes.

19. It will not be possible to arrive immediately at the "best" system. A structured process of evidence informed co-design will be required with sector partners and the community.

20. In particular, it must be understood that the creation of a more integrated and person-centred system of health and community services – to better address disadvantage and support individuals and families – is a complex and significant undertaking. It will require careful change management and linkage with existing work, such as the

Roadmap for Reform: Strong Families; Safe Children project and Victoria's 10-year Mental Health Strategy.

21. Reform should be underpinned by a trial or trials at scale to develop an evidence base, rapidly refine tools, capabilities and processes, create effective feedback loops and guard against unintended consequences – particularly as these reforms would significantly affect some of the most vulnerable members of our community. This work should be accompanied by a commitment to roll-out, state-wide, a tested and refined model to an agreed schedule, to ensure that a comprehensive and integrated response is in place as soon as is practicable.

22. Nevertheless, within this overarching and long term reform agenda, some specific actions to improve responses to family violence can be progressed more rapidly. These include priority initiatives already identified for the Royal Commission by the witnesses from the Department referred to above, such as the state-wide roll out of Risk Assessment and Management Panels (**RAMPS**), the review of the Risk Assessment and Risk Management Framework (also known as the Common Risk Assessment Framework or **CRAF**), and strengthening information sharing arrangements. Work on these actions is either already underway or has been independently committed to by government.

23. It should be noted that the views contained in this statement are my views and not necessarily the views of the Victorian government.

PART 1 – CONTEXT AND RATIONALE FOR REFORM DIRECTION

24. As is clear from the Royal Commission's public hearings, family violence impacts all parts of Victoria's community and is gender-based. Violence inflicted on women by men is by far the most common form. Experts who have given evidence have emphasised that family violence is an event, rather than a condition – albeit an event that can be episodic, or continuing.

25. Submissions and witness testimonies have also highlighted the co-occurrence of family violence with other social and economic determinants of disadvantage. I understand the Royal Commission has heard that:

    25.1 between 50 per cent and 80 per cent of clients in the drug and alcohol sector have either used or experienced family violence;

    25.2 between 50 per cent and 90 per cent of female clients in acute mental health services have experienced interpersonal violence, mostly family violence; and

    25.3 family violence was identified as a factor for approximately 35 per cent of people seeking help from homelessness services.

26. The Royal Commission has also heard about the co-existent risks of family violence and child maltreatment. Family violence is a factor in 64 per cent of child protection substantiations, 41 per cent of Child FIRST referrals and 48 per cent of out of home care placements.

27. The hearings have also highlighted that family violence must be understood within its social and community context. The incidence of family violence is higher in regional and outer metropolitan communities. The Royal Commission has heard about the specific barriers to reporting and escaping violent relationships for people with a disability (in particular where their abuser is also their carer). There has also been testimony about the experiences and service needs arising from family violence in LGBTI relationships, for older Victorians and within Indigenous and other communities.

28. The current design and operation of health, education, social and justice systems is not conducive to improving outcomes for those experiencing or at risk of experiencing family violence.

29. While the nature of risk factors increases the likelihood that victims and perpetrators will interact frequently with multiple government funded and delivered services:

    29.1 co-ordination of health, community service and justice responses is strongest at the point of crisis – with inadequate co-ordination of support when early signs of violence emerge or to support recovery and sustained changes in perpetrator behaviour;

    29.2 new initiatives can add complexity to an already fragmented set of systems and fail to address the critical issue of system design;

    29.3 the lack of systemic evaluations makes it difficult to assess whether government investment is being targeted in an effective way; and

    29.4 outcomes for people affected by family violence are likely to be sub-optimal, leading to additional health, community services and justice costs.

30. The Department is responsible, on behalf of government, for funding, regulating and directly delivering a broad range of health and community services. The Department also has a lead role in:

    30.1 advising government on community service standards and regulations;

    30.2 administering funding and managing statements of priorities with health services and service agreements with non-government service providers; and

    30.3 active management of the health and social services system architecture and enabling environment.

31. While there are strong examples of cross-agency collaboration and service innovations, to effect sustained change in the prevalence of family violence, and outcomes for affected children and families, the Department will need to change how it functions.

32. As a core provider of health and community services, the Department will need to develop its service models and methods of collaboration with other agencies, and it will need to deepen its networks with experts to further develop the evidence of what works.

33. In its role as system steward for Victoria's health and community services, the Department will need to deepen its capabilities in designing and actively managing the health and community services system architecture. In performing these functions, the Department will need to engage the Commonwealth government, which shares responsibilities for the design of the health system. It will also need to strengthen its approach to co-designing solutions with service partners, clients and communities.

34. Finally, in exercising shared stewardship for services within a family violence eco-system, the Department will need to:

    34.1 ensure that data is collected, shared and used in ways that enhance system performance;

    34.2 identify the barriers to, and opportunities for, improving the way relevant service systems are designed, governed and operated; and

    34.3 play a leadership role in the wider conversations required to achieve that change.

PART 2 – THREE PRIORITY AREAS FOR SERVICE DELIVERY REFORM

1. Changing community attitudes to gender equality and family violence

35. Community attitudes to gender relations and appropriate behaviours within families and between intimate partners are an important predictor of the prevalence of family violence.

36. Different studies have found significant links between gender inequality and violence against women. For example:

    36.1 Levels of domestic violence across the whole population are higher in societies where laws, institutions and cultural beliefs promote or support stereotypical or rigid roles for men and women, and where women have less access to power and resources than men.

    36.2 Individuals who do not believe men and women are equal are more likely to condone, tolerate or excuse family violence.

    36.3 Within intimate relationships, male dominance and control of wealth is a significant predictor of higher levels of violence.

37. The 2014 National Community Attitudes Survey on Violence against Women showed that most measures of community understanding and attitudes on violence against women have not improved in Australia over the past 20 years.

38. Respondents showed a tendency to trivialise and excuse violence against women, with young people under the age of 25 one of the groups who showed the least understanding.

39. This is consistent with VicHealth reports that 25 per cent of young people say that partner violence can be excused if they regret it, 20 per cent of young people say that men should take control in relationships,

and 60 per cent think violence is caused by men being unable to control their anger.

40. These sorts of attitudes not only perpetuate violent behaviours, they also prevent many victims and witnesses from reporting violence in the family.

41. One important step towards the prevention of family violence is therefore to change the community's attitude to gender equality and its view of violence.

42. These attitudes are not innate – they are socially constructed via exposure to cultural norms and structural arrangements (such as the extent of participation of women in education and leadership positions).

43. Changing community attitudes requires a concerted effort by all three levels of government, community leaders, institutions and organisations and the broader population.

44. For example, State Government efforts to expand leadership opportunities for women on councils, boards, committees and community groups send a powerful message.

45. The Royal Commission has also heard of innovative local examples of prevention initiatives, such as the Maryborough Rotary Club's use of a harness racing meet to say no to family violence.

46. Effective community engagement will be at the heart of successful local approaches to changing attitudes. Essential to community engagement will be arrangements developed to enable and empower local leadership and create a dialogue with government, along with an ability to influence its decision making. In this light, consideration should be given to a range of emerging community engagement models, such as collective impact techniques.

47. A shift in community attitudes will take time but research shows that achieving sustained change must:

    47.1 be driven by communities;

    47.2 be driven across all settings in which people work and play;

    47.3 be mutually reinforcing (the effectiveness of a prevention initiative is strengthened when it is carried out in conjunction with initiatives in other settings (e.g. a schools-based program accompanied by a social media campaign);

    47.4 begin at early childhood and continue to engage at key points in the life cycle (childhood; adolescence; marriage; new parents);

    47.5 engage communities, schools and organisations;

    47.6 respond to diversity and local community need; and

    47.7 for Aboriginal communities – be driven and owned by that community.

48. All parts of the public purpose sector have a role to play – from modelling values and behaviours, through to deliberate actions. Schools provide a powerful platform to inform young people and shape their attitudes – as well as identifying early signs of violence. The criminal justice system's response to family violence, for example, is critical to a broad community understanding that family violence is unacceptable.

49. The Department can lead and support changes in attitudes through our own workplaces and through our programs and services.

50. As an employer of approximately 11,200 full time equivalent staff, the Department can help to change attitudes, reduce risk factors by facilitating women's economic participation, and support people who are experiencing or escaping violence. Actions include participating in the whole of government, 'Male Champions for Change' program, rolling

out domestic violence workplace policies and actively facilitating more flexible working options.

51. The Department can work with VicHealth, sport and recreational clubs, general practitioners, community health and community services, to drive changes in culture, behaviours and attitudes that perpetuate violence.

2. Intervening earlier and more effectively before violence escalates

52. The Royal Commission has heard evidence that the system is too heavily focussed on crisis or tertiary end supports. Too often supports are only provided once people are experiencing a crisis and opportunities to intervene earlier are missed.

53. As with changing community attitudes, earlier and more effective intervention relies on multiple actors and systems playing their part.

54. Universal health services, maternal and child health, early childhood and education services and many other parts of the broad health and community services system, all need to be better equipped to identify early signs of violence and to take account of the impacts of violence in personalising their services. This will involve training workforces across all of our services to recognise signs of abusive and controlling behaviour, to know how to ask questions about abuse and to know what to do with that information. Key strategies include:

    54.1 wider adoption of screening tools (such as the CRAF, discussed further below);

    54.2 broader application of training and workforce development to improve awareness and capability to support victims of family violence; and

    54.3 stronger links, information sharing and referral pathways to police and other specialist and crisis support services.

55. For example, the Violence Intervention Program in New Zealand has improved the capability of health services to act as access points into support for people affected by family violence. District Health Boards run local programs of routine screening and assessment to pick up on violence risks so that people can be channelled into appropriate support. Upskilling of health and community service workforces, and better connections between universal services and specialist family violence responders will go some way to preventing the escalation of violence.

56. A more joined up community services system is required to better support people experiencing or at risk of experiencing family violence – particularly for those who face particular barriers to leaving a violent relationship; or who have multiple and complex needs.

57. There are currently a number of ways that people who experience or fear violence can seek help. This diversity can be seen as a potential strength of the system as it reflects the need for appropriate access points for people with different needs, circumstances and backgrounds. However, the Royal Commission has heard evidence that these entry points:

 57.1 can be difficult to identify and navigate;

 57.2 can be complicated by information sharing arrangements, the availability of services and the capability of the first point of professional contact being able to effectively screen for and identify that family violence is occurring; and

 57.3 often commence once a person has already experienced significant harm and statutory interventions are engaged.

58. This complicated array of entry points is also an issue impacting on all clients of the broader community services system.

59. The Department supports several existing platforms for integrating access to services for a particular cohort – such as the Child FIRST and Opening Doors platforms. These approaches have made significant contributions to improving service access, however they largely remain access points for entry to a particular service "silo" or program area. As a result, they do not resolve one of the core problems with the way community services are delivered – namely the need for vulnerable people with more than one area of need to often access multiple service sites or programs, and engage with multiple assessments and case managers, in order to receive services that meet their needs.

60. A simpler first point of contact for all community services, with a strong capability for identifying family violence, could improve responses to a broad range of community services clients. This integrated 'front door' could include a comprehensive intake and screening service, with strong and effective mechanisms to manage risk, triage responses and place people on holistic service pathways.

61. To improve visibility and avoid stigmatisation, this entry point would be best located in a community setting, closely connected to universal services.

62. This capacity to deliver an earlier and more integrated screening and referral to government delivered and funded services could sit within government or in dedicated partnerships of government or non-government practitioners.

63. Whether someone reaches out for assistance via a universal service, a specialist service, or a new community based intake service, it is clear that we need to reduce the need for victims to retell their story, and offer more seamless support.

64. The Royal Commission has heard a wide variety of evidence demonstrating that people experiencing and perpetrating family violence often have multiple and complex needs, and family violence

often co-occurs with other social and health issues. This requires an approach to service delivery that is flexible and holistic – designed around individual preferences and needs rather than programmatic boundaries.

65. The phenomenon of multiple and overlapping needs is not confined to family violence; it is also associated with other forms of disadvantage and vulnerability. Recognising this, a genuinely integrated response to disadvantage would require a service capable of dealing with the full range of issues that people may experience as well as an increased focus on addressing family violence.

66. No single model of integrated care exists. All models lead to various degrees of integration along a spectrum from person-centred to service provider-centred.

67. Efforts to improve integration might include:

    67.1 a group of agencies signing protocols to share information and work in more coordinated ways together;

    67.2 sharing the same assessment or referral tools;

    67.3 establishing contractual agreements for the delivery of shared services for a common client group; or

    67.4 the co-location of services, and so on.

68. The Productivity Commission of New Zealand has identified the following conditions for arrangements that would support effective and integrated services:

    68.1 a skilled, client-centred "navigator" (or case manager) who is close enough culturally and geographically to understand the client's circumstances and to build a relationship of trust with them (be they individual, family or community);

68.2 clear responsibility of the navigator for achieving outcomes for the client that are agreed by both the client and the funder;

68.3 a realistic allocation of funds to the navigator to provide the means and flexibility for an integrated package of services for the client to help them turn their life around;

68.4 information systems and a decision-making framework that allocates funds to where they have the most effect; and

68.5 devolved decision making that gives the navigator the freedom to provide or purchase services in the way that will best meet the client's needs.

(See New Zealand Productivity Commission, *More effective social services: Final report*, (2015)).

69. The New Zealand Productivity Commission then proposes two possible models that could fulfil these conditions.

69.1 The creation of a new agency operating either at a regional level or for a defined population group. The agency would be responsible for the high level design, goal setting, standard setting, data gathering, monitoring and evaluation of a local network of services. Mainstream health and social services would be purchased through a navigator, operating at arm's length from the agency and from service providers.

69.2 Widening the remit of District Health Boards to become purchasers in their regions of health and social services for disadvantaged people.

70. In the Victorian context, support for people and families with complex or multiple needs (including both family violence victims and those not affected by family violence) could involve a 'primary case manager'. This case manager could become involved when a risk of violence is

emerging, or following a violent episode. The primary case manager could:

70.1 lead the development of the person's needs assessment and a single plan to meet the needs identified through this assessment;

70.2 support people to get the help they need – either through holding a budget and brokering packages of support, or through mobilising cross-agency support;

70.3 better support people through the justice/legal process where this is necessary;

70.4 'stick with' people through both the early stages of crisis and the recovery process;

70.5 enable people to direct their own support, including setting goals and aspirations and exercising choice in line with their own needs, circumstances and preferences; and

70.6 connect and (re)engage people with primary and universal services.

71. These primary case managers could build on any pre-existing service or sector-specific expertise they may possess and be trained to develop broader expertise to enable them to provide support that meets the full range of their client's needs - rather than being restricted to only offering help specific to any one problem or program.

72. As suggested by the Productivity Commission of New Zealand, this coordinated case management service should be separated from individual service providers and from the conduct of research, evaluation and data analytics.

73. Specialist interventions would be deployed at the points at which they are needed – and people would be supported by their primary case manager to access and benefit from these.

74. While such models hold promise, important design questions need to be worked through. These include:

74.1 The skills of the workforce – these workers would require the expertise to work with people and families facing a range of challenges or issues (e.g. family violence, homelessness, substance abuse). They would not be a new workforce or additional support layer, but would represent a more professional and comprehensive case management service response.

74.2 The functions of the service – the precise roles and responsibilities of these workers would need careful design – to avoid duplication and/or over-reaching in terms of the expertise and skills required of them. Tasks they might undertake could include actively managing the integration of services and purchasing a bundle of services with or on behalf of a client; holding responsibility for the achievement of a range of outcomes; advocating for the client with the justice or legal system and so on.

74.3 The duration and intensity of the service – the intensity and duration of support should be enough to ensure support and recovery, but should also be aiming to reduce as the victim/client achieves greater safety and self-sufficiency

74.4 Mapping of service pathways to determine whether there is a logical ordering of services for clients with different needs.

75. The success of any model like this will depend on the ability of government and community leaders to transform the current system

from one built around specific problems and programs to one built around the needs of people. This would not be a simple task, and would require significant reform to areas such as funding and governance – as explored further below.

76. Finally, better screening, pathways and case management need to be accompanied by continuous improvement in service interventions. The growth in family violence places pressure across health and community services. More housing options, including for perpetrators, are a key priority. There is a continuing need to build evidence about, and implement high quality therapeutic interventions for, children and adult victims of violence.

3. Ensuring safety and holding perpetrators to account

77. A more integrated response is also needed if we are to more successfully hold perpetrators to account – and appropriately support victims, including children, through this process.

78. Holding perpetrators to account is critical to ensure that victims are safe and able to rebuild their life in the absence of fear. Perpetrators must be compelled to acknowledge their behaviour and its impact on victims and take steps to rehabilitate.

79. Depending on the nature and seriousness of their actions, perpetrators will engage with many government-funded and delivered services. This may include the Department's services funded to engage with men who use violence; child protection services; engagement with police to address immediate safety concerns; and interaction with the justice system where necessary. It is critical therefore that all of these services work closely together to hold perpetrators to account and reduce reoffending.

80. The Department funds a number of programs for men who use violence through both the Children, Youth and Family and Housing portfolios, including:

    80.1 Men's referral;

    80.2 Enhanced Intake;

    80.3 Men's Behaviour Change Programs (**MBCP**);

    80.4 Time out and Men's Family Violence Groups;

    80.5 Men's case management services; and

    80.6 the Adolescent Family Violence Program.

81. Corrections Victoria is rolling out a new Victorian cognitive behavioural therapy program for men who use violence. The *Change About* program is an 88-hour program (in contrast to MBCP which ranges from 12 to 18 sessions, each two hours in duration) that is targeted at moderate and high-risk family violence offenders.

82. The MBCP is the primary mechanism to reducing reoffending. However, the Royal Commission has identified a number of limitations with the current program:

    82.1 It is unsuited to all men who use violence;

    82.2 MBCP facilitators have limited training and skills to respond to complex cases and deeply entrenched behaviours;

    82.3 While facilitators are trained to understand men's violence, they are not qualified mental health professionals;

    82.4 The program has significant waiting lists; and

    82.5 There has been no robust evaluation of the MBCP in Victoria.

83. Evidence given to the Royal Commission indicates that there is scope to better understand the elements of an effective evidence-informed rehabilitation program for perpetrators. For example, for those who express a willingness to change their behaviour versus a program for perpetrators who are resistant to change.

84. Evidence has also illustrated that there is some merit in considering how to support a person at critical points in their life to prevent family violence. For example, the transition to fatherhood has been identified as a high risk period in terms of family violence and antenatal and post-natal programs have been shown to achieve positive outcomes.

85. The Royal Commission has heard evidence about programs in other jurisdictions that focus on perpetrators' role as fathers to bring about change:

    85.1 The 'Caring Dads' program which operates in Canada and selected parts of the US and Europe attempts to increase perpetrator awareness of impacts of their use of violence on their children and reinforce their role as protector. A trauma informed approach is utilised based on the assumption that many perpetrators of violence have their own history of trauma.

    85.2 "Breathing Space" is run by Communicare in Western Australia and is a three-month intensive live-in program that includes transitional accommodation. The model keeps perpetrators accountable and in view and deals with offending causes.

    85.3 'HOPE' and related approaches to perpetrator accountability in the USA – for example, flash imprisonment as a response to breach of probation and use of probation officers to oversee orders.

86. The process of ensuring perpetrator accountability can be a long and difficult one for victims. It is essential that the community services,

police and justice systems work in coordinated ways throughout this process. In this context, it is important that our services play a proactive role in supporting police and justice agencies in holding perpetrators to account.

87. This starts with coordinated crisis responses – where the investigation and immediate response to family violence must be undertaken swiftly and thoroughly, including cases where children and young people may be victims of this violence.

88. The Royal Commission has considered evidence on a range of efforts that adopt more integrated approaches to strengthen integration of safety and crisis responses:

88.1 Multi-disciplinary centres (**MDCs**) bring together Victoria Police, Child Protection and sexual assault counselling services at the one site to provide integrated support for adults and children experiencing family violence. Co-location improves access to services as well as collaboration between providers.

88.2 The Multi-Agency Protection Service (**MAPS**) in South Australia brings together staff from police, corrections, education, health, Housing SA and Families SA to share information and intervene early in relation to family violence and child protection matters. MAPS also involves co-location, and better information sharing, risk assessment and allocation of resources.

88.3 The Multi-Agency Safeguarding Hubs (**MASH**) in the United Kingdom are another model of sharing information to assess risk and allocate responses. The MASH model is a partnership of service providers, often co-located, who share risk information and assign a service response.

88.4 RAMPS provide one example of where integration has been attempted at the "tertiary" end of the system in Victoria – where

risks are extreme and often longstanding or intractable and a range of statutory or legal services may be involved.

89. Effective, joined up investigation and crisis response is essential – and this is the first step to ensuring perpetrator accountability. In those cases where the legal and justice system come into play, there also needs to be strong cooperation and coordination between all parties, especially to ensure that any workers supporting the victim are aware of the stages of proceedings.

90. Looking forward, the respective roles and relationships between an integrated crisis response and an earlier intervention model would need to be delineated.

91. For example, at key times in any legal proceedings, women may need the support of a case manager or other support service. This could be provided through the integrated forensic team, or by a community-based case manager to provide consistency of support through recovery.

PART 3 – SIX KEY ENABLING ACTIONS

92. Establishing the system architecture set out above would take time and careful development with sector partners.

93. Irrespective of the detailed design of prevention, earlier intervention, crisis and recovery approaches, new governance mechanisms will also be required to enable more person-centred and integrated services. In what follows, I address six of the key enabling actions at a governance level that demand attention in considering service system reform.

1. Adopting an outcomes approach

94. Using outcomes to drive – rather than passively monitor – strategic and operational decisions can build momentum for change.

95. The process of co-designing a shared set of outcomes can help to build a shared purpose and open up space for greater collaboration.

96. An outcomes framework helps to provide clarity on what success looks like – shifting the focus from problems and programs, to a clear articulation of what must be achieved for individual clients, including at a system level.

97. A well designed data infrastructure, connecting clear outcome statements with service performance metrics is critical to an effective outcomes approach. There are three relevant levels at which an outcomes approach would function.

98. Client level outcomes and associated measures can help to guide case planning – driving a focus on safety and the broader aspirations and needs of victims and perpetrators.

99. System level outcomes and measures provide a basis for rigorously assessing the impact of a shift to earlier intervention and personalised support, as well as specific service interventions and investments. Client and system level outcomes can also provide the basis for transparent monitoring of performance.

100. Population level outcomes can then help to track whether the prevalence of family violence is reducing.

101. Public reporting against an outcomes framework can also help to make family violence reforms durable. For example, progress in reducing and eliminating family violence could be tracked against outcomes such as:

    101.1 Victorians are able to live free from violence in their home; and

    101.2 Victorians who experience violence are protected from further harm.

102. Given the link between family violence and broader social needs, some client outcomes are likely to be relevant for other department clients. For example, outcomes relating to stable housing, secure employment and educational opportunities.

103. The Department has developed a draft set of client outcomes, as a basis for assessing changes in circumstances for individual clients. Outcome areas include:

 103.1 Housing: suitable and stable housing;

 103.2 Work and meaningful use of time: engagement in the labour market and meaningful activity;

 103.3 Learning and development: school achievement, post compulsory learning, independent living skills and early childhood development;

 103.4 Cultural and social wellbeing: family and relationships, sense of place and belonging, and social involvement;

 103.5 Health: mental and physical health;

 103.6 Safety: abuse and neglect, family violence injury, and safe environment; and

 103.7 Behaviours: alcohol and drug use, sexual risk, financial stability, gambling and offending.

104. Each outcome area has indicators, measures and capture questions that will provide rigorous information to effectively measure whether services are making a difference in people's lives. Further detail on the outcomes framework is attached to this statement at **Attachment KP-1**.

105. The framework is currently being tested with 115 non-government service providers delivering child and family services and six community sector organisations that support children and young people in out-of-

home care. These tests will provide outcomes data on separate client cohorts, but will also enable the Department to test the feasibility of this type of outcomes monitoring.

2. Enabling better risk management and information sharing

106. Risk and information sharing capabilities are critical in:

   106.1 keeping family violence victims safe;

   106.2 reducing the risk of further harm;

   106.3 holding perpetrators to account; and

   106.4 assessing and better responding to children's needs.

107. The CRAF is the main tool which provides a common approach to family violence risk assessment and risk management. This framework is to be reviewed to ensure the guidance and tools provided reflect current risk assessment evidence and best practice standards. In addition, the review will consider how improvements can be made to respond to different cohorts of victims and how dynamic risks can be better assessed and managed.

108. RAMPS are also being rolled out across the State to improve the risk management of women and children at risk of serious harm or death as a result of family violence and strengthen information sharing between key agencies.

109. While models like RAMPS offer improved information sharing for women and children at the high end of the risk spectrum, information sharing for those at the low to medium risk is less advanced – as is sharing of information about different family members.

110. The Department has developed a range of information sharing protocols between different government and non-government

stakeholders, providing a high level commitment between agencies about what and how information should be shared.

111. However, information sharing in the family violence context must take into account multiple Acts and privacy frameworks, and is impacted by the way the Department funds and collects data along programmatic lines. This has created real and perceived barriers to information sharing and created numerous and separate client information systems.

112. As part of the potential solutions, the earlier discussion of models for integrating screening, referrals and case management within the community services sector, and across family violence networks, present structural options to drive change.

113. The Department is currently pursuing the Better Client Information project, which will identify and address specific service delivery challenges to information sharing. This will include strategies to improve information management and technology systems. Adaptive strategies to change culture and behaviour will also be examined. It is anticipated that the business case for the project will be completed by early 2016.

3. Designing fit for purpose funding and accountability models

Funding models

114. Currently, Victoria's services for disadvantaged and vulnerable people are structured along portfolio and program lines, with a service delivery frontline that reflects those boundaries.

115. Use of prescriptive and programmatic funding models can create inflexibility in the system, inhibit innovation, and create a large reporting burden for agencies.

116. Currently, funding to non-government agencies for health and community services are predominantly provided through:

116.1 *Block funding*: funds are allocated to service agencies in a lump sum on a periodic basis. Agencies are required to meet demand for services within the allocated funding.

116.2 *Unit funding*: funding is allocated per unit measure - often, but not exclusively, associated with volume and throughput targets.

116.3 *Individual Support Packages*: funds are allocated based on an assessment of each client's requirements. Funds are used to support achievement of an individual's goals and needs. Funds are applied directly to clients or to a financial intermediary.

116.4 *Activity based funding* - a funding approach that pays for outputs (activity). The level of funding for each patient corresponds to the average costs across all patients with that specific condition or set of needs. Providers are allocated capped funding and a target that corresponds to the expected volume of outputs.

117. Most services that support people affected by family violence (including specific family violence programs and broader community and social supports) are funded either through block or unit funding.

118. More flexible funding models, designed to offer more flexibility to meet multiple needs and provide service users with more control over the supports they receive, include:

118.1 The National Disability Insurance Scheme - taking individualised, client-driven funding, already in use for people with disability in several Australian jurisdictions, to a national scale. Eligible individuals are given an entitlement based on their assessed level of need, and can use this to flexibly purchase a range of support to achieve self-determined goals. Individuals may manage the funding for their plan, nominate

someone to help them, or ask the National Disability Insurance Agency to manage all or part of the funding.

118.2 Victoria's Flexible Post-Crisis Support Packages - a small scale example of how individualised funding could be applied to family violence. These packages, which are soon to be rolled out, will support women experiencing family violence who are in crisis. Clients work with their case managers to identify their needs and the outcomes they wish to achieve, including stable housing and strong health. The client can receive up to a $7,000 package to achieve these outcomes.

119. The choice of funding model should be informed by an assessment of the characteristics of the services being purchased, the providers of those services and the needs of the service users.

120. Individualised or pooled funding models – with or without an outcomes component – could be most appropriate for clients requiring multiple services. Consideration would need to be given to:

120.1 who would be eligible to access support (for example, victim or perpetrator) and who would undertake the assessment of eligibility;

120.2 whether funding is for an episode or package of supports; and

120.3 under a packaged model, the duration and value of support and how changes in client circumstances would be managed.

121. Prior to implementation, any potential funding mechanisms should be analysed against actual data to assess the outcomes produced by the model. Modelling should also test for perverse, unintended or undesirable outcomes (including through engagement with existing service providers and potentially through trialling).

122. This type of testing is important to examine the likely impact of a funding model on service and system performance in areas such as equity, budget management and accountability. Funding models, especially to support full co-operation, should be designed to encourage collaboration and avoid the risk of perverse incentives like cost-shifting and client-shifting, or the benefits of the work of one sector only being realised in another.

Accountability models

123. The use of prescriptive funding models for family violence is further complicated by current budget output structures relating to the majority of funding for family violence services, which is split across two output groups – namely, the housing assistance output group and the child protection and family services output group. There are currently no Budget Paper 3: Service Delivery measures specific to family violence services. Issues associated with these current arrangements include:

    123.1 A lack of visibility over what is being spent on family violence as well as outcomes being achieved;

    123.2 Duplication and inconsistency in funding of services and specifications; and

    123.3 Administrative complexity, with some funded agencies having to acquit against two output groups and use multiple IT systems.

124. Some of these issues could be addressed in the short term by developing with the Department of Treasury and Finance some family violence-specific measures, moving over time to family violence outcome measures. Consideration might also be given to creating a new output group which encompasses specialist family violence service delivery.

125. Quality assurance and oversight arrangements vary across health and community services. Hospital oversight occurs primarily through health

service boards, who are accountable to the Minister for Health. Each health service submits an annual statement of priorities, which spells out funding and activity-based performance targets. Performance against those targets is monitored by the Department.

126. Community services delivered directly by the Department include Child Protection, disability and a range of residential services. Performance of these services is also measured predominantly on the basis of financial performance and activity.

127. Community services, including community health services are predominantly delivered by community organisations.

128. The Department outlines its expectations in service agreements. These agreements establish mandatory requirements, such as compliance with Department policies, delivery specifications and arrangements, performance targets and data collection.

129. Contract management is mainly focused on levels of activity delivered and responses to serious client incidents.

130. The development of an outcomes framework would provide richer performance information. Over time, greater sharing of information that compares the performance of services using a common measure could help to spread innovation and inform ongoing adjustment of service design.

131. Disability, homelessness services and child and family services are also regulated by the Department under relevant Acts. Regulatory failure may lead to the appointment of an administrator. Generally, the focus is on continuous improvement.

132. There is an opportunity to further consider the best regulatory approaches to promote continuous improvement of service quality. One model which could be considered is the regulation of Early Childhood Education against the National Quality Framework.

133. Under this model services are assessed and rated against seven quality areas and are assigned one of the following overall service ratings:

   133.1 Excellent;

   133.2 Exceeding national quality standards;

   133.3 Meeting national quality standards;

   133.4 Working toward national quality standards; or

   133.5 Significant improvement required.

134. Each approved provider must prepare a service improvement plan. Service ratings must be published on the provider's website, and are also published by government on a site that compares the results of all providers.

135. There are a range of oversight bodies, including the Ombudsman, Commission for Children and Young People, Health Services Commissioner and Disability Services Commissioner.

136. More information is provided at **Attachment KP-2** on the nature and coverage of regulation and complaints management across the range of health and community services relevant to this Royal Commission.

4. Strengthening data analytics, evidence, evaluation and performance reporting

137. A critical feature of a strengthened approach to family violence in the future requires the capacity to systematically gather and utilise data and broader system intelligence to inform development and oversight. Drawing on evidence and data which are reliable, empirical, credible and robust will be critical to ensuring Victoria is well placed to inform ongoing system improvement. Improved data collection and utilisation would facilitate a sharper focus on monitoring system level performance.

138. Effective feedback loops are critical to evaluating whether services that are funded by the Department are working from the perspective of the person receiving them and the community service organisation that is delivering them.

139. Building Victoria's family violence research and evaluation capability will contribute to driving change that encourages new ideas to be tested rigorously and validated, where an evidence base informs policy and practice. The creation and use of system data and intelligence also facilitates the opportunity for greater transparency with the community. It helps to build community awareness and engagement thereby contributing to whole of community engagement in the prevention of, and responses to, family violence.

140. Current initiatives are in development or underway in response to a lack of data analytics and evaluation currently active in the system. The Family Violence Index will bring together data from across the fields of crime, justice, health, education and community to create a single indicator of family violence enabling a measurement of the size and scale of the problem in Victoria.

141. Another example is Australia's National Research Organisation for Women's Safety (**ANROWS**), an independent, research agency established as an initiative under Australia's National Plan to Reduce Violence against Women and their Children to deliver academic evidence to drive policy development and evaluation.

142. Further to these initiatives, there would be benefit in growing applied research, data and analytics of service practice and delivery. This would help to promote ongoing system improvement focused on performance monitoring and prevention based on analytics and data linkage.

143. There may be lessons that Victoria can learn from the approach taken by the Cochrane Collaboration. The collaboration draws on contributions from leading health professionals to produce high-quality,

relevant and up-to-date synthesised research evidence. They assess health information to produce relevant and accessible systematic reviews to inform health decisions and policy.

144. There may also be lessons that Victoria can learn from the approach taken by the Washington State Institute for Public Policy (**WSIPP**). The WSIPP carries out practical policy research to identify options for a policy response, estimate the implementation costs and develop comparable cost benefit ratios through a system of common outcomes.

5. Building workforce capacity

145. A number of Victorian workforces play a role in the identification of and response to family violence.

146. The Organisation for Economic Co-operation and Development has reinforced the importance of workplace development and training initiatives when implementing integrated delivery methods. This contributes to developing a common vision and culture that is essential in settings which bring together traditionally hierarchical professional statuses and cultures.

(See Organisation for Economic Co-operation and Development, *Integrating Social Services for Vulnerable Groups: Bridging Sectors for Better Services Delivery* (2015))

147. Advanced assessment, engagement and clinical skills will be particularly important if the integrated case management model currently being trialled is rolled out more broadly. While there are potential benefits of a comprehensive, integrated case management service (as outlined at paragraphs 70-74 above), there is also a greater risk of misidentification of a service user's needs when there is one case worker.

148. There may be lessons that the Victorian workforces can learn from the approach taken by the VDDI. The VDDI is a cross-sector initiative which

aims to build the capacity of workforces in the mental health and drug and alcohol sectors to recognise and respond effectively to people experiencing concurrent mental health and substance use disorders. This long-term initiative has embedded knowledge and skill across the two workforces around assessment and case management.

149. Moving towards a similar initiative in response to family violence would require workforce development to a far greater extent, covering a larger cross section of workers and sectors.

6. Strong leadership and governance

150. Within the bureaucracy, Victoria has a strong tradition of devolved governance. Under the *Public Administration Act 2004* (Vic) and *Financial Management Act 1994* (Vic), Departmental secretaries are accountable for the operations of their Departments and statutory agencies within their portfolio of responsibilities.

151. The Victorian Secretaries Board and interdepartmental committees provide institutional vehicles for collaborative governance of cross-cutting responsibilities.

152. At a regional level, Regional Management Forums, each chaired by a Departmental Secretary or Deputy Secretary, were established in 2005 to facilitate engagement with local government and community leaders. There are now 10 Regional Management Forums.

153. The types of governance mechanisms that Mr Eccles describes in his witness statement are designed to:

    153.1 drive leadership on policy, system and service design through mechanisms at Ministerial and senior public service levels;

    153.2 foster partnerships through collaboration across government and non-government sectors, providing input on system design and leading cultural and practice design;

153.3 coordinate and integrate multiple portfolios to ensure coherence and drive improvement;

153.4 create partnerships at a local level to coordinate service delivery and identify specific priorities for joint action; and

153.5 support system improvement through performance monitoring and oversight mechanisms, such as the development of family violence-related performance measures and the creation of formal analytics functions.

154. A number of family violence stakeholders have given evidence to the Royal Commission that place-based and state-wide structures for engagement across the sector would benefit from revitalisation.

155. The Department operates through 17 local areas for community services and eight regional catchments for health. **Attachment KP-3** provides a description of the relevant regional catchment boundaries.

156. Further detail on existing regional partnerships which aim to improve services for family violence victims and perpetrators is also provided at **Attachment KP-4**.

157. Following on from the independent Regional Economic Development and Services Review, there is an opportunity to revitalise the way in which regional strategic planning is undertaken.

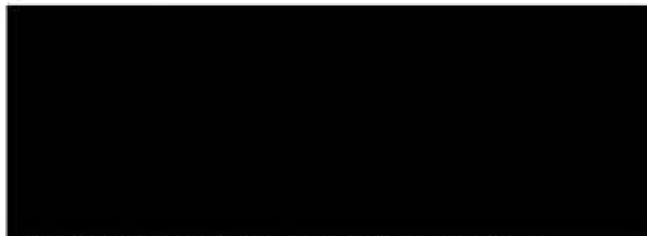
158. Cascading from this, and as part of the implementation of broader service delivery reform, local area governance mechanisms will have a critical role to play. In addition to involving state agencies, local government, and key local service delivery agencies, Commonwealth Government representation would work to ensure all opportunities to identify and better respond to family violence would be maximised.

159. The Family Violence Initiative, led by the Public Health Agency of Canada, is an example of a collaborative platform which supports

collective action and data collection and research about family violence. Its approach is consistent with the directions outlined in this statement.

160. Strong governance arrangements will ensure different governments and organisations are enabled to play their roles individually and collectively.

Signed by)
Kym Lee-Anne Peake)
at Melbourne)
this 14th day of October 2015)



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